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:

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

Submission Requirements:

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

- The deadline for completing this narrative return is **19 May 2026.**
- Please submit this return to both: england.bettercarefundteam@nhs.net and your regional better care manager(s).

Submission details

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

Adapt as necessary	**HWB area 1**	**HWB area 2**
HWB	**Oxfordshire**	**N/A**
ICB	**Thames Valley**	**N/A**
ICB	**Bath, North-East Somerset, Swindon and Wiltshire**	**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:

Priorities for 26/7

Oxfordshire's 25/6 plan focused on reducing non-elective admissions to support system flow. We achieved a 3% reduction in NELs against a zero-growth target, while also reducing conveyances to ED by 4%. However, we saw an increase in delay bed day consumption and our previously improving trajectory for discharge delays has slowed. In 26/7 we will further improve our ability to divert and prevent admissions, particularly for people with complex needs and/or frailty, and also retain discharge capacity but improve discharge processes, and improve outcomes to independence in the community. Ultimately, we aim to ensure that we can support people to stay at home and living independently for as long as possible. This approach is aligned with our local strategy – *The Oxfordshire Way* – and national guidance, including the NHS strategic commissioning and neighbourhood health frameworks.

Integration

Partners across health, social care and the voluntary sector in Oxfordshire work together to design and deliver services which prevent health crisis, reduce conveyances and hospital admissions and support more efficient discharge. We continue to fund several cross system 'integrator' posts, including our system UEC lead, Transfer of Care and Home First leads and joint commissioning and data analytical resource. These posts are also key in developing Oxfordshire's approach to delivering neighbourhood health and care.

Home First, Discharge and Intermediate Care

We will further develop our established 'Home First' approach by 'right-sizing' our capacity to respond more effectively and efficiently to system and user demand. We have sufficient capacity through our care market, with over 130 providers on our Live Well at Home Framework, which enables continued delivery of reablement. However growing discharge demand in 25/6 meant demand exceeded Home First staffing capacity which led to D2A assessment delays. With the improvements in NEL performance discharge demand has since stabilised, meaning this year we have increased Home First MDT staffing capacity aligned to system need. We have also reviewed our bedded intermediate care capacity and funded 10 additional Short Stay Hub Beds in Pathway 2 to address the needs of more complex and frail patients who were previously supported through enhanced care packages via D2A. A review of outcomes for this cohort showed 40% were admitted to care homes – this has since lowered since we reviewed bedded capacity. We are committed to achieving high outcomes to independence following reablement and maintaining low rates of permanent admissions to care homes.

Prevention: supporting people in their own homes in their own communities

Admission avoidance

We will further develop our admission avoidance capability through continued funding for urgent community response, including community same day emergency care, hospital @ home (adults and children's), community therapy and specialist mental health and support. We will also increase our capability to coordinate and direct these resources via Single Point of Access – our front door for urgent community support, used by GPs, ambulance crews, care homes and hospital teams - and ambulance call (999/111) stack expansion – additional clinical decision support for ambulance staff to avoid unnecessary trips to A&E. Since it was first developed in 24/5, SPA has enabled us to improve coordination of community response to support people in their own homes, prevent the need for conveyance and risk of admission. To complement this, we have also funded the expansion of stack diversion (8am – 8pm), adding additional medical, administrative and visiting capacity support to reduce unnecessary conveyances to ED. Our community equipment and telecare contracts will further support this by helping people stay safe at home (e.g., rapid provision of equipment and alarms/sensors) and reducing avoidable escalation to 999 and ED.

Community capacity, information and support

We have an extensive community information and support offer which enables Oxfordshire residents to access advice, guidance and support to proactively manage their health and wellbeing. Services aligned to this

approach both within and outside the BCF include our Local Area Coordination programme, Community Capacity Grants and falls prevention services. Also, key for 26/7 is developing our approach to measuring the impact of prevention – see response to question 3.

Unpaid Carers

We have continued investment in supporting unpaid carers to enable us to support people in their own homes and communities. This includes projects delivered jointly with health partners such as carer's IDs and passports to support identification of carers. In 26/7 we will be refreshing our system-wide All-Age Unpaid Carers Strategy which will involve input from people we support, carers, and local health and VCSE partners. We are also developing a carer's strain index to enable identification of carers at the highest risk of crisis. This will enable us to respond proactively and prevent carer breakdown and subsequent social admissions to hospital.

Disabled Facilities Grant (DFG)

The County and District Councils work in partnership though occupational therapy and BCF-funded Home Improvement Agencies to deliver DFGs. This includes adaptations such as level access showers, ramps and stairlifts, and working with our community equipment provider to deliver equipment to support people to live independently at home. We have developed joint KPIs to measure funding impact and we are exploring opportunities to use DFG funding more innovatively, such as developing joint plans for shared extra care temporary accommodation to support people while they are waiting for major adaptations on discharge from hospital

Changes in planned spend

As 26/7 is a transition year ahead of BCF reform, the majority of core schemes are being maintained, with targeted additional investment focused on front door diversion, discharge processes and neighbourhood enablement. To reflect the priorities outlined above, key changes in planned spend for 26/7 include:

- Additional investment in urgent response and front door diversion through SPA and expanding stack capability
- Additional funding to develop Integrated Neighbourhood Teams in areas of deprivation, with high and/or complex needs and health inequalities
- Investment in technological infrastructure (OPTICA) to reduce discharge delays relating to process issues
- Home First D2A & reablement budgets include provision for additional staffing and bedded intermediate care capacity
- A small amount of funding has been reallocated from pilot mental health schemes into the Oxfordshire Health and Homelessness Integration team. This reflects our ongoing commitment to supporting some of our most complex people and diverting them away from ED and ensuring that discharge from acute and mental health in-patient beds supports them to more sustainable support in the community
- Support for the development of Neighbourhood Health and Care, including resourcing for coordination, comms, business intelligence, engagement and training

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:

Oxfordshire agreed system trajectories 26/7

Oxfordshire has used a combination of local and national data to set trajectories against BCF core metrics and interrelated local metrics which impact system flow. According to national data, our current performance for NELs and discharge delays remains better than our peer averages. The trajectories for 26/7 are as follows:

Priority area	Performance metric	25/6 target	25/6 actual / position	Agreed system targets	Data underpinning performance
1. Non-elective admissions (NELs)	a) All non-elective admissions aged 65+ (BCF core)	Zero growth vs 24/5	3% reduction vs 24/5	Zero growth compared with 2025/26	System
	b) General Medicine & Geriatric Medicine admissions at OUH (local frailty subset aligned with national target)	Zero growth vs 24/5	2.5% reduction	2% reduction on 2025/26 levels • 4 fewer admissions per week (progression towards 10% reduction by 2029)	System
	c) Conveyances to ED (local stretch)	No formal target	4% reduction	3% reduction on 2025/26 levels • (3 fewer conveyances per day)	System, inc. OH (stack) & SCAS
2. Discharge delays and flow	a) Average delay per discharge (BCF core)	0.6 days	0.74 days	0.6 days	System
	b) % discharged on Discharge Ready Date (BCF core)	88%	86.4%	88%	System
	c) Average delay for those not discharged on DRD (BCF core)	5 days	5.4 days	5 days	System
	d) Length of stay MOFD	Pathway 1: 4.4 days Pathway 2: 3 days Pathway 3: 9 days	Pathway 1: 5 days Pathway 2: 3.9 days Pathway 3: 14.7 days	Pathway 1: 4.4 days Pathway 2: 3 days Pathway 3: 14.7 days (zero growth)	System
	e) MOFD patients per day (OUH) f) MOFD patients per day (OH)	80 per day 15 per day	108 per day 23 per day	80 per day 15 per day	System, inc. OUH, OH
3. Outcomes after discharge	a) % of people in the community 12 weeks after reablement (new BCF metric) - End of life cohort outcomes (national target)	N/A (new metric for 26/7)	Baseline established: 72%	Indicative baseline - 72% • 8% died within 12 weeks – audit ongoing	OCC
4. Long-term care home admissions	a) Admissions to residential and nursing care aged 65+ (BCF core)	760	~800	Zero growth on 2025/26 • (~800 admissions per year)	OCC

5

Non-elective admissions

As in 25/6, we have modelled NEL demand on >65 admissions to General Medicine and Geratology (GMG). NEL bed days currently average at 5.9 days per admission. In 25/6 Oxfordshire outperformed our zero-growth BCF target and achieved a 2.5% reduction in admissions for this cohort. This equated to 284 fewer admissions and a 3.66% reduction in bed days lost compared to 24/5.

The GMG cohort is the frailty cohort for whom systems must achieve a 10% reduction in admissions and bed days by 2029, as stipulated in the NHS Neighbourhood Framework. We have modelled the 10% reduction to 2029 and our 26/7 BCF target is a 2% reduction on 25/6 performance. To deliver this, we must divert 4 additional patients per week against the 2025/6 baseline.

Following expansion of the stack to 12 hours per day Monday – Friday, we have also set a local stretch target to achieve a 3% reduction in all conveyances for people 16+, equating to 3 people diverted per day. The BCF schemes will impact on people above and below 65 and so we will map locally the impact in both groups, and how this impacts people in the GMG frailty cohort. This includes monitoring trends across our acute sites in Banbury and Oxford City and overlaying with our developing neighbourhood geographies and underpinning population analysis.

Delayed discharges

Throughout 25/6 we have maintained high numbers of discharges and overall Length of Stay for GMG emergency admissions remains stable at 8 days. However, we have not been able to control bed day consumption from delayed discharges in line with 25/6 NEL performance. In broad terms we have seen an upwards trajectory for bed days lost to discharge delay across all pathways in 25/6. The average length of delay has increased from 5.6 days in 24/5 to 5.8 days in 25/6, meaning we did not achieve our 5-day 25/6 target.

In 26/7 we will aim to reduce the average length of delay days to our 25/6 target of 5 days. Internal audits for delays in pathways 1 & 3 have identified that delays are driven by process issues, particularly for more complex cases, rather than provider capacity. Schemes such as OPTICA will support improve efficiency of processes. We have also increased staffing in Home First to respond to discharge demand. Progress will be monitored against local targets set for each pathway.

We do not anticipate significant changes to the percentage of people discharged on discharge ready day where predominantly the population in this instance is people on Pathway 0. The system view is that the focus for Oxfordshire needs to continue shifting to front door rather than discharge to maintain flow.

Long-term care home admissions

In 25/6 Oxfordshire has not been able to maintain our downwards trajectory for care home admissions due to increased levels of frailty. At year end we had 800 admissions to care homes against our target of 760. Despite this, admissions to care homes remain broadly stable over the last decade, and Oxfordshire continues to perform well nationally, ranking 41 of 152 local authorities in 25/6.

In 26/7 Oxfordshire will aim for zero-growth on 25/6 figures, equating to 800 admissions across the year.

Of the 40 additional admissions this year, almost a quarter were self-funders who have depleted capital and now quality for LA support. At the point that they hit the metric there are limited opportunities to divert people into community-based support. We have continued to invest in resources to support self-funders, such as our Live Well Oxfordshire directory, and ensure they have the information they need to consider alternatives to residential care. Overall, nursing client numbers continue to be on a downward trajectory and residential client numbers have been falling since December 25 which attests to the reduction in permanent admissions over time.

Improving outcomes from reablement

Oxfordshire has reviewed our reablement outcomes to baseline our performance against this new metric. Over the last 12 months, 1669 people in Oxfordshire were reabled post-discharge and 72% remained in the community after 12 weeks. Of the remaining 28%, the majority were readmitted. 8% of the total number of people who underwent reablement died. We are completing further analysis of this cohort to determine if we can develop more tailored approaches towards people leaving hospital via D2A who are approaching their last months of life. This will involve working closely with palliative community services and aligns with national targets to increase identification and reduce admissions for people who are EoL.

All system trajectories have been endorsed by our cross-system Urgent Care Delivery Group and approved by our Urgent and Emergency Care Board on 23 April 2026. We are committed to continually improving data quality and monitoring via these forums.

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:

Non-elective admissions

Our targets for NELs are informed by the impact achieved in 25/6 following ongoing significant investment in urgent care services and SPA. Our 26/7 plan will build on this achievement to further reduce non elective admissions by 4 per week, saving 1905 additional bed days compared to 25/6, and reduce conveyance to ED by 3 people per day.

- The stack expansion will increase from 4 hour to 12-hour operation from 8am-8pm Monday to Friday. This is informed by local analysis which identified a direct correlation between ED attendance in the evenings and increased emergency admissions, with 4-8pm highlighted as a key pressure point for ambulance arrivals in ED. We have modelled that SPA & stack can divert 3 conveyances per day to progress us towards our 26/7 target. Longer term we may also expand this provision to cover weekends.
- Investment in SPA has enabled us to better utilise and coordinate our resources to prevent admission. While NELs have reduced, there has been 41% increase in community same day emergency care attendances since February last year. We have also seen an increase in referrals to our adults and

children's hospital at home provision and we are on track to reach our upwards trajectory of 450 H@H admissions per month. Following an increase in emergency admissions from care homes, we also introduced an advice line specifically for care home staff and expanded our existing Care Home Support Service. Analysis of South Central Ambulance Service data in September 25 showed Oxfordshire has the lowest conveyance rate for care homes in the South East at 45.9%. Emergency admissions from care homes have also stabilised. We will continue to work with our care home market to further improve this and achieve our target of 4 additional diversions per week.

- We are continuing targeted interventions to avoid admission for specific cohorts of more complex people that are at an increased risk of admission to hospital and/or likely to be more complex to discharge once admitted. This includes children with respiratory conditions, people with learning disabilities, people at risk of falls, people with dementia in care homes and people with complex mental health and/or experiencing homelessness. Impact thus far has been reductions in mental health bed occupancy for older adults, and a reduction in ED attendances for people 65+ who have fallen. However, 40-50% of ED attendances relating to falls are walk-ins rather than conveyances. Developing knowledge about SPA and other community resources, in addition to funded falls prevention services, should reduce this figure.
- Integrated Neighbourhood Teams also impact conversion rate into admission. We have developed INTs in areas of deprivation in Bicester, 2 in Banbury and Blackbird Leys in the City and invested further in 26/7. The combined caseload has been on an upward trajectory, averaging at approximately 700 people per month.

Delayed discharges

The reduction in non-elective admissions should in turn reduce supported discharge demand and enable us to reduce the average discharge delay to 5 days across all pathways. As identified already, we have invested into more Home First MDT staffing to support flow, as well as completing internal audits to understand the reasons for delayed discharges. One of the key drivers for delays in P1 was double handed (DH) care packages. We conducted an audit on DH cases and concluded that prescriptions were proportionate to care needs. We have worked with our provider market to develop our pricing model and ensure providers are incentivised to reduce the length of delay for more complex people in P1 and plan to monitor delays specifically for this cohort. For P3, our care homes framework and banded care rates has already reduced the administrative burden both for the Council and our care home providers, and we have also identified opportunities to further develop our trusted assessment provision to reduce delays at the point of assessment. Our MOFD LoS targets across each pathway are:

- Pathway 1: 4.4 days
- Pathway 2: 3 days (generic community hospital)
- Pathway 3: 14.7 days from point of discharge notice

We have also set targets for daily MOFD patients in the acute and community trusts. For the acute, following an average of 108 patients per day against an 80 per day target in 25/6, we are proposing that the above interventions will achieve the same target – c.8% of the current open bed base. For our community trust, we intend to reduce daily MOFD from an average of 25 people per day to 10. Achievement of this target will be supported through conveyance reduction, as well as investment in technology like OPTICA.

Improving outcomes from reablement

Well-timed, early reablement can reduce the risk of first admission to hospital or the risk of deterioration after discharge and prevent future admissions. Improvement in delays in P1 discharges and reducing assessment timeframes will ensure reablement starts as soon as possible. We will also complete further modelling of readmission rates following reablement to better understand the root causes for delays. As mentioned previously, we anticipate further work is needed with community palliative care teams to develop more tailored approaches to people in their final months of life. 25/6 also saw an increase in community reablement referrals compared to previous years, meaning we are proactively supporting more people to remain independent at home.

BCF also funds our community equipment and telecare provision, both of which support people to remain independent in their homes. Over 25/6 we have also worked with District council colleagues to identify shared

KPIs for DFG funding so that we can monitor impact, reduce inequity in terms of wait times for assessments and installations, and identify opportunities for improvement.

As part of our Prevention Strategy, in 26/7 we are also developing our capability to measure the impact of preventative schemes and services which support independence, reduce social isolation, prevent health decline and enable people to remain in their communities. This work involves mapping existing grants, projects and services at county and neighbourhood level, and working with university, public health and health partners to robustly evaluate impact, overlaps and gaps. This work will feed into the development of Oxfordshire's neighbourhood health and care structure.

Long-term care home admissions

We have a recurring challenge with self-funders entering care homes earlier than may be necessary to meet their care needs. We are developing projects to support self-funders to provide them with the information and advice needed to make informed decisions about their care provision. This includes steering people to other alternative support funded by the BCF, such as Extra Care Housing. We are also undertaking work to further analyse length of stay in care homes to ensure they are used as a last resort.

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:

Oxfordshire's BCF planning process centres on achieving best value for the *Oxfordshire pound,* rather than solely savings made by individual organisations. As a continuation from 25/6, we have aligned the BCF plan with other 'system' funding streams, such as Urgent and Emergency Care funding, to ensure we plan in relation to system context and ensure best value and use of resources. This year we also aligned BCF plan development with Community Growth and Mental Health Investment Standard funding.

We have allocated the additional funding uplift for 26/7 to 5 core schemes – SPA, stack expansion, INTs, OPTICA and Neighbourhood development – all of which closely align to our system trajectories and national targets to increase productivity by 2%. We will improve productivity through digitisation - OPTICA – which will improve our ability to track and monitor tasks relating to discharge in real time. We have also undertaken work to review staffing requirements and ensure we optimise Home First staff time and capacity – see below.

Progress to increase the impact of the *Oxfordshire pound* will be aligned to the development of neighbourhood health and care models. To inform BCF planning for 27/8 the system will review funded contracts and identify opportunities to further transform how we deliver services. We are developing our understanding of the value and impact of preventative services and mapping the interaction of our population across mental health, homelessness and acute care pathways. BCF funds joint schemes with system partners, such as our complex alcohol team funded jointly with Public Health and is directly aligned to spend in other areas such as mental health and City and District homelessness spend.

Our plan includes ongoing investment in Business Intelligence expertise and as a result we have developed a comprehensive UEC sit-rep, collating data from across health and social care, to enable robust monthly monitoring of our performance against our trajectories. Our longer-term ambition is to develop a live dashboard enabling us to monitor performance in real time. In addition, we have developed the capability to monitor the productivity of each of our services – mapping activity and cost against system bed day savings. This enables system oversight of performance, expenditure and impact as well as comparison between commissioned services to ensure value for money. Both resources inform evaluation of system performance and are monitored in both our System Urgent Care Delivery Group and System Urgent and Emergency Care Board.

Ongoing monitoring enables us to proactively review outcomes and continuously improve. Home First D2A was one of our biggest cost drivers in 25/6. We completed in-year analysis the reasons for increasing costs and identified that this was broadly due to mitigation payments to providers resulting from inadequate Home First staffing capacity and high cost enhanced D2A care packages. Analysis of the outcomes of the latter cohort showed a high care home admission rate, which led us to recommission additional bedded intermediate care capacity to deliver improved outcomes in a more cost-effective way. This has released funding to further

support Home First staffing capacity and productivity, and these changes can now be delivered within existing budget envelopes in 26/7. The additional process improvements required to meet our discharge delay targets will also be delivered with minimal additional funding.

Newly funded schemes for 26/7 are developing service specifications with metrics specifically aligned to our system trajectories to enable ongoing monitoring and ensure value for money.

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:

Oxfordshire's BCF plan is developed by a system-wide BCF Oversight Group which is attended by operational, clinical and commissioning leads together with the voluntary and community sector. Organisations represented include:

- Oxford University Hospital NHS FT
- Oxford Health NHS FT (Community and Mental Health)
- Oxford City Council (Homelessness and Home Improvement Agency)
- West Oxfordshire, South & Vale and Cherwell District Councils (Home Improvement Agency)
- Oxfordshire County Council (Public Health, Adult Social Care);
- OCC/ICB integrated commissioning team;
- Oxfordshire Association of Care Providers;
- Age UK;
- Healthwatch

To meet the requirements of National Condition 1, this group will continue to meet regularly to review expenditure and progress of the 26/7 plan against our system trajectories. The data to inform this will be collected through quarterly returns from each of the BCF scheme leads. Schemes that received new or significantly increased investment in 26/7, such as STACK diversion and SPA, will develop service specifications and targets aligned to the system and BCF trajectories. This will enable us to closely monitor impact and spend. More broadly, this group will also capture and share lessons learned and adjust spending plans over time. In Q1, we will also work with the ICB to review block contracts that the BCF contributes to and increase visibility of the Oxfordshire funding landscape. This insight will inform planning for 27/8.

The BCF Oversight group reports into several other system-wide forums and will continue to do so throughout 26/7. The decision-making process and responsibilities in Oxfordshire are as follows:

Role in BCF planning	Responsibility
System endorsement of BCF Plan – including guidance around narrative and strategic direction and alignment with Oxfordshire priorities	Place Based Partnership
New for 26/7 - Assurance that the BCF Plan is developed in alignment with Oxfordshire's approach to Neighbourhoods, and reflect the national ambition for BCF funding streams to be used to progress this approach	Primary & Community Care Board

Alignment of BCF investment and system Urgent and Emergency Care (UEC) Funding, and setting robust, system-owned targets and trajectories that deliver the BCF metrics in relation to hospital avoidance and discharge, and is responsible for coordinating course correction should performance against the trajectories go off track	Urgent and Emergency Care Board
Approval of investment and expenditure plans, and assurance to Council, Cabinet and ICB Board for the wider BCF Plan - Including variations and in-year allocations	ICB/OCC Joint Commissioning Executive (JCE)
Final sign off for 26/7 BCF Plan	a) Chief Executive and s151 Officer for the Council b) Chief Executive TV ICB c) Chief Executive NHS Bath, North-East Somerset, Swindon and Wiltshire Integrated Care Board d) Chair, Oxfordshire Health & Wellbeing Board

The BCF Oversight Group reports to all of the above groups. The responsibility for the delivery of this plan similarly will be governed by these bodies with Joint Commissioning Executive retaining the responsibility to report to HWB.