READING HEALTH AND WELLBEING BOARD

Date of Meeting	18 March 2026
Title	BCF Integration Update
Purpose of the report	To note the report for information
Report author	Beverley Nicholson
Job title	Integration Programme Manager
Organisation	RBC – Adult Social Care / BOB Integrated Care Board
Recommendations	1. That the performance against BCF Metrics for 2025/26 is noted as at Quarter 3. 2. That the Board note the BCF 2025/26 Quarterly Returns for Quarters 1, 2 and 3 were submitted by due dates following the Delegated Authority procedure. 3. That the Board note that the Reading BCF 2025/26 arrangements remain compliant with the Four National Conditions, and that the Section 75 Deed of Variation for 2025/26 was signed and sealed on 8 October 2025. 4. That the Board note progress updates related to the Community Wellness Outreach project and the South East Neighbourhood Accelerator Programme.

1. Executive Summary

1.1 The purpose of this report is to provide a highlight update on the Integration Programme and performance of Reading against the national Better Care Fund (BCF) targets 2025/26, and an update on the Community Wellness Outreach programme of health checks and wellbeing support, and the South East Neighbourhood Accelerator programme in Whitley and Church Wards.

1.2 We are compliant with the BCF National Conditions, and the metrics were agreed with system partners during the BCF Planning process for 2025/26. We received confirmation of acceptance of our BCF plan from the National Better Care Fund team on 30th May 2025. We are on track to meet two of the three metrics, in relation to emergency hospital admissions and the number of people admitted into care homes to meet their long term care needs. We are not on track to meet the new hospital discharge targets but have improved performance compared to 2024/25 as a result of process changes to triage, introduction of a hospital to home service, and continued support through our dedicated hospital discharge team.

1.3 The Community Wellness Outreach programme has delivered over 4,400 health checks and wellbeing reviews, identifying risks early to prevent progression to cardiovascular disease. Of those seen, 78% were from priority cohorts. We had a 43% response rate to

our questions about awareness of risks, and 95% of those responding, reported improved understanding of health risks and how to make healthier choices.

1.5 The South East Accelerator programme for Neighbourhood Working is progressing well, focused on a cohort of people who live alone in Whitley and Church Wards, who have an enhanced care plan. The team is multi-disciplinary and have mapped out the initial approach to segmentation of our cohort to identify a core group who would benefit from a concentrated holistic review of their needs. Learning from the accelerator programme is being shared with the Neighbourhood Steering Group to inform the development of Neighbourhood Teams across Reading.

2. Policy Context

2.1. The Better Care Fund Policy Framework 2025/26[1] sets out the principles for the pooling of funds to support integrated working across health and social care, to ensure the right care is available to people at the right time. The Reading Integration Board (RIB) is responsible for leading and overseeing system working with Local Authority Adult Social Care and Housing, Acute and Community health providers, Primary Care, Integrated Care Board (ICB) Commissioners, Voluntary Community and Social Enterprise (VCSE) sector partners and Healthwatch, across Reading. The aim of the board is to enable partners and other interested stakeholders to agree and deliver a programme of work that promotes integrated working to achieve the national Better Care Fund (BCF) performance targets and objectives and align with the Council Plan, and Place based objectives.

3. Performance Update for Better Care Fund and the Integration Programme

3.1. BCF Performance as at the end of Quarter 3, 2025/26

An overview of the BCF targets and performance compared to the previous period are shown in this table:

BCF Performance Highlight

BCF Metric	Target	Actual *(Adj. due to pop changes 65+)*	Last Mnth - Trend
4.1 Emergency admissions to hospital for people aged 65+ per 100,000 population	No more than 18,226 per annum	12,539 (Cumulative data, Dec), Current projection to end of year 16,718	G Stable
4.1.1 The number of avoidable admissions (unplanned hospitalisation for chronic ambulatory care) per 100,000 population	No more than 753 per annum	375 (Cumulative data, Dec), Current projection to end of year 500.	G Stable
4.1.2 The number of emergency hospital admissions due to falls in people aged 65 and over, per 100,000 population.	No more than 1,601 per annum	892 (Cumulative data, Dec), Current projection to end of year 1,189	G Stable
4.2 Proportion of adult patients discharged from acute hospitals on their discharge ready date. (DRD)	No less than 79.9% (ave. per annum)	70.4% (Dec data), Current projection to end of year 72.8%	A Worse
4.2.1 Average length of delay for adult patients not discharged on their DRD (Per 100,000 pop)	Average delay no more than 3.2 days (ave. quarter 3)	4.14 days (Dec data), Current projection to end of year 4.14 days	R Improved by 1 day
4.3 The number of older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population	No more than 880 per annum	487 (Cumulative data, Dec), current projection to end of year 650	G Stable
4.3.1 The proportion of people discharged home using data on discharge to their usual place of residence	Not less than 92.2% (ave. per annum)	93.1% (Dec data), Current projection to end of year 91.6%.	A Improved
4.3.2 The proportion of people who received reablement during the year, where no further request was made for ongoing support *(ASCOF 2a)*	No target set - monitored	86.1%% (December data), current projection to end of year 92.2%	Worse

[1] https://www.england.nhs.uk/long-read/better-care-fund-planning-requirements-2025-26/

Operational services have reported that often delays are caused as a result of awaiting equipment, court of protection processes and family expectations about ongoing care. Whilst we are not on track to meet the hospital discharge metrics this table shows the improvements in performance compared to the previous year:

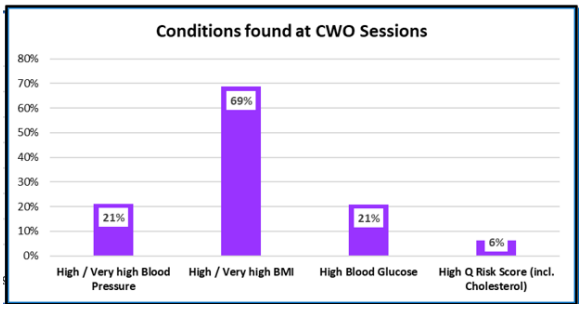
Comparison 2024/25 to 2025/26			
Pathway 0 *(1 day)*	**2024/25 Average**	**2025/26 Average**	**Change**
Reading	2.4	1.8	▼
Pathway 1 *(2 Days)*			
Reading CRT	2.1	2.1	⟷
Reading POC	6.7	4.8	▼
Reading P1 Average	**3.6**	**3.1**	▼
Pathway 2 *(2 days)*			
Reading	2.7	2.7	⟷
Pathway 3 *(6.5 days)*			
Reading	18.8	13.3	▼

3.2 Community Wellness Outreach

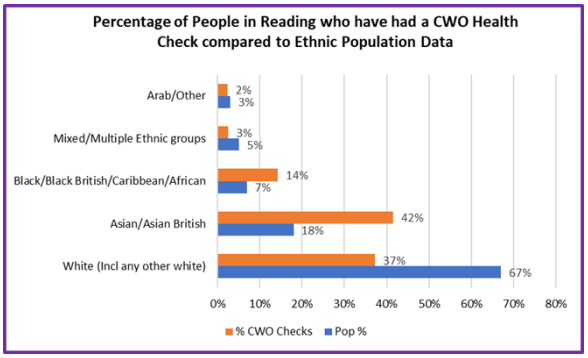
There have been 4,416 checks (as at end of Jan 2026), which represents 51% of the adjusted target (8667 to 30/06/26). 95% of respondents agreed that they have a better understanding of CVD risk and how to reduce the risk, after talking with the Nurses at the check.

Since April 2025, 76% of appointments have been booked through the website https://rva.org.uk/community-wellness-outreach/ and 26% were drop-ins, which clearly demonstrates the need for a drop-in option for this service.

Conditions identified during the checks to date: 69% very high/high body mass index (BMI), 21% very high/high blood pressure, 21% with high blood glucose levels (a pre-indicator of diabetes) and 6% high Q-risk score, indicating potential high cholesterol and higher cardiovascular risk factors.



The team have maintained the reach to ethnically diverse groups, with 61% of people attending being from ethnically diverse backgrounds, 56% from Asian/Black background, who have a higher risk of developing cardiovascular disease and diabetes.

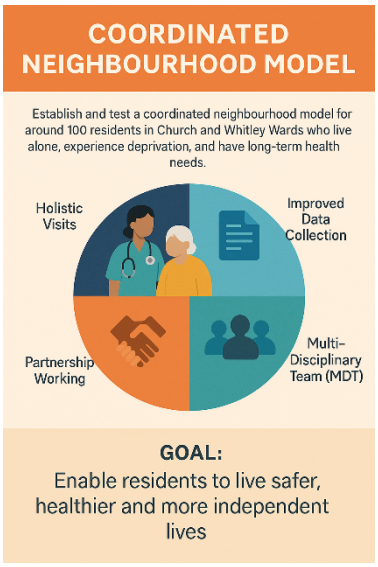


The age range was widened for these community-based checks and 5% of people seen were above 75 yrs and 36% were below 40 years of age. These checks have enabled early intervention to prevent development of heart disease and diabetes and improve overall wellbeing.

Filming was arranged with BBC South Today and That's TV, organised by the RBC Media and Communications Manager. TV clip broadcast 27 January (watch here) and article published 1 February (read here). Both highlighted the impact on an individual who had previously provided an individual case study, and highlighted the impact of this scheme, and the recently opened space in the Broad Street Mall, currently available until third week of April. A case study from the programme is included in section 4 of this report.

3.3 **South East Neighbourhood Accelerator Programme**

Using data collated via the Thames Valley Shared Care Record *(also referred to as Connected Care)* using a risk stratification approach, we have identified a "rising risk" group of people who are living alone, in Whitley and Church Wards, two of the most deprived areas in Reading, have higher instances of hospital admissions, A&E attendances and 111/GP interaction, as well as admissions into long term care. We know that this cohort are at greater risk of isolation, poorer health and wellbeing outcomes and unmet care needs because they live alone. This makes the approach of providing proactive, joined-up support essential to maintain wellbeing, independence and social connection.



By April 2027, we aim to ensure that people living alone with anticipatory care plans, in Church and Whitley Wards in Reading, feel supported and connected through a co-produced neighbourhood model. Through resident engagement it is clear that having a "trusted point of contact" is an important factor to aid us in improving timely access to health and wellbeing services. This improvement will primarily be monitored through an increase in the Patient Activation Measure (PAM) Scores, using two questions to identify current level of need.

Q1: How confident are you managing your health? (Scale of 1 to 4)

Q2: How good or bad is your health today? (Scale of 0 to 100)

4. Contribution to Reading's Health and Wellbeing Strategic Aims

4.1. The Health and Wellbeing Board has reviewed the priorities that had originally been set out in the Berkshire West Joint Health & Wellbeing Strategy 2021-30. .

The priorities that our local neighbourhoods will focus on are:

a) Reducing risk of cardiovascular disease
b) Reducing poor health outcomes due to respiratory conditions
c) Improving Mental Health
d) Reducing frailty

4.2. The programme of work being delivered through the Reading Integration Board (RIB) covers a wide range of schemes and grant funding to community services that are aligned with these adjusted priorities, alongside schemes such as 'Dying Well' to create compassionate communities supporting people and their families at end of life, the development of our Falls Team and the Community Wellness Outreach project to enable early intervention to reduce risks of cardiovascular disease. Here are three case studies *(names changed to protect anonymity)* that demonstrate the impact of these community based schemes:

Case study 1 (ACRE Men to Men project)
Ahmed, a 32-year-old migrant from Guinea, had been experiencing depression linked to unemployment and cultural adjustment challenges. He often felt isolated due to language barriers and the stigma around mental health in his community. When introduced to *Men2Men Talk*, Ahmed was relieved to find a culturally sensitive space where discussions could happen openly without judgement. The session helped him in recognising signs of depression, accessing local NHS Talking Therapies, and peer-to-peer encouragement. Over time, Ahmed grew confident enough to speak with a mental health practitioner, something he had resisted for years. He has since started part-time work, encouraging others from his community to attend.

Case study 2 (Reading Gateway Church - Parish Nursing)
A young man came to our attention through a referral from Readifood. He had been experiencing prolonged emotional and physical abuse and was living in unsafe conditions. Initially, building trust was essential, and our team worked patiently to establish a supportive relationship. Recognizing the safeguarding concerns, we made an immediate referral and initiated close collaboration with multiple agencies both statutory services and charitable organizations. This multi-agency approach ensured that he received comprehensive support tailored to his needs.

Outcomes and Impact: Within a matter of months, the young man's life was transformed:

- Housing Stability: Successfully rehoused in an HMO with the support of a dedicated key worker
- Financial Security: Began claiming benefits, reducing financial stress and vulnerability.
- Access to Resources: Started attending our Church Pantry, ensuring access to nutritious food
- Skill Development: Enrolled in the Food Coach course, learning practical life skills and healthy eating habits
- Emotional Well-being: Through consistent listening, trust-building, and encouragement, he regained self-esteem and a sense of self-worth.

Holistic Impact: This case demonstrates the power of Parish Nursing to act as a bridge connecting individuals to essential services while providing compassionate, faith-rooted care. By listening, advocating, and working collaboratively, we helped this person move from crisis to stability, fostering independence and hope for the future.

Case study 3 Community Wellness Outreach
A carer who had to return home to Reading to look after her mother, who had become ill with a serious condition, was able to approach a carers group at the Atrium. They were also able to meet the RBC carers lead and have a health check with the CWO team. They found their newfound circumstances and the various avenues of information overwhelming and were given information about the carers partnership, carers rights, pathway into Adult Social Care and Social Prescribing. They will be supported with time and consideration of their needs in order to receive the support that is right for them to navigate this monumental change in personal circumstances to be a Carer.

5. Environmental and Climate Implications

5.1. The Council declared a Climate Emergency at its meeting on 26 February 2019 (Minute 48 refers).

5.2. No new services are being proposed or implemented that would negatively impact the climate or environment, however, climate implications are being considered in relation to the wider context of the Health and Wellbeing Board Strategic Priority Action Plans, and the potential impact on avoidable admissions, particularly those related to respiratory conditions and we work with our Public Health colleagues to provide information to the public and our system partners to raise awareness of climate impact.

6. Community Engagement

6.1. Engagement in relation to specific services takes place, such as feedback on customer satisfaction for services such as Reablement. Stakeholder engagement continues to be a key factor in effective integrated models of care, and engagement with all system partners is important to the Reading Integration Board. The Service User feedback forms submitted by people using the Community Reablement Team, indicate 98% satisfaction rates with the service. We have also held co-production sessions with Carers to support us in shaping a Carer's breaks and respite service, funded through the Accelerating Reform Fund, and feedback from people engaged has been very positive. A Carers' lead joined the Council in March 2025 and is leading on the delivery of our Carers' Strategy and action plan.

1.1. Reading Adult Social Care have a co-production lead who has set up a Working Together Group of service users, carers and self-funders. This is helping to ensure that services are co-designed with service users, carers and families as much as possible, and feedback on user experiences will be gathered.

7. Equality Implications

7.1. Under the Equality Act 2010, Section 149, a public authority must, in the exercise of its functions, have due regard to the need to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

7.2. There are no new proposals or services recommended in this report that would impact negatively on anyone with protected characteristics. We continue to monitor equality data to ensure people are not adversely affected.

8. Other Relevant Considerations

8.1. The BCF Planning Requirements for 2025/26[2] have introduced some changes to the National Conditions and the Objectives for 2025/26:

National Condition 1: Plans to be jointly agreed
National Condition 2: Implementing the objectives of the Better Care Fund
National Condition 3: Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care
National Condition 4: Complying with oversight and support processes

BCF Objective 1: Support the shift from sickness to prevention

[2] https://www.england.nhs.uk/long-read/better-care-fund-planning-requirements-2025-26/

BCF Objective 2: Support people living independently and the shift from hospital to home

8.2. Confirmation of acceptance of the Reading BCF 2025/26 Plan was received on 2nd June 2025.

9. Legal Implications

9.1. Compliance with the Better Care Fund (BCF) 2025/26 National Conditions has been confirmed in the BCF quarterly returns.

9.2. The Section 75 Framework Agreement for 2025/26 was signed by both Reading Borough Council and the BOB Integrated Care Board, and sealed on 8th October in accordance with the governance arrangements agreed by the Health and Wellbeing Board.

10. Financial Implications

10.1 BCF Quarterly Returns were submitted by the due dates following a briefing to the Lead Councillor for Health and Wellbeing and the Director of Adult Social Care through the delegated authority procedure. The returns demonstrated our compliance with the four national conditions and progress against the metrics and expenditure,

As the BCF provides a contribution towards Adult Social Care costs and locally commissioned community based services, the reported position at Quarter 3 was that 75% of the £21,177,782 budget had been spent. Following month end adjustments, the final position at the end of quarter 3, reported to the Reading Integration Board was £17,389.008, 82%, with a small underspend which has yet to be allocated through discussion and agreement in line with the Section 75 Framework Agreement.

RIB Summary Report 2025/26 @P10	Original Budget £	YTD Budget as at 31/12/25 £k	YTD as at 31/12/25 (Actuals) £k	Forecast to 31/03/26 £k	Variance £
Reading Borough Council Hosted Schemes	13,384,921	10,894,958	10,722,115	13,384,921	-56,266
BOB Integrated Care Board	1,551,064	1,292,553	1,292,553	1,551,064	0
Cross BOB ICB Hosted Schemes	3,558,062	2,965,051	2,965,051	3,558,062	0
Hospital Dischrage Funding	1,505,300	1,254,417	1,254,417	1,505,300	0
24/25 Under spend	1,178,435	982,029	982,029	1,178,435	0
Total	**21,177,781**	**17,389,008**	**17,216,164**	**21,177,781**	**-56,266**

10.2 Funding allocated by BOB Integrated Care Board, from the Inequalities Fund to deliver the Community Wellness Outreach pilot project has been spent in line with the plan, and included within the Section 75 Framework Agreement.

11. Timetable for BCF Submissions

11.1. The schedule for the quarterly BCF reporting:

Quarter	Template available to HWB areas	Signed off HWB submission date
Quarter 1	16 June 2025	15 August 2025
Quarter 2	29 September 2025	10 November 2025
Quarter 3	15 December 2025	30 January 2026
End of Year	12 March 2026	29 May 2026

All templates will be available on the Better Care Exchange

HWB submissions once signed off must be emailed to the national Better Care Fund team england.bettercarefundteam@nhs.net and to the regional Better Care Manager by noon on the submission date.

11.2 The BCF Planning Guidance for 2026/27[3] was released in February 2026, and plans will be developed in consultation through the Integration Board and through workshops with key stakeholders. The submission date for the 2026/27 plans is 19th May 2026.

Background Papers

The BCF performance data included in this report is drawn from the Reading Integration Board Dashboard – January 2026 *(Reporting up to 31st December 2025).*

Appendices

None

[3] https://www.gov.uk/government/publications/better-care-fund-framework-2026-to-2027