READING HEALTH AND WELLBEING BOARD

Date of Meeting	16 July 2026
Title	Integration Update Report
Purpose of the report	To note the report for information
Report author	Beverley Nicholson
Job title	Integration Programme Manager
Organisation	Reading Borough Council, DCASC/Thames Valley Integrated Care Board
Recommendations	1. That the board note the content of the submitted BCF Plan and Narrative for 2026/27 – submitted by due date 19/05/2026 2. That the board note the content of the submitted BCF End of Year Report for 2025/26 – submitted by due date 05/06/2026 3. That the board note performance against BCF Metrics 4. That the board note updates on the South East Neighbourhood Accelerator programme and the closure of the Community Wellness Outreach 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, for our submission of the 2026/27 BCF Plan and Narrative, and the metrics were agreed with system partners during the BCF Planning process. Plans will be scrutinised by the National BCF team and we expect a response by 31st July confirming acceptance of our BCF plan. Section 75 Framework Agreements will need to be in place by 30th September.

1.3 For 2025/26 we met two of the three core BCF metrics:

- emergency hospital admissions. 9% below maximum target **(Met)**
- number of people admitted into care homes to meet their long term care need, 18% below maximum target **(Met)**
- hospital discharges on same day as discharge ready date (DRD) 9% below minimum target and average length of delay for those not discharged on DRD, 4.16 days (End of year average) 15% above maximum target at year end **(Not Met)**

1.4 The 2026/27 BCF plan has identified funding to support neighbourhood working, and set metrics based on actual performance in 2025/26, recognising the productivity improvements requested in the BCF planning guidance and the neighbourhood planning framework. The Reading Integration Board (RIB) has agreed that support for development

of Neighbourhood working will be a key priority for 2026/27; this is reflected in an updated Terms of Reference and establishment of a Neighbourhood Working sub-group involving all system partners.

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 with multiple long term conditions. The team is multi-disciplinary and have mapped out the initial approach to segmentation of our cohort and identified 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 Integrated Neighbourhood Teams across Reading, and feeding into the wider frailty work and neighbourhood plans.

1.5 The Community Wellness Outreach programme has delivered over 5,200 health checks and wellbeing reviews, identifying risks early to prevent progression to cardiovascular disease. 77% of people seen were from priority cohorts and the Executive Summary of the Berkshire West CWO evaluation (*see Appendix 4)* reports that evidence of behaviour change is promising: 75% reported making a lifestyle change, and 97% of those believed it would be maintained for 2 years. The programme has now come to an end and the Prevention Board are working together to agree future interventions to address inequalities of health and wellbeing outcomes for our residents, which will be informed by the CWO evaluation report and population health data.

2. Policy Context

2.1. The Better Care Fund Policy Framework 2026/27[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 representation from 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, Strategic Health and Wellbeing and ICB Place based priorities, including Neighbourhood Working.

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

3.1. BCF Performance as at the end of year 2025/26

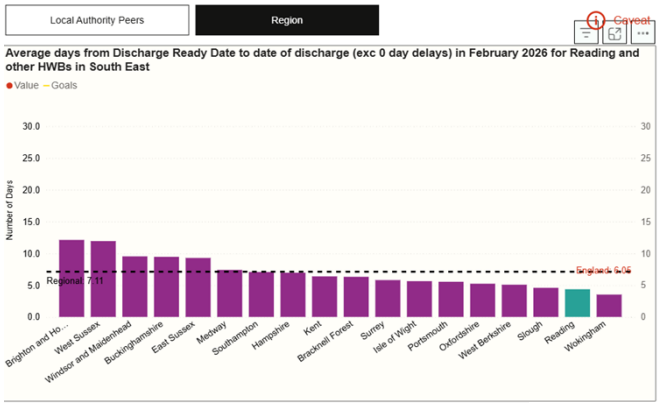
An overview of the BCF targets and performance compared to the previous period are shown in this table:

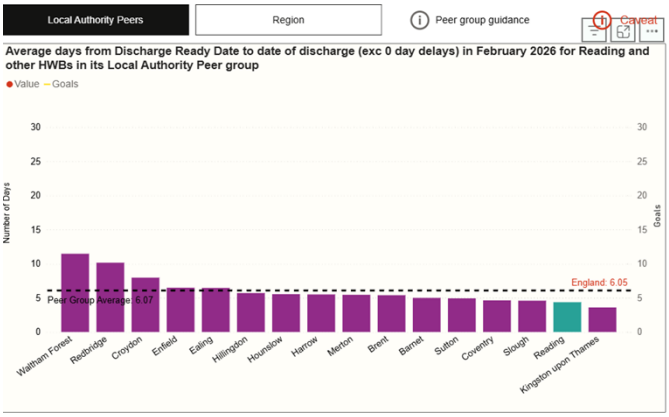
[1] https://www.gov.uk/government/publications/better-care-fund-framework-2026-to-2027/better-care-fund-framework-2026-to-2027

BCF Metric	Target	Actual	Last Mnth - Trend
4.1 Emergency admissions to hospital for people aged 65+ per 100,000 population	No more than 18,226 per annum	16,570 (Cumulative data, Mar) **9% below maximum target at year end.**	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	488 (Cumulative data, Mar), **35% below maximum target at year end.**	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	1,125 (Cumulative data, Mar) **30% below maximum target at year end.**	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)	72.5% (End of year average) **9% below minimum target at year end.**	R Improved
4.2.1 Average length of delay for adult patients not discharged on their DRD (Per 100,000 pop)	Average delay no more than 3.6 days (ave. quarter 4)	4.16 days (End of year average) **15% above maximum target at year end.**	R Improved
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	722 (Cumulative data, Mar) **18% below maximum target at year end.**	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)	91.6% (End of year average) **0.05% below minimum target at year end.**	G Worse
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	93.4% (End of year average).	Worse

Operational services have reported that often delays are caused in complex cases as a result of family expectations about ongoing care, court of protection cases *(as Courts do not prioritise these because the person whilst in hospital, is deemed to be in a place of safety)*, and access to specialist equipment e.g., bariatric. The discharge teams also report delays due to hospital transport risk assessments and medications on discharge. The "home first" approach is the main aim of the discharge hub and daily sit-rep reviews are undertaken to support discharge planning.

Although we have not met the minimum targets for discharge and average days delayed, the DH Exchange dashboard, which compares performance across regions and with peer local authority areas, shows that in February *(latest data available)* Reading performed better than the England average and better *(lower is better)* than the majority of local authorities in the South East Region and Peer Group.





3.2. **BCF Plan and Narrative for 2026/27**

The Better Care Fund 2026/27 Narrative Return sets out how Reading will use pooled investment between Reading Borough Council and Thames Valley ICB to support integrated, preventative and neighbourhood-based care. It focuses on reducing avoidable hospital admissions, improving discharge and reablement, and preventing unnecessary long-term care admissions through a strong "home first" approach. The return also highlights, performance oversight and value-for-money arrangements to ensure investment is targeted effectively and supports continuous improvement.

Reading's Better Care Fund 2026/27 plan sets out a balanced pooled budget of £21.37m, with income and expenditure aligned. The plan confirms compliance with the core Better Care Fund requirements, including maintaining the NHS minimum contribution, pooling funding through Section 75 arrangements, and operating through established joint governance. Planned investment is focused on integrated and preventative care, particularly hospital discharge, reablement, home-based support, carers' services, technology-enabled care and wider system integration.

For 2025/26, the BCF metrics reflect a 5% reduction target for emergency admissions against actuals, as a result of successful performance against this target in 2025/26. Discharge-related targets for discharge, discharge-ready date and length of wait are being retained at the same level as 2025/26 because, although improvements were made, the target was not met, and in some areas where actual performance exceeded plan, targets have been adjusted to align with 2025/26 actuals so as not to show a worse position this year. A 4% overall reduction target has been set for long-term admissions to care homes, following achievement of an 18% reduction against the 2025/26 targets. The proposed target for 2026/27 is informed by a 12-month rolling average methodology (Client Level Dataset). We have limited historical CLD data, and therefore believe this target represents an optimistic but achievable stretch; neighbourhood planning framework aspirations were for a 10% reduction in core admissions activity over two years.

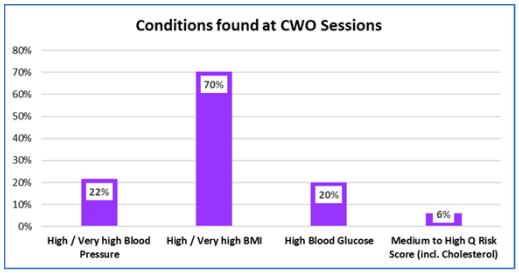
The underspend from 2025/26, £844,5k is being carried forward, some of which (£70.9k) is from Disabled Facilities Grant and sits within housing services, and the majority (£527.4k) continues to be applied to ongoing Integration Board projects and neighbourhood working development. There are some new schemes added to the plan (£246.2) funded from these reserves, which are outlined in section 10 of this report.

3.3. **Community Wellness Outreach**

The evaluation of the Community Wellness Outreach project shows that bringing NHS Health Checks and wellbeing support directly into our communities has made a real difference. Participants reported improved health, early identification of conditions, and greater confidence in managing their wellbeing. Reading Borough Council is proud to support initiatives that empower residents and reduce health inequalities

There have been 5,203 checks completed as at the end of the programme in Reading, which represents 60% of the adjusted target (8667 to 30/06/26). 88% 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, 75% of appointments were booked through the website https://rva.org.uk/community-wellness-outreach/ and 25% were drop-ins, which clearly demonstrated the need for a drop-in option for this service.

Conditions identified during the checks to date: 70% very high/high body mass index (BMI), 22% very high/high blood pressure, indicator of hypertension, 20% with high blood glucose levels (a pre-indicator of diabetes) and 6% medium to high Q-risk score, indicating potential high cholesterol and higher cardiovascular risk factors.



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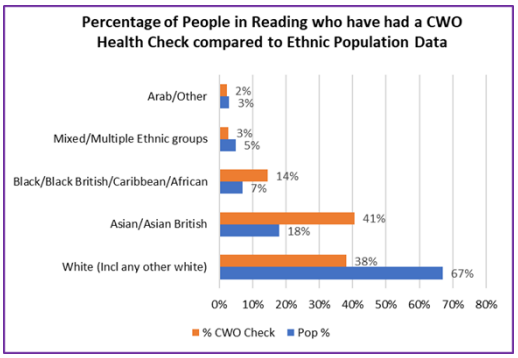
The team have maintained the reach to ethnically diverse groups, with 64% of people attending being from ethnically diverse backgrounds, 56% from Asian/Black background, who have a higher risk of developing cardiovascular disease and diabetes.



The age range was widened for these community-based checks and 2% of people seen were above 75 yrs and 31% were below 40 years of age. These checks have enabled early intervention to prevent development of heart disease and diabetes and improve overall wellbeing. A case study from the programme is included in section 4 of this report.

3.3 South East Neighbourhood Accelerator Programme

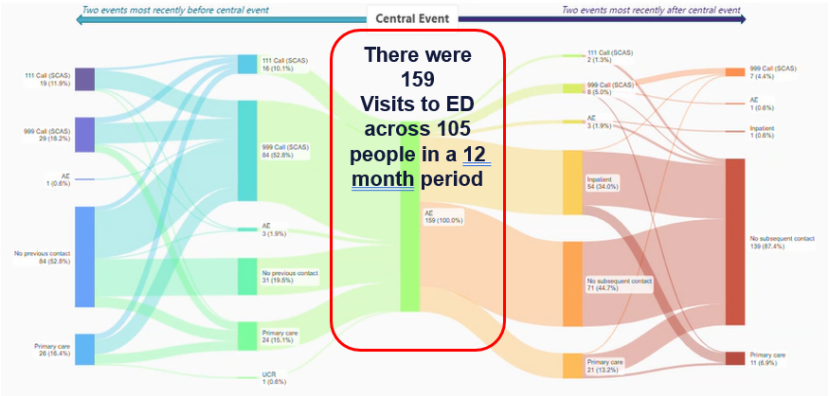
The cohort selected for the accelerator programme was a based on stratification of data from Connected Care (Thames Valley Shared Care Record) to identify a “rising risk” group of people who are living alone, in Whitley and Church Wards. These wards were selected because they were two of the most deprived areas in Reading, where there were higher instances of hospital admissions, A&E attendances and 111/GP interaction, as well as admissions into long term care.

The Problem

High emergency use: Frequent GP, 111 and 999 contacts escalating to A&E attendance for 100% of our cohort

Outcomes: Over 87% required no significant follow-up care

Preventable demand: better-aligned support could have avoided escalations.



“Why did this cohort of people living alone in Whitley and Church Wards, who already have an Anticipatory Care Plan in place, end up at A&E?”

We also know that this cohort, due to living alone, are at greater risk of isolation, poorer health and wellbeing outcomes and unmet care needs. This makes the approach of providing proactive, joined-up support essential to maintain wellbeing, independence and social connection.

Due to data sharing challenges, the two GPs where the largest proportion of our cohort were registered, were asked to review the lists of patients with their local knowledge and identify those on the list that may benefit from the neighbourhood scheme approach; i.e., home visit, holistic assessment of need and co-ordinated response. One of the GPs, working with their Social Prescriber, has identified 10 people from the lists sent to them and we are now working with a local community provider, pending completion of risk assessments and assurances, to undertake the home visits and progress these cases to test the approach and apply learning to the further development of neighbourhood working models, applying a design, test and learn methodology.

Next steps:

- Align partners and collaborate to achieve outcomes through neighbourhood working group
- Map and repivot resources
- Unlock data sharing across neighbourhood partners
- Turn PHM insight into action
- Integrate services more effectively
- Clarify decision rights and accountability
- Build shared digital dashboards
- Acknowledge reality: neighbourhood working requires a culture shift – which takes time and persistence!

The Reading Integration Board has agreed that neighbourhood working will be a key priority for 2026/27, recognising its role in strengthening prevention, improving coordination and supporting people closer to home. A dedicated Neighbourhood Working sub-group has been established to bring system partners together, oversee delivery and ensure learning from the South East Neighbourhood Accelerator programme is used to shape future models. This work will also align with wider neighbourhood developments across Berkshire West to support a consistent, joined-up approach.

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 for children and adults
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: Community Wellness Outreach
A female in her 40s, accessed a Community Wellness Outreach health and wellbeing check. She was a carer for both her parents and a child, and felt socially isolated and was inactive because of her caring responsibilities. She had a high BMI and was interested in starting a physical activity with support. With a parent also in hospital, hospital care packages and making sure one was in place was discussed and a care directory for follow on care was emailed for information. She was signposted to the Carers 'Have a Go' sessions commissioned by RBC and given a date when they could meet the RBC Carers lead. She was also provided with information on the Carers Partnership, carers' assessment and carers' rights and showed interest in joining a carers support group and the Carer Care Plan sessions with Compass Recovery College.

Case Study 2: Get Berkshire Active – Ever Active programme
'I enjoy the seated exercise sessions very much, and I particularly like practicing the Fall Proof Standing Exercises as I find these very beneficial. I attend the exercise sessions to help with my tiredness after experiencing postural hypertension. The sessions certainly help to boost my mood and relieve me of my symptoms. Although it is early days yet for me, I can feel the benefit from the exercises in a manner of ways. My mobility has improved, I feel like I have more energy and they are certainly something to look forward to. I nearly forgot to mention that I also very much enjoy the brain game activities. Just writing this, highlights how much can be achieved to improve our health from attending a seated exercise class. I would highly recommend this programme.

Case Study 3: Parish Nursing - Supporting the Whole Family Through Home Visiting
Background: J is a 95-year-old individual living in their own home, supported by family and social services. The Parish Nursing Service provides monthly home visits to help reduce isolation and offer ongoing emotional and practical support.
Intervention: During a routine visit, J's daughter, who is the primary carer, expressed interest in our newly introduced therapy dog service. A Parish Nursing volunteer arranged a visit with the therapy dog, which was warmly welcomed by both J and her daughter. During this visit, the daughter felt able to open-up about the challenges she was facing in her caring role. She shared significant anxiety and the pressures of caregiving, alongside managing her own medical concerns. This opportunity to talk in a relaxed, informal setting proved invaluable.
Outcome: As a result of this conversation, the Parish Nursing Service was able to recognise the needs of the carer, not just the individual being cared for
We expanded our support to include the daughter, ensuring she was not facing these challenges alone. A wider support network was put in place to help reduce her stress and improve her wellbeing. Trust and relationship-building were strengthened, making future support more effective
Impact: This case highlights the importance of home visiting in identifying hidden needs that may not be immediately visible. Through a trusted relationship and informal setting, we were able to:

- Support both the individual and their carer holistically
- Address emotional wellbeing and caregiver strain
- Enable earlier intervention to prevent further deterioration in health and wellbeing
- Strengthen family resilience and support systems

Conclusion: This example demonstrates how Parish Nursing goes beyond individual care, recognising that supporting carers is essential to sustaining care at home. By building trust and creating safe spaces for conversation, we can identify wider needs and provide meaningful, family-centred support.

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.

6.2. 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. The BCF Plan for 2026/27 has allocated funding for Policy review and Engagement & Prevention roles.

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 2026/27[2] have maintained the BCF National Conditions and the Objectives for 2025/26:

National Condition 1: Plans to be jointly agreed

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

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

9. Legal Implications

9.1. Compliance with the Better Care Fund (BCF) 2026/27 National Conditions has been confirmed in the BCF plans submitted on 18th May 2026.

9.2. The Section 75 Framework Agreement for 2026/27 will be agreed and signed by both Reading Borough Council and the Thames Valley Integrated Care Board, by 30th September 2026, in accordance with the governance arrangements agreed by the Health and Wellbeing Board.

10. Financial Implications

10.1. The BCF 2025/26 End of Year report, shows that 96% of the budget was spent in year and the amount carried forward, including the Disabled Facilities Grant underspend, which remains with Housing, has been allocated against continuing projects and some new schemes, such as Magic Notes, into 2026/27 and beyond and to support the development of neighbourhood working models.

Better Care Fund 2025-26 EOY Reporting Template

5. Income & Expenditure

				Checklist
Selected Health and Wellbeing Board:		Reading		Complete:
	2025-26			
Source of Funding	Planned Income	Updated Total Income for 25-26	DFG EOY Actual Expenditure	
DFG (including top-up)	£1,590,186	£1,590,186	£1,519,286	Yes
Minimum NHS Contribution	£14,886,847	£14,886,847		Yes
Local Authority Better Care Grant	£3,321,794	£3,321,794		Yes
Additional LA Contribution	£866,221	£1,483,435		Yes
Additional NHS Contribution	£0	£0		Yes
Total	**£20,665,048**	**£21,282,262**		
			% of Planned Income	
End of Year Actual Expenditure		£20,437,769	**96%**	Yes

10.2 The BCF Plan for 2026/27 totals £21,387,323. The budget is balanced against income lines, and the planned spend on Adult Social Care, from the NHS Minimum Contribution, exceeds the minimum required spend by 39.2%.

Better Care Fund 2026-27 Numerical Template

4. Expenditure

Selected Health and Wellbeing Board: Reading

Running Balances	Income	Expenditure	Balance
DFG	£1,535,942	£1,535,942	£0
NHS Minimum Contribution	£15,360,094	£15,360,094	£0
Local Authority Better Care Grant	£3,321,794	£3,321,794	£0
Additional LA Contribution	£1,149,493	£1,149,493	£0
Additional NHS Contribution	£0	£0	£0
Total	**£21,367,323**	**£21,367,323**	**£0**

Required spend on adult social care from NHS minimum allocations

	2026-27		% Planned spend above min
	Minimum required spend	Planned Spend	
Adult Social Care services spend from the NHS	£7,191,066	£10,012,131	**39.2%**

The funding carried forward from reserves has been allocated as follows;

2025/26 Reserves and Underspend c/fwd to 2026/27	Projected c/fwd to 2026/27	
Bariatric/Obesity/Delirium Pathway	26,800	
End of Life/Dying Well project	46,716	
Co-production post	20,612	
Carer's Action Plan	33,000	
Front Door Service	200,000	
Falls Service *(allocation plan agreed at RIB)*	100,000	
Reconditioning Programme (to-up)	28,672	
Creative Health post (Match funding)	12,500	
Equipment Costs (Top-up)	59,121	
Disabled Facilities Grant 2025/26 Underspend	70,900	Passported to and retained by Housing
Sub-Total:	**598,321**	Scheme 44 on Plan (Project c/fwd)
New lines on plan funded from Reserves		
Neighbourhood Health Integration	£109,172	New line Scheme 20a
Hospital discharge Optimisation of Care	90,000	New line Scheme 50
Hoarding Service	47,000	New line Scheme 52
Sub-Total:	**246,172**	
Total Committed	**844,493**	

11. Timetable for Implementation

11.1. The timetable for the review of BCF plans for 2026/27 are shown below

Regional review Timetable

Action	By When	Who	Comments
BCM to provide support to HWBs with developing robust plans	18/02-19/05/2026	Better Care Managers	
Draft submissions reviewed	Deadline for receipt 12/05/2026	Better Care Managers	Subject to receipt. Feedback to be provided within 7 days. BCM to follow-up if not received
BCF template submission from local Health and Wellbeing Boards (agreed by ICBs and Local Government)	19/05/2026	Health & Wellbeing Boards	To be sent to england.bettercarefundteam@nhs.net & england.awandbcf@nhs.net
BCM check of submissions for accuracy to enable national aggregation of data & resubmission window	20-27/05/2026	Better Care Managers Better Care Fund team	
Review of HWB submission	28/05-17/06/2026	All relevant Reviewers	Plans shared with wider stakeholders for feedback as appropriate
Regional & national touchpoint meeting	01-05/06/2026		
Review panel meeting	22/06/2026 tbc	Better Care Managers ADASS Reviewers	Collated feedback reviewed to agree consensus for sign off
Regional moderation (Sign Off level)	26/06/2026	All Relevant Reviewers and Sign Off	Summary slides available in advance and shared with RD to support sign off
NHS England Regional Director sign off	29/06/2026	SE Regional Director	
Regional outcomes sent to Better Care Fund team	30/06/2026	Better Care Managers	
Recommendations considered by Departments and NHS England	01-22/07/2026	National Partners	
Approval letters issued giving formal permission to spend	23-31/07/2026	Better Care Fund team	
All Section 75 agreements to be signed and in place	30/09/2026	Health & Wellbeing Boards	

12. Background Papers

12.1. There are none.

Appendices

1. Reading BCF 2026-27 Narrative Return (Final)
2. Reading HWB - BCF 2026-27 Numerical Template (Final)
3. Reading HWB - BCF 2025-26 EOY Report (Final)
4. Community Wellness Outreach [CWO] BW Evaluation – Executive Summary