# Better Care Fund 2026-27
# Narrative return

## Submission details

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

| ***Adapt as necessary*** | **HWB area** |
|---|---|
| **HWB** | **Reading** |
| **ICB** | **Thames Valley Integrated Care Board** |

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.**

   In Reading, Better Care Fund (BCF) investment is used as a shared mechanism for the local authority and Thames Valley Integrated Care Board (ICB) to plan and fund integrated neighbourhood health and social care services. It supports joint decision-making across community health, adult social care, primary care and the voluntary and community sector, enabling partners to align resources around local need rather than organisational boundaries. For 2026/27, the plan has been updated to include investment that supports neighbourhood working, including resident engagement, care coordination and digital infrastructure.

   The rationale for this investment is grounded in the pressures facing Reading's health and care system. These include rising complexity and frailty, continuing demand on urgent and emergency care, delayed discharges where people need timely community capacity and social care support, and ongoing pressure on community-based pathways. BCF funding provides a means of pooling budgets and agreeing joint priorities so that partners can invest in the parts of the system that need coordinated, cross-organisational action and cannot be addressed effectively through separate funding routes alone.

   BCF investment is also needed to support Reading's approach to neighbourhood working and prevention, particularly where local need is greatest. This includes targeting support towards communities and cohorts experiencing higher levels of deprivation, long-term conditions, frailty and unmet need, and using Connected Care and population health management approaches to identify rising-risk groups and shape neighbourhood priorities. In this context, the BCF provides a flexible, locally governed funding route that can connect statutory services with community-based support and help align developing neighbourhood teams around shared objectives.

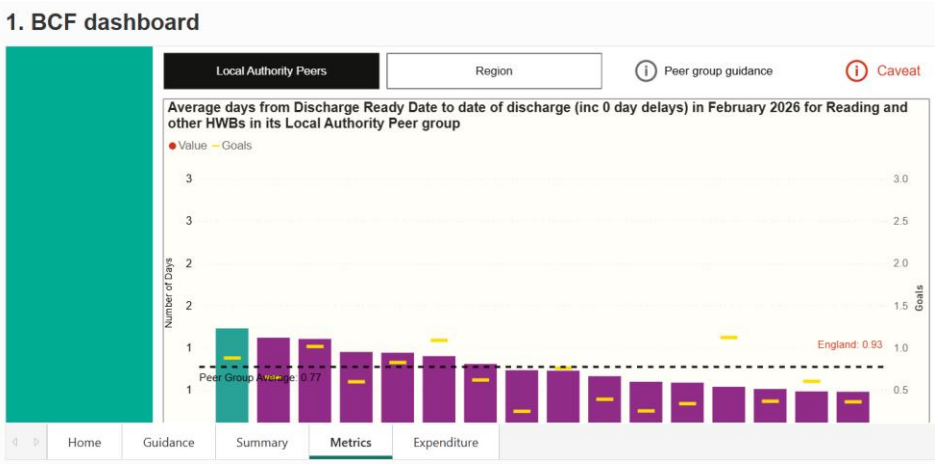
   The BCF is therefore an important enabler of integrated planning in Reading. It helps partners maintain shared accountability, sustain neighbourhood capacity, and direct investment towards areas of greatest system pressure and local need. It also helps ensure that funding complements rather than duplicates other programmes by providing a single place-based framework for joint prioritisation, oversight and coordination.

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.**

BCF goals for national metrics (non-elective admissions people aged 65+ and delayed discharges) have been set using consistent, evidence-based approaches across Reading partners, combining: (1) recent baseline performance and trend; (2) expected demand and case-mix over 2026–27; and (3) costed impact assumptions from BCF-funded services and pathway changes in the numerical return. This aligns ambition to investment ensuring delivery is achievable within workforce, provider capacity and housing/care market constraints. Through 2025–26, Berkshire West funded a Single Point of Access at the Royal Berkshire Hospital so ambulance crews could get clinical advice before conveying patients, including whether community care was more appropriate. The service handles 450+ calls a month, diverts 30% of patients away from the Emergency Department, estimated to avoid 330 ED attendances and 120 admissions per month. There was also a pro-active scheme, funded via the ICB, from December 2025 to April 2026, using the BRIGHT frailty model, which resulted in 170 avoided admissions (*see Appendix 1*), and we will be reviewing learning from that and linking this into development of our Neighbourhood Working models.

Non-elective admissions (65+), goals reflect process changes, ongoing development of Same Day Emergency Care (SDEC) 10am–10pm, and a shift to proactive, neighbourhood-based management of long-term conditions and frailty. They assume BCF-funded prevention, rapid response and intermediate care will reduce escalation and crises.

For delayed discharges, our goals remain unchanged from 2025/26 while we strengthen discharge coordination and increase responsiveness of discharge services. We recognise performance is influenced by acute length of stay, community capacity and availability of longer-term options, and our goals reflect that challenge. Comparing local data from 2024/25 with 2025/26 showed that wait times reduced on Pathways 1 and 3, showing impact of investment to date. An extract from the BCF Dashboard for February 2026 data, showed that our average delayed days for discharge was 1.2 days (incl. 0 day delays), higher than our peers 0.77 days.



We will monitor and drive progress through our multi-agency Reading Integration Board and established operational delivery groups. Our integrated dashboard brings together non-elective admissions (65+), BCF delayed discharge measures, long-term admissions to residential/nursing care, and reablement performance and outcomes, triangulated with qualitative intelligence (front-door pressures, homecare capacity, step-down utilisation) to identify issues early and agree mitigating actions.

To prevent avoidable long-term care home admissions, we maintain a clear “home first” approach supported by consistent decision-making. This includes timely crisis response and enhanced community support as alternatives to admission; strengthened discharge planning to avoid premature care home placement; strengths-based assessments and carer support; and multidisciplinary decision-making for proposed long-term placements ensuring community and reablement options have been explored. We will agree (and keep under review) a local goal for long-term residential and nursing care admissions, informed by historic rates, demographic change and the planned scale of intermediate care and reablement capacity.  Targets are phased to reflect the 2025/26 seasonal cadence, with higher expected residential admissions in winter due to increased frailty/complexity and system capacity constraints impacting timely home-based support.

We will continue monitoring the impact of reablement, including time from referral to start and the proportion of people who require no ongoing package of care (or a reduced package) following reablement. We use routine case and pathway reviews (including provider and practitioner feedback) to address variation and bottlenecks (e.g., therapy capacity, equipment, homecare availability) and strengthen discharge-to-reablement handovers. Where performance is off-trajectory, an improvement plan is agreed with named owners and monitored through the Reading Integration Board, with escalation via joint BCF governance and HWB as required.

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

BCF funding is planned to have a direct, measurable impact on delivery of our goals by sustaining and scaling the integrated neighbourhood services that prevent avoidable escalation, support timely discharge, and reduce the need for long-term care. The planned investment (as set out in the numerical return) supports a coherent set of interventions across three connected pathways: prevention and proactive care, urgent community response and admission avoidance, and discharge-to-recover / intermediate care.

For non-elective admissions (65+), BCF-funded activity is expected to reduce avoidable admissions by improving early identification and management of deterioration (including frailty) through neighbourhood working, and by providing rapid, short-term support at home as an alternative to hospital admission. By strengthening multidisciplinary coordination and ensuring timely access to community-based support, we expect fewer crises to result in ambulance conveyance or acute admission, and more people to be supported safely in the community.

For delayed discharges, the planned impact comes from improved discharge coordination and greater responsiveness of intermediate care, reablement and onward community support. BCF funding supports capacity and joint working arrangements that enable quicker assessment, timely access to equipment/therapy inputs, faster start-up of homecare, and use of step-down options where needed. Together, these changes are expected to reduce the number and duration of discharge delays and improve overall flow through the acute pathway.

BCF funding is also expected to reduce avoidable long-term admissions to residential and nursing care by strengthening the “home first” pathway, increasing the availability and effectiveness of reablement, and supporting consistent strengths-based practice and decision-making. By improving reablement timeliness and outcomes—so that more people regain independence and fewer require ongoing packages of care—we expect to slow growth in long-term care placements and reduce the downstream demand that contributes to discharge delays.

We will track delivery and impact through an integrated performance dashboard and agreed governance, using routine pathway reviews to test whether the expected benefits are being realised and to take corrective action where required. This includes monitoring activity and capacity (e.g., intermediate care utilisation, reablement throughput), outcome measures, and the national BCF metrics, alongside qualitative feedback from practitioners and people using services. This approach ensures BCF funding remains tightly linked to achievement of our goals and supports continuous improvement during 2026–27. We recognise that our discharge rates are worse than our peers and improvement will be delivered through aligning services with best practice examples; consistent setting and daily validation of DRDs, improved data quality through comparison of local and national data and working with data and performance leads, weekly deep-dives on breaches with named owners, and strengthened escalation across acute, community and social care to unblock capacity and increase same/next-day discharge throughout the year.

Population health management (PHM) insights from Connected Care are used to segment the population and identify ‘rising risk’ cohorts (e.g., people with frailty, frequent attenders, multiple long-term conditions, and those with high deprivation). This informs neighbourhood priorities and targets BCF-funded proactive case finding, MDT input and preventative support where avoidable admissions and delays are most likely.

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.**

Reading Borough Council and Thames Valley Integrated Care Board (ICB) have confidence that BCF-funded services represent value for money (VFM) because investment decisions are made jointly, are grounded in evidence of need and impact, and are subject to robust financial and performance assurance. BCF schemes are agreed through established place-based governance and must demonstrate a clear line of sight from spend to outcomes, including contribution to the national metrics (non-elective admissions 65+ and delayed discharges) and local priorities such as preventing avoidable long-term care admissions and improving reablement outcomes. The NHS 2% productivity target reinforces the need for BCF-funded schemes to deliver measurable efficiency gains (e.g., higher throughput, reduced duplication and fewer delays) as well as improved outcomes, so we prioritise MDT working and early interventions that release capacity and reduce avoidable activity to improve our use of resources. We also have longer term contracts, e.g. 5 years plus 2, to improve efficiencies, and these are monitored through quarterly contract meetings with a quality improvement focus.

At commissioning and planning stage, partners use proportionate business cases and scheme reviews to confirm need, cohort/volume assumptions, delivery model, and expected benefits versus alternatives. Where possible, we compare unit costs and outputs (e.g., cost per episode of intermediate care/reablement, cost per bed-day avoided, cost per discharge supported) and benchmark against prior year performance and peer services. We also assess whether schemes are duplicated through other funding, and whether there are lower-cost options (including service redesign, digital enablement or VCSE solutions) that can deliver the same or better outcomes.

In-year, VFM is monitored through routine contract and performance management, with a focus on both activity and outcomes. A shared dashboard and regular pathway reviews allow us to track throughput, timeliness and outcomes (including reablement independence outcomes), alongside the national metrics. Financial controls include agreed payment/contract mechanisms, spend profiling, variance analysis and reconciliation to the BCF numerical return. Where required, audits and assurance checks are undertaken, and financial sign-off (including Section 151 Officer assurance for the local authority elements) provides additional confidence that spend is appropriate, compliant and delivering intended benefits. We also incorporate a requirement for cases studies from our providers that are funded through the BCF to demonstrate impact of investment.

We will also maintain a benefits realisation approach: setting expected outcomes at scheme level, reviewing delivery against those expectations, and using learning to improve design. Where evidence shows limited impact or poor VFM, partners will agree remedial action, redesign, or (where appropriate) decommissioning and reinvestment into higher-impact preventative and integrated services.

To raise productivity, we will focus on maximising the value produced from existing capacity and reducing avoidable delays and duplication across pathways. This includes standardising referral criteria and processes, such as optimising single handed care, strengthening “home first” decision-making, and improving handovers between hospital, community health and

social care so that people move through discharge-to-recover and reablement pathways quickly and safely. We will use flow and demand/capacity analysis to identify bottlenecks (e.g., therapy capacity, equipment provision, care package start-up) and target improvement actions that increase throughput, reducing delays and length of stay.

Practical productivity levers will include: optimising workforce models (right skill mix, supervision and caseload management); using digital tools to streamline assessment, scheduling and communication; reducing unwarranted variation through shared protocols and outcome-focused KPIs. We will review productivity and VFM routinely through place-based governance, supported by deep-dives where performance is off-track, to ensure continuous improvement and that BCF investment delivers the best possible outcomes for Reading residents.

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.**

Governance for the Better Care Fund (BCF) in Reading is jointly owned by Reading Borough Council and Thames Valley Integrated Care Board (ICB), working through the Health and Wellbeing Board (HWB). It is designed to provide clear accountability for expenditure, delivery and outcomes, with agreed decision rights, strong financial control and routine performance oversight.

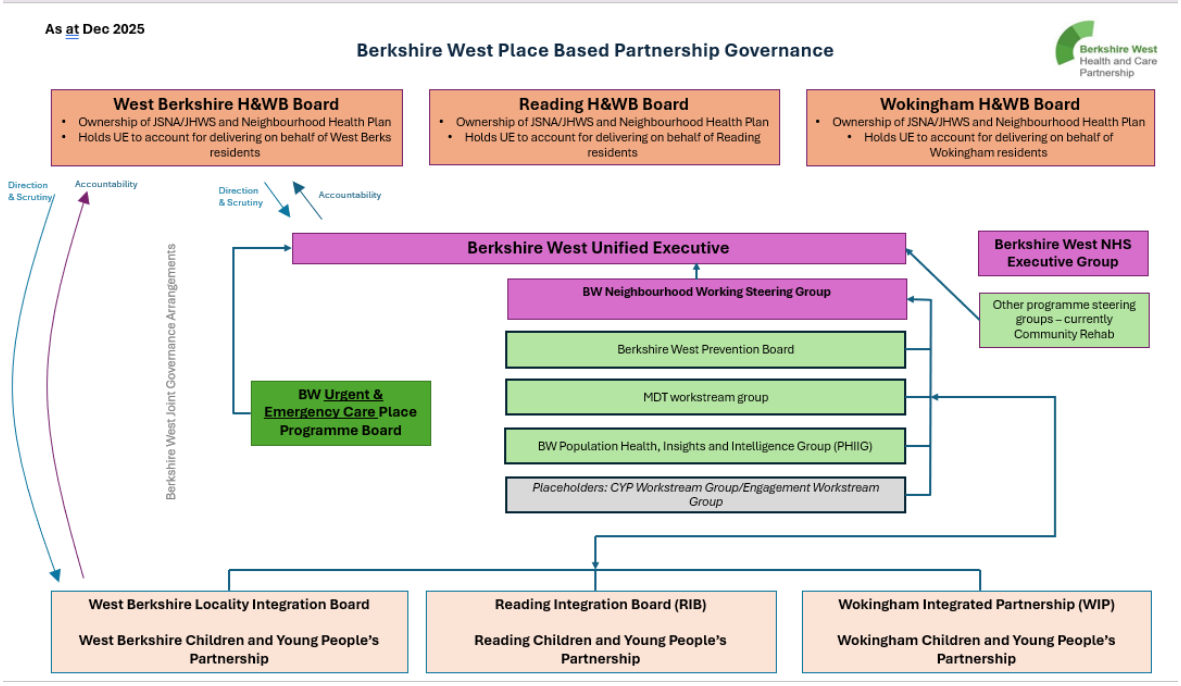
Overall strategic oversight is provided via Reading's HWB arrangements (including delegated authority briefing and sign-off where applicable), supported by place-based partnership governance (for example, the Reading Integration Board and Berkshire West Prevention Board), that brings together senior leaders across health, social care, finance and commissioning. Day-to-day scheme delivery is managed through operational pathway groups (e.g., discharge, intermediate care/reablement and community capacity) with clear named leads and escalation routes into the place-based board where issues need joint resolution.

Financial governance is maintained through joint planning and in-year financial monitoring aligned to the BCF numerical return. Schemes have agreed budgets, funding routes and accountable owners, with spend profiled and reviewed regularly (including variance and risk). Changes to scheme scope or material in-year budget changes are agreed jointly through place-based governance, with assurance from both partners' finance teams. The local authority's Section 151 Officer provides assurance on the local authority elements of the BCF plan, and Thames Valley ICB finance governance (including executive oversight/CEO sign-off where required) provides assurance on the NHS elements and overall affordability and compliance.

Impact is assessed through a combination of scheme-level monitoring and whole-system metrics. A shared performance dashboard tracks delivery against the national BCF metrics (including non-elective admissions for those aged 65+ and delayed discharges), alongside local indicators such as long-term admissions to residential/nursing care and reablement timeliness and outcomes. This is supplemented by qualitative intelligence (e.g., pathway feedback from practitioners and providers) and case studies/evaluation where appropriate to evidence how investment is improving people's experience, independence and flow through services.

Value for money is built into decision-making and oversight. New or materially changed schemes are supported by proportionate business cases and agreed success measures. In-year, contract and performance management focuses on activity, outcomes and unit cost/productivity (e.g., throughput, episode length, utilisation of intermediate care capacity, and independence outcomes from reablement). Where performance or VFM is off-track, the relevant operational pathway group completes a time-limited deep dive and agrees a recovery plan with named owners; findings and actions are reported to the Reading Integration Board (RIB) and, where issues affect system flow or urgent care, escalated to the Urgent and Emergency Care (UEC) Board and/or targeted workshops for wider learning and decision-making.

Continuous improvement is delivered through routine pathway reviews and cross-partner learning. Operational groups (e.g., discharge, intermediate care/reablement and community capacity) share learning, variation and good practice through regular multi-agency workshops and bring recommendations to RIB for agreement and coordination across pathways. Delivery, risks and dependencies are tracked with named owners and timescales, with escalation from operational groups to RIB, then (where required) to the UEC Board for system flow decisions and to HWB delegated arrangements for formal assurance and sign-off. This connected governance ensures BCF spend stays aligned to priorities and that corrective action and learning are acted on quickly.



# **Appendix 1:** BRIGHT Model Infographic