# READING HEALTH & WELLBEING BOARD MINUTES – 11 JULY 2025

**Present:**

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| Councillor Rachel Eden (Chair) | Lead Councillor for Education and Public Health, Reading Borough Council (RBC) |
| Andy Ciecierski | Clinical Director for Caversham Primary Care Network |
| Councillor Paul Gittings | Lead Councillor for Adult Social Care, RBC |
| Councillor Wendy Griffith | Lead Councillor for Children, RBC |
| Alice Kunjappy-Clifton | Lead Officer, Healthwatch Reading |
| Gail Muirhead | Prevention Manager, RBFRS |
| Matt Pearce | Director of Public Health for Reading and West Berkshire |
| Katie Prichard-Thomas | Chief Nursing Officer, Royal Berkshire NHS Foundation Trust (RBFT) |
| Ben Riley | Chief Medical Officer, BOB ICB |
| Rachel Spencer | Chief Executive, Reading Voluntary Action |
| Councillor Liz Terry | Leader of the Council, RBC |
| Melissa Wise | Executive Director – Community & Adult Social Care Services, RBC |
| Theresa Wyles | Interim Chief Operating Officer, BHFT |

**Also in attendance:**

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| Jamie Evans | Area Director, Healthwatch in Berkshire West |
| Lara Fromings | Assistant Director for Transformation, Commissioning and Performance, RBC |

**Apologies:**

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| Colin Hudson | Reading LPA Commander, Thames Valley Police (TVP) |
| Steve Leonard | West Hub Group Manager, RBFRS |
| Lara Patel | Executive Director of Children's Services, Brighter Futures for Children (BFfC) |
| Helen Troalen | Interim Chief Finance Officer, RBFT |

## 1. MINUTES

The Minutes of the meeting held on 14 March 2025 were confirmed as a correct record and signed by the Chair.

## 2. DELEGATED DECISIONS

The Board received the list of delegated decisions from previous meetings.

## 3. QUESTIONS IN ACCORDANCE WITH STANDING ORDER 36

The following question was asked by Tom Lake in accordance with Standing Order 36:

### a) Virtual Hospital/Hospital at Home

The Royal Berkshire Hospital (RBH) has a well-established "Virtual Hospital" programme with sometimes over 100 patients on its pathways, being treated at home. The programme provides treatment stated to be equivalent to hospital care in the patient's home and can have significant benefits for patient and hospital trust.

But it provides no personal care, no nutrition, hydration, washing, toileting assistance, shopping or housework or cleaning, which could become impossible

for a patient at home without a carer able to perform these functions. The services are described as hospital care at home but would be better described as hospital treatment at home.

The RBH "Virtual Acute Care Unit" covers the more acute pathways of the "Virtual Hospital" service where patients require continued monitoring at home.

The BOB ICB website states that "Hospital at Home" services in West Berkshire are delivered by RBH under the local name "Virtual Acute Care Unit" (VACU) and by Berkshire Healthcare under the name "Frailty Wards"/"Urgent Care Response" (UCR).

Berkshire Healthcare website states that their "Frailty Ward" or "Urgent Care Response" services put you under the care of either your GP or a geriatrician. But this does not cover people needing personal care who are placed in the VACU system by RBH.

RBH have stated that patients placed in the VACU service can be referred to the "Hospital at Home" service but there is no information on what that is - perhaps it is one of the Berkshire Healthcare services.

The decision to refer a patient to "Hospital at Home" for the personal care element seems to be relatively informal and I am aware of this having led to very poor experience in the past.

The VACU service can only operate safely if there is a clear protocol for decision making by staff with appropriate expertise on the need for personal care support. There is apparently a Frailty Team at the RBH but it is not automatically involved. Is the present situation satisfactory?

There is clear confusion in the various public sources of information and no single complete account for the public of how services cooperate where no carer is available at home. Can this situation be cleared up with a clear statement of how these services operate and cooperate?

(I apologise for the length of this question, but it is just the complexity and lack of clarity about these new services which gives rise to concern.)

**REPLY** by Katie Prichard-Thomas (Chief Nursing Officer, Royal Berkshire NHS Foundation Trust) on behalf of the Chair of the Health and Wellbeing Board (Councillor Eden):

Thank you for your question and for highlighting the need for greater clarity around the scope, eligibility criteria, and coordination of services provided through the Royal Berkshire Hospital’s Virtual Hospital programme, including the Virtual Acute Care Unit (VACU).

I can confirm that the Virtual Hospital service does not provide any form of personal care, including support with nutrition, hydration, washing, toileting, shopping, housework, or cleaning tasks. Our service is designed to provide clinical treatment and monitoring at home for patients who would otherwise require hospital-based care. While the term “hospital at home” is used, it is important to recognise that

our remit is limited to medical care, not social care provision. A more accurate description may be “hospital treatment at home,” as you have noted.

To ensure patient safety and suitability for home-based care, we follow a strict referral and admission criteria. Patients referred to the Virtual Hospital must be:

- Clinically stable and appropriate for remote monitoring or treatment,
- Able to manage independently at home or have a reliable support network,
- Not reliant on assistance with personal care or basic daily living activities.

If a patient is unable to manage their personal care needs or lacks the necessary support at home, they will not meet the criteria for admission to the Virtual Hospital. In such cases, referrals would be declined, and the referring team advised to explore more appropriate care pathways.

We recognise that some patients being discharged home from the Emergency Department may present with frailty or reduced ability to manage independently. In such cases, they may be assessed by the Frailty Team prior to discharge. Where needed, support can be sought via the Urgent Community Response (UCR) service, delivered by Berkshire Healthcare NHS Foundation Trust. UCR may provide time-limited assistance to help individuals manage at home while other longer-term care solutions are considered. More information about the UCR service can be found here: https://www.berkshirehealthcare.nhs.uk/our-services/physical-and-community-healthcare/urgent-community-response-service/.

Although the Virtual Hospital team can liaise with services such as UCR when appropriate, we are not responsible for arranging or delivering personal care. It is important to understand that these services are provided by different organisations, and the pathways are distinct but complementary.

We are aware that public-facing information can sometimes cause confusion, particularly given the range of terms used (e.g., Virtual Hospital, Hospital at Home, UCR, Frailty Wards). The terminology "virtual ward" itself is not nationally standardised, which increases the risk of it being interpreted differently across the country. This contributes to inconsistency and confusion for patients, carers, and professionals alike. We agree that clearer and more accessible communication is needed to ensure patients, families, and carers understand how these services operate and interact.

Over the last month, we have launched a dedicated Virtual Hospital webpage on the Trust’s internet site, which provides patient information leaflets and a clear explanation of the Virtual Hospital service and what it offers. The page can be accessed here: https://www.royalberkshire.nhs.uk/wards-and-units/virtual-acute-care-unit-vacu. In addition, our patients are contacted directly and are provided with information from the point of admission to the Virtual Hospital to ensure they understand the service, how it operates, and what support is available. We continue to work closely with our partners across the system to improve coordination, transparency, and ensure patients are directed to the right service at the right time.

Lastly, while I am unable to comment on individual cases, I would like to reassure you that all referrals to the Virtual Hospital (including VACU) are reviewed by clinical staff. The patient's ability to cope at home independently is a core consideration in determining suitability for the service. If it becomes apparent that the patient is unable to manage safely at home, then they may need to attend the Emergency Department, where a frailty assessment may be offered. This often helps guide appropriate ongoing care or support arrangements. However, there are occasions when patients are assessed and support is offered, but they choose to decline it. In such circumstances, we ensure the patient is fully informed of the risks and that decisions are documented appropriately.

Thank you again for raising these important points. We welcome ongoing feedback and remain committed to delivering safe, effective, and appropriately targeted care for all patients.

The following question by Francis Brown was answered in writing:

**b) Is the Health and Wellbeing Strategy Quarterly Implementation Dashboard sound?**

It is like a toolkit inventory. A sophisticated check list that seeks to confirm that the various action plans to support the five priorities identified in the RBC Health and Wellbeing Strategy are present. Each action is updated every three months with a status of green amber or red. The wording of the actions has been honed over time to improve the chances that the entire strategy will be delivered on time. Indeed, the development of a dashboard is an essential step on the pathway to delivering the strategy. The completeness of this large tool kit is not questioned. The timeliness of the metrics for each action is its potential weakness.

Two worrying observations:

1 The commentary clarifies the scope of each action and the identity of the associated partners. The text is invariably qualitative but never quantitative.

2. In the Jan 2025 report the text is supported in Appendix A by 50 charts. In more than half of these the latest data is for the year 22/23 or earlier. These data series are helpful in identifying relevant historic trends. However, they are of little relevance as dashboard indicators. The feedback loop is far too long.

These two observations challenge the integrity of the dashboard which currently shows the majority of the dashboard ratings as green. To continue with the analogy: we have the tools (the actions) but we will not know (in some cases for years) if the tools are being used effectively and efficiently. It may be a while before it is realised that the desired strategy is not on track for delivery. This is very risky.

The completeness of this large tool kit (of actions) is not questioned. The lack of timely and meaningful dashboard metrics is questioned.

- Does the Board commend the progress so far but share my concerns?

To make a second analogy: a grower is interested in the overall yield, every step of the way losses can be expected. A proportion of seeds geminate, a proportion will show two leaves and so on. These are timely "proxy" measures. Each wave of sowings can be progressively assessed. The probability of achieving the seasons target becomes clearer as time progresses.

- Does the Board feel that using proxy measures would increase the probability of a timely delivery of the strategy?

**REPLY** by the Chair of the Health & Wellbeing Board (Councillor Eden):

Thank you for this well-timed question. You raise important points including about the timeliness of the measures in the Joint Health and Wellbeing Strategy dashboard.

You are right that there is a risk of measures becoming meaningless because they are dependent on outcomes that are measured with an unavoidable time lag. This is part of the conflict between ensuring the level of quality to identify trends over time, and promptness for monitoring purposes. You are also right to ask about the potential imbalance between the use of quantitative and qualitative data.

There are a range of ways the board could do this, including proxy measures as you suggest.

It is important to ensure that we are using our scarce resources most effectively to achieve the outcomes that are our priorities.

This is not easy and in some of the priority areas within the strategy it is particularly difficult. This may partly explain your observation about an apparent dependence upon qualitative data.

As you know, the Joint Health and Wellbeing Strategy for Reading is the responsibility of the Health and Wellbeing Board and this problem has been recognised by the board.

Our Director of Public Health and his team have been taking action to address this by engaging the Local Government Association to conduct an independent review of the Reading Health and Wellbeing Board over the past six months.

The review interviewed board members and held workshops with stakeholders to develop a shared view of the role, purpose and priorities of the Board, to consider best practice and new ways of working that will drive action and impact.

We will be discussing their recommendations at this meeting and I hope you will be able to stay to listen to this discussion, but I would certainly encourage you to take a look at the report.

One of the recommendations was a desire for the board to reduce the number of priorities which they wish to focus on.

A 'rapid' Joint Strategic Needs Assessment is being undertaken that will come to the next Health and Wellbeing Board meeting to inform our key priorities.

As well as informing the work of the health system locally it will also give us an opportunity to identify the most valid indicators so that our dashboard can be most useful. I also hope that we will be able to refresh the way our board works to be more dynamic and responsive to the needs of our town.

## 4. REVIEW OF THE READING HEALTH AND WELLBEING BOARD

Matt Pearce submitted a report presenting the findings of the Local Government Association (LGA) review of the Reading Health and Wellbeing Board (HWB) and setting out proposals for how the Board could revise its governance arrangements and working practices in response to the feedback received. The LGA feedback was attached at Appendix A to the report.

The report explained that, further to the Board's decision on 11 October 2024 to undertake a review (Minute 22 refers), the LGA had been invited to carry out a review of the Health and Wellbeing Board's governance and working practices to evaluate its effectiveness in improving the health and wellbeing of the local population and reducing health inequalities and make recommendations for improvement. The LGA had undertaken interviews with HWB Members and other stakeholders between December 2024 and February 2025. The intelligence gathered in those conversations had then been triangulated and compared with best practice and understanding of what made for an effective HWB. A workshop had been held on 24 March 2025 for the LGA to provide feedback and for HWB Members to reflect on the findings. The report summarised the main points raised at the workshop.

A Task and Finish Group had been set up to consider the outputs from the workshop and to develop a plan setting out the steps that the Board could take in response to the feedback received. The Task and Finish Group's recommendations had formed the basis for the proposals set out at paragraph 4.1 in the report, as follows:

- A Health and Wellbeing Board Compact would be developed that defined the shared principles and jointly set expectations for how Reading Health and Wellbeing Board members would work collectively as a strategic partnership to drive meaningful action and achieve the vision of its Joint Health and Wellbeing Strategy.

- It was proposed to move from four formal HWB meetings per year to three – these would be in-person and relatively brief, being focused on reports where formal decisions were required.

- Given that the HWB was a committee of the Council, meetings would be required to take place in public, with publication of formal agendas and minutes. It was proposed that members of the public would still be able to ask formal questions, but meetings would not be live-streamed. Alternative meeting venues would be explored, to address concerns about the formality of the Council Chamber, but any venue would need to have sufficient capacity and be accessible to the public.

- Formal HWB meetings would be followed by informal strategic meetings focused on the 'plan–do–review' cycle in relation to agreed priorities, and on the efficacy of partnership working arrangements.

- In addition, there would be informal deep-dive workshops in between HWB meetings, which would bring in additional partners and stakeholders – these would be focused on discussing barriers and challenges related to the agreed priorities,

sharing best practice and building on evidence-based approaches, as well as seeking to develop innovative solutions.

- The JSNA (State of the Borough Report) would be updated and brought back to the October HWB meeting – this would be used to identify a small list of priorities which the board wished to focus on.
- Once the priorities were agreed, subgroups would be established and tasked with developing a implementation plan which would be brought back to the March meeting (or earlier if possible).
- There would be a focus on raising the public profile of the Board, including:
    - A regular newsletter for stakeholders (and possibly residents)
    - Improving online information provision about the Board, including an interactive version of the performance dashboard and links to the Joint Strategic Needs Assessment, the Pharmaceutical Needs Assessment, and the Health and Wellbeing Strategy/implementation plan.
    - An annual conference to update stakeholders and residents on the previous year's activities, and priorities for the coming year, including workshop sessions.

The report stated that officers would work on the proposals and bring further details of any amendments needed to the HWB's Terms of Reference and operational arrangements to a future meeting for formal decision, informed by the new priorities of the Board.

The report also stated that one of the findings from the review had been confusion about the roles of and difference between the HWB and the Adult Social Care, Children's Services and Education (ACE) Committee in its role as the Council's Health Overview and Scrutiny Committee, and the report set out guidance to inform how each committee would operate and how the scope of their agendas would be determined, as well as a table summarising the key differences between them.

The report noted that the NHS 10 Year Plan that had been published on 4 July 2025 would need to be considered alongside the proposals in the report. In particular, the 10 Year Plan outlined future conversations between the LGA and the Government regarding democratic oversight and accountability within the new NHS operating model and the role of mayors and reforms of local government. The new plan also stated that a neighbourhood health plan would be developed under the leadership of the Health and Wellbeing Board.

**Resolved –**

That the proposed changes to the Health and Wellbeing Board following the LGA Review, as set out in paragraph 4.1 of the report, be approved.

## 5. JOINT STRATEGIC NEEDS ASSESSMENT REVIEW

Matt Pearce submitted a report on the process and timeline for reviewing and refreshing the Joint Strategic Needs Assessment (JSNA) in Reading, a key shared intelligence resource that enabled the Health and Wellbeing Board (HWB) and its partners to understand local population needs and informed strategic decision-making.

The report explained that the current JSNA, hosted on the Reading Observatory, included a wide range of thematic needs assessments and data. However, upon a public health self-assessment using the LGA Strengths and Risk tool, issues and opportunities relating to the JSNA had been identified and discussed, highlighting the need for improvement to ensure the JSNA was fit for purpose.

The recent LGA review of the Health and Wellbeing Board had identified a desire by board members to focus on a smaller number of priorities that were informed by evidence of need. A relatively short overview of the key health needs of Reading would be produced using data and intelligence that was readily available. This would be reviewed by HWB members in a workshop in the autumn to inform decisions about the Board's priorities for action in the short to medium term.

The report proposed an approach combining the delivery of this rapid "State of the Borough" JSNA, in parallel with conducting a broader review of the JSNA's structure, content, and delivery model. The latter process would run until October 2025 and involve cross-sector collaboration, including the formation of a Steering Group, stakeholder workshops, and a survey to inform development.

A further report including the outcomes of the review and an updated State of the Borough JSNA, would be brought back to the Board later in the year.

**Resolved –**

(1) That the production of a rapid "State of the Borough" JSNA, in parallel with conducting a review of the current JSNA, be approved;

(2) That the members of the Board commit to actively supporting the JSNA review process;

(3) That the HWB partners identify and nominate suitable representatives from their organisations to participate in the JSNA Steering Group.

## 6. HEALTHWATCH READING ANNUAL REPORT 2024-25 – UNLOCKING THE POWER OF PEOPLE-DRIVEN CARE

Alice Kunjappy-Clifton submitted the 2024/25 Annual Report for Healthwatch Reading "Unlocking the Power of People-Driven Care" which gave details of the work carried out by Healthwatch Reading in 2024/25.

The report explained who Healthwatch Reading were and how they had: made a difference during the year; worked together for change; made a difference in the community; listed to people's experiences; heard from all communities; provided information and signposting and showcased volunteer impact.

The report gave details of Healthwatch Reading's full and diverse engagement programme in 2024/25, centred around the following core projects:

- Language Matters
- NHS Eligibility to Treatment
- GP Access
- Improving Sexual Health Awareness and Services for Young Women (16-24)
- Oral Health and Dentistry (Core20Plus5 project)

The report also gave details of Healthwatch Reading's 2024/25 finances and set out its priorities for 2025/26:

- Primary Care
- Women's Health
- Men as Carers

Alice Kunjappy-Clifton and Jamie Evans explained that, whilst there had been recent national announcements about the abolition of Healthwatch, Healthwatch England's functions would be moved into the Department of Health and Social Care, and Healthwatch Reading would be continuing with its work until legislation had been passed, which was not expected to be for at least another 12-18 months. Members of the Board expressed gratitude for the valuable work of Healthwatch and noted its importance in providing an independent public and community voice and scrutiny, and the need to replace this work in future following the legislative changes.

**Resolved -** That the report and position be noted.

## 7. AUTISM STRATEGY YEAR 3 (2024/25) ACTION PLAN UPDATE

The Board received an information report on the progress of the Year 3 (2024/25) All Age Autism Strategy Action Plan across Reading.

**Resolved -** That the report be noted.

## 8. BOB ICB UPDATE BRIEFING

The Board received a briefing note from the BOB Integrated Care Board, as at June 2025.

The report covered the following areas:

- BOB ICB Board meetings
- BOB ICB Capital Resource Use Plan 25/26
- Update on Key Priorities
- Urgent Dental Appointments

**Resolved -** That the report be noted.

(The meeting started at 2.00 pm and closed at 2.57 pm)