

To: All Members of the Health and
Wellbeing Board

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8 July 2026

Your contact is: Nicky Simpson - Committee Services

NOTICE OF MEETING - HEALTH AND WELLBEING BOARD 16 JULY 2026

A meeting of the Health and Wellbeing Board will be held on **Thursday, 16 July 2026 at 2.15 pm** in the **Large Hall, Whitley Wood Community Centre**, 28-35 Lexington Grove, Reading RG2 8UG**. The Agenda for the meeting is set out below.

- *Please note that the Chair will be leading a short walkabout of the local area before the meeting. If you would like to join this, please meet at the Centre at 1.45pm for leaving at 1.50pm and returning by 2.05pm – the formal meeting of the Board will start at 2.15pm after the walkabout has returned.*

AGENDA

Page No

1. WELCOME & BRIEF SUMMARY OF THE AREA

The Chair, Councillor Rachel Eden, will give a brief summary of the area for the Board members.

2. APOLOGIES & DECLARATIONS OF INTEREST

3. MINUTES OF THE MEETING HELD ON 18 MARCH 2026

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4. QUESTIONS

Consideration of formally submitted questions from members of the public or Councillors under Standing Order 36. Submissions should be emailed to committee.services@reading.gov.uk and must be received no later than 12noon, four clear working days before the meeting.

5. PETITIONS

Consideration of any petitions submitted under Standing Order 36 in relation to matters falling within the Board's Powers & Duties which have been emailed to committee.services@reading.gov.uk and received no later than four clear working days before the meeting.

6. **REVIEW OF THE JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)** 9 - 46
- A report on the results of a review of the Joint Strategic Needs Assessment and proposing next steps to improve and strengthen the JSNA.
7. **WHOLE SYSTEM APPROACH TO HEALTHY WEIGHT STRATEGY AND IMPLEMENTATION PLAN 2026-2036** 47 - 108
- A report presenting the Reading Whole System Healthy Weight Strategy for 2026-2036, the proposed governance arrangements and the Implementation Plan for the initial phase of delivery, 2026-28.
8. **BEST START FAMILY HUB AND BEST START IN LIFE DELIVERY PLAN** 109 - 150
- A report providing a strategic overview of the Best Start Family Hub and Best Start in Life (BSIL) delivery model and expected outcomes to improve early years development and reduce inequalities across Reading.
9. **HEALTHWATCH READING ANNUAL REPORT 2025/26** 151 - 202
- A report presenting Healthwatch Reading's Annual Report for 2025/26, giving details of the work carried out by Healthwatch Reading in 2025/26.

INFORMATION ONLY REPORTS

10. **INTEGRATION UPDATE** 203 - 268
- A report giving an update on the Integration Programme and performance of Reading against the national Better Care Fund targets, as well as the Community Wellness Outreach programme and the South East Neighbourhood Accelerator programme.

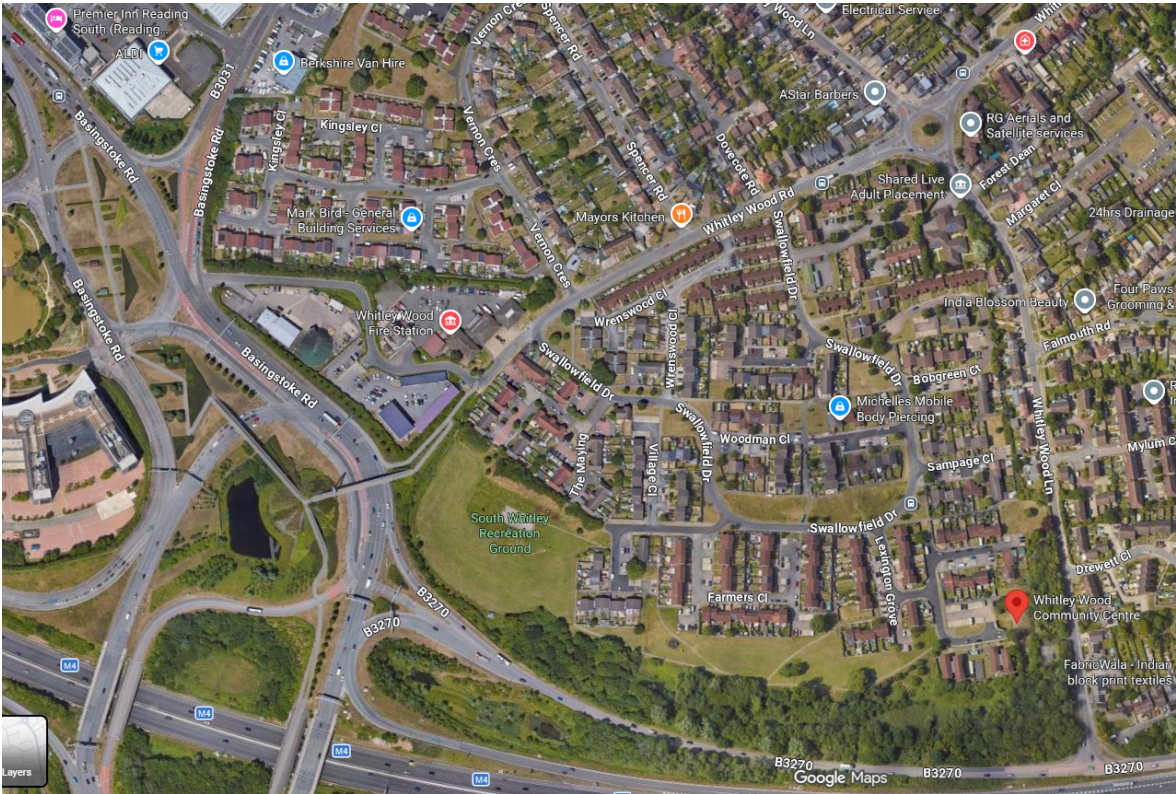
**** Getting to the Meeting Venue – The Whitley Wood Community Centre**

The meeting will be held in the Large Hall at Whitley Wood Community Centre, 28-35 Lexington Grove, Reading RG2 8UG (see location map overleaf)

- *The nearest bus route is number 6 – the bus stop is called Farmers Close, and is on Swallowfield Drive, near Lexington Grove (**not** the bus stop called Whitley Wood Community Centre)*
- *There is a car park next to the centre, shared with residents*

If you have any questions about access, please contact Nicky Simpson – contact details above

Whitley Wood Community Centre location map



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Present:

Councillor Rachel Eden (Chair)	Lead Councillor for Education and Public Health, Reading Borough Council (RBC)
Andy Ciecierski	Clinical Director for Caversham Primary Care Network
Helen Clark	Associate Director of Place (Berkshire West), Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB)
Councillor Paul Gittings	Lead Councillor for Adult Social Care, RBC
Brian Grady	Director of Education, 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
Arran Rogers	Chief Nursing Informatics Officer & Workforce Lead, Royal Berkshire NHS Foundation Trust (RBFT)
Rachel Spencer	Chief Executive, Reading Voluntary Action
Melissa Wise	Executive Director – Community & Adult Social Care Services, RBC
Theresa Wyles	Interim Chief Operating Officer, Berkshire Healthcare NHS Foundation Trust (BHFT)

Also in attendance:

Nina Crispin	Public Health Practitioner, Place, RBC
Jamie Evans	Area Director, Healthwatch in Berkshire West
Lara Fromings	Assistant Director for Transformation, Commissioning and Performance, RBC
Bev Nicholson	Integration Programme Manager, RBC
Amanda Nyke	Public Health & Wellbeing Manager, RBC

Apologies:

Colin Hudson	Reading LPA Commander, Thames Valley Police (TVP)
Councillor Micky Leng	Deputy Leader, RBC
Steve Leonard	West Hub Group Manager, RBFRS
Lara Patel	Executive Director of Children's Services, RBC
Katie Prichard-Thomas	Chief Nursing Officer, RBFT
Ben Riley	Chief Medical Officer, BOB ICB
Councillor Liz Terry	Leader of the Council, RBC

14. MINUTES

The Minutes of the meeting held on 7 October 2025 were confirmed as a correct record and signed by the Chair.

15. HEALTH AND WELLBEING BOARD PRIORITIES 2026-2028

Matt Pearce submitted a report setting out the proposed three priorities to be the focus for the Health and Wellbeing Board over the next two years, a proposed governance model and proposed sponsors for the priorities.

The report explained that the Local Government Association Review of the Board's governance and working practices had recommended that the Board should focus on two or three priorities at a time, informed by local need and evidence, in order to deliver meaningful change in population health.

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A high level “state of the Borough” Joint Strategic Needs Assessment had been presented to Board Members and other stakeholders at a workshop on 7 October 2025, and the workshop had generated a long list of potential priorities, and had identified the following three areas as important priorities for the medium term:

- Healthy Neighbourhoods
- Best Start in Life
- Children and Young People and Adult Mental Health

A second workshop had been held on 4 December 2025 to review current activity, possible future options and next steps for the development of delivery plans for each of the priorities. The report set out key outcomes for each priority.

In order to have effective oversight of the priorities, the following three partnership groups had been identified to oversee each priority, with sub-groups tasked with developing delivery plans and outcomes frameworks for the priorities. The report also proposed the following three sponsors from partner members of the Board, to be responsible for overseeing development and delivery of plans and accountable to the Health and Wellbeing Board:

Priority	Partnership Group	Sponsor
Healthy Neighbourhoods	Reading Integration Board	Helen Clark, Associate Director of Place, ICB
Best Start in Life	One Reading Partnership	Lara Patel, Director of Children’s Services, RBC
Children and Young People and Adult Mental Health	All Age Mental Health & Wellbeing Board	Kathryn MacDermott, Director of Strategic Planning, BHFT

The Reading Integration Board and One Reading Partnership were existing partnership arrangements, but work was being done to establish a Mental Health & Wellbeing Board.

It was reported at the meeting that the awaited government guidance on the Neighbourhood Health Framework had been issued on 17 March 2026, which had confirmed that Health and Wellbeing Boards would have oversight of signing off the Neighbourhood Health Plans.

Resolved –

- (1) That the priorities for the Health and Wellbeing Board for the medium term be agreed as:
 - Healthy Neighbourhoods
 - Best Start in Life
 - Children and Young People and Adult Mental Health
- (2) That the proposed governance model for the priorities be implemented through the partnership arrangements set out above, with sub-groups tasked with developing delivery plans and outcomes frameworks;

- (3) That the Board sponsors for each priority area be agreed as set out above, to have responsibility for overseeing development and delivery of plans.

16. HEALTH AND WELLBEING BOARD COMPACT

Matt Pearce submitted a report presenting a draft Reading Health and Wellbeing Board Compact for approval and adoption, attached at Appendix 1.

The report explained that the Local Government Association Review of the Board's governance and working practices had recommended that the Board should develop a compact, setting out how members would work collectively as a strategic partnership to drive meaningful action and achieve the vision in the Joint Health and Wellbeing Strategy. The Board had agreed this recommendation at its meeting on 11 July 2025, and the Director of Public Health had developed a draft Compact with reference to other best practice examples across the country, in consultation with Board members.

The Compact sought to establish a mutual understanding of how the Board would operate and to define members' roles and responsibilities in delivering its function, to deliver meaningful change and improve outcomes for people in Reading. It set out a number of core principles and how those should practically be supported.

Resolved –

That the Reading Health and Wellbeing Board Compact be approved and adopted, and Board members agree to adhere to the principles and ways of working set out within it.

17. BERKSHIRE WEST SAFEGUARDING CHILDREN PARTNERSHIP (BWSCP) ANNUAL REPORT FINANCIAL YEAR 2024/25

Brian Grady submitted a report presenting the Berkshire West Safeguarding Children Partnership (BWSCP) Annual Report for 2024/25, a copy of which was appended to the report. The BWSCP was a multi-agency partnership to promote the safeguarding and wellbeing of children in Reading, West Berkshire and Wokingham, whose role was to co-ordinate the partners' safeguarding services; act as a strategic leadership group in supporting and engaging others; and implement local and national learning including from serious child safeguarding incidents.

The report explained that the BWSCP had entered 2024/25 with the following main priority areas and provided information on the work and progress made on them:

- Creation of a Berkshire West-Wide Neglect Strategy
- Extra-familial Harm: Contextual Safeguarding, Exploitation and Serious Youth Violence
- Establishing a Berkshire West-wide Multi-Agency Safeguarding Hub (MASH) & Front Door Arrangements Leadership Group
- Development of the Partnership Learning and Development Group Training offer
- Continuing Development of the BWSCP Partnership

The report stated that five new priority areas had been established for 2025-28:

- Safeguarding & Support for Children and Young People from Intra Familial Harm
- Safeguarding & Support for Children and Young People from Extra Familial Harm

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- Safeguarding & Support for Children and Young People from Domestic Abuse
- Safeguarding & Support for Children Not in School
- Safeguarding & Support for Pre-School Children and Reducing Neglect

The report stated that a Joint Targeted Area Inspection (JTAI) had taken place in Reading from February-March 2025 focussing on the multi-agency response to children aged 7 and under who were victims of domestic abuse and gave details of the findings, which had found significant weaknesses in the multi-agency approach to prevention, help and support for children and their families who were victims of domestic abuse in Reading. The inspection had also found that the safeguarding partnership priorities had not been sufficiently focused on outcomes for children, which had been addressed by the development of the five new child-focused priorities set out above.

The report stated that an options appraisal of the multi-agency safeguarding arrangements in response to the findings of the JTAI was under way and it was reported at the meeting that, following consideration by lead safeguarding partners, a decision had been made to move to single local authority safeguarding arrangements and a Reading Safeguarding Children's Partnership would be established to replace the Berkshire West Children's Safeguarding Partnership.

Resolved – That the report be noted.

18. BETTER CARE FUND INTEGRATION UPDATE

Bev Nicholson submitted a report giving an update on the Integration Programme and the performance of Reading against the Better Care Fund (BCF) targets 2025/26, an update on the Community Wellness Outreach programme of health checks and wellbeing support, and an update on the South East Neighbourhood Accelerator programme in Whitley and Church Wards.

The report stated that the BCF programme was compliant with the BCF National Conditions, and the metrics had been agreed with system partners during the BCF Planning process for 2025/26. Confirmation of acceptance of the BCF plan had been received from the National Better Care Fund team on 30 May 2025. The programme was 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. It was not on track to meet the new hospital discharge targets but had 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 the dedicated hospital discharge team.

The report stated that the final BCF 2025/26 Quarterly Returns for Quarters 1, 2 and 3 had been submitted by their due dates, using the delegated authority of the Executive Director for Communities and Adult Social Care, in consultation with the Lead Councillor for Education & Public Health, and that the Reading BCF 2025/26 arrangements remained compliant with the four National Conditions and the Section 75 Deed of Variation for 2025/26 had been signed and sealed on 8 October 2025.

The Community Wellness Outreach programme had delivered over 4,400 health checks and wellbeing reviews, identifying risks early to prevent progression to cardiovascular disease. Of those seen, 78% had been from priority cohorts. There had been a 43% response rate to questions about awareness of risks, and 95% of those responding had reported improved understanding of health risks and how to make healthier choices.

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

Resolved -

- (1) That the Quarter 3 performance against BCF Metrics for 2025/26 be noted;
- (2) That it be noted that the final BCF 2025/26 Quarterly Returns for Quarters 1, 2 and 3 had been submitted by their due dates, using the delegated authority of the Executive Director for Communities and Adult Social Care, in consultation with the Lead Councillor for Education & Public Health;
- (3) That it be noted that the Reading BCF 2025/26 arrangements remained compliant with the four National Conditions and the Section 75 Deed of Variation for 2025/26 had been signed and sealed on 8 October 2025;
- (4) That the progress updates on the Community Wellness Outreach project and the South East Neighbourhood Accelerator Programme be noted.

19. DATES OF FUTURE MEETINGS

Resolved – That the meetings of the Health and Wellbeing Board for the Municipal Year 2026/27 provisionally be held at 2.00pm on the following dates, subject to any comments on the draft dates:

Formal public meetings	Informal private meetings
15 July 2026	23 September 2026
21 October 2026	9 December 2026
10 February 2027	24 March 2027

20. BOB ICB UPDATE BRIEFING

The Board received a briefing note from the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board, as at March 2026.

The report covered the following areas:

- Thames Valley ICB operating model and staff consultation
- Planning 2026/27
- Thames Valley Innovation Fund
- Dr Nick Broughton

Resolved - That the report be noted.

(The meeting started at 2.05 pm and closed at 2.39 pm)

CHAIR:.....**DATE:** 16/7/26

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READING HEALTH AND WELLBEING BOARD

Date of Meeting	16 July 2026
Title	Review of the Joint Strategic Needs Assessment
Purpose of the report	To make a decision
Report author	Paul Trinder and Isobel Braithwaite
Job title	Senior Public Health Intelligence Analyst (PT), Consultant in Public Health (IB)
Organisation	Reading Borough Council Public Health and Wellbeing Team
Recommendations	That the Health and Wellbeing Board: 1. Approves the implementation of a programme of work to strengthen the Joint Strategic Needs Assessment, ensuring that it becomes embedded as a core system-wide intelligence tool to inform decision-making, commissioning and action on health inequalities in Reading; 2. Approves the proposed governance arrangements, including the establishment of a multi-agency JSNA Steering Group and Working Group for Reading over the next 3 months, reporting to the Health and Wellbeing Board and Berkshire West Population Health Intelligence and Insights Group (PHIIG), to ensure joint ownership, oversight and delivery across system partners, and provides a steer on system representation; 3. Endorses the refreshed purpose and approach to the JSNA, including more granular analysis (with a first set of neighbourhood health profiles to be developed over the next 6 months), a stronger focus on health inequalities, community voice, service-level intelligence and action-focused insight. 4. Approves the development and use of a performance framework to monitor usage, quality, impact and alignment with Health and Wellbeing Board priorities. 5. Requests a progress update to the Health and Wellbeing Board, including detailed delivery plans in 3 months and updates on implementation progress.

1. Executive Summary

- 1.1. The Joint Strategic Needs Assessment (JSNA) is a statutory responsibility of the Health and Wellbeing Board (HWBB). It is a key tool for understanding the current and future health, care and wellbeing needs of the local population to inform and guide strategy development and the planning and commissioning of health, wellbeing and social care services.
- 1.2. A joint review of the Reading and West Berkshire JSNAs, including a stakeholder survey, workshops, attendance at RBC directorate leadership teams and good practice analysis, was carried out between October 2025 and April 2026. This has identified that while the current

JSNA is valued for its accessible, comprehensive data, consistent with national findings,¹ it is under-utilised and does not sufficiently drive action.

1.3. Key findings include:

- High awareness amongst surveyed stakeholders, but very low regular use (4.1%);
- Limited interpretation regarding the “So What?” i.e. the key implications of data and evidence presented for decision-making;
- The overarching borough-wide summary can lack an action focus;
- Gaps identified in community voice, service level data and VCSE sector insight;
- Limited influence on key policy and strategic decisions e.g. Council strategy development, master planning and health and care system strategy;
- Lack of clear governance, ownership, and communication strategy.

1.4. The review has identified a clear set of actions needed to ensure the JSNA can act as a strategic intelligence tool to underpin evidence-informed decision-making across the system. This report sets out how these will now be implemented through a time-bound improvement plan, with early delivery within 3-6 months and full embedding over time.

1.5. This is an opportunity to reposition the JSNA as the authoritative, intelligence resource for the Reading health and care system, supporting the Health and Wellbeing Board, Council Strategies and individual partner organisations to strengthen evidence-informed and joined-up action on prevention and health inequalities. It is also an opportunity to support neighbourhood health and Health In All Policies approaches through more granular local intelligence.

1.6. The proposed improvements to the JSNA process align with the Council's broader ambition to become more evidence and intelligence-led, and the work of the Reading Local Authority Research Practitioner (LARP). Underpinning them are wider programmes of work to strengthen core evidence and research skills across the Council, to develop stronger partnership working with local research institutions, to support the neighbourhood health agenda through evidence and intelligence, inform strategic decision making and to strengthen our approach to research ethics and governance, and we will monitor and evaluate the impact of the changes implemented.

1.7. This report therefore seeks the Board's approval to proceed with developing an action plan to implement identified recommendations (see appendix 1) to improve the Reading JSNA, including establishing stronger governance arrangements, implementation of early actions and development of a detailed implementation plan developed with system partners, to be brought to the HWBB in Autumn 26. These changes aim to ensure the JSNA is embedded as a key tool by the health and care system and consistently used to improve outcomes.

2. Policy Context

- 2.1. The JSNA is a statutory function of the HWBB under the Health and Social Care Act 2012, updated following the Health and Care Act 2022,² requiring local partners to jointly assess and understand the health and wellbeing needs of the population to inform service planning and commissioning. Recent national policy changes, including the Neighbourhood Health Framework, now require that neighbourhood health plans (from 2027/28) are explicitly informed by JSNA evidence and address the health inequalities it identifies.³ This represents a step change in the role of the JSNA as the core evidence base for system-wide planning and commissioning.
- 2.2. The JSNA is intended to be a foundational component of:
- The Joint Local Health and Wellbeing Strategy;
 - Commissioning decisions across local authority and NHS/ICB partners;
 - Neighbourhood health development and preventative approaches to improving population health and reducing health inequalities.
- 2.3. Current policy expectations and national good practice emphasise that JSNAs should:
- Be jointly-owned across the system;
 - Inform strategic priorities, policy development and investment decisions in an area;
 - Provide a systematic assessment of needs, including both quantitative data and qualitative insight (community voice), including residents' lived experience and voluntary, community and social enterprise (VCSE) sector perspectives;
 - Identify and reduce health inequalities, including for health inclusion groups;
 - Be accessible and easy to navigate;
 - Incorporate features such as dashboards and interactive maps for different geographies;
 - Support Health in All Policies approaches.
- 2.4. The current Reading JSNA is not a single product, but a range of resources hosted on the [Reading Observatory](#).⁴ Overall the JSNA process comprises outputs at the following levels:
1. A recently introduced State of the Borough JSNA Report,⁵ proposed to be published every two years going forwards, in conjunction with self-serve outputs from the Reading Observatory);
 2. 'Deep dive' Health Needs Assessments on priority areas, identifying health and unmet health and wellbeing needs within a defined topic area;
 3. Data updates, local area population health profiles (e.g. ward profiles developed for Whitley and Church), and/or factsheets on specific topics of local relevance.
- 2.5. The findings from the local review indicate that, while the Reading JSNA broadly aligns with its statutory purpose, current delivery does not fully meet the above expectations, particularly regarding:
- Joint ownership and consistent use to inform decision making and commissioning;
 - Integration of community voice and service intelligence;
 - Clarity of purpose and accessibility for users.

² [JSNA and JHWS statutory guidance - GOV.UK](#)

³ [Joint Strategic Needs Assessment: A springboard for action | Local Government Association](#)

⁴ [Berkshire Observatory – Reading – Welcome to the Reading Observatory](#)

⁵ [Berkshire Observatory – Reading – New “State of the Borough” Joint Strategic Needs Assessment \(JSNA\) Report for Reading – Berkshire Observatory – Reading](#)

- 2.6. The proposed improvement programme is therefore consistent with statutory duties but represents a necessary evolution of policy into practice, ensuring the JSNA fulfils its intended role as a decision-support and system leadership tool.

3. **The Proposal**

- 3.1 Findings from the review process indicate a need for further development of the JSNA process. The review findings demonstrate that the current JSNA provides a wide range of data, reports and geographies, accessible via the Berkshire Observatory. It is positively rated and valued for its breadth, presentation and accessibility, and can support a range of uses including awareness, strategy and planning.

- 3.2 However, key limitations include:

- Low regular use and unclear purpose across stakeholders;
- Lack of clear and shared system governance, engagement and communication;
- Limited interpretative commentary and action-focused insight (making clear the “So What” of quantitative findings for policies and service planning);
- Gaps in community and voluntary sector voice, service-level data and community asset mapping;
- Lack of small area analysis to inform local and neighbourhood decision making.

- 3.3 This suggests that the JSNA is currently data rich but underutilised and has limited impact on system-level decisions.

- 3.4 The key recommendations proposed are:

1. Clarify and agree the purpose, scope, and role of the JSNA so it is clearly understood, aligned to HWBB priorities, and focused on solving real system and community problems;
2. Establish the ‘State of the Borough’ JSNA report as a regular biennial high level summary of the key health challenges and needs across Reading;
3. Establish strong governance arrangements and shared ownership to ensure the JSNA remains current, relevant, and used, moving it towards a ‘living’ JSNA;
4. Make interpretive commentary and action-focused insight a mandatory part of all JSNA outputs, including within the 2-yearly State of the Borough JSNA reports, and strengthen the quality and impact of deep-dive Health Needs Assessments (HNAs);
5. Make health inequalities a central, visible, and consistent focus across the entire JSNA, and develop granular insights (e.g. neighbourhood health profiles) for small areas;
6. Embed community voice and lived experience throughout the JSNA using co-production approaches, and ensure the JSNA identifies and maps community assets alongside needs;
7. Strengthen the JSNA’s role in linking need to service provision and holding the health and care system to account;
8. Embed Health in All Policies across the JSNA to influence decisions beyond health service (e.g. to support completion of health impact assessments);
9. Modernise how data is analysed, interpreted, and presented to improve insight and usability;
10. Redesign the JSNA to be accessible, user-friendly, and consistent, and ensure JSNA outputs are tailored to key audiences, including HWBB members, commissioners, integrated neighbourhood teams and VCSE partners;
11. Actively promote and champion the JSNA to build awareness, increase routine use and demonstrate its value.

- 3.5 These insights and key recommendations have informed development of the proposed options set out in greater detail below.

- 3.6 Early actions will include strengthening communication and visibility of JSNA outputs, including regular intelligence updates and development of a system-wide data and intelligence newsletter to promote new insights and datasets.
- 3.7 The intention is that the JSNA becomes the central, shared intelligence framework for the Reading system, and that it is routinely used to inform and challenge strategic and commissioning decisions across the system. Rather than duplicating existing datasets, it will bring together and work to better integrate data and intelligence from across the Council, NHS/ICB, Connected Care and VCSE partners into a coherent, strategic view of need, inequalities and service response. This will support consistent, evidence-informed decision-making across all partners and will ensure the JSNA provides the evidence base for neighbourhood health planning in Reading, in line with national requirements.⁶
- 3.8 Additional detail and proposed actions aligned to each of these are provided in the slide set in Appendix 1, and additional detail on the proposed implementation timetable is set out in section 11.0, with early implementation beginning within the first 6 months.
- 3.9 **Governance and accountability**
- 3.10 We propose that governance will be provided through:
- JSNA Steering Group – including senior leaders across the Council, NHS primary and secondary care, ICB, and VCSE (strategic oversight at Reading level);
 - JSNA Working Group – analysts and delivery leads (implementation);
 - Reporting to the Reading Health and Wellbeing Board and (via a dotted line) to the Berkshire West level Population Health Intelligence and Insights Group (PHIIG) - see Appendix 1, slide 17.
- 3.10 The proposed governance arrangements will formalise the expected role of the JSNA in informing strategic priorities and commissioning decisions across partners. The JSNA will be explicitly aligned with HWBB priorities and reviewed annually by the Board.
- 3.11 Options appraisal
- Option 1: Maintain the current JSNA approach (current position)**
- Continue with existing inputs, structure and outputs.
- Option 2: Incremental improvements to the Reading JSNA**
- Improve selected elements (e.g. regular data updates, work to improve usability and accessibility, regular stakeholder communications, additional reports).
- Option 3: Comprehensive JSNA improvement programme**
- Implement a structured, phased programme to address the above recommendations, strengthen JSNA governance and position the JSNA as a system-wide intelligence and decision support tool, with stronger joint ownership across HWB partners.
- Option 4: Comprehensive improvement programme with additional technical support (Recommended)**
- As above for Option 3 but including additional resourcing to support a programme of re-design and improved user-accessibility of the Berkshire Observatory website, potentially incorporating improved automated outputs at ward and other new locally-defined small area geographies, such as Neighbourhood Health Profiles.

	Option 1	Option 2	Option 3	Option 4
Advantages	- No additional resource or changes to governance and engagement required; - Maintains existing data provision.	- Less resource-intensive than 3/4; - Limitations partially addressed; - Some improvement in usability and content.	- Addresses most key issues identified in the review; - Aligns with statutory purpose and best practice; - Strengthens decision-making, commissioning and impact; - Creates a sustainable, system-owned resource.	As per Option 3, with improved functionality and user-accessibility of the Berks Observatory.
Dis-advantages	- Does not address low usage or impact - Risks continued disconnect of intelligence from decision-making; - Fails to respond to stakeholder feedback.	- Does not fully address issues of purpose, governance, community voice and impact; - Risk of continuing lack of a joint approach; - Limited improvement in community voice; - Limited system-wide change.	- Will require buy-in and coordinated effort across all HWB partners; - Requires programme management and governance; - May require additional analytical resource to ensure sustainability; - Consideration of additional resource needed to support community voice and co-production.	Additional resource requirement relative to Option 3.

3.12 The options above demonstrate that partial or minimal change would not address the core issues identified, particularly around the JSNA's purpose, ownership, and impact.

3.13 Maintaining the status quo or making incremental changes risks continuing underuse of the JSNA, resulting in limited system influence and missed opportunities to target resources effectively, reduce health inequalities and support evidence-informed work at a neighbourhood level. This would not represent best value given the existing JSNA resource and system ambitions.

3.14 Additional resource for Option 4 would come from the Public Health Grant to make the necessary changes to the Berkshire Observatory, as well as the exploration of additional tools and resources to strengthen the JSNA e.g. asset mapping functionality. Furthermore, Members of the Health and Wellbeing Board will be required to actively engage in the ongoing development and JSNA process/

3.15 Monitoring and evaluation

3.16 A performance framework will be developed and used by the Steering Group to monitor progress and impact, across each of the 10 recommendation areas above (in section 3.3), with KPIs co-produced with partners. Benefits will be tracked over time, moving from improved clarity and engagement to better decision-making, and ultimately toward improved outcomes and reduced inequalities.

4.0 Conclusions

4.1 The evidence demonstrates a clear need to reposition and strengthen the JSNA to ensure it fulfils its statutory and strategic role.

4.2 A comprehensive programme to implement the recommended improvements to the Reading JSNA including commissioned improvements to the Berkshire Observatory (Option 4) is the recommended option as it:

- Better aligns the JSNA with HWBB priorities
- Embeds it in system decision-making
- Strengthens action on health inequalities
- Ensures long-term relevance, sustainability and impact

4.3 The Board is therefore recommended to approve Option 4 to improve the JSNA in line with the review findings.

5.0 Contribution to Reading's Health and Wellbeing Strategic Aims

5.1 The proposed improvements to the JSNA will directly support delivery of Reading's Health and Wellbeing Strategy by:

1. Reducing health inequalities (differences in health between different groups of people) and reducing unwarranted variation, through improved identification of inequalities in need and outcomes at neighbourhood and population-group level;
2. Enabling evidence based decision-making and commissioning across partners;
3. Strengthening prevention and early intervention, including in relation to children and families, adults at high risk of poor health outcomes, and mental health and wellbeing across the life course, supported by better insight and asset mapping;
4. Embedding a Health in All Policies approach, influencing wider determinants such as housing, planning, employment and the local environment;
5. Increasing community involvement and co-production, ensuring services reflect lived experience;
6. Through all of the above, better supporting integrated, evidence-based and neighbourhood-level working across the health and care system.

5.2 Overall, the refreshed JSNA will act as a core enabler of the Health and Wellbeing Strategy, ensuring that decisions and priorities are informed by robust, actionable, and jointly-owned intelligence and insights, and that the JSNA's development in turn is informed by the HWB's strategic priorities.

6.0 Environmental and Climate Implications

6.1 The proposal is consistent with the Council's Climate Emergency declaration (February 2019) and aligns with the objectives of the Reading Climate Emergency Strategy. While no direct, significant impacts on emissions, resource use or biodiversity are anticipated, the decision has the potential to deliver minor positive climate and environmental benefits. In particular, the improved JSNA could support improved use of intelligence and evidence in areas such as planning, housing and transport policy-making (e.g. through strengthened Health Impact Assessments and data insights). These in turn can help to inform and enable more effective mitigation and climate adaptation actions, especially for vulnerable groups. full Climate Impact Assessment is not considered proportionate.

7.0 Community Engagement

7.1 Stakeholders from RBC and partner organisations including the NHS, Healthwatch, voluntary sector, University sector responded to the JSNA survey which has shaped the recommendations underpinning this paper.

7.2 In addition, engagement with the HWB including RBC officers, Councillors and the voluntary sector took place as part of a HWB Workshop (10/02/2026), along with further engagement with leaders across multiple RBC Directorates (30/03/2026 and 29/04/2026).

8.0 Equality Implications

8.1 The recommended improvements are explicitly designed to strengthen the identification and reduction of inequalities across the population and therefore has a positive equality impact overall.

8.2 Assessment against the Public Sector Equality Duty questions:

1. Risk of discrimination, harassment or victimisation

There is no anticipated risk of discrimination, harassment or victimisation. The proposal relates to strengthening the JSNA as an evidence and intelligence tool, rather than the provision of services, and this is expected to reduce the risk of unequal or uninformed decision-making.

2. Impact on access, participation in activities, disadvantages and inequalities

Yes - the proposal is expected to have a positive impact on this. Current evidence shows gaps in community voice, service-level data and inequalities analysis within the JSNA, meaning some groups' needs may not currently be fully understood. The proposed improvements directly address this. See further details in Appendix 2.

3. Impact on community relations, prejudice and understanding

Yes – the proposal is expected to have a positive impact on these. By strengthening how we embed community voice, qualitative insights and lived experience, and ensuring a stronger focus on health inequalities and inclusion groups within all Needs Assessment outputs, it is anticipated that the improved JSNA will help to improve understanding of different communities and their needs. It aims to support a more inclusive, evidence-led approach to population health and wellbeing.

8.3 Conclusion / EIA requirement

As the proposal is expected to have a positive equality impact ('Yes' answered to Qs.2 and 3) and supports the reduction of inequalities, a full Equality Impact Assessment (EqIA) has been undertaken (Appendix 2). This will be reviewed at key design and implementation.

9.0 Other Relevant Considerations

9.1 Procedural requirements

The proposal follows established HWBB governance processes. It introduces strengthened governance (including a proposed new JSNA Steering Group and Working Group, reporting to the PHIIG and HWB) rather than departing from existing procedures.

9.2 Consultation and engagement

The JSNA review has already included stakeholder survey and workshop engagement. Future improvements to the JSNA will embed ongoing engagement and co-production with communities, VCSE and system partners to meet legitimate expectations for consultation.

9.3 Risk management implications

Key risks include:

- Insufficient resources to deliver recommendations from the review
- Low partner engagement
- Data overload without impact
- JSNA becoming rapidly outdated

Mitigations include:

- Consideration of a fixed term jointly-appointed public health/corporate intelligence team analyst role to strengthen data integration across Directorates
- Formal governance and shared ownership
- Mandatory "So What / What Next" insight
- Scheduled review, update and monitoring processes

9.4 Transparency and Freedom of Information

The JSNA supports transparency through publicly accessible data and intelligence. Future activities will improve clarity, accessibility and communication of information.

10.0 Privacy Impact Assessment

A Privacy Impact Assessment (DPIA) will be undertaken where required, particularly where new data sources or linked datasets (e.g. Connected Care) are utilised.

11.0 Impact on Human Rights Act duties

No adverse impact is identified. The proposal supports fair and equitable decision-making, aligning with human rights principles.

12.0 Effects on the Armed Forces Community

The improved JSNA will improve identification of needs across all population groups through systematic inclusion of health inclusion groups including the Armed Forces community, within the JSNA and deep-dive Needs Assessments conducted.

13.0 Corporate Parenting

The inclusion of care experience as a locally-recognised characteristic within inclusion health components of the JSNA will strengthen understanding of needs for children in care and care leavers, supporting corporate parenting responsibilities.

14.0 Community safety implications

Improved intelligence on population need may support better targeting of community safety and prevention interventions.

15.0 Others

Not applicable.

16.0 Legal Implications

16.1 The JSNA is a statutory responsibility of the Health and Wellbeing Board under the Health and Social Care Act 2012. The Board therefore has the power to produce and maintain a Joint Strategic Needs Assessment and to use this to inform strategic priorities and commissioning. This report seeks approval to refresh and strengthen the delivery of this statutory function.

16.2 No additional formal delegation is required beyond existing HWBB authority, although regular oversight will be supported through the proposed JSNA Steering Group. All governance arrangements will operate within existing partnership decision-making frameworks.

16.3 Jayne La Grua (Director, Legal and Governance) has cleared these Legal Implications.

17.0 Financial Implications

17.1 Budget provision: The proposed improvements to the JSNA will primarily be delivered within existing Public Health Intelligence resourcing and partner resources.

17.2 No new core budget allocation is requested at this stage. It is expected that the Public Health Grant will cover all related expenditure. Existing expenditure relating to the JSNA (Berkshire Observatory platform costs) is covered by the Public Health Grant (joint agreement).

17.3 We will explore options for further development of the Berkshire Observatory (anticipated costs c. £20-50K) and to support the inclusion of qualitative insight and community voice (requires further scoping). These costs, expected to apply within the 26/27 financial year and on a 2-year pilot basis in relation to community voice, are indicative only at this stage, and would initially be funded from the Public Health reserve; final proposals regarding any additional expenditure will return to the Public Health Board for decision.

- 17.4 The proposal represents strong value for money as it is expected to:
- Improve the effectiveness and use of an existing statutory resource;
 - Support better, evidence-based commissioning and resource allocation;
 - Enable improved identification of unmet need and inefficiencies;
 - Strengthen preventative approaches, contributing towards reducing longer-term cost pressures for front-line services.
- 17.5 This will in turn support more efficient use of public resources.
- 17.6 Risk assessment of key financial risks: There is a risk that delivery within existing resources (particularly analytical capacity) may constrain pace and scope; this will be managed through phased implementation and prioritisation of early actions. Future development costs will be reviewed as part of ongoing budget planning. The above costs are indicative only at this stage and further decisions will return to the PH Board.
- 17.7 Katie Marriner (Head of Finance; Adult Social Care & Communities) has cleared these Financial Implications.

18.0 Timetable for Implementation

- 18.1 Implementation will be phased as follows to ensure early impact and sustainable improvement, whilst working within intelligence team capacity:

0-3 months (immediate actions):

- Develop detailed delivery plan;
- Establish new JSNA governance arrangements (Steering Group and Working Group);
- Agree JSNA purpose and priorities;
- Scope options for commissioned improvements to the Berkshire Observatory platform and/or a new external JSNA platform;
- Scope format of neighbourhood-level profiles and gather best practice.

3–6 months (early delivery):

- Develop structured templates for all priority JSNA outputs reflecting review recommendations, including addressing “So What?” questions, and guidance for incorporating community voice;
- Pilot new ethics and governance review process on a test-and-learn basis, aiming to provide ethical assurance and improve the quality of qualitative and quantitative data collection;
- Develop and seek stakeholder feedback on a first round of Neighbourhood Health profiles;
- Develop measures to improve inclusion of community voice, including residents’ lived experience and VCSE perspectives, within the JSNA and to support neighbourhood working. This will involve multiple steps, including: delivery of training for team members in co-production and qualitative methods, establishment of basic participation infrastructure and resourcing, and in conjunction with the community participatory action research (CPAR) programme where applicable (e.g. to support deep-dive health needs assessments).

6–12 months (embedding):

- Review how new governance arrangements are working in practice and ensure effective joint representation;
- Strengthen service-level and cross-Council data integration, including through mapping of available datasets, health intelligence team training on Connected Care

and progress data sharing arrangements and initial integration of additional datasets into JSNA outputs (e.g. Neighbourhood Health Profiles and deep-dive HNAs);

- Improve usability and accessibility of JSNA outputs;
- Embed JSNA in commissioning and strategy processes;
- Evaluate impact and effectiveness of improved JSNA outputs with system partners.

12–24 months (sustained improvement and evaluation)

- Full embedding of improved JSNA approach and ensuring consistent use by Council Directorates and system partners as the core system intelligence function;
- Ongoing monitoring and evaluation of impact and ongoing improvement.

18.2 An update with a detailed delivery plan and progress against the recommendations will be brought to HWBB in Autumn 2026.

19.0 Background Papers

19.1 There are none.

Appendices

1. Accompanying slideset - Review of the Joint Strategic Needs Assessment for Reading 2025-26: Background, Key Findings and Recommendations
2. Equalities Impact Assessment

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Review of the Joint Strategic Needs Assessment for Reading 2025-26: Background, Key Findings and Recommendations

*Accompanying Paper for Reading Health and Wellbeing Board -
July 2026*

Paul Trinder

Senior Public Health Intelligence Analyst



Background

- A Joint Strategic Needs Assessment (JSNA) is a process through which the current and future health, care and wellbeing needs of the local population are assessed to inform and guide the planning and commissioning of health, wellbeing and social care services within a local authority area. Under the 2012 Health and Social Care Act, local Health and Wellbeing Boards (HWBB) are responsible for producing a JSNA.
- A JSNA is:
 - **Joint** – owned by, and for the benefit of, all HWBB partners
 - **Strategic** – high level, identifying the key priorities for an area and informing the Joint HWB Strategy.
 - **Needs Assessment** – outlines the health and wellbeing needs of residents
- The current Reading JSNA is not a single product, but a range of resources hosted on the [Reading Observatory](#).
- A recent Local Government Association review of the HWBB identified issues and opportunities relating to the JSNA and highlighted the need for improvement to ensure the JSNA is fit for purpose.
- The purpose of this review is to ensure the Reading JSNA is fit for purpose for informing the HWBB and partner organisations about the needs of local people to support decision making to improve their health and wellbeing outcomes.
- This also aligns with the Council's ambition to become more evidence and intelligence-led, and the work of the Reading Local Authority Research Practitioner over the coming 18 months.

Objectives of the Review

- Review the required functions and use of the Reading JSNA.
- Determine whether the current JSNA is fulfilling its function and, if not, what we can change to improve this.
- Review how the JSNA is governed, produced and delivered and what the final product looks like.



Methodology

- 3 stages to the review:

Stage 1

- **Initial review by JSNA Leads for Reading and West Berkshire**

Identified strengths and areas for improvement of the current JSNA focusing on its content, output, and process (creation and post-production).

- **Review of good practice**

Page 26
Review of JSNA examples of good practice from other local authorities to help identify what works well elsewhere and what could be adapted or improved to increase the value of the JSNAs in Reading and West Berkshire.

- **JSNA Survey**

A survey was distributed to stakeholders to help understand levels of awareness and use of the JSNA.

- **Review of the Reading and West Berkshire Observatory**

This explored the cost, design, and use of the Reading and West Berkshire Observatory.

- Emerging themes for recommendations generated from Stage 1.



Methodology

Stage 2

- **HWBB engagement**

Findings from Stage 1 and emerging themes for recommendations shared with HWBB members.

- Engagement included an interactive workshop focused on prioritising emerging themes alongside a broader discussion on what data should be included in the JSNA and what should the JSNA be used for.
- Additional themes for recommendations generated from Stage 2.

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Stage 3

- **Directorate Leadership Team (DLT) engagement**

Findings from Stage 1 and emerging themes for recommendations shared with DLT members from Adults, Children and Place Directorates.

- Involved feedback and discussion on the JSNA Survey findings and emerging themes alongside a broader discussion on what data should be included in the JSNA and what should the JSNA be used for.
- Additional themes for recommendations generated from Stage 3.

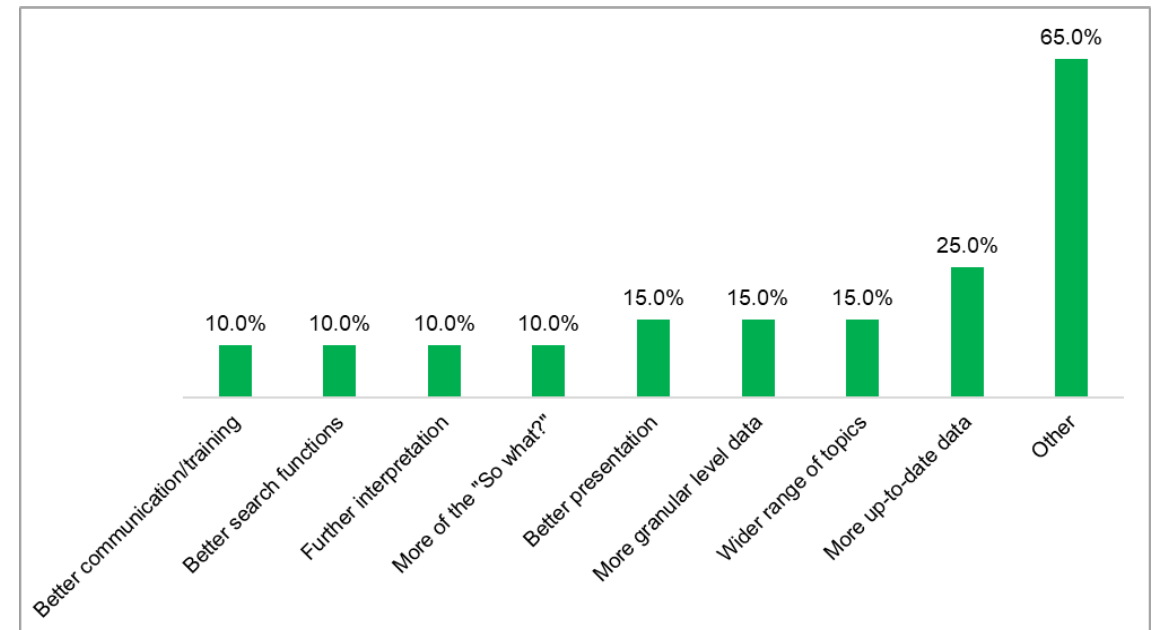


Reading JSNA Review – summary of survey findings

83 valid respondents; **76%** had heard of the JSNA; 79% knew how to access it; 90% used the JSNA **occasionally or rarely**; 4.1% (2) used it **regularly**.

- 9.3% (4 respondents) rated the JSNA as **excellent**, 81.4% (35/43) rated it as either **very good or good**, no-one rated the **JSNA as poor**.
- The top three themes that people liked about the JSNA was that it was **accessible to use and navigate** (34.8%), it included a **broad range of data** and it was **well-presented** (both 30.4%).
- The top five most common uses of the JSNA were: **general awareness** (59.1%), **policy/strategy development** (50%), **needs assessments** (45.5%), **service planning** (43.2%), and **deciding priorities** (40.9%).
- 50% (22/44) thought there was **something missing** from the JSNA; the two main themes about what was missing were a **lack of internal and partnership data** and **detailed information on specific geographies and cohorts**.

What changes can be made to the JSNA to make it better?



Number of respondents = 23 (35 total responses)

Reading JSNA Review – areas for improvement

- Establish **HWBB governance** and **joint ownership** of the JSNA programme
- Data quality, relevance, and scope
 - Implement a process for **regular review, archive, and update** of JSNA content
 - Ensure all JSNA outputs include **interpretative comment** and **implications for services/action** ("So What?")
 - Develop the JSNA as a “Living” document
- Inclusion of **community voice** and **assets**, ensuring marginalised groups are represented
- Usability, navigation, design and communication
 - Investigate feasibility of **displaying data** in different ways
 - Make information easy to find
 - **Improve system communication** about the JSNA
- Place-based and **granular data**, aligned to the **neighbourhood health agenda**
- Ensure all **stakeholders** are **jointly involved in** and **collaboratively own** the JSNA
- Embed the development and delivery of **Health in All Policies** in the JSNA
- Implement a process and **training for wider staff on deep-dive HNA production** (HNAs seen as the most valuable by survey respondents)



Recommendations

1 Clear purpose, scope and alignment

- **Recommendation**

Clarify and agree the purpose, scope, and role of the JSNA so it is clearly understood, aligned to HWBB priorities, and focused on solving real system and community problems.

- **Key actions**

- Agree the core purpose of the JSNA (what problems it aims to solve);
- Align JSNA priorities explicitly with HWBB priorities and outcomes;
- Review whether there should be alignment with, or contribution to, a Berkshire-wide JSNA through further engagement with wider Berkshire partners;
- Clarify how the JSNA supports commissioning, neighbourhood working, and system planning and the interface with the new ICB-level PH Intelligence Unit.



Recommendations

2 Establish the 'State of the Borough' JSNA report as a regular biennial high-level summary of the key health challenges and needs across Reading

- **Recommendation**

Following on from the State of the Borough Report initiated in 2025, establish the 'State of the Borough' JSNA report as a structured, overarching borough-level summary report published every 2 years, aligned to JSNA priorities and ensuring its use as a structured tool to inform system decision-making

- **Key actions**

- Align the State of the Borough report with the JSNA and Health and Wellbeing Board cycle
- Embed community insight and co-production with Council and system partners within the report development process
- Use the report as a strategic tool to inform neighbourhood health plan development and system decision-making



Recommendations

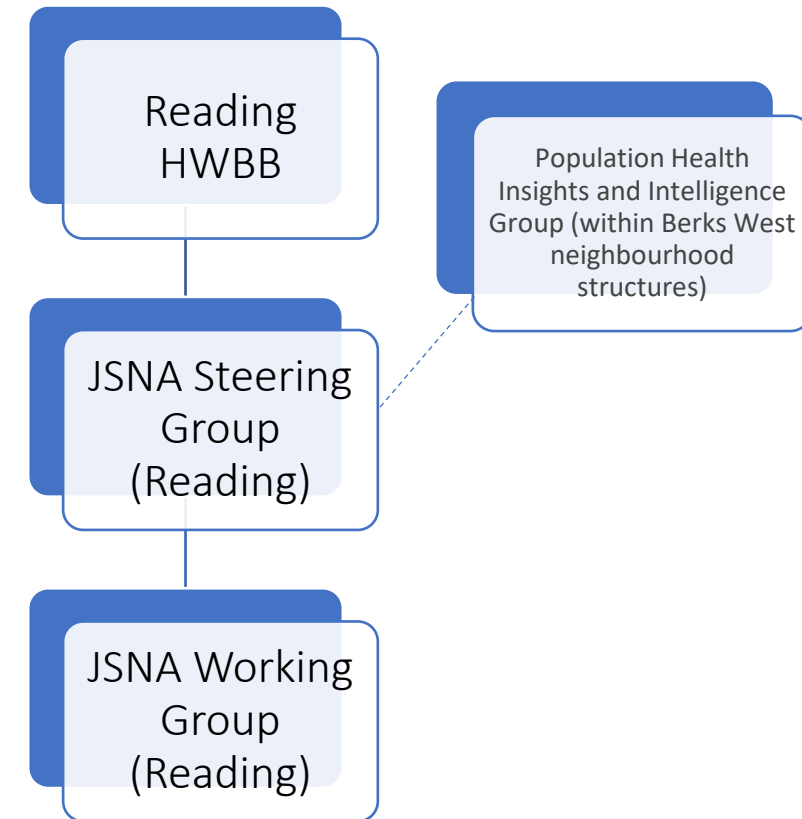
3 Engagement, governance and sustainability

• Recommendation

Establish strong governance arrangements and shared ownership to ensure the JSNA remains current, relevant, and used, moving it towards a 'living' JSNA.

• Key actions

- Establish a JSNA Steering Group (providing joint, strategic oversight) and Working Group (including analysts from partner organisations and leading implementation) at Reading level, with the Steering Group reporting to the HWBB and via a dotted line to the PHIIG (Population Health Insights and Intelligence Group) at Berkshire West level, to support connections with neighbourhood health governance;
- Agree a rolling programme of work, including a 2-yearly State of the Borough Report, with clear timelines;
- Ensure council directorates, NHS, VCSE, and partners are actively involved;
- Review JSNA and Observatory content item by item;
- Implement review, update, and archive schedules.



Recommendations

4 “So What?” and “What Next?” – moving from insight to action

- **Recommendation**

Make interpretive commentary and action-focused insight a mandatory part of all JSNA outputs, including within 2-yearly 'high level' State of the Borough JSNA reports, and strengthen the quality and impact of deep-dive Health Needs Assessments (HNAs).

- **Key actions**

- Commit to publishing State of the Borough JSNA reports on a 2-yearly rolling basis for system partners' use;
- Ensure that each State of the Borough JSNA section, and deep-dive HNA outputs, includes:
 - So What? – implications for people, services, and places
 - What Next? – actions for strategy, commissioning, and delivery;
- Support training, Health Needs Assessment templates, and JSNA champions to appraise and reference evidence on what works to improve outcomes, and to embed JSNA use to inform action.

Recommendations

5 Health inequalities focus and granular, local-level population insight

- **Recommendation**

Make health inequalities a central, visible, and consistent focus across the entire JSNA, and develop granular insights for small areas.

- **Key actions**

- Use granular geographic and demographic data and present health intelligence and insights for smaller geographies to support decision-making (e.g. at neighbourhood and ward level);
- Analyse inequalities by place, population group, and service access;
- Develop local capacity for future modelling to predict emerging inequalities and need.



Recommendations

6 Community voice, co-production and lived experience

- **Recommendation**

Embed community voice and lived experience throughout the JSNA, and ensure the JSNA maps community assets alongside needs.

- **Key actions**

- Explore opportunities to develop participation infrastructure, building on existing local assets, and make further use of participatory research approaches to strengthen inclusion of qualitative insight, to improve understanding of the needs and experiences of groups experiencing structural disadvantage and poor health outcomes;
- Explore options to co-produce asset mapping and needs analysis with the voluntary, community and social enterprise (VCSE) sector and communities;
- Include detailed case studies and narratives where appropriate.



Recommendations

7 Service-level and system intelligence

- **Recommendation**

Strengthen the JSNA's role in linking need to service provision and ensuring local accountability of the health and care system.

- **Key actions**

- Strengthen data sharing, map available datasets across the system to strengthen understanding of the landscape, and include additional service-level data from NHS, Adult Social Care, VCSE, and Connected Care;
- Compare prevalence of need with service access and outcomes and highlight gaps, variation, and unmet need (e.g. children's mental health);
- Ensure stronger connections between Council (including public health, social care and other Directorates), ICB, and Connected Care datasets;
- Ensure system partners are involved in shaping the overall JSNA and deep-dive Health Needs Assessments.



Recommendations

8 Health in All Policies

- **Recommendation**
Embed Health in All Policies across the JSNA to influence decisions beyond health services.
- **Key actions**
 - Strengthen intelligence and analysis around the health impacts of housing, transport, employment, culture, leisure, and planning;
 - Provide practical examples showing how services can respond to data insights;
 - Support preventative and upstream action across Council directorates.



Recommendations

9 Data journey, innovation and AI

- **Recommendation**
Modernise how data is analysed, interpreted, and presented to improve insight and usability.
- **Key actions**
 - Clearly describe the data journey: data → insight → action
 - Explore further use of AI to support:
 - Interpretive narrative (“what does the data mean?”)
 - Search and navigation
 - Future modelling
 - Use case examples to show applied intelligence in practice.



Recommendations

10 Structure, accessibility and user experience

- **Recommendation**

Redesign the JSNA to be accessible, user-friendly, and consistent and ensure JSNA outputs are tailored to key audiences, including HWBB members, commissioners, integrated neighbourhood teams and VCSE partners.

- **Key actions**

- Redesign the landing page, navigation, and overall structure;
- Rebrand the JSNA with a clear, understandable title;
- Ensure all documents meet accessibility standards;
- Explore opportunities to develop interactive dashboards and customisable reports.
- *Note: exact options and costs underpinning these improvements will need to be finalised with the external provider (or alternative providers) over the coming months.*



Recommendations

11 Communications, awareness and impact

- **Recommendation**

Actively promote and champion the JSNA to build awareness, increase routine use and demonstrate its value.

- **Key actions**

- Develop targeted re-branding and communication strategies for different user groups (internal and external);
- Clearly articulate what problems the JSNA solves;
- Use Google Analytics to understand usage, alongside qualitative feedback;
- Share impact stories and case studies showing how the JSNA has driven change.



Options for HWBB consideration

- **Option 1: Maintain the current JSNA approach**
Continue with existing inputs, structure and outputs.
- **Option 2: Incremental improvements to the existing JSNA**
Improve selected elements (e.g. data updates, work to improve usability and accessibility, regular stakeholder communications, additional reports).
- **Option 3: Comprehensive Internal JSNA Refresh Programme – all recommendations and actions outlined**
Implement a structured, phased refresh programme to strengthen JSNA governance and transform the JSNA into a system-wide intelligence and decision support tool, with stronger joint ownership across HWB partners.
- **Option 4: Comprehensive Internal refresh with additional technical support**
As above for Option 3 but including additional resourcing to support a programme of re-design and improved user-accessibility of the Berkshire Observatory website, potentially incorporating additional automated outputs beyond ward geographies, such as Neighbourhood Health Profiles. Further engagement with the provider and other Berkshire LAs will be required to refine options and establish expected costs.



Decisions required

The Health and Wellbeing Board is asked to:

- Approve the proposed improvements to the JSNA
- Approve the proposed new JSNA governance arrangements and provide input on system representation
- Endorse the JSNA's purpose as a core system intelligence tool to underpin evidence-based decision-making.



Next steps

Subject to approval by the HWBB:

- Governance arrangements established within the next 3 months
- Early improvements delivered within 6 months
- Phased implementation:
 - Co-design of delivery plan with partners
 - Data and analytical improvements, including exploring procurement of a new or refreshed Reading Observatory
 - Content refresh and pilot outputs
 - Relaunch and embedding
- Updates to HWBB on delivery plan, progress and impact.



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Equality Impact Assessment

A. Information about the policy

Policy title	JSNA Review and Refresh Programme
Lead officer (name and role)	Isobel Braithwaite, Consultant in Public Health
Date of assessment (dd/mm/yyyy)	20/5/2026
Summary of the policy	Review of the Reading Joint Strategic Needs Assessment (JSNA) and proposal of a JSNA Refresh Programme to strengthen the Joint Strategic Needs Assessment as a core system-wide intelligence tool to inform decision-making, commissioning and action on health inequalities in Reading.

B. Initial assessment

	Assessment
PSED Aim 1 (unlawful behaviour): Could your policy lead to direct or indirect discrimination, harassment, victimisation, or any other conduct prohibited by the Equality Act 2010?	No - there is no anticipated risk of discrimination, harassment or victimisation. The proposal relates to strengthening the JSNA as an evidence and intelligence tool, rather than the provision of services, and this is expected to reduce the risk of unequal or uninformed decision-making.
PSED Aim 2 (equal opportunities): - Could your policy affect how service users or employees access services or participate in activities relevant to your policy area? - Could it impact people with particular protected characteristics who have a disproportionately low level of access to services, participation in public life, or other activities? - Could it create or worsen disadvantages and inequalities in your community? - Could it remove or minimise disadvantages and inequalities in your community?	Yes - the proposal is expected to have a positive impact on how people with protected characteristics access services and experience inequalities in the local area through more informed decision making. Current evidence shows gaps in community voice, service-level data and inequalities analysis within the Reading JSNA, meaning some groups' needs may not currently be fully understood. The refresh directly addresses this. The programme is expected to help reduce existing inequalities and improve equitable access to services, including for those with protected and locally-identified characteristics. There is no anticipated risk that it could create or worsen disadvantages and inequalities in Reading.

PSED Aim 3 (good relations): • Could your policy affect how people perceive or interact with others? • Could it help tackle prejudice and promote understanding between people with different protected characteristics? • Could it lead to prejudice, community tensions, conflicts, isolation, or segregation?	Yes – the proposal is expected to have a positive impact on these. By strengthening how we embed community voice, qualitative insights and lived experience, and ensuring a stronger focus on health inequalities and inclusion groups within all Needs Assessment outputs, it is anticipated that the refreshed JSNA will help to improve understanding of different communities and their needs and help tackle structural inequalities. It aims to support a more inclusive, evidence-led approach to population health and wellbeing. There is no anticipated risk that the proposal will increase prejudice, tension or segregation.
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C. Full assessment

i. Impact on protected characteristics

Protected characteristic	Expected impact	Evidence
Age	Positive	It is intended that each of these protected and locally identified characteristics will be systematically included within the refreshed Needs Assessment process through consideration of health inequalities and inclusion health groups, helping to reduce the inequalities they face and improve inclusive local decision-making and service provision for each of these groups.
Disability	Positive	See above comment.
Gender reassignment	Positive	See above comment.
Pregnancy and maternity	Positive	See above comment.
Race	Positive	See above comment.
Religion or belief	Positive	See above comment.
Sex	Positive	See above comment.
Sexual orientation	Positive	See above comment.
Marriage and civil partnership	Positive	See above comment.

Membership of the armed forces community*	Positive	See above comment.
Socio-economic disadvantage*	Positive	See above comment.
Experience of care*	Positive	See above comment.

*Additional characteristics identified by the Council to be considered in Equality Impact Assessments.

ii. Mitigating Actions

Negative impact	Mitigating action
None identified	N/A

iii. Monitoring and Review

Equalities impacts for each of these groups will be monitored and reviewed annually through the refreshed JSNA governance process.

D. Approval

Approving officer (name and role)	Date (dd/mm/yyyy)

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READING HEALTH AND WELLBEING BOARD

Date of Meeting	16 July 2026
Title	Whole System Approach to Healthy Weight Strategy and Implementation Plan 2026-2036
Purpose of the report	To make a decision
Report author	Amanda Nyeke/Nina Crispin
Job title	Public Health Principal/Public Health Practitioner
Organisation	Reading Borough Council
Recommendations	That the Health and Wellbeing Board: 1. endorse the Reading Whole Systems Approach to Healthy Weight Strategy (2026-2036) and its proposed governance arrangements; 2. supports the prioritised Initial Implementation Plan (2026-28) for the first 2 years of the strategy as outlined in Appendix B; 3. agrees to receiving annual updates of the delivery against the action plan for the Healthy Weight Strategy.

1. Executive Summary

- 1.1. On the 14th of March 2025, the Reading Health and Wellbeing Board endorsed the development of a Whole Systems Approach to Healthy Weight for Reading, recognising the scale and complexity of obesity and the need for coordinated, system wide action.
- 1.2. Since then, a comprehensive, evidence-informed and co-produced strategy has been developed through multi-agency collaboration, including stakeholder workshops, a task and finish group, and engagement with system leaders, the One Reading Partnership Board, and other key groups to ensure alignment with priorities such as Best Start in Life and strengthen system-wide ownership.
- 1.3. Engagement through these processes has reinforced strong support for a whole systems approach and clarified the role of the Health and Wellbeing Board in providing strategic oversight, system leadership, and support to unblock barriers to delivery.
- 1.4. The strategy sets out a ten-year vision to create healthier environments that enable residents to achieve and maintain a healthy weight, recognising the influence of wider determinants such as food, transport, and socioeconomic factors.
- 1.5. A structured prioritisation process has been undertaken with system partners using Multi-Criteria Decision Analysis (MCDA) and the Must Have, Should Have, Could Have and Won't Have this time (MoSCoW) frameworks. This has informed the development of the initial implementation plan for the first two years, which sets out a focussed and deliverable set of high impact, feasible actions for the early phase of the strategy. This initial phase prioritises:
 - Best Start in Life (maternal and early years), aligned with Health and Wellbeing Board priorities and the Joint Strategic Needs Assessment;
 - Community involvement and co-design, recognising the importance of lived experience and community led solutions;
 - Actions that support system-wide change, prevention, and reduction of health inequalities.

- 1.6. The Implementation Plan will be reviewed annually and be refreshed on a rolling two-year basis, ensuring that priorities remain responsive to emerging evidence, local need, and system learning.
- 1.7. A governance structure has been developed to support delivery, placing the Health and Wellbeing Board at the centre of oversight and working through existing partnerships to coordinate system wide action.
- 1.8. The strategy is now presented for endorsement, alongside the proposed governance arrangements and prioritised implementation approach for the initial phase of delivery (See Appendix A - Reading Whole System Healthy Weight Strategy (2026-2036)).

2. Policy Context

- 2.1. Obesity and the promotion of healthy weight are significant and complex public health challenges and represent one of the most important opportunities to improve health outcomes and reduce inequalities across Reading.
- 2.2. Maintaining a healthy weight is influenced by a wide range of factors beyond individual choice, including the wider determinants of health such as the environment, access to healthy and affordable food, opportunities for physical activity, socioeconomic conditions, and the commercial determinants of health (the influence of businesses and marketing on people's choices). As such, effective action requires coordinated, system wide approaches across multiple sectors.
- 2.3. The [World Health Organization](#) identifies excess weight as a major risk factor for a range of long-term conditions, including type 2 diabetes, cardiovascular disease, certain cancers, and mental health conditions. These contribute significantly to premature mortality and reduced quality of life.
- 2.4. National policy increasingly emphasises prevention and whole systems approaches. Key drivers include:
 - The NHS [Fit for the Future: 10 Year Health Plan for England](#), which includes weight related issues under the broader obesity prevention theme and prioritises prevention and improving healthy life expectancy;
 - Core20Plus5, which focuses on reducing health inequalities of the most deprived 20% of the population in the UK, across 5 key clinical areas which are co-morbidities to obesity;
 - [The National Institute for Health and Care and Excellence \(NICE\) guideline NG246 \(2025\)](#) on overweight and obesity management, which emphasises prevention, early intervention, culturally appropriate care and addressing inequalities;
 - Office for Health Improvement and Disparities (OHID) priorities to tackle obesity through system-wide interventions.
- 2.5. Locally, the strategy aligns with:
 - The Berkshire West Joint Health and Wellbeing Strategy (2021-2030);
 - Reading's Joint Strategic Needs Assessment, which highlights unhealthy weight and its determinants as a key priority;
 - The Best Start in Life Strategy and wider children and young people priorities;
 - The Council's Health in All Policies framework, embedding health considerations across policy and decision making.
- 2.6. Locally, the scale and pattern of unhealthy weight in Reading reflect wider national trends and reinforce the need for coordinated system wide action. Levels of excess weight are high across the life course, with 21.5% of Reception children and 35.8% of Year 6 children living with overweight or obesity, and higher rates in more deprived communities. Among adults, 61.6% are living with excess weight (approximately 86,400 residents), with prevalence increasing faster than regional and national comparators.
- 2.7. Diet and physical activity patterns further reflect these challenges, with fewer than 30% of adults meeting recommended fruit and vegetable intake and around one in five adults

classified as inactive, alongside clear inequalities across socioeconomic groups. The wider environment also plays a key role. Reading has a higher than average density of fast-food outlets (244 outlets; 136.9 per 100,000 population) and licensed premises (556, equating to 13.8 per km²), alongside factors such as cost of living pressures, transport, and urban design, which influence the choices available to residents.

- 2.8. National and local policy drivers recognise the importance of addressing these wider determinants through system level approaches. These include the Advertising (Less Healthy Food Definitions and Exemptions) Regulations 2024 and Reading Borough Council's local restrictions on high fat, salt and sugar advertising, alongside planning and licensing powers to support healthier environments. Together, these factors highlight the complex interplay of social, economic, environmental, and commercial determinants shaping healthy weight. Obesity related impacts are estimated to cost the local system between £326 - £726 million per year, reinforcing the need for a coordinated, preventative, whole systems approach to improve health and reduce inequalities.
- 2.9. Overall, high levels of excess weight in both adults and children, alongside significant inequalities, reinforce the need for a coordinated, long-term whole systems approach that engages all partners and sectors.

3. The Proposal

- 3.1. Obesity is widely recognised as a complex system influenced by multiple interconnected factors. The Foresight Obesity System Map shows how a wide range of factors including behaviour, biology, environment and social conditions interact to influence weight (See Appendix C for the Governance Structure and System Context and Appendix D for the Foresight Obesity System Map).
- 3.2. It is proposed that the Health and Wellbeing Board:
- Endorses the Reading Whole Systems Approach to Healthy Weight Strategy (2026-2036);
 - Agrees to provide strategic oversight and system leadership for its delivery;
 - Endorses the proposed governance arrangements;
 - Supports the Initial Implementation Plan (2026-28), recognising this as the first phase of a rolling programme of delivery, to be reviewed and refreshed every two years.
- 3.3. The strategy provides a long-term, evidence-informed framework for addressing unhealthy weight across Reading through coordinated system-wide action. It adopts a life course approach and is aligned with national policy and local priorities, including the Health and Wellbeing Strategy and Health in All Policies framework. Significant work has been undertaken to refine the implementation approach, incorporating feedback from system partners and strengthening alignment with key partnership priorities.
- 3.4. A structured prioritisation process has been undertaken with system partners using Multi-Criteria Decision Analysis (MCDA) and MoSCoW frameworks. This has enabled partners to identify a focussed set of high-impact, feasible actions for implementation over the next two years, while maintaining the longer-term ambition of the ten-year strategy.

Governance and System Leadership

- 3.5. To support delivery, a strengthened governance model has been developed, reflecting feedback from the Health and Wellbeing Board and system partners and ensuring clear accountability and alignment across the system.
- 3.6. The Health and Wellbeing Board will provide strategic oversight and system leadership, including monitoring progress, aligning system priorities, and supporting the removal of implementation barriers.
- 3.7. Implementation will be coordinated through a Whole Systems Healthy Weight Network and aligned with existing partnerships across the system, ensuring that implementation is integrated and not delivered in isolation.

- 3.8. Further detail on governance structure and implementation arrangements is set out in Appendix C.

Prioritisation Approach

- 3.9. A structured prioritisation process was undertaken with system partners to identify high-impact and feasible actions for implementation over the next two years. This was informed by local evidence, stakeholder input, and consideration of impact, need, feasibility, and value for money.
- 3.10. This approach ensured that priorities are based on evidence, agreed by partners and focused on reducing inequalities.
- 3.11. Delivery of these actions will be supported through a combination of existing resources, system partner contributions, and, where applicable, internal and external funding opportunities, as outlined in Section 9.

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

- 4.1. The proposals in this report contribute to the [Berkshire West Joint Health & Wellbeing Strategy 2021-30](#) and each of its five priorities:
1. Reduce the differences in health between different groups of people
 2. Support individuals at high risk of bad health outcomes to live healthy lives
 3. Help children and families in early years
 4. Promote good mental health and wellbeing for all children and young people
 5. Promote good mental health and wellbeing for all adults
- 4.2. The strategy also aligns strongly with the priorities of the Reading Borough Council Plan (2025-2028) to deliver its vision to:
- Promote more equal communities in Reading.
 - Deliver a sustainable and healthy environment and reduce Reading's carbon footprint.
 - Safeguard and support the health and wellbeing of Reading's adults and children
- 4.3. In addition, the strategy supports the implementation of the Health in All Policies framework which was adopted in December 2025, by embedding health considerations across multiple policy areas, including planning, transport, education, and the wider determinants of health.

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. The Whole Systems Approach to Healthy Weight Strategy aligns with climate and sustainability objectives by promoting:
- Active travel and reduced reliance on car journeys
 - Healthier, more sustainable food choices
 - Environments that support walking, cycling, and community wellbeing
- 5.3. There are no direct adverse environmental implications arising from this report.

6. Community Engagement

- 6.1. The development of the Whole Systems Approach to Healthy Weight Strategy has been informed by a comprehensive programme of engagement and co-production with residents, stakeholders and partners across the system. This includes consultation undertaken through the Reading Healthy Weight Needs Assessment (2023), alongside ongoing engagement throughout strategy development.
- 6.2. Engagement activities have included multi-agency workshops involving over 25 organisations, a Task and Finish Group providing strategic oversight, and discussions with key partnership boards, including the Health and Wellbeing Board, One Reading Partnership

Board, and Oral Health Board. Targeted engagement has also been undertaken with partners across planning, transport, early years, and the voluntary and community sector to support a Health in All Policies approach.

6.3. Feedback from engagement has been consistent in highlighting:

- The need for a whole systems, preventative approach
- The importance of strong system alignment and integration with existing priorities.
- The value of embedding lived experience and community voice in design and delivery.

6.4. This programme of engagement has ensured that the strategy is co-produced, system-owned, and grounded in local need and lived experience.

Community Involvement and Co-Design

6.5. Community involvement and co-design is a key priority within the strategy, recognising the importance of enabling residents to shape and influence system-wide change.

6.6. Key areas of focus for implementation include:

- Strengthening community co-production and participation through existing networks and structures.
- Developing a structured engagement approach for children, young people, and families.
- Working with partners across planning, transport and local services to improve environments and support healthy behaviours, including active travel.

6.7. This approach supports the Health in All Policies framework and ensures that interventions are relevant, culturally appropriate, and accessible to communities most affected by health inequalities.

6.8. Further detail on the implementation plan is provided in Appendix B.

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. An Equality Impact Assessment has been completed and is included at Appendix E. The strategy is expected to have an overall positive impact, particularly in reducing health inequalities across Reading.

7.3. The strategy has a strong focus on reducing health inequalities and improving outcomes for population groups most affected by overweight and obesity.

7.4. The prioritisation of early intervention, community engagement, and culturally appropriate approaches reflects the commitment to advancing equality of opportunity and addressing the wider determinants of health.

7.5. The co-production approach ensures that the voices of residents, including those from underserved communities, are embedded within the design and implementation of interventions.

8. Other Relevant Considerations

8.1. Not applicable.

9. Legal Implications

- 9.1. There are no direct legal implication arising from this report.

10. Financial Implications

- 10.1. The initial two-year implementation phase (2026-2028) is designed to be delivered primarily through the alignment and coordination of existing resources across the system rather than requiring significant new investment. At this stage, no additional core funding pressure has been identified.
- 10.2. Delivery will be supported through a combination of:
- Existing commissioned public health and prevention services;
 - Reprioritisation of internal resources and programmes;
 - Workforce development and training (e.g. Making Every Contact Count);
 - Contributions from partner organisations, both financial and in-kind.
- 10.3. A proportion of the Public Health Grant is already aligned to relevant programmes, including healthy lifestyle services, early years provision, and community-based interventions. The strategy provides greater coordination and focus across these existing areas rather than establishing wholly new funding commitments. A number of specific actions are expected to be supported through Public Health resources; however, these remain indicative at this stage and will be subject to formal governance and approval processes.
- 10.4. Programme coordination, stakeholder engagement, and performance monitoring will be delivered through existing Public Health staffing capacity, with some reprioritisation of officer time. While this may create opportunity costs in terms of staff focus and programme delivery, no immediate service reductions have been identified.
- 10.5. Delivery is system-wide and will be supported through existing activity across:
- NHS services (e.g. maternity, primary care, lifestyle pathways);
 - Local authority services (e.g. early years, planning, transport);
 - Voluntary and community sector partners, primarily through in-kind contributions and targeted commissioned activity where appropriate;
 - At this stage, contributions are largely through existing programmes and in-kind resource rather than formal pooled budgets. Opportunities to develop more formal funding arrangements will be explored as the programme matures.
- 10.6. Some elements of the implementation plan, particularly community and environmental interventions, may be progressed subject to external funding or grant opportunities. No financial reliance on these has been assumed at this stage.
- 10.7. The strategy is expected to contribute to long-term cost avoidance across the health and care system, including reduced demand on health services and adult social care. Value for money and impact will be monitored through the performance and evaluation framework, including tracking outcomes relating to healthy weight, physical activity, diet, wider determinants, and inequalities.
- 10.8. An Integrated Healthy Lifestyle Service (due to commence in October 2026), already funded through the Public Health Grant, will support delivery of a number of key actions within the strategy.
- 10.9. Key financial risks include reliance on partner engagement and contributions, and the availability of external funding to support specific initiatives. These risks will be managed through established governance arrangements, ongoing monitoring, and annual review of the implementation plan.

10.10. The proposals are deliverable within the current Public Health Grant allocation and existing resources, subject to the reprioritisation described above.

11. Timetable for Implementation

11.1. The strategy will be delivered over a ten-year period (2026-2036), with an initial focused implementation phase over the next two years based on identified priorities.

11.2. It is proposed that:

- A Whole Systems Healthy Weight Network and Operational Group oversee delivery;
- Progress updates are provided to the Health and Wellbeing Board annually;
- The implementation plan is reviewed and updated annually;
- A formal review of the strategy is undertaken after five years.

12. Background Papers

12.1. There are none.

Appendices

- A Reading Whole System Healthy Weight Strategy (2026-2036)
- B Reading Healthy Weight Strategy Initial Implementation Plan (2026-28)
- C Governance Structure and System Context
- D Foresight Obesity System Map
- E Equality Impact Assessment

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A healthier weight and life for everyone

Whole Systems Approach to Healthy Weight Strategy 2026-2036



Reading
Borough Council
Working better with you

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Foreword by Cllr Eden on behalf of the Health and Wellbeing Board

As Chair of the Reading Health and Wellbeing Board, I am pleased to introduce Reading's Healthy Weight Strategy 2026–2036. This strategy is about helping everyone in our town, whether children, young people or an adults to live healthier, happier lives.

We know that keeping to a healthy weight matters at every stage of life. It affects children's development, adults' long-term health, and the wellbeing of our whole community.

Staying healthy isn't just about personal choices. It's shaped by the places where we live, work, learn, and spend time every day. Many people in Reading face real pressures, whether it's financial worries, busy lives or a lack of local options that can make healthy choices harder.

Inequalities also play a big part. People living in some areas can face more barriers to eating well and being active. This strategy makes it clear that tackling these unfair differences is essential. Everyone in Reading deserves a fair chance to be healthy.

This isn't about a short-term fix: real change can only happen if we work together. The Council, the NHS, schools, early years providers, community groups, local businesses, and residents all have a role to play. This strategy sets out how we will join up our efforts and make it easier for people to live well day to day. Exactly what we do will develop over time.

I know the Health and Wellbeing Board is committed to leading and supporting this work over the next ten years. We will help bring partners together and track progress to make sure the strategy delivers real benefits for local people.

I want to thank the organisations, partners, and residents who have shared their experiences and ideas. Their voices have helped shape a strategy that understands the realities of life in Reading. This is only the first step – the next stage will be to start to act.

By working together, we can build a healthier town: Reading can be a place that that supports everyone, at every age, to live well now and into the future.



Cllr Rachel Eden
Lead Councillor for Education & Public Health

Foreword from Director of Public Health

Welcome to Reading's Whole System Approach to Healthy Weight Strategy (2026-2036), which sets out our shared ambition to improve the health and wellbeing of residents across the borough. As Director of Public Health, this strategy provides an important opportunity to highlight one of the most pressing public health challenges we face, and one where collective action can make a real and lasting difference.

Maintaining a healthy weight is central to good health throughout life. The evidence is clear that living with overweight or obesity increases the risk of a range of long-term conditions, including diabetes, heart disease, musculoskeletal problems and some cancers, and can also affect mental wellbeing and quality of life. Importantly, these impacts are not experienced equally. Children and adults living in more deprived circumstances are more likely to face barriers to healthy eating, physical activity and access to support, and are more likely to experience poorer health outcomes as a result.

Data for Reading shows that excess weight is common among both adults and children, and that differences emerge early in life and widen as children grow older. This reinforces the need to act early, but also to sustain action across the life course. While individual choices matter, they are shaped by the environments in which we live – the food that is available and affordable, the places we move through each day, and the opportunities we have to be active and supported.

As a parent, I understand how challenging it can be to balance busy lives with healthy routines. There is no single solution, and no one organisation can address this issue alone. Supporting healthy weight requires coordinated action across local government, the NHS, schools, employers, community and voluntary organisations, and residents themselves. It also requires us to listen to lived experience, reduce stigma, and create environments where healthier choices are easier for everyone.

This strategy reflects that whole systems approach. It has been developed using local evidence and insight, national guidance, and engagement with partners and communities across Reading. It sets out a clear framework for collective action, focusing on prevention, reducing inequalities, and creating healthier places and opportunities that support people to eat well, move more and maintain a healthy weight.

I would like to thank all those who have contributed their time, expertise and experience to the development of this strategy. I hope it provides a clear direction for action and a shared commitment to improving healthy weight outcomes for current and future generations in Reading.



Dr Matthew Pearce

Director Public Health, Reading Borough Council

Executive summary

Healthy weight is shaped by many factors beyond individual choice — including the foods available locally, how communities are designed, access to physical activity opportunities, and broader social and economic influences. In Reading, we want to support residents to live healthier lives by creating environments and systems where healthier choices are the default and are easier to make.

Why this strategy matters

Excess weight increases the risk of serious long-term health conditions — including type 2 diabetes, heart disease, some cancers, and joint problems — and can also negatively affect mental wellbeing.

Data from NHS Digital (2024) ⁽¹⁾ ⁽²⁾ shows that the issue of overweight and obesity is present across the life course. (See infographic, right)

These risks are also not experienced equally across communities; as people in more deprived areas often face greater barriers to healthy eating and physical activity, contributing to health inequalities.

We are committed to tackling these complex challenges through addressing how our system operates and supports people throughout their life course, in their communities.

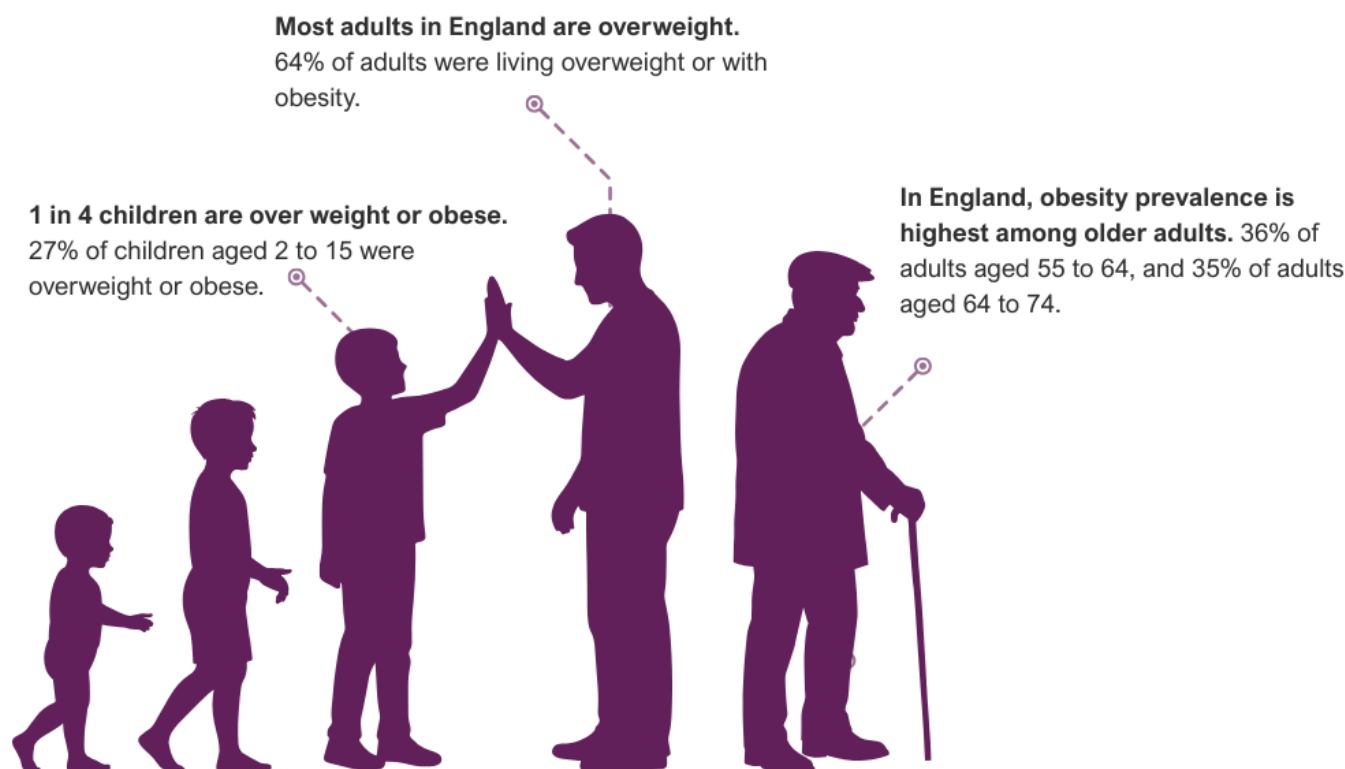
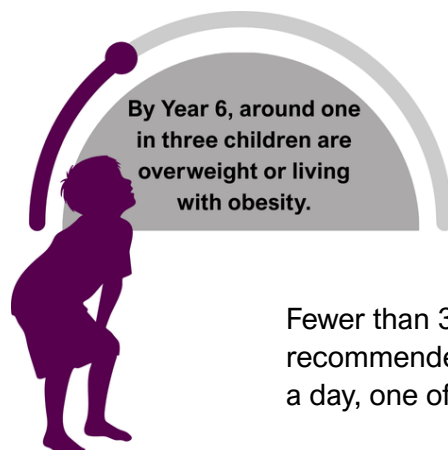


Figure 1: Overweight and obesity levels in children and adults in England over a life course. (Adapted from NHS Digital 2024)⁽²⁾

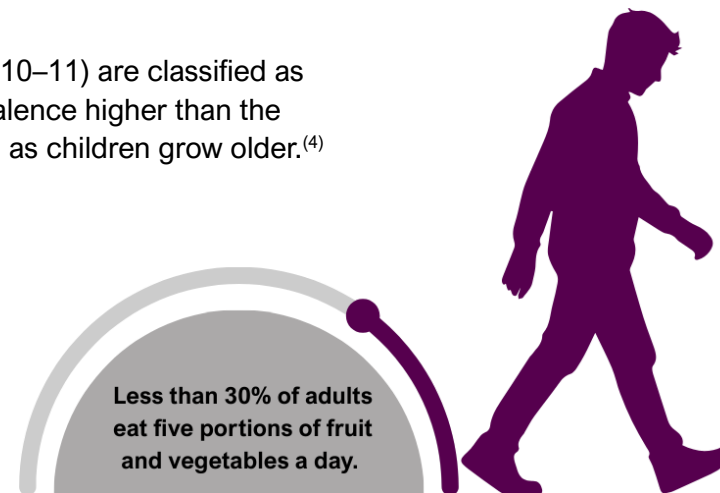
The picture in Reading

Recent national and local evidence, including Reading's 2025 Joint Strategic Needs Assessment (JSNA)⁽¹²⁾, shows that over 60% of adults in Reading are living with overweight or obesity. Although comparable to regional and national patterns, these levels are persistently high and remain a significant public health priority.



Around one in three Year 6 children (ages 10–11) are classified as overweight or living with obesity — a prevalence higher than the regional average and of particular concern as children grow older.⁽⁴⁾

Fewer than 30% of adults in Reading eat the recommended five portions of fruit and vegetables a day, one of the lowest rates in the South East region.⁽⁵⁾



These figures align with broader trends seen across England, where approximately two-thirds of adults are overweight or living with obesity. (NHS Digital 2024)⁽²⁾

Our approach: whole systems action

Obesity is a complex issue driven by interlinked environmental, social and commercial factors. This strategy adopts a whole systems approach - consistent with national guidance - that brings together stakeholders from across Reading's system to understand the local context, coordinate action, and create sustained change across settings that influence daily life.

It sets out our vision for healthy weight across Reading, highlighting our ways of working, and 10 strategic commitments co-developed with system stakeholders, designed to guide collective action and make lasting improvements.

This strategy provides us with a clear, evidence-informed framework for action that connects local leadership, policy, services, community assets and everyday environments to help residents eat well, move more, and maintain a healthy weight.

Measuring progress

Progress against the Whole Systems Approach to Healthy Weight Strategy (2026-2036) will be monitored using a whole-systems, evidence-informed approach. This will bring together population-level data (such as excess weight, physical activity and diet), service and programme monitoring, and lived experience feedback from local residents.

A Multi-Criteria Decision Analysis (MCDA) approach will support transparent prioritisation and decision-making, helping partners focus resources on actions that deliver the greatest impact and reduce inequalities. Each action will have a clearly defined owner, with overall progress overseen by the Health and Wellbeing Board, supported by the Director of Public Health, to ensure continuous learning and improvement over the life course of the Whole System Healthy Weight Strategy (2026-2036).

Further details on Monitoring, Evaluation, and Learning can be found [here](#).

Our vision

A healthier weight and life for everyone across Reading

Together, partners and communities take system-wide action to enable all residents to live healthier lives and maintain a healthy weight, supported by locally shaped environments and opportunities that meet their needs.

Our ways of working

Using evidence to guide our actions, working collaboratively and celebrating progress together.

Working towards a shared vision, strengthening partnerships, and creating lasting change.

Creating open spaces for dialogue, communicating clearly, and co-producing our work.

Our strategic commitments

1. Leadership and governance: creating a strong and accountable system that drives collective ownership and strategic coordination.

2. Policy: developing local and regional policy environments that enable healthy living and equitable opportunities for healthy weight.

3. Commissioning: coordinating investment and service design that prioritises prevention, long-term impact, and equality of access.

4. Partnerships: strengthening multi-sector relationships with the Reading Food Partnership and others, to enable joined-up delivery and shared accountability.

5. Community involvement and co-design: enabling residents to shape and lead change within their own communities.

6. Activation: delivering coordinated, practical action through sustainable resources, shared assets and supportive environments.

7. Technology and innovation: harnessing innovations in practice and technology to strengthen reach, equity, insight, and impacts across the system.

8. Workforce development: equipping everyone who works with people with the confidence and skills to play their part in creating healthier environments and supporting people to maintain a healthy weight.

9. Advocacy, education and communications: providing inspiring, inclusive, and evidence-based communication that builds understanding, reduces stigma, and encourages collective action.

10. Monitoring, evaluation and learning: building an intelligent, adaptive system that learns from data, evidence, and lived experience to drive continuous improvement.

Introduction

Why healthy weight matters

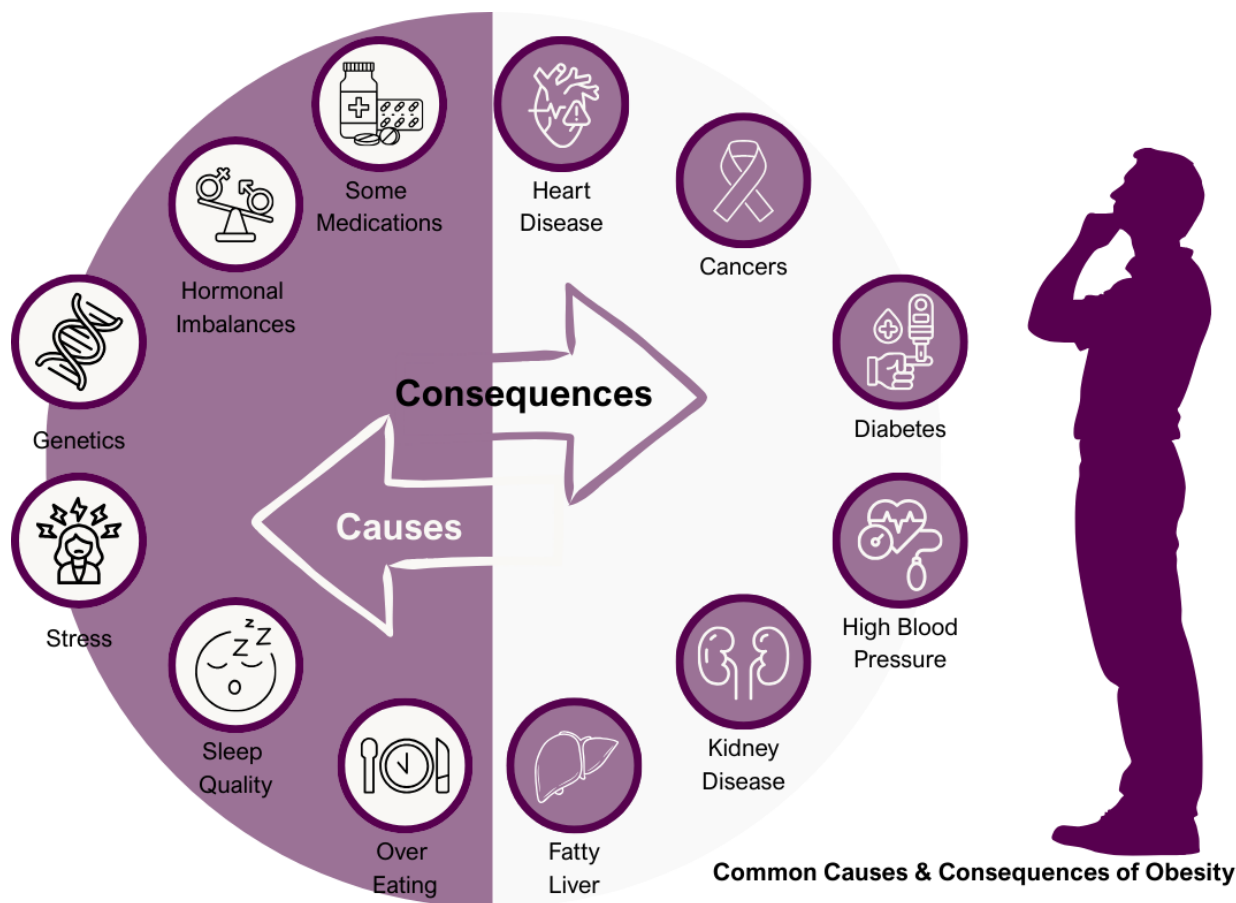
Maintaining a healthy weight is important for physical and mental health at all stages of life. Living with overweight or obesity increases the risk of a range of long-term conditions, including type 2 diabetes, cardiovascular disease, some cancers and musculoskeletal problems, and can reduce quality of life and life expectancy. Excess weight can also affect mental wellbeing, including confidence, self-esteem and emotional health (NICE, 2023).⁽¹⁸⁾

The infographic (right) outlines some of the key causes and consequences linked to obesity on our health.

Health and economic benefits

Excess weight, including overweight and obesity, places a substantial and growing burden on individuals, public services and the wider economy.

Nationally, the total cost of excess weight in the UK is estimated at £126 billion per year, taking account of healthcare and social care costs, productivity losses and reduced quality of life (Frontier Economics for Nesta, 2025)⁽¹⁴⁾. Productivity losses alone are estimated at £30.8 billion annually, with costs disproportionately higher in more deprived communities, where individuals experience around 21% higher economic impact than those in the least affluent areas.



The pressure on the health system is significant. Obesity Healthcare Goals (GOV.UK, 2025)⁽¹⁵⁾ estimate that the NHS now spends over £11.4 billion each year on obesity-related care, reflecting rising demand for treatment of long-term conditions linked to excess weight.

In Reading, excess weight affects an estimated 86,400 adults. Using proportional modelling based on national cost estimates ⁽¹⁴⁾ ⁽¹⁵⁾, the local economic impact of excess weight is estimated at between £326 million and £726 million per year. Of this, the direct cost to Reading Borough Council - primarily through adult social care pressures - is estimated at around £72.6 million annually.

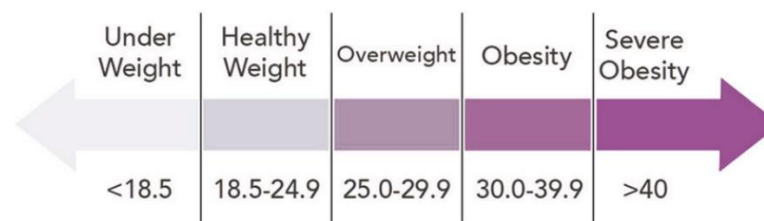
Note: Local cost estimates are indicative and based on proportional allocation of national data, aligned with modelling approaches used by Frontier Economics (2025) ⁽¹⁴⁾ and GOV.UK Obesity Healthcare Goals ⁽¹⁵⁾.

Defining healthy weight

Overweight and obesity are defined by the World Health Organisation (WHO), as abnormal or excessive fat accumulation that may impair health.

In the UK this is defined for adults as having a body mass index (BMI) of greater than or equal to 25 kg/m² (Overweight), 30 kg/m² (Obesity), or 40 kg/m² (Severe Obesity). A healthy weight is defined as maintaining a BMI score of 18.5kg/m² and 24.9 kg/m².

Adult weight categorisation (Based on BMI)



In England, children's overweight and obesity are measured using BMI adjusted for age and sex, compared against the UK90 growth reference. A child is classified as overweight if their BMI is at or above the 85th centile and below the 95th centile, and living with obesity if their BMI is at or above the 95th centile.

Note: BMI is widely used for population-level monitoring. We recognise that alternative measures may better reflect differing health risks, particularly for some ethnic groups.

The national picture

Using these definitions, national data from NHS Digital (2024)⁽²⁾⁽³⁾⁽⁴⁾ shows that excess weight is common across the life course. In England, around two-thirds of adults are above a healthy weight, and one in three children leave primary school overweight or living with obesity.

While local-level obesity prevalence by ethnic group is not routinely available, national evidence also highlights that people from some ethnic minority backgrounds experience higher health risks at lower levels of body mass index. (NHS Digital 2024)⁽²⁾

Both national and local maternity data also reveals that a substantial proportion of women enter pregnancy living with obesity, based on body mass index recorded at the antenatal booking appointment (OHID Fingertips).⁽⁸⁾

Evidence from the National Child Measurement Programme also shows that differences in weight outcomes are already present by early childhood and widen as children get older, with higher levels of overweight and obesity among children living in more deprived areas.⁽⁴⁾

NHS Digital data for England shows that obesity-related NHS hospital visits are rising, with 1.2 million admissions recorded in 2023, more than double those recorded in 2016/17.⁽⁶⁾

Healthy weight is closely linked to levels of physical activity and diet. Many adults and children do not meet recommended levels of physical activity, and fewer than one in three adults eat the recommended five portions of fruit and vegetables each day. These behaviours are shaped by wider factors such as income, housing, transport, food environments and access to safe spaces for activity.

Obesity-related NHS hospital admissions

per 100,000 people in 2023

420 4880

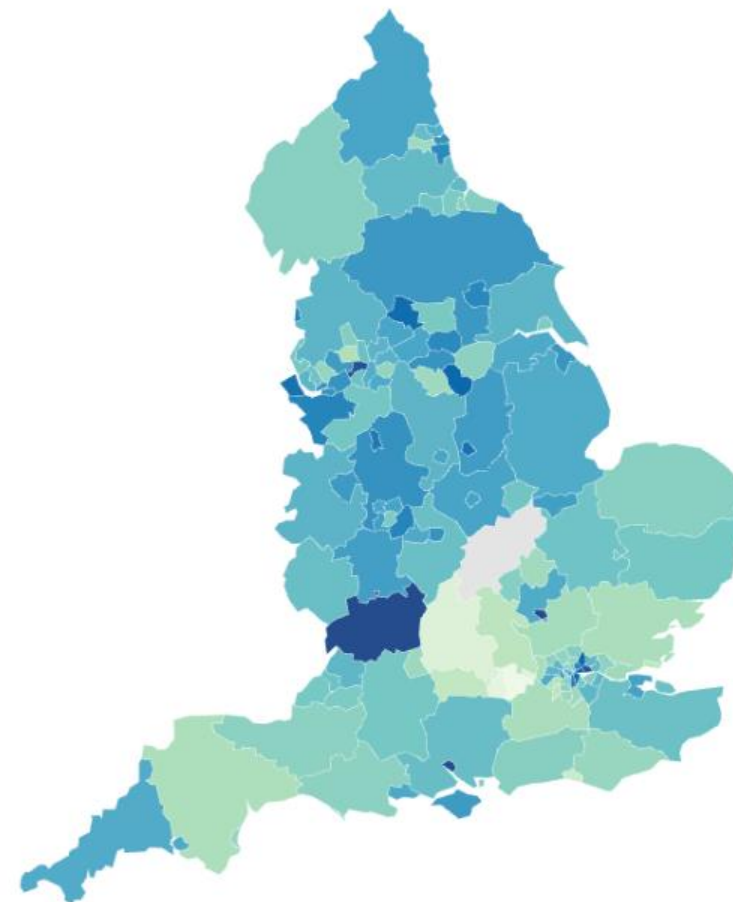
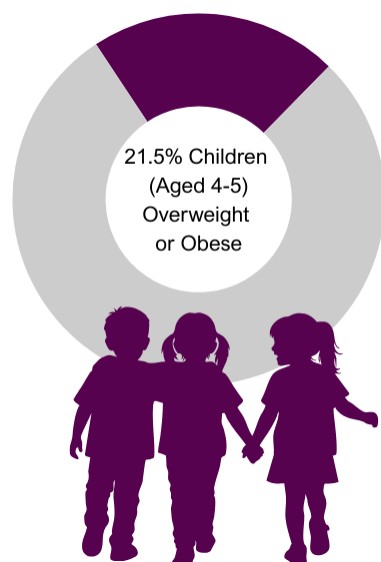


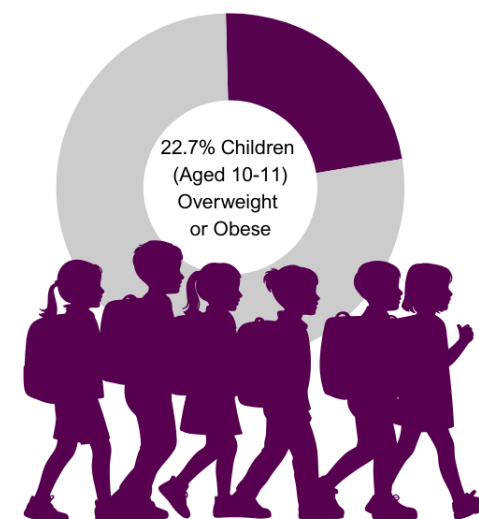
Figure 1: Obesity-related NHS hospital admissions 2022-23 (NHS Digital) ⁽⁶⁾

Our local picture



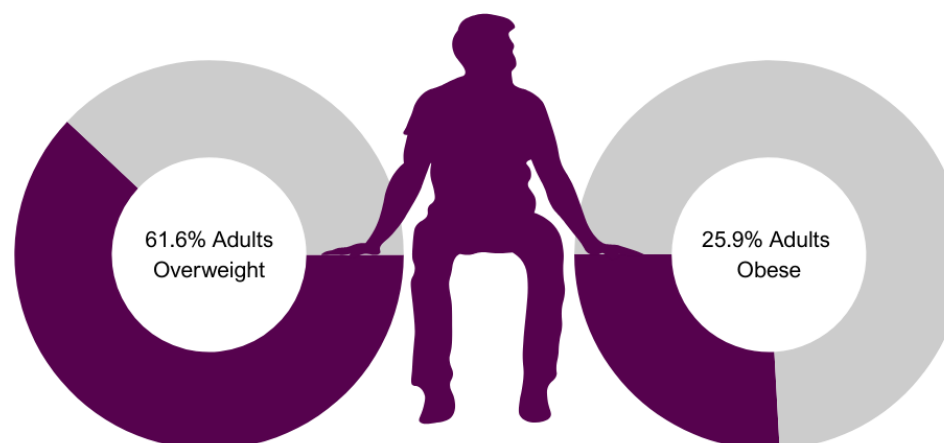
Data from the National Child Measurement Programme for 2024/25 ⁽⁴⁾ indicates that 21.5% of children in reception (aged 4-5 years) were overweight or living with obesity. This is 2% below the national average. Although, the proportion of those living with obesity is slightly above national average, at 10.6%.

By year 6 (aged 10-11 years) it is reported that 22.7% of children are living with obesity, compared to 22.2% across England. As well as 35.8% being overweight or living with obesity, compared to 36.2% in England.



The latest data on healthy weight for Reading (2023/24) indicates that adults are above the national average. Data shows that adults are 2.9% lower for overweight and 0.6% lower for obesity, respectively in England (Public Health Profiles, Fingertips)⁽¹⁾.

However, those living in the most deprived communities were the most affected by overweight and obesity, highlighting the presence of inequalities.



Data Source: Office for Health Improvement and Disparities (OHID) (2024) *Fingertips: Obesity, physical activity and nutrition.*

Factors influencing obesity

Obesity and overweight are driven by a complex mix of factors, including high consumption of energy-dense foods and low levels of physical activity. These behaviours are influenced by environmental, social, commercial and biological factors, such as inherited risk, long-term health conditions and some medications. Other contributing factors that may increase the risk of living overweight or with obesity include smoking, harmful alcohol use, poor oral health, and diets low in fruit and vegetables. We also know that obesity is more common in deprived areas, highlighting the need for systemic change. ⁽¹²⁾⁽¹³⁾⁽¹⁴⁾

The “obesogenic” environment - where food and built environments make healthier choices harder - plays a significant role. This includes limited access to affordable healthy food, widespread marketing of less healthy options, and poor or limited walking and cycling infrastructure. Supporting healthy weight across the life course therefore requires a whole-systems approach, with coordinated action across communities, local government and partner organisations.

While understanding the full impact of these factors can be challenging, as not all are routinely measured. However, the data below provides a snapshot of key influences on obesity.

Obesity both reflects and reinforces existing health inequalities. Rates of overweight and obesity are consistently higher in more deprived communities and among some population groups, driven by unequal access to healthy food, safe spaces for physical activity, stable income and supportive services. These inequalities often emerge early in life and widen over time, contributing to poorer health outcomes, reduced quality of life and increased demand on health and care services. Addressing obesity is therefore a key opportunity to reduce health inequalities and support fairer outcomes across the life course. ⁽¹²⁾⁽¹³⁾⁽¹⁴⁾

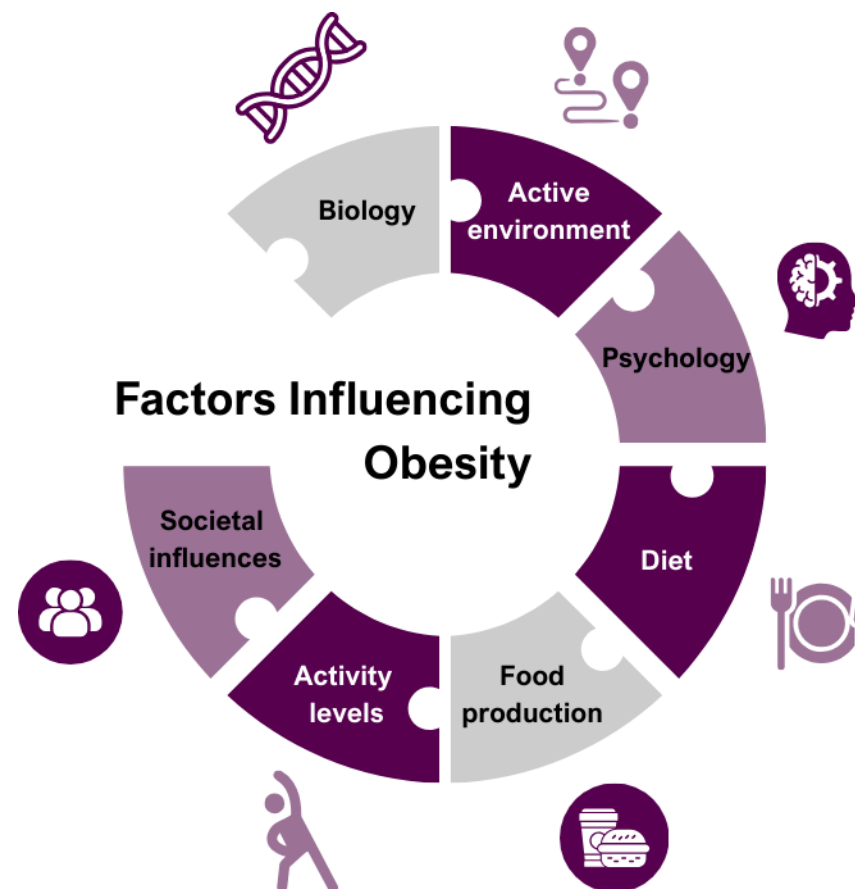


Figure 3: Factors influencing obesity (Adapted from Future Choices Report ⁽²⁴⁾)

Key statistics relating to overweight and obesity

Many people are not eating a balanced, nutritious diet.

Only 28.7% of adults in Reading meet the recommended five portions of fruit and vegetables a day, highlighting poor diet quality across the population. ⁽⁵⁾



The local food environment strongly shapes food choice.

There were 244 fast food outlets in Reading in 2024. The rate of fast-food outlets locally was 136.9 per 100,000, significantly higher than the rates in the South East (91.7) England (115.9 per 100,000). ⁽⁹⁾



More support is required to achieve activity levels.

17.2% of adults (around 29,000 residents) do less than 30 minutes of physical activity a week, increasing their risk of long-term health conditions. ⁽⁷⁾



Obesity is more common in more deprived communities.

Data shows that people living in more deprived areas of Reading face greater barriers to healthy eating and physical activity, contributing to health inequalities. ⁽²⁾⁽³⁾



Local environments do not always support active travel.

The Council's [Transport Strategy](#) recognises that streets and public spaces need improvement to better support walking, cycling and independent mobility. ⁽¹²⁾



Obesity affects wellbeing, productivity and quality of life.

It contributes to reduced productivity (presenteeism), higher sickness absence, premature ill health and early mortality.



Obesity risk is influenced by biology as well as behaviour.

Genetic susceptibility, long-term health conditions and some medications increase the likelihood of weight gain, particularly when combined with an unhealthy environment.



Healthy weight challenges begin early in life.

In Reading, 35.8% of children in Year 6 (ages 10–11) are overweight or living with obesity, reflecting a sharp increase from early childhood and highlighting the importance of early and sustained prevention. ⁽⁴⁾



Taking action

Because these influences are interconnected, supporting healthy weight requires more than individual behaviour change. It requires coordinated action to create environments, services and systems that make healthier choices easier and reduce inequalities.

Nationally, policy direction is increasingly focused on prevention, whole systems approaches, neighbourhood health models and closer integration between local authorities, the NHS and the voluntary and community sector.

Locally, Reading is aligning with this direction through needs assessments, data-led prioritisation and the development of this Whole Systems Approach to Healthy Weight Strategy. Existing community, health and wellbeing services provide a strong foundation on which further coordinated, place-based action can be built.

Together, these approaches, seen both at a national and local level, signal a shift towards coordinated, place-based action to prevent excess weight and support long-term health and wellbeing.

Developing this strategy

Reading's Whole Systems Approach to Healthy Weight Strategy (2026-2036), has been developed collaboratively through a co-design process, using a whole-systems approach. Thanks are given to all the stakeholders and individuals who contributed to this strategy.

Our strategy is informed by the [Whole Systems Approach to Obesity \(OHID, 2019\)](#) ⁽¹²⁾ using key insights from the [Foresight Report on Tackling Obesities \(Government Office for Science, 2007\)](#) ⁽¹⁹⁾, and the [Reading Healthy Weight Needs Assessment \(2023\)](#). ⁽⁸⁾

Our approach included a comprehensive review of existing data and learning from previous strategies, alongside insights gathered through cross-sector stakeholder workshops and detailed consultations with sector experts. The work was supported and overseen by a dedicated task and finish group, including representatives from the county's Health and Wellbeing Board.

This approach reflects the complexity of obesity and its causes. It brings together system-wide and community insights from across Reading to understand the challenge, assess how the local system currently operates, and identify opportunities for change.

The actions within this strategy have been co-developed and collectively agreed. Through this shared commitment, stakeholders will work together to ensure actions are coordinated rather than isolated, maximising impact and supporting healthier weight outcomes.

Note: A full list of contributing organisations and individuals is provided in Annex 1

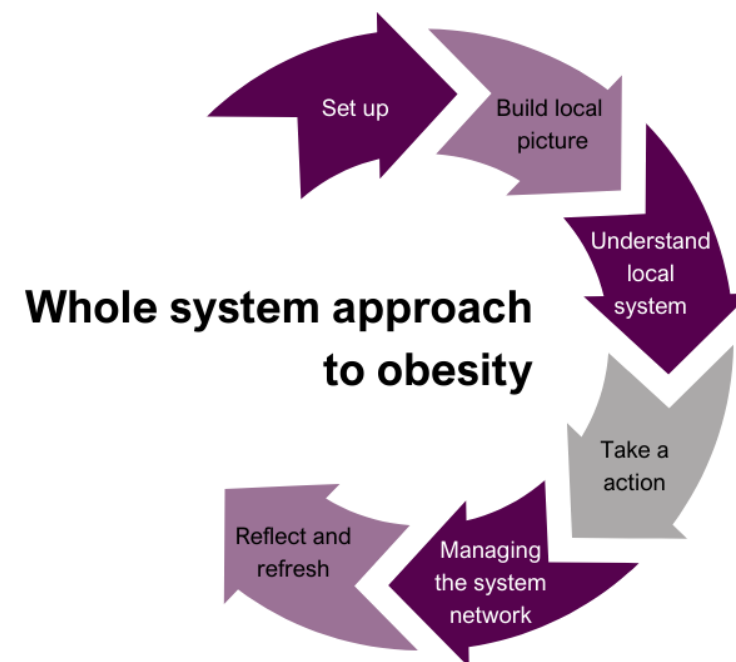


Figure 4: Whole system approach to obesity
(Adapted from Whole System Approach to Obesity (2019)⁽¹²⁾)

Our vision & values

In Reading, partners across health, care, education, planning, and the voluntary sector recognise the need for collective action to create those supportive conditions to support more people to live healthier lives and have co-developed a vision for the Whole Systems Approach to Healthy Weight Strategy (2026-2036).

Our vision encapsulates the shared view that, in order to achieve sustainable change, the focus of our collective actions needs to be on creating the conditions for change, developing and refining the collaborative systems that operate across the region, and enabling more people to lead healthier lives.

A healthier weight and life for everyone across Reading

Together, partners and communities take system-wide action to enable all residents of Reading to live healthier lives and maintain a healthy weight – through environments and opportunities that are shaped locally to meet their needs.

In order to develop strong, sustainable relationships it has been recognised and agreed, by the stakeholders that support the development of our strategy, that three key values should guide our ways of working.



Vision & Purpose: We will work towards our shared vision, seeking opportunities to strengthen partnerships and collaborate to achieve meaningful, sustained change across our system.



Culture & Communication: We will value inclusion and co-production in every decision we make, communicating with openness, clarity, and transparency to create space for honest dialogue and constructive challenge.



Action & Support: We will act with intent, using available evidence, expertise, and assets to make a difference. We will demonstrate accountability and celebrate progress together.

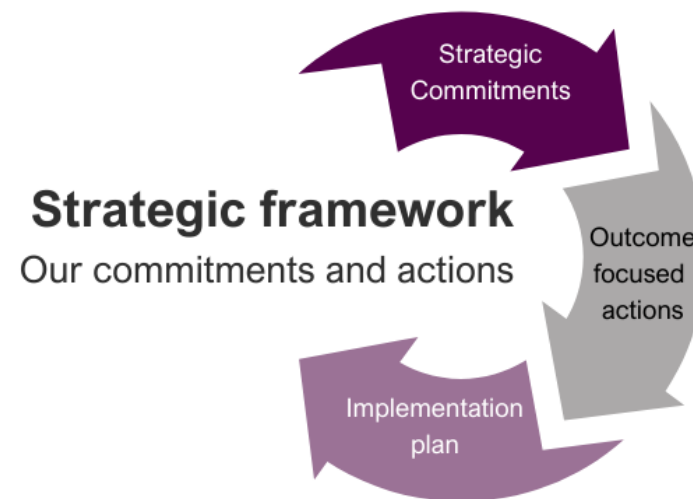


Our strategic framework

The following pages contain our strategic framework which sets out key information associated with our delivery of the Whole System Healthy Weight Strategy (2026-2036). The framework includes:

- ten strategic commitments that form the foundation of our strategy.
- a series of outcome-focused areas for action connected to each commitment.
- a detailed implementation plan designed to enable a coordinated approach to delivery.

Together, the information within the framework applies the principles of a whole-systems approach and provides a clear focus for how we plan, invest, and deliver. This ensures shared accountability and supports continuous improvement.



Our strategic framework

Shaping a healthier system through ten strategic commitments and outcome-focused actions

Strategic commitments

Outcome-focused actions

1. Leadership and governance: creating a strong and accountable system that drives collective ownership and strategic coordination.	Delivering clear and transparent governance for healthy weight action with shared accountability across all sectors.	Facilitating collective system leadership at every level supports sustained, long-term commitment.	Striving to embed healthy weight as a strategic priority across public, voluntary, and private partners.
2. Policy: developing local and regional policy environments that enable healthy living and equitable opportunities for health weight.	Striving to ensure that "Health in All Policies" underpins decisions on transport, housing, planning, and food environments	Aligning local frameworks with recognised national strategies, showcasing local application and impact.	Promoting prevention, reducing inequalities, and addressing commercial, social, and economic determinants.
3. Commissioning: coordinating investment and service design that prioritises prevention, long-term impact, and equality of access.	Ensuring that commissioning decisions are joined-up, evidence-based and help to reshape the environments and conditions influencing healthy weight.	Prioritising prevention, early intervention, and long-term outcomes over short-term fixes, ensuring services address the wider determinants of health.	Striving for co-commissioned, and where possible co-delivered services to create consistent, equitable access to supportive environments.
4. Partnerships: strengthening multi-sector relationships with the Reading Food Partnership and others, to enable joined-up delivery and shared accountability.	A connected local system is operating with clear priorities and shared outcomes understood by all stakeholders	Developing and maintaining trusted partnerships with communities, schools, and businesses create shared ownership of results.	Leveraging cross-sector collaboration to enhance the strengths of statutory, voluntary, and community organisations.
5. Community involvement and co-design: enabling residents to shape and lead change within their own communities.	Co-designing interventions with people with lived experience, and using insights to influence decision making processes.	Making local environments safer, more appealing and conducive to healthy choices.	Targeting resources are to reduce inequality in access and opportunity.



Our strategic framework

Shaping a healthier system through ten strategic commitments and outcome-focused actions

Strategic commitments

Outcome-focused actions

6. Activation: delivering coordinated, practical action through sustainable resources, shared assets and supportive environments.	Creating connected, inclusive services that help people to develop and maintain a healthy weight.	Creating environments within local communities to make healthy choices easier, safer, and appealing.	Targeting resources to reduce inequality in access and opportunity.
7. Technology and innovation: harnessing innovations in practice and technology to strengthen reach, equity, insight, and impacts across the system.	Enhancing access to services, participation, and coordination through exploring digital innovation.	Enabling safe and secure data sharing to support insight-led developments in practice and service delivery.	Exploring the use of technology to support inclusion, innovation, and healthier environments.
8. Workforce development: equipping everyone who works with people with the confidence and skills to play their part in creating healthier environments and supporting people to maintain a healthy weight.	Creating a confident, informed, and connected workforce, equipped to influence environments and reduce inequalities.	Creating and embedding healthy weight and behaviour change into training and CPD.	Facilitating shared learning opportunities to support consistent, compassionate, stigma-free practice.
9. Advocacy, education and communications: providing inspiring, inclusive, and evidence-based communication that builds understanding, reduces stigma, and encourages collective action.	Creating visible and accessible communication channels for sharing information and learning across system stakeholders.	Developing clear evidence-based messages and campaigns to help people and professionals to understand the benefits of healthy living and how to access support.	Supporting policymakers, practitioners and stakeholders recognise their role in shaping healthy environments.
10. Monitoring, evaluation and learning: building an intelligent, adaptive system that learns from data, evidence, and lived experience to drive continuous improvement.	Creating system learning processes to maintain high quality decision-making, address inequalities and improve the delivery of services.	Identifying a consistent set of data, collated across all partners through a centralised system and practical tools.	Utilising credible evidence, including lived experience and views from the community to show our impacts.

Monitoring, Evaluation, and Learning

Progress against the Healthy Weight Strategy (2026–2036) will be monitored and evaluated using a whole-systems, evidence-informed approach, ensuring that actions remain focused on what delivers the greatest benefit for Reading's communities.

Our approach to monitoring and evaluation

The Council will use a Multi-Criteria Decision Analysis (MCDA) approach, as recommended by national government, to support transparent and consistent decision-making. This will help all stakeholders to:

- Assess progress against agreed outcomes
- Prioritise actions based on impact, need, feasibility and value for money
- Identify where changes or additional support are required

What we will measure

Progress will be tracked through a combination of:

- Population-level indicators, including excess weight prevalence, physical activity levels and diet-related measures, using national and local datasets.
- Service and programme data, such as participation, reach, uptake and engagement across communities and settings.
- Inequalities analysis, to understand who is benefiting, who is not, and where action is needed to reduce gaps in outcomes.
- Lived experience and qualitative feedback, ensuring that the voices of children, young people, adults and families shape ongoing delivery and improvement.

Accountability and governance

- Each action within the implementation plan will have a clearly defined owner, responsible for delivery and reporting.
- Delivery responsibility will sit with the relevant partner organisations or teams, reflecting the system-wide nature of the strategy.
- The Health and Wellbeing Board will oversee overall progress, receive regular updates, and provide strategic direction.

- The Director of Public Health, supported by the Public Health Commissioner, will lead the governance process and ensure robust reporting.

Using learning to drive improvement

Monitoring and evaluation will not be a one-off activity. Findings will be used to:

- Inform annual reviews of the action plan
- Support continuous improvement in delivery
- Ensure resources are focused on actions that deliver the greatest impact
- Adapt the strategy over time in response to evidence, learning and local need

This approach will ensure the Whole System Healthy Weight Strategy (2026-2036), remains achievable, measurable, innovative and responsive, while supporting long-term improvements in diet, physical activity and healthy weight outcomes across Reading.

Appendices

1. Acknowledgements

We would like to thank the following individuals and organisations for their time, expertise and contributions to the development of the Whole System Healthy Weight Strategy (2026-2031).

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Boon, Alice – Reading Borough Council – Brighter Futures for Children

Bradbeer, Jane - University of Reading

Bridgeman, Romona – Reading Families Forum

Burfoot, Ben – Reading Borough Council

Burrows, Kirstie – Berkshire Healthcare NHS Foundation Trust

Crispin, Nina – Reading Borough Council – Public Health Team

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Whiffin, Kerry – Working Together Group

Williams, Michelle – Reading Borough Council – Children's Centre Manager

Wagstaff, Carol – University of Reading

Zischka, Dr Lorna – University of Reading - Whitley Community Development Association

2. Glossary

Co-design

Co-design is a collaborative approach to developing strategies, services or actions by working alongside people with lived experience and system partners, helping to ensure solutions are inclusive, relevant and more likely to be effective.

Commercial Determinants of Health

The commercial determinants of health describe how commercial activities, such as food production, marketing and pricing, influence health behaviours and outcomes, including the promotion and availability of less healthy food and drink options.

Health Inequalities

Health inequalities are avoidable and unfair differences in health outcomes between population groups, often linked to factors such as deprivation, ethnicity, disability, age and place.

Health in All Policies (HiAP) Health in All Policies is an approach that integrates health and wellbeing considerations into decision-making across all policy areas, recognising that sectors such as transport, planning, housing and education influence healthy weight and wider health outcomes.

Joint Strategic Needs Assessment (JSNA) A JSNA is a statutory, evidence-based assessment of the current and future health, wellbeing and social care needs of the local population. It brings together local data, intelligence and insights to inform priority-setting, commissioning and strategic planning across the local system.

Life Course Approach

A life course approach recognises that health outcomes are shaped by experiences across the whole of life, from before birth through childhood, adulthood and later life, and that early intervention and sustained support are essential to maintaining a healthy weight.

Multi-Criteria Decision Analysis (MCDA)

An MCDA is a structured, evidence-based approach used to compare and prioritise options by assessing them against multiple agreed criteria, supporting transparent and informed decision-making across a system.

National Child Measurement Programme (NCMP)

The NCMP is a national programme that measures the height and weight of children in Reception and Year 6 in state-maintained schools in England, providing data to track trends in childhood overweight and obesity and inform local action.

Obesogenic Environment

An obesogenic environment describes physical, social and commercial conditions that make it harder to eat well and be physically active, such as limited access to affordable healthy food, high densities of fast-food outlets, and poor walking and cycling infrastructure.

Physical Activity Inactivity

In this strategy, physical inactivity refers to achieving less than 30 minutes of moderate physical activity per week, a level associated with a significantly increased risk of long-term health conditions.

Population-level Indicators

Population-level indicators are measures used to track health outcomes and behaviours across a whole population, such as excess weight prevalence, physical activity levels and dietary patterns, rather than individual outcomes.

Prevention

Prevention refers to actions taken to reduce the risk of overweight and obesity before they develop or worsen, including early intervention, creating supportive environments and addressing the wider determinants of health.

Wider Determinants of Health

The social, economic and environmental conditions that influence health, including income, education, housing, transport, food access and employment. These determinants play a significant role in shaping healthy weight outcomes.

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Reading Whole Systems Approach to Healthy Weight Strategy Initial Implementation Plan (2026-2028)

1. Executive Framework & Strategic Alignment

This master framework consolidates all high-priority action lines for the first two years of the Reading Healthy Weight Strategy execution. Following multi-agency stakeholder workshops and engagement, actions have been organised to clearly show who is responsible for delivery and how they will be coordinated including any cross-departmental integration.

Resource requirements are indicative and reflect current expectations based on existing resources, partner contributions, and potential external funding opportunities. These will be refined as delivery progresses.

2. Category A: Confirmed & Internal Management Actions

The actions shown below are execution over the upcoming two years. These elements fall under the direct mandate, leadership, or active operational influence of the internal Reading Borough Council teams or have received partnership prioritization and agreement for delivery.

Strategic Theme	What are we doing?	Expected outcomes?	Timeline	Lead Partners (Named Owner)	Resource Requirements / Commitment
Food	Apply healthy food and drink guidelines in schools and early years settings.	Production and availability of healthier foods within early years and schools settings.	Medium term (12 - 24 months)	RBC / Education Services (including SEND and Virtual School)	Existing resources within Education Services and Public Health; alignment with existing school food standards and commissioning. Explore funded 1 FTE role via. Public Health Grant

Strategic Theme	What are we doing?	Expected outcomes?	Timeline	Lead Partners (Named Owner)	Resource Requirements / Commitment
Food	Co-develop Community Eatwell, and Eat and Learn programmes for schools, families, and community groups	Programme developed to meet communities needs and convey targeted core messaging linked to healthy eating.	Medium term (12 - 24 months)	RBC / Education Services (including SEND and Virtual School)	Public Health Grant (existing prevention programmes); potential VCS partner delivery (in-kind).
Internal (RBC) / System	Develop a structured engagement plan for stakeholders, representative organisations of children and young people to support development and delivery of strategy and implementation plan.	Greater understanding of and insight to address challenges and support engagement with children and young people, as well as their families.	Short term (6-12 months)	Public Health Team	Existing Public Health resource; officer time and reprioritisation
Weight / Lifestyle Management	Through existing community co-production groups, facilitate community participation to inform service design, understand nuances in audience insights, and identify enablers, needs of specific groups.	Commissioned services and projects are developed collaboratively with communities, leading to increased engagement and impacts for the people they seek to support.	Medium term (12 - 24 months)	Integrated Healthy Lifestyle Service / Public Health and Wellbeing	Public Health Grant (commissioned services); VCS partners
Built Environment	Collaborate with transport and planning teams to expand safe, connected walking and cycling networks with improved lighting, crossings, cycle parking and play parks.	Refer to Public Realm Strategy (for Town Centre) and Local Cycling and Walking Infrastructure Plan (LCWIP) / Section 106 contributions for suburban areas.	Long term (2 years+)	Planning and Transport	Capital programmes (LCWIP, S106, Transport budgets); external funding dependencies (TBC)

Strategic Theme	What are we doing?	Expected outcomes?	Timeline	Lead Partners (Named Owner)	Resource Requirements / Commitment
Process / Operations	Standardise maternal obesity pathways: targeted referrals for expectant mothers (BMI 30+) to LiveWell StayWell.	Reduced risk of high birth weight and improved maternal health outcomes.	Medium term (12 - 24 months)	Maternity Lead / BHT / Maternity Services	NHS resource (existing pathway delivery) and Public Health support for coordination
Internal (RBC)	Developing pathways for complex obesity and bariatric needs for people who need additional interventions to manage their weight.	Regularly exchange updates, recommendations, and actions at the Reading Obesity Project Group; identify and align activities.	Long term (2 years+)	Reading Obesity Project Board / Communities & Adult Social Care	Existing system resource; NHS led pathway development; no new funding identified
Built Environment	Activate open spaces within communities to support the delivery of physical activity such cycle paths, parks and play areas.	Increased number of people being active in local environment.	Short term (6-12 months)	Planning Team	Existing RBC infrastructure budgets; potential external funding opportunities
Internal (RBC)	Early years workforce training (including food hygiene, safety and wider healthy weight themes).	A frontline workforce equipped to provide healthy balanced food and handle nutrition safely in early settings.	Medium term (12 - 24 months)	New Directions College / Early Years and Childcare	Existing workforce training budgets; Public Health support for content development
Internal (RBC)	Ensure communications and briefings for Councillors, senior leaders and staff to show their role in supporting healthy weight.	Reading Borough Council have a clear understanding on how their work impact on healthy weight.	Medium term (12 - 24 months)	Public Health Team	Existing communications resource; no additional funding required

Strategic Theme	What are we doing?	Expected outcomes?	Timeline	Lead Partners (Named Owner)	Resource Requirements / Commitment
Weight / Lifestyle Management	Integrate Full Making Every Contact Count Training Programme into Healthy Lifestyle Service in Action. (Currently partially delivered) e.g., developing standard operating practice models for health, social care, carers, community workers and other key stakeholders. Basics of eating well, physical activity and healthy weight, oral health improvement.	Increased understanding, confidence and skills in behaviour change delivery.	Medium term (12 - 24 months)	Public Health Team/Integrated Healthy Lifestyle Service (IHLS)	PH Grant and part of IHLS offer (training/programme delivery)
Internal (RBC)	Explore feasibility of public health commissioning that other RBC departments could deliver. e.g., Identifying opportunities for other teams to delivery on public health outcomes.	Wider support for Public Health activation across different teams, bring to life Health in All Policies as an approach.	Medium term (12 - 24 months)	Public Health Team	Officer time; existing Public Health commissioning budgets. Part-time Planning Officer Secondment funded via Public Health Grant
Process / Operations	Develop and agree a 'system working charter' to support partnership working and shared accountability across organisations.	Galvanising relationships across the system towards a common goal. Clarity on roles within local system.	Medium term (12 - 24 months)	Public Health Team	Existing resource; partnership contribution (in-kind)
Process / Operations	Complete an audit of all existing collaborative groups.	To understand existing sub structures to support refreshing the network connections to support the delivery of the Healthy Weight Strategy and Implementation plan.	Short term (6-12 months)	Public Health Team	Existing resource; officer time

Strategic Theme	What are we doing?	Expected outcomes?	Timeline	Lead Partners (Named Owner)	Resource Requirements / Commitment
Commercial Determinants	Identify key partnerships with local food businesses and producers to inform a local action.	Visibility of key stakeholders linked to Medium Enterprise food producing and selling organisations.	Medium term (12 - 24 months)	University of Reading/ChangeBox (TBC) / Reading Food Partnership	Partner-led activity; PH Officers, University of Reading, some in-kind contribution
Oral Health	Work with the Oral Health Improvement Board to ensure the Oral Health Improvement Strategy and Whole Systems Approach to Healthy Weight Strategy 2026-2036 are aligned.	Regularly exchange updates, recommendations, and actions at the Oral Health Improvement Board.	Long term (2 years+)	Oral Health Improvement Board	Existing governance structures
Physical activity	Work with the Physical Activity Alliance Group to ensure the Physical Activity Action Plan and Whole Systems Approach to Healthy Weight Strategy 2026-2036 are aligned.	Regularly exchange updates, recommendations, and actions at the Physical Activity Alliance Group.	Long term (2 years+)	Physical Activity Alliance Group (PAAG)	Existing partnership resource
Food	Work with the Reading Food Partnership to ensure the Reading Food Action Plan and Whole Systems Approach to Healthy Weight Strategy 2026-2036 are aligned.	Regularly exchange updates, recommendations, and actions at the Reading Food Partnership.	Long term (2 years+)	Community Food Project Officer / Reading Food Partnership (RFP)	Existing partnership resource
Process / Operations	Facilitate partnership working with voluntary sector organisations, business, ensuring co-designed with partners.	Co-developed plan in place that is considerate of commercial (factors such as availability, cost, and marketing of food) and social determinants.	Medium term (12 - 24 months)	Public Health Team	VCS in-kind and Public Health coordination

Strategic Theme	What are we doing?	Expected outcomes?	Timeline	Lead Partners (Named Owner)	Resource Requirements / Commitment
Commercial / Policy	Establish operational bridging mechanism with local licensing authorities to evaluate fast food outlet approvals, promotions, and street trading practices near vulnerable hubs.	Co-designed fast food licensing frameworks; minimization of harmful commercial determinants (factors such as availability, cost, and marketing of food) and environments that make unhealth choices easier. Formally establish operational mapping of the proliferation of hot food takeaway clusters and establishing shared micro-environment metrics.	Short term (6-12 months)	Licensing/Strategic Planning / Public Health Team	Existing regulatory functions and Public Health input

3. Category B: Cross-System, Partnership & Community-Led Actions

The following interventions use the capacity of broader system partners across Reading, third-sector frameworks, or county-wide physical alliances to distribute operational weight evenly across the whole local public sector ecosystem.

Strategic Theme	What are we doing?	Expected outcomes?	Timeline	Lead Partners (Named Owner)	Notes / Opportunities	Resource Requirements / Commitment
Food	Support the growth of local food networks and community health champions.	A trained and supported workforce is in place to promote positive messaging about healthy eating within communities.	Medium term (12-24 months)	Reading Food Partnership	Public Health Team through Systems Leadership Framework.	Supported through existing partner programmes

Strategic Theme	What are we doing?	Expected outcomes?	Timeline	Lead Partners (Named Owner)	Notes / Opportunities	Resource Requirements / Commitment
Physical activity	Appoint senior Physical Activity Champions with a role to promote and co-develop community and workplace physical activity.	Increased intelligence from within communities, facilitated through improved and proactive promotion and support.	Long term (2 years+)	Physical Activity Alliance Group	Explore structural learning and synergies through the ACRE community champion model.	Supported through existing partner programmes e.g., Place Universal Offer with Public Health support (officer time)
Weight / Lifestyle Management	Co-develop tiered weight management provision. Increase choice in Tier 2 and Tier 3 with Thames Valley ICB.	Clear and co-efficient pathway in place, enabling signposting and referral to appropriate level of support.	Long term (2 years+)	Public Health Practitioner / Thames Valley ICB	Focuses heavily on regional NHS clinical integration mapping.	Supported through existing partner programmes with Public Health support (officer time)
Weight / Lifestyle Management	Embedding physical activity within health pathways (including social prescribing, and long-term health conditions).	Individuals with long term health conditions can access appropriate activity options.	Long term (2 years+)	Get Berkshire Active (GBA) / VCS	Linking health practitioners directly to verified neighbourhood physical providers.	Existing partnerships with Get Berkshire Active (GBA) and VCS
Commercial Determinants	Explore development of a plan with local food producers to support the provision of available healthy food options that are available.	Improved food security through the increased provision and choice of healthy food options.	Long term (2 years+)	University of Reading / Reading Food Partnership	Leverages University of Reading's research capacity and localized production loops.	Partner-led activity; PH Officers, University of Reading, some in-kind contribution
Process / Operations	Create and maintain a diary of networking opportunities for system partners to engage with. (Online & F-2F).	Maintained awareness of opportunities to collaborate, and improved relationships between partners.	Medium term (12 - 24 months)	PAAG/Place Universal Offer / Get Berkshire Active (GBA)	Provides regular baseline communications framework for the broader WSO network.	Supported through existing partner programmes

Strategic Theme	What are we doing?	Expected outcomes?	Timeline	Lead Partners (Named Owner)	Notes / Opportunities	Resource Requirements / Commitment
Built Environment	Consult with local communities and school leaders to explore interest and opportunities to activate spaces for activity with local communities.	Improved access to available venues to support activation. Enhanced engagement potential.	Short term (6-12 months)	RBC / GBA / Education Services	Feeds directly into Active Travel and suburban green infrastructure design projects.	Delivered through the funded Place Universal Offer Systems Leadership Programme with Public Health support
Physical Activity	Utilise place-based investment opportunities to develop a programme of affordable, equitable and inclusive interventions.	Increased physical activity provision and access to support for people within local communities.	Ongoing	GBA Place Universal Offer/ Public Health Team/PAAG/Integrated Healthy Lifestyle Service	Linked explicitly to high unmet need geographical clusters inside Reading.	Supported through existing commissioned programmes e.g., Integrated Healthy Lifestyle Service and Place Universal Offer (Targeted)
Physical activity	Continue work undertaken by the Physical Activity Alliance Group to create a heat map provision, identify gaps and target placement of provision and support.	Live directory of activation sites and opportunities, with potential to support development of digital directory.	Medium term (12 - 24 months)	Physical Activity Alliance Group (PAAG)/Public Health	Essential data tracking tool for strategic capital placement applications.	Existing internal RBC officer resource. Alternatively, fixed term contract to develop mapping.
Process / Operations	Create a 'what works' system leaders community of practice and learning.	Portfolio leaders share learning and approaches, reduce duplication and develop common practices.	Medium term (12 - 24 months)	Get Berkshire Active – Place Universal Officer (PUO)	GBA have capacity to support via Place work. Learning shared from Readifood projects	Delivery through the funded Place Universal Offer Systems Leadership Programme with Public Health support
Physical activity	Work with physical activity, education and professionals to provide training and support to increase inclusive practice.	More opportunities provided for disabled people.	Medium term (12 - 24 months)	Get Berkshire Active	Requires initiating a formal technical audit of local physical access restrictions.	Delivery through existing commissioned programmes to expand reach.

Strategic Theme	What are we doing?	Expected outcomes?	Timeline	Lead Partners (Named Owner)	Notes / Opportunities	Resource Requirements / Commitment
Internal (RBC)	Procure and develop a system leadership training programme to support the governance approaches for the strategy.	System leaders hold the skills and confidence to fulfil their role effectively, with additional capacity and capability.	Medium term (12 - 24 months)	Get Berkshire Active	Tied directly to registration numbers, multi-agency attendance, and confidence indices.	Delivery through the funded Place Universal Offer Systems Leadership Programme with Public Health support
Physical activity	Engage with CIMSPA Workforce Skills hubs to understand physical activity workforce skills and requirements and explore available opportunities through National Academy.	Increased awareness of existing / planned education and skills training available to sector professionals.	Short term (6-12 months)	Get Berkshire Active	Review baseline documentation; localized activation thresholds may dynamically vary.	Supported through existing partnerships e.g., Get Berkshire Active
Process / Operations	Explore development of a campaign/initiative/toolkit aimed at Small and Medium sized Enterprises (SME)'s to promote healthy behaviours in the workplace.	Consistent messaging being shared, supporting increase confidence in supporting a healthy weight / lifestyle narrative across Reading - supported by businesses.	Medium term (12 - 24 months)	TBC: Connect Reading / REDA / RBC	Focuses heavily on structural engagement with localized enterprise networks.	Proposed funding via the Public Health Grant
Process / Operations	Offer specific health related human resource support/information to SME organisations, including practical tools.	Consistent messaging being shared, supporting increase confidence in supporting a healthy weight / lifestyle narrative across Reading - supported by businesses.	Long term (2 years+)	TBC: Connect Reading / REDA / Public Health Team	Extends preventative healthcare tools beyond typical public authority boundaries.	Partner-led delivery with in-kind contribution; no additional funding identified at this stage

Strategic Theme	What are we doing?	Expected outcomes?	Timeline	Lead Partners (Named Owner)	Notes / Opportunities	Resource Requirements / Commitment
Internal (RBC)	Co-developed community-based learning offers that support families around nutrition, physical activity and healthy lifestyles.	Broadened community support networks delivering jointly executed community-based education packages equipping families with baseline cooking, meal planning, physical activity and lifestyle skills.	Medium term (12 - 24 months)	VCS/New Directions College	Conditional upon administrative confirmation of funding.	Proposed funding via the Public Health Grant
Internal (RBC) / System	Develop criteria for a 'register of trusted community organisations' to support the development and delivery of interventions, & engagement with people with lived experience.	Diversification of organisations linking with the Council to support delivery.	Medium term (12 - 24 months)	RVA (Reading Voluntary Action)	Direct academic-voluntary crosslink established with University of Reading.	Partner-led delivery with in-kind contribution and Public Health coordination; no additional funding identified at this stage

4. Category C: Conditional & Grant-Dependent Initiatives

These targeted programs remain contingent upon administrative sign-off and drawdowns from funding stream opportunities.

Strategic Theme	What are we doing?	Expected outcomes?	Timeline	Lead Partners (Named Owner)	Notes / Opportunities	Resource Requirements / Commitment
Weight / Lifestyle Management	Collaborate with community networks to develop a 'Reading-centric' healthy lifestyle campaign with audience sensitised resources.	Residents feel more confident in where, how and what to do to incorporate a healthier lifestyle.	Long term (2 years+)	Integrated Healthy Lifestyle Service / Public Health Team	Requires localized qualitative mapping of language/access needs at ward level.	External funding required; subject to PH Grant prioritisation or external funding bids.
Weight / Lifestyle Management	Explore feasibility of Education on Healthy Living (Better Adult Weight Management Course and cookery education) delivered in collaboration with community partners e.g., Food Banks, voluntary hubs.	Broadened neighbourhood safety nets providing neighbourhood level, culturally sensitized dietary and lifestyle interventions within high-need are.	Medium term (12 - 24 months)	Better – GLL/VCS partners/Food Banks/RVA	WSA PH Funding Dependent. Execution aligned with third sector voluntary hubs.	External funding required; subject to PH Grant prioritisation or external funding bids.

Strategic Theme	What are we doing?	Expected outcomes?	Timeline	Lead Partners (Named Owner)	Notes / Opportunities	Resource Requirements / Commitment
Commercial Determinants / Food Environment Page 98	Healthy Takeaway Improvement Scheme (HTIS): Targeted Support for High-Need Food Businesses	To improve the nutritional quality, hygiene, and health offer of takeaway food in deprived areas of Reading by working intensively with businesses rated Food Hygiene Rating Scheme (FHRS) 3 or below.	Medium term (12 - 24 months)	Public Health and Environmental Health	Aligned with PHE healthier catering toolkit approaches Encouraging healthier out of home food provision toolkit Annexes Small grants for: - Equipment (e.g. grills, air fryers) - Healthier ingredients - Menu redesign/printing Subsidised or free FHRS re-inspection.	Public Health
Weight / Lifestyle Management	Develop a Tier 2 children's weight management provision.	Clear and co-efficient pathway in place, enabling signposting and referral to appropriate level of support.	Long term (2 years+)	Public Health and Wellbeing	Vital clinical pathway connection for school-age demographics.	Public Health Grant

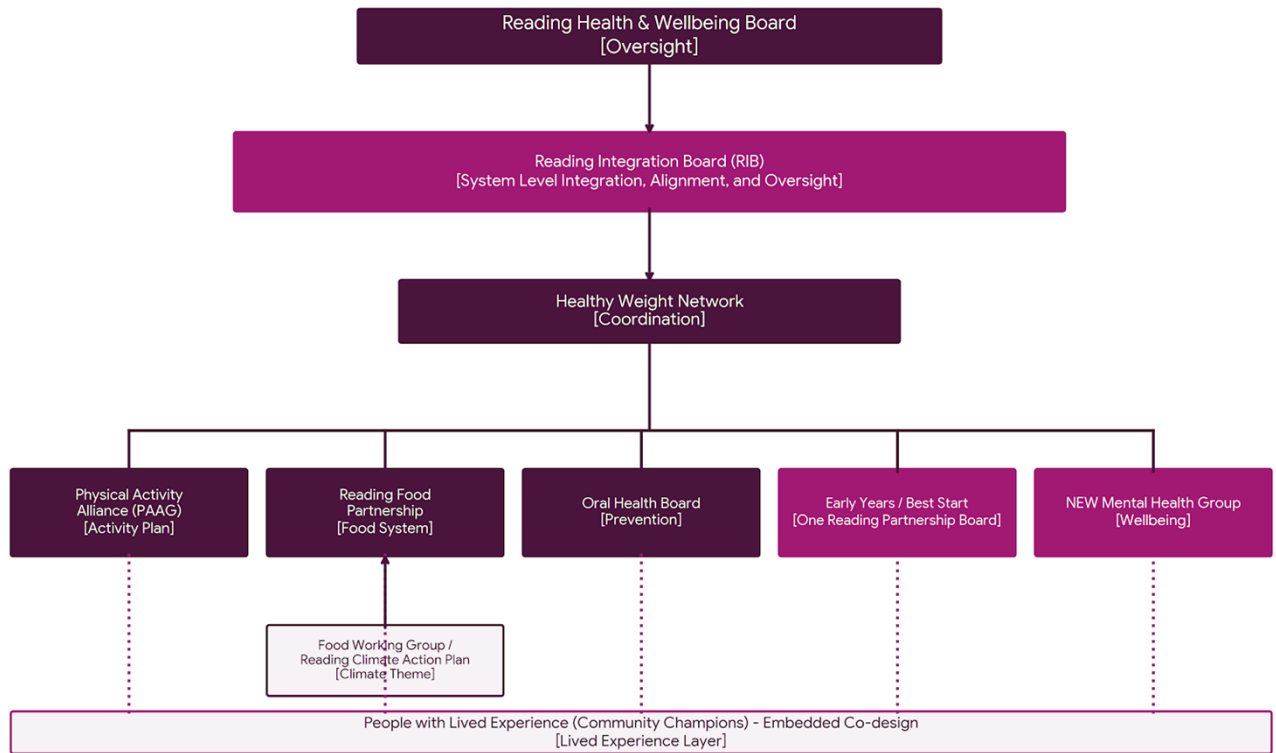
Strategic Theme	What are we doing?	Expected outcomes?	Timeline	Lead Partners (Named Owner)	Notes / Opportunities	Resource Requirements / Commitment
Weight / Lifestyle Management / Built Environment	Implement a Healthy Schools Programme (targeted pilot implementation)	To strengthen universal prevention, food and physical activity environments, and family engagement in priority schools and in areas of high need.	Medium term (12 - 24 months)	Public Health and Wellbeing / Schools & early years	Alignment with NCMP identification and referral pathways. Culturally appropriate, trauma-informed programme design. Family and equity focused support, through geographic and population prioritisation	Public Health officer time. School. Small-scale support for priority schools (training, resources, coordination) funded via Public Health Grant

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Appendix C. Governance Structure and System Context

Governance Overview

Proposed Reading Whole Systems Approach to Healthy Weight Strategy
Governance Structure (Draft)



The governance model ensures:

- Strategic oversight by the Health and Wellbeing Board
- System coordination through the Healthy Weight Network
- System integration and alignment through the Reading Integration Board (RIB)
- Delivery via existing partnerships

Governance Structure

Level 1: Strategic Oversight

- Reading Health and Wellbeing Board

Level 2: System Integration and Alignment

- Reading Integration Board (RIB)

Level 3: System Coordination

- Healthy Weight Network

Level 4: Delivery Partners and Subgroups

- Physical Activity Alliance Group

- Reading Food Partnership
 - Food Working Group / Reading Climate Action Plan
- Oral Health Board
- One Reading Partnership (Best Start in Life)
- Mental Health Group
- Reading Borough Council internal teams

Key Features

- System-led delivery
- Integration with existing structures
- Strong focus on prevention and inequalities
- Embedded lived experience
- Inclusion of mental health

1.1. Governance and System Leadership Detail

- 1.2. A strengthened governance model has been developed and refined following feedback from stakeholders, including the Health and Wellbeing Board workshop and the Whole Systems Healthy Weight Network. This ensures the approach is fully aligned with system priorities, promotes integration, and provides clear accountability for delivery.
- 1.3. The Health and Wellbeing Board will provide strategic oversight and system leadership for the Whole Systems Approach to Healthy Weight Strategy. This includes:
 - Setting the strategic direction and maintaining alignment with Health and Wellbeing Board priorities.
 - Receiving regular progress updates.
 - Providing collective system leadership to unblock barriers and reduce siloed working.
 - Championing a Health in All Policies approach across partner organisations.
- 1.4. Beneath this, a Whole Systems Healthy Weight partnership which will act as the central “engine room” for delivery, bringing together strategic coordination, integration and operational leadership across partners. This includes:
 - The Healthy Weight Network, providing multi-agency system coordination, shared accountability, and oversight of delivery.
 - An operational delivery function, supporting implementation, monitoring progress, and coordinating delivery partners.

In parallel, the Reading Integration Board (RIB) provides system-level integration, alignment, and oversight across health and care, ensuring that the Whole Systems Approach to Healthy Weight is embedded across health and care and within broader system priorities and transformation programmes.

RIB will:

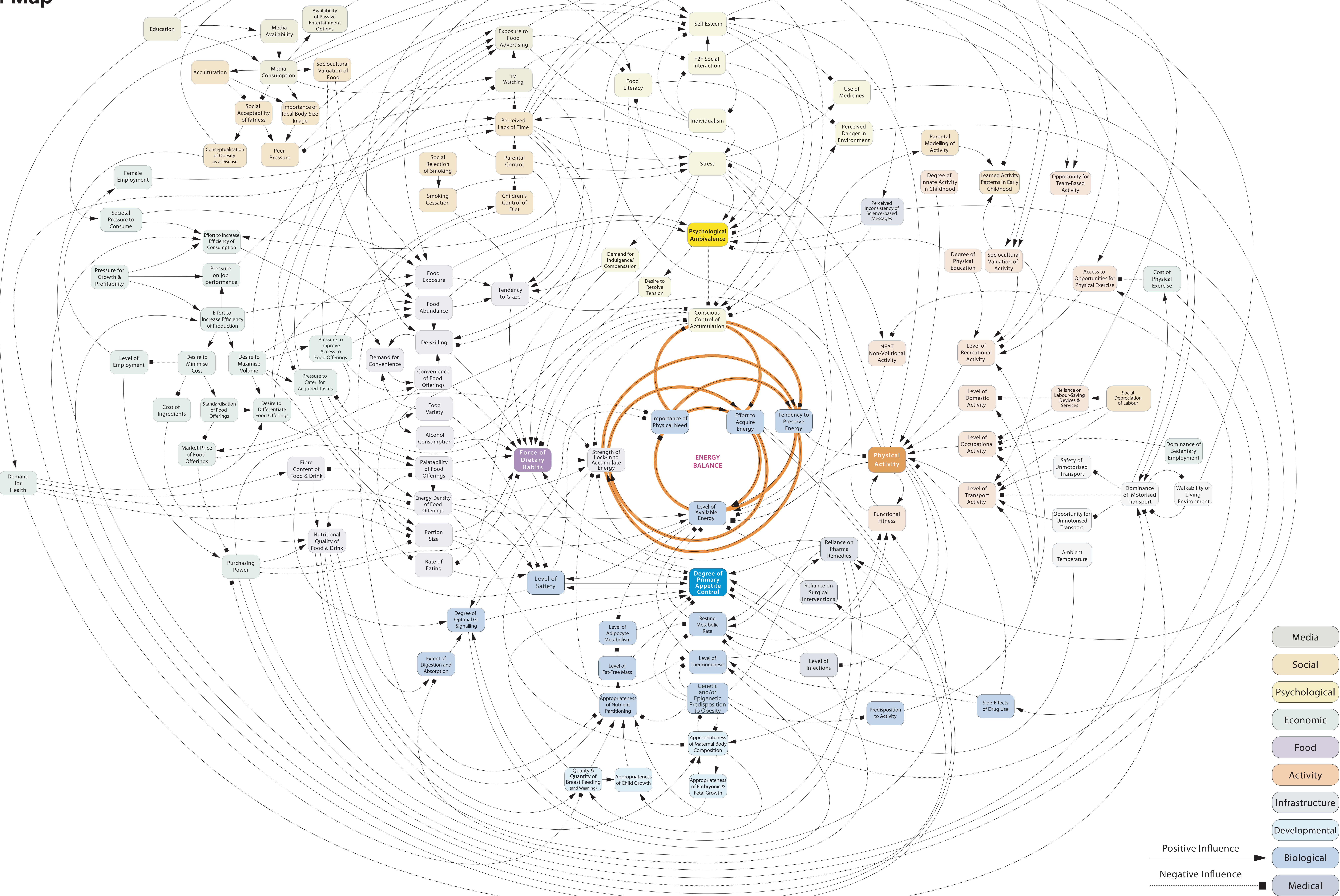
- Ensure alignment between Healthy Weight priorities and NHS, local authority, and integrated care system objectives
- Provide a platform to influence system-wide decision-making, including resourcing, commissioning, and service transformation
- Support integration across pathways, including prevention, treatment, and wider determinants (e.g. mental health, maternity, long-term conditions)
- Help to remove system barriers and unblock delivery issues that require multi-agency resolution
- Enables Healthy Weight to be embedded within existing programmes and partnerships, avoiding duplication and additional governance burden

- 1.5. Delivery of the strategy is planned through existing partnerships and system groups, rather than creating new structures, alongside partnership working where groups do not exist. These include:
- Physical Activity Alliance Group (PAAG)
 - Reading Food Partnership
 - Oral Health Board
 - One Reading Partnership (Early Years / Best Start in Life)
 - Reading Obesity Group (clinical and specialist input)
 - Reading Borough Council internal teams
- 1.6. In response to stakeholder feedback, the governance model has been strengthened to ensure that mental health is explicitly integrated and visible within the system, recognising its critical role in both the causes and consequences of unhealthy weight. Links with a dedicated Mental Health Group explored for inclusion within the governance structure, ensuring stronger alignment across physical and mental health priorities and supporting a more holistic, person-centred approach.
- 1.7. Across all levels of the governance structure, lived experience will be embedded through community champions and co-design approaches, ensuring that the voices of residents shape both strategic direction and delivery. This reflects a commitment to inclusive, culturally appropriate, and community led solutions.
- 1.8. This model ensures that delivery is:
- System led and partnership driven
 - Integrated across services and sectors
 - Focused on prevention and inequalities
 - Accountable to the Health and Wellbeing Board

See Appendix D for the Full Foresight Obesity System Map which illustrates the complex, interconnected drivers of obesity. (*Source: Government Office for Science, Tackling Obesities: Future Choices - Obesity System Atlas, 2007*)

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Appendix D
Foresight Obesity
System Map



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Equality Impact Assessment Template

A. Information about the policy

Policy title	Reading Whole Systems Approach to Healthy Weight Strategy (2026-2036)
Lead officer (name and role)	Amanda Nyeke, Public Health Principal (Place)
Date of assessment (dd/mm/yyyy)	27/05/2026
Summary of the policy	The Whole Systems Approach to Healthy Weight Strategy (2026-2036) sets out a long-term, evidence-informed framework to improve healthy weight outcomes across Reading. It adopts a life course and whole systems approach, recognising that healthy weight is influenced by a wide range of environmental, social, and economic factors. The strategy focuses on prevention, reducing health inequalities, and creating environments that enable healthier choices. Delivery will be coordinated across system partners, with an initial two year implementation phase prioritising Best Start in Life, community involvement and co-design, and cross-system prevention activity.

B. Initial assessment

	Assessment
PSED Aim 1 (unlawful behaviour): • Could your policy lead to direct or indirect discrimination, harassment, victimisation, or any other conduct prohibited by the Equality Act 2010?	No, the policy is not expected to result in discrimination, harassment, or unlawful conduct. It has been designed to reduce inequalities.
PSED Aim 2 (equal opportunities): • Could your policy affect how service users or employees access services or participate in activities relevant to your policy area? • Could it impact people with particular protected characteristics who have a disproportionately low level of access to services, participation in public life, or other activities? • Could it create or worsen disadvantages and inequalities in your community?	Yes, the policy directly aims to improve access to services and reduce health inequalities, particularly for underserved and disadvantaged groups.

• Could it remove or minimise disadvantages and inequalities in your community?	
PSED Aim 3 (good relations): • Could your policy affect how people perceive or interact with others? • Could it help tackle prejudice and promote understanding between people with different protected characteristics? • Could it lead to prejudice, community tensions, conflicts, isolation, or segregation?	Yes, the policy promotes co-design, community engagement, and inclusive approaches that support stronger relationships and understanding across communities.

C. Full assessment

i. Impact on protected characteristics

Protected characteristic	Expected impact	Evidence
Age	Positive	The strategy adopts a life course approach, with specific focus on early years (Best Start in Life) and prevention across all ages.
Disability	Positive	People with disabilities may face barriers to physical activity and healthy living. The strategy includes inclusive design and access to services.
Gender reassignment	None	No specific differential impact identified; inclusive, population-level approach.
Pregnancy and maternity	Positive	Specific focus on maternal health and obesity pathways supports improved outcomes for pregnant individuals and infants.
Race	Positive	Evidence shows higher obesity-related risk in some ethnic groups and inequalities linked to deprivation; strategy prioritises culturally

		appropriate approaches and co-design.
Religion or belief	None	No direct impact identified; co-design approach supports culturally appropriate interventions.
Sex	Positive	Recognises gendered health inequalities (e.g. maternal health, workforce behaviours, service access).
Sexual orientation	None	No direct differential impact identified; services are designed to be inclusive.
Marriage and civil partnership	None	No direct impact identified.
Membership of the armed forces community*	None	No direct impact identified; will benefit from universal access to services.
Socio-economic disadvantage*	Positive	Central focus. The strategy explicitly targets inequalities linked to deprivation and access to healthy environments.
Experience of care*	Positive	Co-design and community-based approaches support inclusion of vulnerable groups, including individuals with experience of care.

*Additional characteristics identified by the Council to be considered in Equality Impact Assessments.

ii. Mitigating Actions

Negative impact	Mitigating action
*Risk of stigma associated with weight	Whole systems approach focuses on environments and systems rather than individual blame; emphasis on inclusion and lived experience
N/A	
N/A	
N/A	
N/A	

iii. Monitoring and Review

Equality impact will be monitored and reviewed as part of the overall strategy evaluation framework.

This will include:

- Monitoring access, uptake, and outcomes across different population groups
- Tracking inequalities in healthy weight, diet, and physical activity
- Using population-level and service-level data (e.g. NCMP, OHID profiles)
- Capturing lived experience feedback through co-design and engagement processes
- Annual review of the implementation plan and priorities

Findings will be used to:

- Identify inequalities in impact
- Adapt delivery approaches
- Ensure resources are targeted effectively to reduce disparities.

D. Approval

Approving officer (name and role)	Date (dd/mm/yyyy)
Matt Pearce	27/05/26

READING HEALTH AND WELLBEING BOARD

Date of Meeting	16 July 2026
Title	Best Start Family Hub and Best Start in Life Delivery Plan Update
Purpose of the report	To make a decision
Report author	Becky Bateman & Zoe Campbell
Job title	Head of Early Years and Childcare, Strategic Lead for Best Start in Life and Public Health Principal (Children)
Organisation	Reading Borough Council
Recommendations	1. Endorse the delivery model for Best Start Family Hubs and Best Start in Life programme 2. Note the proposed data reporting set

1. Executive Summary

1.1 Best Start Family Hubs play a crucial role in reducing inequalities by providing accessible, integrated support for children, young people, and families - particularly those facing disadvantage. By bringing together services such as early years education, health, parenting, and wider support in one place, they improve access and remove barriers linked to income, location, or awareness. This supports early intervention and helps ensure children have the foundations for healthy development and school readiness.

1.2 The Best Start Family Hubs and Start for Life (BSFH and BSIL) programme forms part of the national early years transformation agenda, with a focus on improving outcomes for children aged 0-5. Locally, the programme aims to increase the proportion of children achieving a Good Level of Development (GLD) from 68% to 75% by 2028, while reducing inequalities for groups, including children with SEND, those eligible for Free School Meals (FSM), and those with English as an Additional Language (EAL). The programme strengthens early identification and intervention and delivers integrated, accessible services through a Family Hub “single front door” approach.

1.3 The approach reflects the strong evidence base that early childhood - particularly the earliest years - has a significant influence on long-term health, wellbeing, and life chances. As such, the programme prioritises prevention, early help, and improving outcomes for families at the earliest stage.

1.4 This report provides a strategic overview of the BSFH and BSIL delivery model, and expected outcomes to improve early years development and reduce inequalities across Reading.

2. Policy Context

2.1) The programme aligns with the national early years transformation agenda, including the Department for Education Start for Life and Family Hubs programme. It also aligns with SEND and Families First reforms and supports the Neighbourhood Health Framework and local delivery priorities.

It contributes to improving Good Level of Development (GLD) outcomes and reducing inequalities in Reading, particularly for:

- Children with Special Educational Needs and Disabilities (SEND)
- Children eligible for Free School Meals
- Children with English as an Additional Language

This reflects a shared system priority to improve outcomes in the early years through prevention, early intervention, and integrated working.

3. The Proposal

3.1 DfE funding is ring-fenced and used strategically to deliver an integrated early years system through four core delivery areas:

- Home Learning Environment (HLE)
- Parenting Support
- SEND & Early Identification
- System Integration & Family Hubs

The model is designed to strengthen early intervention, improve access to services, and ensure support is targeted effectively using local data and need.

3.2 Key enabling infrastructure includes:

- **Family Hubs Leadership** – to operationalise the delivery of the programme
- **Early Years Curriculum & Quality Leadership** for maintained schools sector – support curriculum quality and transition from Early years
- **Early Years Advisory Support to PVI Sector** support high quality curriculum delivery and transition to schools
- **Dedicated Programme and Project Leadership** – development of locality level partnership boards and joint planning meetings with roles drawn from each respective service and voluntary/community sector groups. Mapping existing services and identifying gaps data analysis of service need * *BSIL strategic lead could deliver this as alternative option*
- **Data Analyst** - embedded data, performance reporting and evaluation
- **Family Hub Navigators** to improve access, signposting, referral pathways
- **Strengthened Early Years Leadership Capacity** for HLE team and BSIP delivery to strengthen a cross-service, shared understanding of home learning, to broaden cohesive support for families.

3.3 Target outcomes include:

- Increase GLD to 75% by 2028
- Improve early language development
- Increase parenting programme engagement and completion
- Improve early SEND identification before age 4

3.4 Investment Profile

Area	Investment 26/27	Investment 27/28	Investment 28/29	Purpose
Home Learning Environment (HLE) (3-4 years)	£139,200	£141,000	£147,100	Early language & parent-child interaction

Parenting Support (3-4 years)	£104,400	£105,700	£110,400	Parenting confidence & behaviour
SEND & Early Identification (0-5 years)	£175,400	£280,600	£280,600	Early identification & inclusion
Programme funding	£345,100	£282,000	£289,000	System Integration / Family Hubs Access, workforce, data & leadership
Capital	£69,000	£70,000	£71,000	Capital modifications/improvements

Funding is ring-fenced and supports early intervention, workforce capability, service integration, and improved access through Family Hubs.

4. Priority Delivery Areas

These delivery areas reflect national programme requirements and are aligned to evidence-based approaches to improving early childhood outcomes, particularly through early intervention, strong family support, and integrated service delivery.

4.1 Home Learning Environment (HLE)

Focus on speech, language and communication (ELKLAN informed approach), with targeted support for disadvantaged families using local data.

Impact:

- Improved early development and communication and GLD
- Increased attainment of language milestones
- Increase school readiness and GLD

4.2 Parenting Support

Delivery of evidence-based parenting programmes for three- to four-year-olds alongside universal offers, supported by improved referral pathways and workforce training.

Impact:

- Increased parental confidence
- Improved child behaviour and attachment, self regulation
- Increase school readiness
- Greater engagement from priority groups

4.3 SEND & Early Identification

Shift from reactive to preventative model through:

- Best Start Inclusion Practitioners (BSIPs) x 4
- Experts at hand multi-disciplinary support (EP, SaLT, OT)
- Training for workforce and parents
- Peer support networks

Impact:

- Earlier identification (pre-age four)

- Reduced waiting times
- Improved outcomes for SEND children

4.4 System Integration & Family Hubs

Family Hubs act as the central delivery model enabling:

- Single front door access
- Improved multi-agency working
- Data-led targeting of support

Developments include:

- Locality-based partnership boards
- Co-location of services (health, SEND, early years)
- Expanded outreach through community and VCFS partnerships
- Integrated working with Families First to provide seamless support pathways

Impact:

- Increased service reach
- Improved family experience
- Reduced system fragmentation

5. Performance and Outcomes Framework

Please refer to the BSIL outcomes framework in appendix 3.

6. Value for Money

The programme contributes to:

- Reducing inequalities in health and early years outcomes
- Supporting children and families in the early years
- Promoting wellbeing through prevention and early intervention
- Improving long-term life chances
- It aligns particularly with priorities to support early years development and reduce differences in outcomes between groups.

7. Risks and Considerations

Key risks include:

- Delivery reliant on effective cross-agency integration
- Workforce capacity, staff resource and training sustainability
- Data system maturity and reporting capability
- Engagement of priority and seldom-heard groups
- Change of government direction

Mitigation focuses on strengthening governance, partnership working, and performance monitoring.

Options

- **Option 1 (Recommended):** Approve the full programme and funding model to enable system-wide integration and early intervention.
- **Option 2:** Deliver a reduced model focusing on selected priority areas – this would limit impact and reduce system change.
- **Option 3 (Do Nothing):** Do not proceed – this risks worsening early years outcomes and does not maximise available funding.

7.1 Contribution to Reading's Health and Wellbeing Strategic Aims

The programme contributes to:

- Reducing inequalities in health outcomes
- Supporting children and families in early years
- Promoting wellbeing through early intervention
- Improving life chances and long-term outcomes

The programme aligns particularly with helping children and families in early years and reducing differences in health outcomes between groups.

8. Environmental and Climate Implications

No significant environmental or climate implications have been identified.

The programme primarily relates to service delivery and integration rather than infrastructure changes.

9. Community Engagement

Engagement is delivered through:

- Locality partnership boards
- Voluntary and community sector organisations
- Co-design and feedback from families

10. Equality Implications

The programme targets disadvantaged and vulnerable groups and is expected to have a positive impact on reducing inequalities in access, experience, and outcomes. A full Equality Impact Assessment may be required.

11. Other Relevant Considerations

Key risks include workforce capacity, effective cross-agency integration, data system maturity, and engagement with priority groups. Mitigation will focus on governance, partnership working, and performance monitoring.

12. Legal Implications

To be confirmed in consultation with Legal Services prior to submission.

13. Financial Implications

The programme is funded through ring-fenced Department for Education funding allocated across delivery areas including Home Learning Environment, Parenting, SEND, and System Integration. Investment is focused on early intervention, workforce capability, and system integration to improve outcomes and deliver longer-term value by reducing future demand on services.

Grahame Craig, Finance Business Partner DSG and Education - has cleared these financial Implications.

14. Timetable for Implementation

Delivery will take place from **2026 to 2029**, with phased implementation, ongoing monitoring, and evaluation through programme governance arrangements.

15. Background Papers

<https://www.gov.uk/government/publications/best-start-family-hubs-and-healthy-babies-guidance-for-local-authorities>

Appendices

1. Governance Document
2. Best Start in Life Strategy
3. Proposed data set

Best start Family hubs and Best start in Life – Governance Document (v1)

Reading Borough Council

May 2026

1. Purpose of this Document

This document sets out the governance framework for the implementation of the Best start in life strategy through the Best start Family hubs within Reading Borough Council's Education and Children's Services.

It defines the decision-making structures, roles and responsibilities, and project management arrangements that will ensure the programme is delivered effectively, transparently, and in alignment with the council's strategic priorities.

The document is iterative and will evolve as the programme progresses and as local deliverables are confirmed.

The Programme will be delivered within the wider context of national and local learning and findings. These governance arrangements ensure that the programme is delivered in a transparent, accountable and collaborative way across all partner agencies. Programme management will adopt an agile, waterfall style of management to be responsive to iterative learning and an emerging local and national context.

This Best start in Life programme transformation is being delivered within the wider context of national early years reforms which prioritise prevention, early intervention and integrated place-based support for families. These reforms emphasise improving outcomes in the critical early years, particularly from pregnancy to age two, through stronger partnership working and system wide accountability.

2. Programme Overview

The Best Start in Life programme is a strategic, system-wide transformation programme focused on improving outcomes for babies, young children and families, particularly during the critical first 1,001 days from conception to age two.

The programme brings together partners across health, local government, education and the voluntary and community sector to deliver integrated, prevention-focused services that support healthy child development, reduce inequalities and improve school readiness.

The programme aligns with national priorities including the Start for Life agenda and the development of Family Hubs, strengthening early intervention and ensuring families can access coordinated support at the earliest opportunity.

Key areas of focus include:

- Early child development and school readiness
- Parent-infant relationships and family wellbeing
- Speech, language and communication development
- Perinatal and infant mental health
- Reducing health and developmental inequalities
- Integrated early help and safeguarding support

Delivery is underpinned by strong multi-agency partnership working, data-informed decision making and a place-based approach to service integration.

The programme is outcomes-focused, aiming to improve children's life chances, enhance family resilience and ensure that all children have the best possible start in life.

3. Governance Structure

The programme will be governed through a three-tier structure to ensure both strategic oversight and operational delivery.

Level	Group	Purpose	Frequency
Strategic Oversight	Health and Wellbeing Board and One Reading partnership Board	Provides high-level direction and accountability; approves funding and key decisions	Two monthly
Operational Delivery	Best Start in Life Operational Board	Oversees day-to-day delivery, risks, and dependencies; ensures alignment across workstreams; monitors progress against plan.	Monthly
Programme Management	Project Meetings / Workstream Groups	Coordinate detailed actions, update progress, escalate issues.	Two Weekly

A visual representation of the governance hierarchy can be added once membership is confirmed.

4. Programme Roles and Responsibilities

4.1 Sponsor

Role: Senior responsible owner for the programme.

Postholder: Executive Director of Children's Services

Responsibilities:

- Provides strategic leadership and ensures alignment with council priorities.
- Approves key decisions and resource allocations.
- Co-Chairs or delegates chairing of the Strategic Board.
- Resolves escalated issues beyond the control of the Strategic Lead.
- Champions the programme across partner agencies.
- Provides regular updates to Corporate Management Teams

4.2 Partner Agency Sponsorship

Role: Act as leads for their organisations, responsible for engagement, information-sharing, and funding / resource commitments.

Responsibilities:

- Represent their agency at Board or Operational level.
- Ensure their organisation understands and supports BSFH and BSIL objectives.
- Proactively supports the identification of risks and impediments to progress and proactively seek solutions/mitigations
- Coordinate internal decision-making and communication.
- Confirm contribution to funding and workforce (where applicable).

4.3 Strategic Lead

Role: Senior operational lead responsible for overseeing delivery and embedding of the FSM within practice.

Likely postholder: Head of Early years and Childcare & Best start in Life Strategic Lead

Responsibilities:

- Leads on local design and implementation of BSIL.
- Chairs the BSIL Operational Board.
- Provides direction to delivery leads.
- Ensures staff and partner engagement.
- Signs off deliverables prior to sponsor approval.

4.4 Programme Manager

Role: Responsible for coordinating all aspects of project delivery, planning, monitoring and reporting. (* This post could be undertaken by Head of Early years and Childcare and Strategic lead for BSIL with PMO support)

Responsibilities:

- Develops and maintains the project plan, governance documentation and risk/issue logs.
- Facilitates governance meetings and ensures timely reporting.

- Coordinates BSIL Board and tracks progress against milestones.
- Produces highlight reports and dashboards for boards.
- Supports the Strategic Lead in stakeholder engagement.
- Ensures adherence to council project management standards and methodologies.
- Drives agile working practices (sprints, iterative updates, regular feedback loops).

4.5 Delivery leads

Role: Subject matter experts responsible for delivering agreed deliverables within the BSIL strategy

Delivery leads:

- Perinatal and early health improvement -0-19 lead BHFT
- Neurodivergence and SEND early identification – EY SEND TM
- Home learning and early language development – EY TM
- Early years quality and workforce development – EY TM/ Strategic lead for school effectiveness
- Family hubs and place based early help – Family hubs TM
- Public health nursing and integrated partnerships – Public Health Principal
- Outcomes, insight and evaluation – Delivery leads inform Data analyst via BSIL Board

Delivery leads will sit on the Operational BSFH and BSIL Board

Responsibilities:

- Define scope, deliverables and timelines for their area.
- Coordinate input from partners and internal teams.
- Report progress and risks to the Programme Manager.
- Ensure dependencies are identified and managed.
- Escalate delays or decisions required to the Operational Board.

5. Decision-Making & Escalation

Level	Decisions Made	Escalation Route
Delivery leads	Operational activities, task prioritisation	To Programme Manager/Strategic Lead
Operational Board	Milestones, dependencies, operational risks	To Strategic Board
Strategic Board	Strategic direction, impact and effectiveness, partnership resolution, integrated commissioning and sustainable funding	Integrated Care Board /Reading Borough Council Adult Social Care, Education & Children's Services Committee

6. Reporting & Assurance

- **Highlight Reports:** Monthly by the Programme Manager to the Stakeholders.
- **Performance Dashboard:** Regular oversight of key metrics, tracking progress to Strategic Board.
- **Risk / Issue Logs:** Maintained live by Programme Manager and reviewed regularly.
- **Change and Decision Log:** Used to track new requests, deliverable changes or delays.

7. Meetings & Frequency

Meeting	Chair	Frequency	Purpose
Strategic Board	Sponsor / Lead member for public health/Director for public health	Two Monthly	Strategic oversight, approvals, alignment
Operational Board	Strategic Lead	Monthly	Delivery oversight, dependencies, risks
Project Meeting / Workstream Leads	Programme Manager	Two Weekly	Progress updates, blockers, next sprint
Partner Check-ins	Programme Manager / Strategic Lead	As required	Clarify roles, funding, expectations

8. Documentation & Controls

Document	Owner	Description
Governance Document	Programme Manager	Defines structure, roles, and controls (this document).
Project Plan	Programme Manager	Milestones, workstreams, deliverables.
Partnership Agreement	Strategic Lead	A formal agreement between RBC and partner agencies
Highlight Report	PM	Bi-weekly summary of progress, issues, and next steps.
Risk & Issues Log	PM	Tracks risks and mitigations.
Change Log & Decision Log	PM	Captures scope or timeline changes.

9. Communication & Engagement

- Internal staff updates (through existing communications channels).
- Partner engagement events

- Regular feedback loops between PM, workstream leads, and practice teams.
- Public communications as agreed by Comms workstream and approved by Strategic Board.

10. Review & Updates

This document will be reviewed and updated at key milestones or when significant structural or partnership changes occur.

Version control will be maintained, and all updates will be approved by the Project Sponsor.

Review and updates will be maximised to enable a culture of continual learning and improvement.

Version Control

Version	Date	Author	Summary of Changes
1.0	May 2026	Becky Bateman -Strategic Lead for BSIL	Initial draft for discussion with DMT

Best Start in Life Strategy for Reading 2026 - 2028

Owner

Andrea King, Berkshire Neurodiverse System Transformation Lead
Strategic Transformation Lead for Mental Health & Emotional Wellbeing
& Families First Strategic Lead

Version

V1.0

Date

February 2026

Review Date

February 2028

Foreword, Councillor Wendy Griffith and Councillor Rachel Eden

(Lead Councillor for Children and Lead Councillor for Education and Public Health, Reading Borough Council)

This strategy reflects Reading's ambition as a town to give all our children the best start in life.

Voluntary groups and public services have worked together in partnership to develop this strategy, which most importantly has involved careful listening and co-design with our local families and communities.

Our strategy recognises that the first 1001 days of a child's life are crucial to ensure that our children grow, develop, learn and thrive in childhood and adulthood. It is the responsibility of us to work together to help Reading's babies and children to have the very best start in life.

In Reading's Best Start in Life Strategy we set out how our town will come together to help Reading's babies and children have the best start in life. This will involve partnerships between midwifery, health visiting, early years, libraries and culture, family support and mental health as well as services that support neurodivergence, special educational needs and disabilities, and care. This offers a wide range of help including support with housing, debt advice, cooking skills, guidance around substance and alcohol dependency, support for mums and dads-to-be and other key carers for our children, and much more.

This strategy is ambitious, but our children deserve nothing less.

The principles of respectful, inclusive, family-centred, trauma-informed, accessible and welcoming environments, shape our approach to early support. We are determined to ensure that enabling a good life and improving outcomes for Reading's residents starts from the earliest moments of life.

Improving what we offer to families in our local communities is something we can be proud of in response to what our children and families most need.

We also want to provide a foundation for integrated neighbourhood support throughout our communities' lifetimes. We believe that the integrated family help set out in this strategy will enable every child in Reading to have equal access to good quality support and help, in the right place, and at the right time.

Reading's children and young people, describe our shared vision in these words:

'Children and Families' voices will be heard, that our children will be supported to prepare for the future, reach their full potential and become the best person they can be'.

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Our Vision

In Reading, we want every baby and child to grow up feeling safe, loved and able to flourish.

Together, we will work as one team in Reading to support our children and young people to live lives free from fear and harm, to help them feel safe, be healthy, achieve their potential and experience a sense of belonging.

Trusting relationships matter. We commit to understanding the specific experiences and identities of our children and their families, shaping our help and support to reflect that.

By working together with families and communities, we will help children from pregnancy through to starting school to:

- feel secure and supported
- be healthy, happy and confident
- develop strong communication and learning skills
- experience a sense of belonging.

Strong, trusting relationships are at the heart of a good start in life. We know that every family is different, and we shape our support around children's individual needs, strengths and identities.

Our Values

The Best start strategy articulates how we, as a network of partners and organisations across Reading, work in more integrated and collaborative way with families that is respectful, inclusive and empowering, particularly at a time of rising child poverty.

We will work alongside families in ways that are:

Respectful and inclusive – grounded in anti-discriminatory practice and cultural humility, recognising and valuing the diverse experiences, identities and strengths of Reading's communities, and ensuring that services are responsive rather than prescriptive.

Family-centred – strengths-based approach and recognising the wider pressures families face, we aim to reduce barriers to support, build resilience, and deliver help that is accessible, equitable and focused on improving outcomes for those most affected by hardship.

Trauma-informed – understanding the impact that adversity, inequality and poverty can have on children and families, and prioritising safety, trust and compassion in all interactions.

Accessible and welcoming – reducing barriers and making support easy to find.

Early and preventative – offering help before problems escalate.

Why the first 1,001 days matter, and what this means for Reading

The first 1,001 days of life, from conception to age two, are a critical period for brain development, physical health, emotional regulation, and attachment. Research shows that experiences during this window have lifelong impacts on learning, wellbeing, and future outcomes. Early intervention has the greatest effect because the brain's capacity for change is highest in the earliest years. Investing in babies, young children and families creates lasting benefits across education, health and society.

[The Best Start for Life, A Vision for the 1,001 Critical Days, The Early Years Healthy Development Review Report.](#)

Reading's [Director of Public Health Annual Report](#) (2025) sets out the case for change and the importance of investing in a child's early years. We recognise that while the brain remains adaptable throughout life, the ability to influence development decreases with age—making early family help the most effective and efficient way to improve outcomes and reduce future demand on statutory services.

What shapes children's early development

From pregnancy through early childhood, key factors influence outcomes:

Brain and Cognitive Development

- Good nutrition, sleep, and physical health support optimal brain growth
- Chronic illness, malnutrition, or frequent infections affect attention, memory, and learning
- Early health problems can have long-term consequences for school performance.

Physical Development

- Health in infancy underpins growth, motor skills, and coordination
- Illness or poor nutrition can delay important milestones such as walking and fine motor control.

Emotional and Social Development

- Warm, responsive relationships build emotional security and resilience
- Healthy children have more energy to explore, play, and learn social skills

- Stress, poor health, or trauma can lead to anxiety, irritability, or withdrawal.

Immune System and Resilience

- Healthy children miss fewer days in early education, giving them more consistent learning experiences
- Feeling physically well supports confidence, coping skills and successful transitions
- Collectively, this evidence shows that early intervention - before difficulties escalate - is one of the most effective and cost-efficient ways to improve population outcomes. Investment in early years is estimated to return 9–10 times the financial value through improved life chances and reduced need for intensive services later in life.

The Picture in Reading: Key Challenges

While many children in Reading do well, outcomes are not equal. There are a range of early health and social factors that disproportionately affect families in the borough:

Poverty and Inequality

- 24% of children under 16 live in low-income households, including around 2,000 under-fives, with concentrations in the most deprived wards
- Poverty is linked to poorer physical health, delayed language development and emotional difficulties.

Oral Health

32.9% of five-year-olds have tooth decay—well above the national average.

Healthy Weight

- Around 1 in 5 children are overweight or obese at the start of school; 1.9% are underweight—higher than the national average
- Physical activity in early childhood supports motor, cognitive and emotional development, yet not all children have equal access to safe play and green space.

Immunisation

Uptake for under-fives is below the national 95% target and below the minimum 90% standard for several vaccines.

Teenage pregnancy and maternal health

- Reading's under-18 conception rate (18.9 per 1,000) is significantly higher than England's rate (13.1).

- 5.9% of pregnant women smoke, a key risk factor for stillbirth, complications and low birth weight.

Early Trauma and Family Stress

Exposure to domestic abuse, parental mental ill-health and substance misuse in early childhood is linked to lifelong risks across health, education and relationships.

Neurodivergence and SEND

Early identification reduces later mental health difficulties, exclusion and social marginalisation, yet families report inconsistent access to early support.

School Readiness

Reading aims for 75.9% GLD by 2028, but current outcomes show inequalities:

- GLD overall: 68.5%
- GLD FSM: 49.8%
- GLD SEND: 26%

Children facing adversity and children from minority backgrounds are less likely to begin school with the skills they need.

Why this matters for Reading

- The foundations of brain development, attachment, and healthy behaviours, are laid in the early years of a child's life (before school)
- Early inequalities such as poverty, poor housing, low birth weight and delayed communication all impact mental health, educational attainment and long-term employment
- Inclusive early identification of neurodivergence improves opportunities for adjustment of home and community environments, increases inclusion and belonging, reduces crisis, and increases positive long-term outcomes
- Integrated services help families access support earlier, reducing escalation to statutory intervention
- Parents' mental health strongly influences infant development, bonding, and emotional wellbeing.

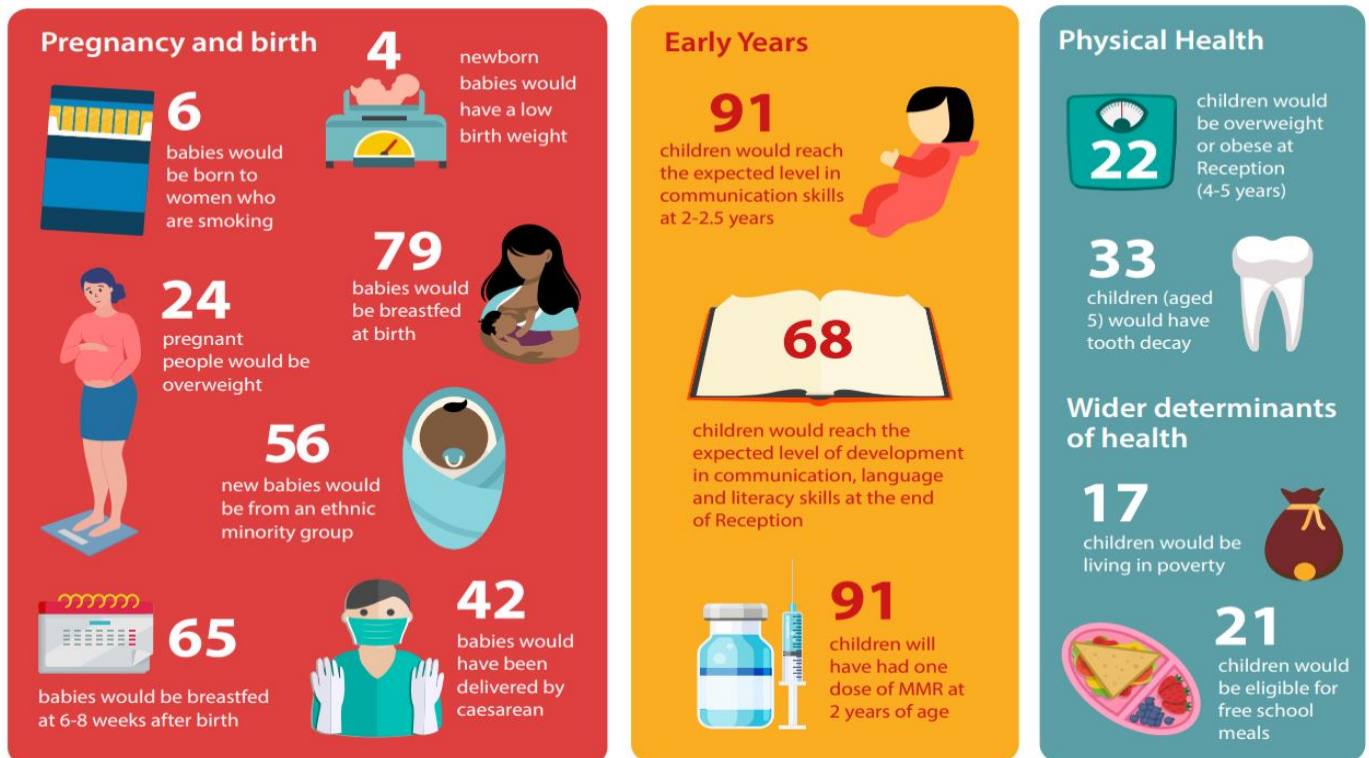
Our Commitment

Reading's Best Start in Life Strategy focuses on early help, joined-up services and removing barriers to support, especially for families who need it most. Strong integrated pathways—midwifery, early years, health visiting, Family Hubs and voluntary or community partners—provide wraparound support from pregnancy to school entry.

Through improved early intervention, targeted support, strengthened early years provision and high-quality Family Hubs, Reading is committed to:

- reducing inequalities
- supporting children's development from birth
- improving GLD outcomes for all children
- ensuring more children thrive by the time they enter Reception
- enabling every child to have the strongest possible start in life

If Reading were a town of 100 children:



Listening to the voice of our children and families

Reading's partners have committed to listening carefully to the voice of local children and families in the design and development of the Best Start in Life (BSIL) Family Hubs and our overall BSIL Strategy for Reading.

Family Hubs act as a universal prevention offer, with additional targeted support that specifically aims to mitigate and reduce exposure to known early life risk factors including poverty, parental mental ill health, domestic abuse and language delay. Family Hubs bring services such as infant feeding advice, parenting classes and perinatal mental health support together in one place to make it easier to get help and advice early, to support children aged 0-18 and up to 25 with SEND, and their families.

Key themes from young people's responses.

Young people said:

Access and atmosphere: Friendly people and having a welcoming vibe are important.

Physical environment: Colourful spaces, variety of activities (games, physical activities, books, art), music, a relaxing sensory space, a quiet area. Soft furnishings are important.

Young people identified that they needed additional help and support with: Mental health, social media safety, job opportunities and career advice support.

Digital engagement: Interest in young person led podcasts interviewing voluntary sector youth support leaders and wider stakeholders with a voice that young people are interested in engaging with apps, and social media with useful content/videos.

Participation: Lots of young people expressed interest in shaping or running parts of Reading's Family Hubs.

In response to Young People's requests, Reading's Family Hubs have been designed to:

Reading's Family Hubs have embraced the theme of 'welcome and belonging'.

Reading's Family Hubs have been designed with artwork chosen by, or created by, our local young people.

Reading's Family Hubs have specific new emotional health and training/work support services embedded in them and Reading has co-designed an innovative emotional health triage support to coordinate our local emotional health service offers and help all of our children who need emotional health support to have greater access to the right help at the right time.

A dedicated digital platform has been designed for Reading's Family Hubs to provide help, support and advice online, for young people and families who prefer to access information or help online.

Quotes from our children:

"Gaming can result in new friendships."

"Access to new opportunities and things to do rather a boring white room with just chairs."

"I would love to be part of running and shaping parts of the Family Hubs."

"It could have a space where you can talk to people about things and just have a safe space for people to be able to just relax after a stressing day."

Parents and carers asked for:

More support: With worklessness, benefits and asked if Citizen's Advice Bureau support could be linked to Family Hubs

Specific help was needed with: Perinatal mental health support, breastfeeding support, access to health visitors, mental health and emotional wellbeing support.

Being able to find out about: Local childcare options, musical and physical play groups, sports for all ages, toddler groups and weekend activities

Specialist support: Support for families with multiple births, for families with English as a second language classes, continuing wraparound care beyond the age of 5, housing advice and local community support.

Levels of Need in Reading – and How We Are Responding

Ensuring every child has the Best Start in Life requires a clear understanding of the pressures faced by families in Reading. While many children thrive, outcomes are not shared equally. Socio-economic disadvantages, health inequalities, and barriers to accessing early support continue to shape a child's early development, school readiness and long-term outcomes. Families, parents, caregivers and young people have told us what they need, and this has directly shaped our design of Reading's Best Start in Life Strategy and Family Hubs.

1. Key Areas of Need in Reading

1.1 Poverty and Early Development

Around 24% of Reading's children under the age of 16 live in poverty. This includes approximately 2,000 children under the age of five who live in low-income households. Poverty increases the risk of:

- delayed speech and language development
- poorer physical and mental health
- emotional and behavioural difficulties
- reduced school readiness

Parents told us they need clearer information, accessible local help with benefits, childcare, housing and employment support.

1.2 Maternal and Infant Health

Reading has the **highest rate of low birth weight in the South East (4.1%)**, which is most commonly linked to smoking in pregnancy, maternal stress, poor nutrition, and substance or alcohol dependency.

Teenage pregnancy also remains above the national average, and families highlighted difficulties accessing perinatal emotional health support.

1.3 Oral Health and Healthy Weight

Children in Reading experience significantly poorer oral health:

- 32.9% of five-year-olds have tooth decay - a level far above the national average.

Weight inequalities begin early, in Reading:

- 1 in 5 Reception age children are overweight or obese
- 1.9% are underweight, which is higher than the national average.

1.4 Housing and Environmental Health

- 10.1% of households are overcrowded, contributing to stress, disrupted sleep, and developmental challenges.
- Emergency admissions for respiratory infections have nearly doubled in five years, with worsening housing conditions a contributing factor.

1.5 Low immunisation uptake

Vaccination coverage for under-fives is below the 90–95% required for population protection. Parents told us they need better reminders, easier booking, and trusted information.

1.6 SEND, neurodivergence and early identification

SEND needs are increasing, with 61% of under-fives with SEND having communication and interaction as their primary need.

In qualitative reviews and co-production conversations, Reading's families said support in the first 1,001 days can be hard to access and that some services can feel unwelcoming or inaccessible.

1.7 Attendance and school readiness

Although school readiness has improved (**GLD 68.4%**, above national), outcomes are not equitable:

- FSM children: **49.8% GLD**
- Non-FSM children: **72.5% GLD**
- SEND children: **26% GLD.**

Persistent absence in Reception particularly affects disadvantaged children and those with SEND.

1.8 Safeguarding pressures

Children later needing child protection services often experience domestic abuse, parental mental health difficulties and substance/alcohol misuse. Parents consistently ask for earlier, easier-to-reach support.

1.9 Cultural and linguistic diversity

Over 30% of Reading's residents are from global majority backgrounds, and many children grow up multilingual. Families said they need ESOL support, culturally humble services and home-language-inclusive early learning.

Our shared priorities (2026–2028): What we will do and why

Based on our analysis of need and what families, parents, young people and professionals told us, Reading will focus on five strategic priorities, delivered through six integrated areas of work (A–F). These reflect the areas where early intervention has the greatest impact, and where inequalities in Reading are most evident.

1. Strengthening Perinatal and Early Health Support

Families asked for more **perinatal mental health support**, help with **breastfeeding**, and clearer early guidance. Many told us they struggled to navigate the system during pregnancy and the first 1,001 days.

In response, we are:

- Expanding smoking cessation, infant feeding and perinatal mental health support through Family Hubs.
- Co-locating midwifery with early years teams to ensure seamless identification of vulnerabilities and early help from pregnancy onwards.
- Delivering weekly outreach support for domestic abuse, substance misuse and parental mental health in communities with the highest levels of need.
- Embedding a stronger focus on healthy pregnancy, attachment, maternal wellbeing and early development.

This work addresses key local needs including high rates of low birth weight, low immunisation uptake, and inequalities linked to maternal health.

2. Earlier identification of neurodivergence and SEND

Parents told us that identifying developmental needs early, and receiving support that is respectful and accessible, is crucial and makes a significant difference to children's outcomes, but they also described significant delays in identification of neurodivergence and SEND in Berkshire.

We are responding by:

- Reading is leading Berkshire's whole system transformation and the introduction of the innovative neurodiversity early-identification needs and strengths tool and co-designing multi-disciplinary training 2,000+ professionals across health visiting, early years and family support.
- Doubling Portage (specialist home visiting educational service for children under 5 with developmental delays or disabilities) capacity (100% expansion), reducing waiting times by 58% and removing the waiting list.
- Creating SEND advice drop-ins and webinars from 2026 to improve parent access to guidance.
- Strengthening specialist partnerships with the Berkshire Sensory Consortium and CYPIT (Children and Young People's Integrated Therapies Team i.e. Speech and language, physiotherapy and occupational health) to support children with hearing, visual and multisensory needs.

This will reduce inequalities in access to assessment, improve school readiness for SEND children, and ensure families receive adjustments that reflect their child's strengths.

3. Stronger home learning and early language support

Parents told us they need more support with early language, routines, and knowing how to help their children learn at home.

We are responding by:

- Launching culturally humble Home Learning Environment outreach for 2- to 4-year-olds who need additional support.
- Introducing the ELKLAN Home-Based Learning Initiative (March 2026) to strengthen early language and literacy skills
- Supporting families to use every day play, stories and conversations to build strong communication foundations.
- Valuing home languages, reducing barriers for multilingual families and supporting inclusive early learning.
- Aligning home-learning support with schools and early years settings to strengthen consistency for Reception entry.

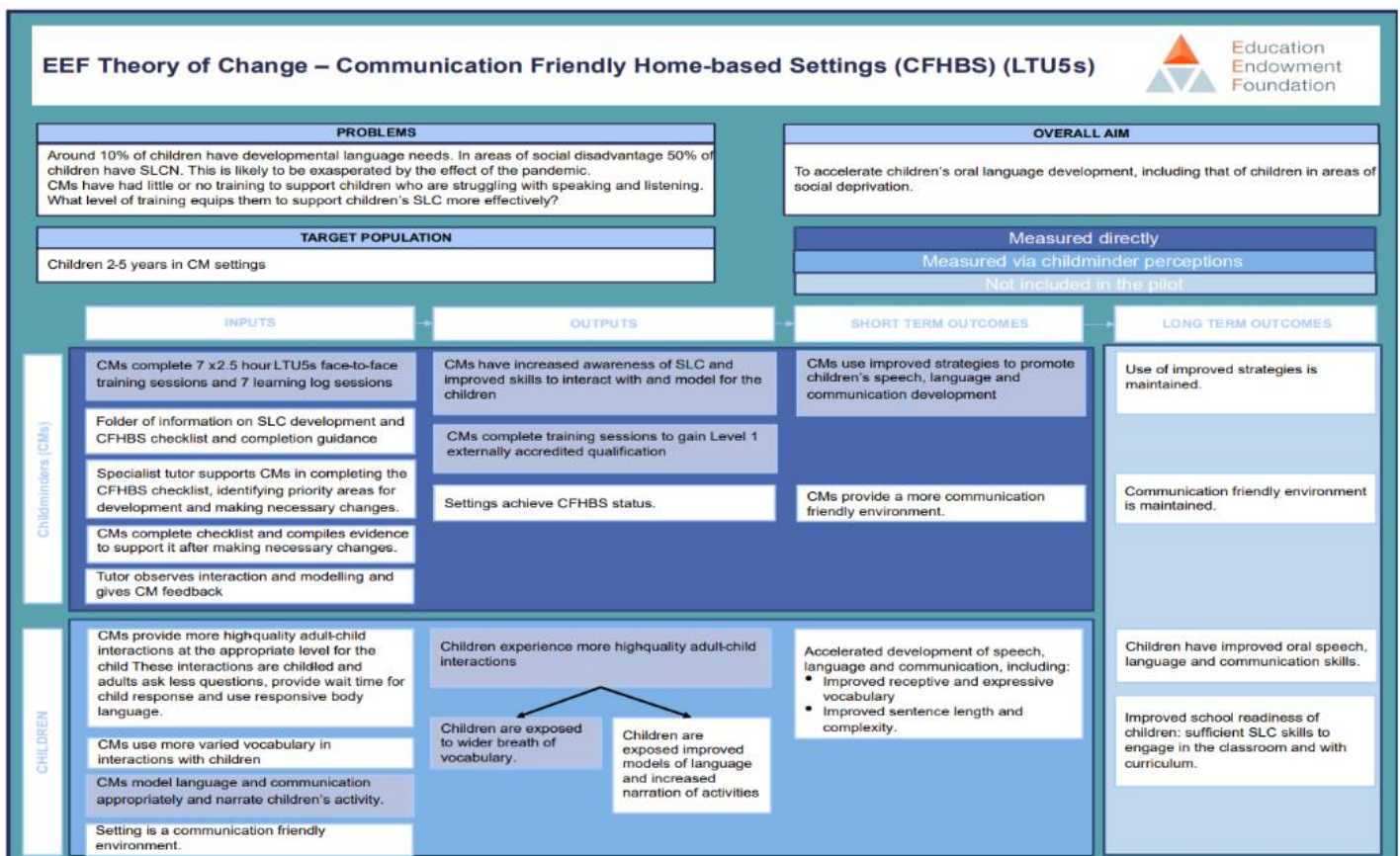
This directly addresses Reading's challenges in language development, literacy, GLD outcomes and preparation for school.

ELKLAN Model

This sets out some additional information on the evidence-based ELKLAN model that will be adopted in the Home Learning Environment outreach for two-, three- and four-year-olds in families who need additional help and support.

Children benefit from increased exposure to high-quality language input and emotionally supportive interactions. The CFHMB pilot study provided evidence-informed mechanisms of change that led to:

- Home carers reported that over a 1/3 noticed improved receptive and expressive language, including vocabulary in their children.
- Over ½ of home carers reported improved sentence structure complexity and length in their children.
- Reported better listening, attention and turn-taking
- Enhanced social communication skills, such as initiating interaction and sharing play
- Improved emotional understanding and self-regulation, supporting positive behaviour



4. Strong early years provision and workforce development

To improve GLD outcomes and reduce inequalities, Reading is strengthening quality across early years settings through:

- Advisory visits, Stronger Practice Hub support and DfE programmes focused on communication and language, self-regulation, emotional wellbeing, physical development and early maths.
- Standardised transition guidance across early years, Family Hubs and schools.
- Workforce development focused on early identification, inclusion and support for diverse needs.
- Targeted projects such as Little Foundations, Mental Health First Aiders, and Enrichment for Twos.
- Improved access to qualifications, leadership development and peer-to-peer networks.

This builds on strong evidence from the PADO programme, which delivered measurable improvements in communication, PSED and physical development, and reduced referrals to specialist services.

5. Family Hubs as Inclusive, Local, Place-Based Support

Families and young people told us they want welcoming spaces, clear information, mental health support, safe places to talk, digital access, and help with ESOL and finances.

We have responded by:

- Establishing four Best Start Family Hubs in communities with the highest levels of need offering a joined-up package of support.
- Creating a digital Family Hub platform for childcare, activities, infant feeding, health visiting and specialist services.
- Designing hub environments with young people to promote belonging, inclusion and emotional safety.
- Extending outreach to families who have previously felt unwelcome in services.

This strengthens early help, reduces crisis escalation, and improves access for families who experience language, cultural or systemic barriers.

Reading benefits from rich cultural, leisure and skills providers who have been consistently passionate about supporting children, young people and families. Thousands of Reading's families engage with the libraries, museums, theatres and leisure providers in Reading, which contribute to our children's early development, parent and caregiver confidence and positive activities for children and young people. Together we have worked hard to link Best Start in Life Family Hubs to our library offers, physically co-locating our services and linking our digital support, whilst also helping to create language-rich home environments, strengthening early literacy, creating multi-lingual outreach and reducing social isolation.

Family Hub locations

Our Best Start in Life Family Hubs are located in our areas of greatest need and provide outreach across Reading:

- **Southcote**
- **Ranikhet**
- **South Reading**
- **East and North Reading**

Reading Family Hub digital platform:

<http://www.reading.gov.uk/beststartinlifefamilyhubs>

The range of help and support available from the Best Start in Life Family Hubs, includes:

1. Child & Family Health

Amongst other things, our Best Start in Life Family Hubs offer on-site midwives, health visiting, baby groups, developmental reviews, infant-feeding support, health clinics and public-health campaigns.

There is a range of physical advice and online resources that are specifically tailored to the needs of Reading's children and families, to support early development and promote safety and welfare of our children.

2. Early Learning & School Readiness

A range of very specific Early Years Foundation Stage (EYFS) aligned play and learning groups are available in Reading and are linked to our wider Best Start in Life Family Hub offer, including free Ofsted-registered crèche, library access in some hubs, school-readiness activities and preparation for nursery and reception.

3. Family Support & Special Educational Needs & Disabilities (SEND)

Best Start in Life tailored support now includes emotional wellbeing support, SEND and speech-and-language drop-ins, neurodivergence outreach and advisory support, parenting programmes (sleep, behaviour, routines, feeding, safety, emotional wellbeing), help with two-year-old funding and benefits, housing, work, financial guidance and referrals to additional specialist services that some of our services need.

4. Family Help & Safeguarding

Family help for families has been brought together in Reading to work as one team, co-located in Best Start in Life Family Hubs, providing a range of support from universal advisory support, outreach and home visits, and practical support with housing and school issues; to specific tailored help for families working with social care (providing a golden thread for our families receiving multi-agency child protection support). Partnerships with

health, midwifery, and neurodivergent advice or Special Educational Needs and Disabilities (SEND) support enable early risk identification and consistent support for families facing multiple needs and challenges.

5. Parenting Offer

A trauma-informed, early-intervention pathway supports families from pregnancy to age 5. This includes antenatal support, perinatal mental health programmes, Mums in mind, young parent programmes, dad-specific sessions, trauma-informed courses (Mellow Bumps & Babies) and evidence-based toddler programmes such as Incredible Years.

Links to Neighbourhood Health

Reading's Health and WellBeing Board recognised in their workshop co-designing the Best Start in Life Strategy on 10th February 26, the potential of Reading's Best Start Strategy, the careful listening to Reading's communities in the co-design of Reading's offer, and the multi-disciplinary support embedded in Family Hubs, has strong potential to act as a foundation for the new Neighbourhood Health design. The explicit focus on children and young people, and their families, in the draft proposals for local Neighbourhoods is very welcome.

6. Stronger Partnerships and Public Health Nursing

To deliver integrated support, partners across health, education and the voluntary sector are strengthening the 0–19 (up to 25 SEND) Public Health Nursing Service.

This includes:

- A workforce strategy to improve recruitment, retention and training pipelines
- Clearer specialist roles within the service to help support children and families that need safeguarding, or have complex or multiple needs. areas)
- Strengthened links between health visiting and immunisations, nutrition, oral health, smoking cessation and safety
- Improved quality of mandated reviews to enhance early identification
- Better digital systems for data sharing, reporting and risk identification
- Alignment with the national Healthy Child Programme, safer staffing tools and a strengthened quality framework.

This ensures families receive the right support at the right time, and that partners work together around shared goals.

What difference do we hope to make to the outcomes of Reading's children?

Reading has a relentless focus on improving outcomes for our children and a specific sensitivity to children and families facing multiple challenges or disadvantages. We want to see:

“A future where every child grows up safe, nurtured and supported to reach their full potential, regardless of background or circumstance.”

By 2028, the Best Start in Life Strategy will deliver measurable improvements in children’s health, development and school readiness. We aim to see more babies born healthy, with increased uptake of smoking cessation support and early perinatal mental health help, and improved birthweight outcomes (please see our specific outcomes below).

- Immunisation rates for under-fives will rise towards the 95% national target, childhood obesity at Reception will stabilise, and levels of tooth decay among five-year-olds will reduce.
- More children will be identified earlier for neurodivergent and SEND needs, with faster access to help, advice and support, including Portage and Family Hub support.
- By strengthening home learning, early language and early years provision, we expect a sustained increase in the proportion of children achieving a Good Level of Development, with a narrowing of the gaps for disadvantaged children, children with SEND and those from backgrounds facing marginalisation or multiple disadvantages.
- Persistent absence in Reception will fall, and more children will start school with the independence, communication and self-regulation skills they need to thrive.
- We want:
 - to hear back from families reporting feeling seen, heard and supported
 - to hear that our children and families experience feeling included and have a sense of belonging
 - our children and families to be able to access help early and subsequently see a reduced number of children and families reaching crisis without previous support.

Ultimately, these improvements will contribute to a future where every child in Reading grows up safe, nurtured and able to reach their full potential.

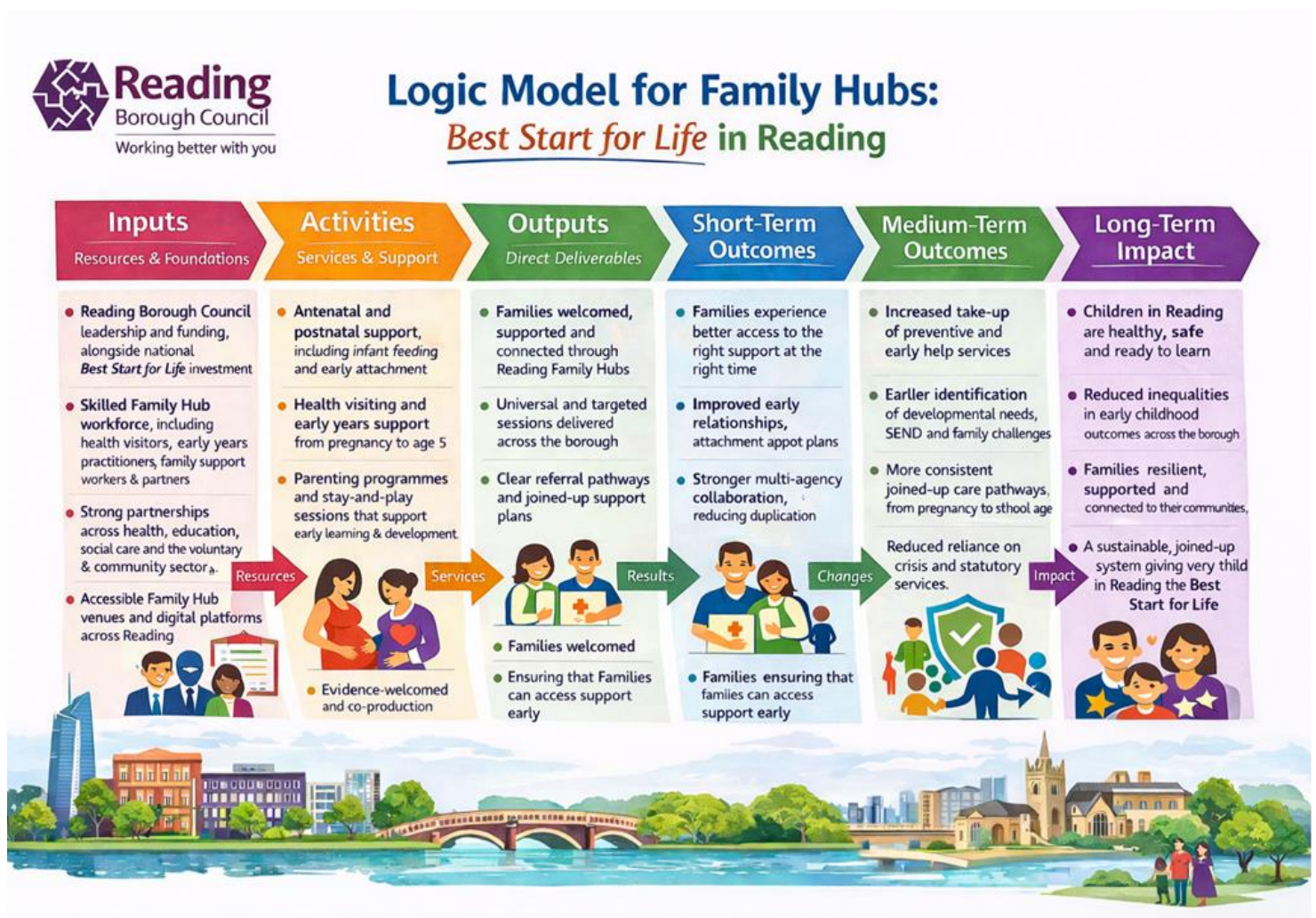
Governance

Given the system-wide response needed by partners and communities to improve outcomes for children, the Best Start in Life Strategy has been overseen by the One Reading Partnership on behalf of the Health and Wellbeing Board and has been proactively discussed at co-design stage by Reading’s Health and Well-Being Board members.

‘Best Start in Life’ has been identified as one of three priorities of the Health and Wellbeing Board for 2026-2028. In practice, this means that the Board will regularly review the progress of the delivery plan and ensure shared accountability across partners. The

Health and Wellbeing Board will also ensure links are made with other key programmes of work such as Neighbourhood Health and we are delighted that children and young people's integrated support through Family Hubs has been identified as a key foundation for Neighbourhood Health development.

Visually, this can be described in the following ways:



RESOURCES	ACTIVITIES	OUTPUTS	SHORT & LONG TERM OUTCOMES	IMPACT PUBLIC HEALTH OUTCOMES
Partnership services responding to levels of need and parental requests for help to be coordinated in Family Hub Offer (e.g., midwifery, health visiting, early years advisory support, family workers, mental health, domestic abuse, substance/ alcohol recover, housing worklessness, smoking cessation, perinatal mental health, speech and language, Portage, etc. 4 Family Hubs to be established in the communities of greatest need. Analysis of evidence-based practice to inform parenting and home learning education support Early years and childcare sufficiency review Early Years SEND outreach to settings and via Family Hubs	One coordinated partnership offer via Family Hubs running weekly in the four communities of greatest need, with outreach. Culturally humble Home Learning Environment home outreach service Increase in childcare sufficiency. Digital resources on childcare, weaning, breastfeeding, child development, parenting, perinatal mental health, speech, and language, etc to be brought together on Family Hub digital platform. Speech and language telephone advisory support to be offered	Support for all parents/ caregivers with nutrition, breastfeeding, mental health and wellbeing, child development, parenting, health literacy, school readiness, good level of development Targeted support for home learning environments specifically supports Good Level of Development, language rich environments. Early identification of neurodivergence and support plans to adjust home, setting and community environments. Earlier targeted emotional and mental health, positive relationships parenting and substance/ alcohol recovery support in local communities	Children and families experience being welcomed and listened to – a sense of belonging. More children achieve a Good Level of Development and are school ready. Neurodiverse and SEND children can understand and describe their diversity, strengths and needs and experience adjustments to their environment to increase inclusion and belonging. Improved emotional well-being and resilience. Reduced substance/ alcohol dependency Increased positive relationships and reduction in harm. Decreased numbers of children escalating to child protection without previous experience of help.	B02a/b/c/d – School readiness B03 – Pupil absence (Reading 7% vs England 7.1%) B11 – Domestic abuse related incidents and crimes (Reading 25.1 per 1,000 vs England 27.1 per 1,000) C08a/b/c – Child development (2 to 2.5 years old) C11a/b – Hospital admissions caused by unintentional and deliberate injuries to children. C19a/b/c – Successful completion of drug/alcohol treatment (all red for Reading) C28 – Self reported wellbeing E02 – Percentage of 5-year-olds with experience of visually obvious tooth decay C09a – reduction in Reception obesity (gap in outcomes for Reading's children) C09b – reduction in Year 6 obesity (gap in outcomes for Reading's children)

			Reduced potentially avoidable accidents and injuries in under 5s.	CO2a – Under 18s conception rate Rate of immunisations for Reading's children
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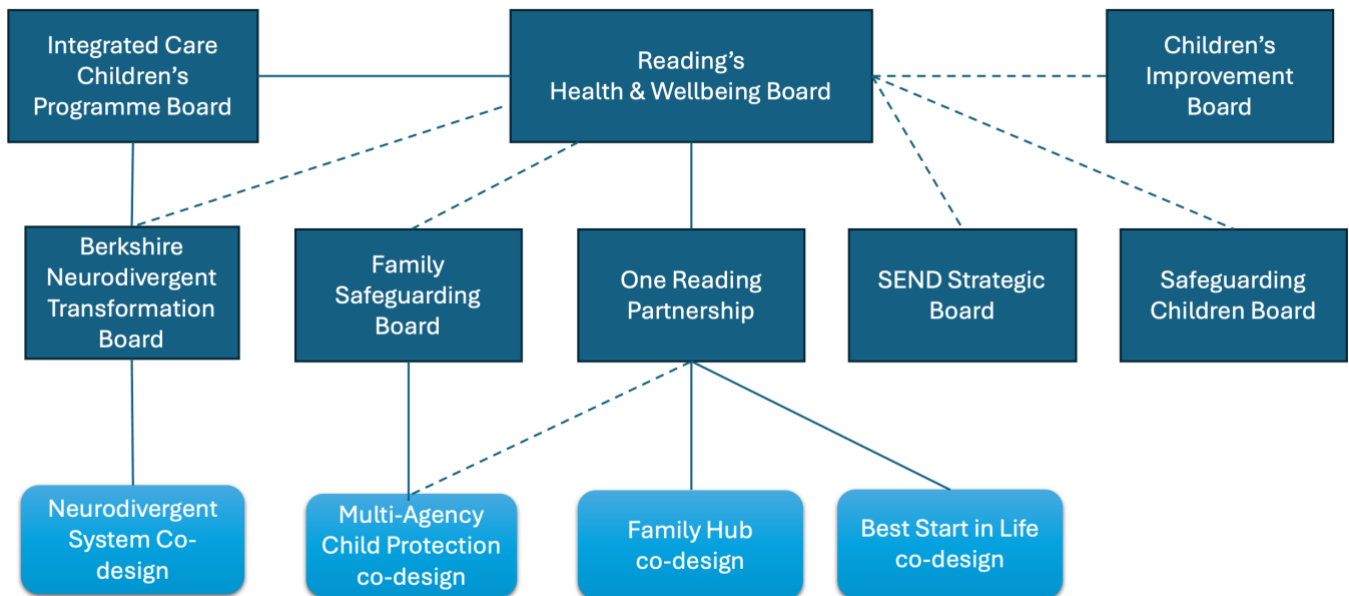


Figure x Diagram showing governance for the Best Start in Life Strategy and Reading's integrated Best Start in Life, Families First and SEND Reform child-centred focus

Reading Borough Council's policy committee and ACE committee will provide local authority statutory oversight and governance of the Best Start in Life Strategy.

Conclusion

Reading's statutory and voluntary partners will work as one team to maximise the very best outcomes for children and young people and provide the very Best Start in Life in Reading. This is a commitment into the medium to long term from Reading's leaders, recognising that strategic change of this nature takes time to embed and will require the shared investment of all our local services in Reading:

'It takes a village to raise a child'

NB. "It takes a village to raise a child" is an African proverb meaning that a child's upbringing is a communal effort, requiring support from extended family, neighbours, professionals, and friends, rather than just parents or caregivers. It emphasizes shared responsibility, where the "village" ensures a safe, nurturing environment to help children thrive.

We leave you with the words of Reading's children, who describe this vision in their own words:

"Your voices will be heard, and you will be supported to prepare for the future, reach your full potential and become the best person you can be"

Appendix

Appendix A - Good Level of Development (GLD) in Reading (at end of reception year)

This visualisation demonstrates the number of Reading children's achieving a Good Level of Development in the period 2022/23 to 2024/25:

	Year	2022-2023	2023-2024	2024-2025
All achieving a good level of development	Achieving a Good Level of Development	63.8%	66.9%	68.4%
	National Average	67%	68%	68%
Boys Achieving a good level of development	Boys	56.3%	59.6%	60.4%
	Boys National Average	61%	61%	62%
Girls Achieving a good level of development	Girls	71%	74.3%	76.4%
	Girls National Average	74%	75%	75%
FSM eligible children achieving GLD	FSM eligible	50.6%	55.3%	49.8%
National FSM eligible children achieving GLD	National FSM eligible	49%	51.6%	52%

Non-FSM eligible children achieving GLD	Non-FSM	68.4%	71.2%	72.5%
National Non-FSM eligible children achieving GLD	National Non-FSM	69%	71.5%	72%
FSM Gap	FSM Gap	17.8%	15.8%	22.7%
	National FSM gap	20%	19.9%	20%
SEN achieving a good level of development	SEN	24%	23%	26%
	SEN National Average	20%	20%	21%
SEN GAP	SEN Gap Reading	40%	44%	43%
	SEN Gap National Average	47%	48%	47%

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Best Start in Life Outcomes Framework

Domain	Level	Indicator / Measure	Baseline / Current Value	Target	Timeframe	Data Source
1: PERINATAL & EARLY HEALTH						
1: Perinatal & Early Health	Impact	Low birth weight rate	3.1%	Reduction toward / below England average (3%)	2026–2029	OHID Fingertips – Child & Maternal Health Profile
1: Perinatal & Early Health	Impact	MMR vaccination coverage – 1 dose (2 year olds)	89.60%	95% (national herd immunity target)	2026–2029	OHID Fingertips – Child & Maternal Health Profile
1: Perinatal & Early Health	Impact	MMR vaccination coverage – 2 doses (5 year olds)	86%	95% (national herd immunity target)	2026–2029	OHID Fingertips – Child & Maternal Health Profile
1: Perinatal & Early Health	Impact	Percentage of 5 year olds with visually obvious dental decay	32.9% (2021/22)	Reduction year-on-year	2026–2029	OHID Fingertips – Child Dental Health Survey
1: Perinatal & Early Health	Impact	Number of families accessing Togetherness parenting support programme	TBC (baseline to be set)	Increase year-on-year	2026–2029	Togetherness programme data / BHFT
1: Perinatal & Early Health	Outcome	Breastfeeding rate at 6–8 weeks	71.80%	≥75% by 2028	2026–2028	OHID Fingertips – Health Visiting data; BHFT health visiting returns
1: Perinatal & Early Health	Outcome	Smoking in early pregnancy	11.20%	Reduction	2026–2028	OHID Fingertips; Royal Berkshire Hospital maternity data
1: Perinatal & Early Health	Outcome	Healthy Start voucher uptake (value of unclaimed vouchers)	~£166k estimated unclaimed gap	Close gap by 50% within 2 years	2026–2028	Healthy Start national database; OHID
1: Perinatal & Early Health	Outcome	New Birth Visits completed on time	TBC (baseline to be set)	Improvement in completion rate	2026–2028	BHFT health visiting contract data
1: Perinatal & Early Health	Outcome	6–8 week health visitor contacts completed on time	TBC (baseline to be set)	Improvement in completion rate	2026–2028	BHFT health visiting contract data
1: Perinatal & Early Health	Outcome	2–2.5 year development review uptake	77.8% (2024/25); 83% Q3 2025/26	Increase toward 95%+	2026–2028	OHID Fingertips; BHFT health visiting data
1: Perinatal & Early Health	Outcome	Integrated early years and health visitor 2–2.5 year development review uptake	TBC (baseline to be set)	Increase year-on-year	2026–2028	BHFT health visiting data; Family Hub MI system
1: Perinatal & Early Health	Output	Number of families receiving perinatal support through Family Hubs	TBC (baseline to be set at launch)	Increase quarter-on-quarter	Quarterly	Family Hub management information system
1: Perinatal & Early Health	Output	Number of referrals made from hubs to specialist perinatal mental health services	TBC	Increase year-on-year	Quarterly	Family Hub MI system; BHFT PMHS referral data
1: Perinatal & Early Health	Output	Number of Healthy Start voucher outreach contacts made	TBC	Increase year-on-year	Quarterly	Family Hub MI system; Healthy Start database

Best Start in Life Outcomes Framework

Domain	Level	Indicator / Measure	Baseline / Current Value	Target	Timeframe	Data Source
1: Perinatal & Early Health	Output	Uptake of infant feeding support programmes per hub per quarter	TBC	Increase quarter-on-quarter	Quarterly	Family Hub MI system; BHFT health visiting data
1: Perinatal & Early Health	Output	Number of immunisations delivered through Best Start Family Hubs	TBC	Increase year-on-year	Quarterly	Family Hub MI system; OHID immunisation data
2: CHILD DEVELOPMENT & SCHOOL READINESS						
2: Child Development & School Readiness	Impact	Percentage of children achieving Good Level of Development (GLD) at end of reception	TBC (Reading 2024/25 figure – to be confirmed)	75% by 2028 (national government target)	2026–2029	DfE Explore Education Statistics – EYFSP data
2: Child Development & School Readiness	Impact	Gap in GLD between FSM and non-FSM children	50.4% FSM GLD vs 64.9% non-FSM	Reduce gap year-on-year	2026–2029	DfE Explore Education Statistics – EYFSP data
2: Child Development & School Readiness	Outcome	Percentage of 2 year olds from disadvantaged families accessing funded nursery places	62%	Increase toward 75%+	2026–2028	DfE Early Years statistics; local LA data
2: Child Development & School Readiness	Outcome	Percentage of children entering reception having accessed Early Years provision	TBC	Increase year-on-year	2026–2028	DfE EYFSP data; BHFT health visiting data
2: Child Development & School Readiness	Output	Number of families actively engaged in home learning education offer	TBC	Increase quarter-on-quarter	Quarterly	Family Hub MI system
2: Child Development & School Readiness	Output	Progress on Individual Journey to Reception Child Assessment Tool	TBC	Implementation and roll-out milestones	Quarterly	Family Hub MI system; School readiness data
2: Child Development & School Readiness	Output	Case studies showing changed parental practice and engagement with child's development	TBC	Qualitative evidence each quarter	Quarterly	Family Hub qualitative reporting
2: Child Development & School Readiness	Output	Number of Early Years practitioners trained as SLCN Champions and Parent Home Tutors	TBC	Increase year-on-year	Annual	Family Hub MI system; training records
2: Child Development & School Readiness	Output	Number of families engaged in ELKLAN language development workshops	TBC	Increase quarter-on-quarter	Quarterly	Family Hub MI system; ELKLAN provider data
2: Child Development & School Readiness	Output	Number of children referred to SALT via hub pathways and health visiting	TBC	Increase year-on-year	Quarterly	Family Hub MI system; BHFT SALT referral data
2: Child Development & School Readiness	Output	Uptake of Early Years Pupil Premium among eligible children in Reading	TBC	Increase toward 100% of eligible children	Annual	DfE Early Years statistics; LA data
2: Child Development & School Readiness	Output	Number of Early Years Transition Events delivered / Journey to Reception Campaign engagement	TBC	Increase year-on-year	Annual	Family Hub MI system; school readiness programme data
3: MENTAL HEALTH, TRAUMA & FAMILY WELLBEING						
3: Mental Health, Trauma & Family Wellbeing	Impact	Referrals to CAMHS from Reading's most deprived wards	TBC (baseline to be confirmed from BHFT)	Reduction year-on-year	2026–2029	BHFT CAMHS referral data

Best Start in Life Outcomes Framework

Domain	Level	Indicator / Measure	Baseline / Current Value	Target	Timeframe	Data Source
3: Mental Health, Trauma & Family Wellbeing	Impact	Number of children becoming subject to a Child Protection Plan for the first time	TBC (baseline from Reading CP data)	Reduction year-on-year	2026–2029	Reading Children's Services – Early Help and CP data
3: Mental Health, Trauma & Family Wellbeing	Outcome	Proportion of parents/carers reporting improved parental wellbeing (WEMWBS or equivalent)	TBC (baseline to be set at programme entry)	Increase year-on-year	2026–2028	Hub exit surveys; validated wellbeing tool (WEMWBS)
3: Mental Health, Trauma & Family Wellbeing	Outcome	Families reporting feeling less isolated and better connected to community (hub exit survey)	TBC	Increase year-on-year	2026–2028	Family Hub exit surveys
3: Mental Health, Trauma & Family Wellbeing	Outcome	Domestic abuse incidents in households with children under 5 in hub catchment areas	TBC (baseline from TVP)	Reduction year-on-year	2026–2028	Thames Valley Police domestic abuse data
3: Mental Health, Trauma & Family Wellbeing	Outcome	Families completing evidence-based parenting programmes	TBC	Increase year-on-year	2026–2028	Family Hub MI system; parenting programme provider data
3: Mental Health, Trauma & Family Wellbeing	Output	Number of families accessing parenting programmes per hub per quarter	TBC	Increase quarter-on-quarter	Quarterly	Family Hub MI system
3: Mental Health, Trauma & Family Wellbeing	Output	Number of trauma-informed practice referrals made from hub staff to specialist services	TBC	Increase year-on-year	Quarterly	Family Hub MI system; BHFT referral data
3: Mental Health, Trauma & Family Wellbeing	Output	Number of early years and hub staff trained in trauma-informed practice	TBC	Increase year-on-year	Annual	Training records; Family Hub MI system
3: Mental Health, Trauma & Family Wellbeing	Output	Number of families with identified domestic abuse concerns supported through hub	TBC	Increase year-on-year	Quarterly	Family Hub MI system; Thames Valley Police data
4: SEND & NEURODIVERGENCE						
4: SEND & Neurodivergence	Impact	Age at diagnosis/identification for autism and neurodevelopmental conditions in Reading	TBC (baseline from BHFT SEND pathway data)	Reduction in average age at identification	2026–2029	DfE SEND data; BHFT SEND pathway data
4: SEND & Neurodivergence	Impact	Level of unmet SEND need at school entry	TBC	Reduction year-on-year	2026–2029	DfE SEND data; Brighter Futures for Children SEND data
4: SEND & Neurodivergence	Outcome	Number of children with SEND identified before age 3	TBC	Increase year-on-year	2026–2028	BHFT SEND pathway data; DfE SEND data
4: SEND & Neurodivergence	Outcome	Waiting times between hub referral and SEND assessment	TBC	Reduction year-on-year	2026–2028	BHFT SEND pathway data; hub MI system
4: SEND & Neurodivergence	Outcome	Parent/carer satisfaction with SEND support and information available through hubs	TBC	Increase year-on-year	2026–2028	Hub exit surveys; parent/carer feedback
4: SEND & Neurodivergence	Output	Number of SEND specialist sessions delivered per hub per quarter	TBC	Increase quarter-on-quarter	Quarterly	Family Hub MI system

Best Start in Life Outcomes Framework

Domain	Level	Indicator / Measure	Baseline / Current Value	Target	Timeframe	Data Source
4: SEND & Neurodivergence	Output	Number of EHC needs assessment referrals initiated via hub pathway	TBC	Increase year-on-year	Quarterly	Family Hub MI system; Brighter Futures for Children SEND data
4: SEND & Neurodivergence	Output	Number of families supported by SEND information and advice at hubs	TBC	Increase year-on-year	Quarterly	Family Hub MI system
4: SEND & Neurodivergence	Output	Reach of Early Years SEND practitioners accessing training	TBC	Increase year-on-year	Annual	Training records; Family Hub MI system
4: SEND & Neurodivergence	Output	Number of settings achieving inclusion award	TBC	Increase year-on-year	Annual	LA inclusion award records; Family Hub MI system
5: REACH, EQUITY & ACCESS						
5: Reach, Equity & Access	Outcome	Proportion of families using hub services drawn from most deprived areas of Reading	TBC (baseline to be set at launch)	≥70%	2026–2028	Hub MI system; Index of Multiple Deprivation; Census ward-level data
5: Reach, Equity & Access	Outcome	Hub reach among families from Black, Asian and minority ethnic communities	TBC	Increase year-on-year	2026–2028	Hub registration data with ethnicity breakdown; Census data
5: Reach, Equity & Access	Outcome	Hub reach among families experiencing homelessness and/or substance misuse needs	TBC	Increase year-on-year	2026–2028	Hub MI system; Housing and substance misuse referral data
5: Reach, Equity & Access	Output	Total number of unique families registered per hub per quarter, by ward and deprivation decile	TBC	Increase quarter-on-quarter	Quarterly	Family Hub MI system; IMD data; Census ward-level data
5: Reach, Equity & Access	Output	Number of outreach visits to families who have not engaged with hub	TBC	Increase year-on-year	Quarterly	Family Hub MI system
5: Reach, Equity & Access	Output	Proportion of hub users who self-report as previously unknown to services	TBC	Increase year-on-year	Quarterly	Hub registration / intake data
5: Reach, Equity & Access	Output	Number of sessions delivered in community languages	TBC	Increase year-on-year	Quarterly	Family Hub MI system; language accessibility records
6: PARTNERSHIP, INTEGRATION & WORKFORCE						
6: Partnership, Integration & Workforce	Outcome	Proportion of early help referrals originating from or co-ordinated through a hub	TBC	Increase year-on-year	2026–2028	Family Hub framework dashboard; Reading Early Help data
6: Partnership, Integration & Workforce	Outcome	Families who first contact children's services at statutory threshold with no prior early help contact	TBC	Reduction year-on-year	2026–2028	Reading Children's Services data; Early Help data
6: Partnership, Integration & Workforce	Outcome	Number of agencies co-locating or delivering sessions through the hubs	TBC	Increase year-on-year	2026–2028	Family Hub MI system; partner agency records
6: Partnership, Integration & Workforce	Output	Number of partner agencies delivering services through hubs (health visiting, midwifery, school nursing, SEND, employment, housing, substance misuse)	TBC	Increase year-on-year	Quarterly	Family Hub MI system; partner service data

Best Start in Life Outcomes Framework

Domain	Level	Indicator / Measure	Baseline / Current Value	Target	Timeframe	Data Source
6: Partnership, Integration & Workforce	Output	Number of multi-agency team meetings hosted through hub network	TBC	Increase year-on-year	Quarterly	Family Hub MI system
6: Partnership, Integration & Workforce	Output	Percentage of health visiting contacts completed at a hub	TBC	Increase year-on-year	Quarterly	BHFT health visiting contract data; Family Hub MI system

Legend

Level	Description
Impact	Population-level change over 3 years (2026–2029)
Outcome	Service/behaviour change over 1–2 years (2026–2028)
Output	Activity and process measures (quarterly)

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READING HEALTH AND WELLBEING BOARD

Date of Meeting	16 July 2026
Title	Healthwatch Reading Annual Report
Purpose of the report	To note the report for information
Report author	Alice Kunjappy-Clifton
Job title	Lead Officer
Organisation	Healthwatch Reading
Recommendations	1) Notes the achievements, impact and findings of Healthwatch Reading during 2025/26. 2) Recognises the contribution of community feedback, lived experience and independent public voice in shaping local health and care services 3) Supports continued partnership working to address identified inequalities and improve access to health and care services across Reading.

1. Executive Summary

The report demonstrates the value of an independent public voice in identifying health inequalities, highlighting barriers to access, amplifying the experiences of underserved communities and influencing improvements in local health and care services.

At a time of significant change across health and care systems, an independent public voice remains essential in ensuring services are shaped by the people who use them and informed by the realities of their experiences. Healthwatch Reading has continued to ensure that the views and experiences of local people remain central to the planning, delivery, and evaluation of services.

2. Policy Context

Healthwatch Reading is the statutory independent champion for people who use health and social care services, established under the Health and Social Care Act 2012. Its role is to ensure that local residents' views, experiences and needs are heard, understood and acted on by commissioners, providers and decision-makers across the health and care system. Through engagement, evidence gathering, information and advice, and statutory functions such as Enter and View, Healthwatch Reading supports public involvement in the planning, delivery and evaluation of services.

The work undertaken during 2025/26 aligns with national health and care priorities, including reducing health inequalities, improving access to services, strengthening prevention and early intervention, supporting digital inclusion and transformation, and increasing community participation in service design and decision-making. It also supports the ambitions of the NHS 10-Year Plan, neighbourhood health approaches, and wider efforts to address the broader determinants of health.

Locally, Healthwatch Reading supports the priorities of the Berkshire West Joint Health and Wellbeing Strategy and Reading's commitment to reducing inequalities, improving population health, promoting community wellbeing and ensuring services respond to the needs of diverse communities. By amplifying residents' voices, particularly those less often heard, Healthwatch Reading provides insight that informs policy, service improvement and strategic decision-making across the local health and care system.

3. The Proposal

The Health and Wellbeing Board is asked to receive and note the Healthwatch Reading Annual Report 2025/26.

During 2025/26, Healthwatch Reading:

- Engaged with more than 8,489 residents through information, advice, outreach and participation activities.
- Published reports on interpreter services, NHS overseas billing and Community Wellness Outreach.
- Contributed to the development of a supervised toothbrushing programme expected to benefit approximately 1,800 children in Reading.
- Evaluated the Community Wellness Outreach Programme, showing positive health impacts and improved access to preventative healthcare.
- Gathered local experiences to support implementation of the NHS 10-Year Plan and understand use of the NHS App.
- Raised concerns about language barriers and inconsistent interpreter provision.
- Facilitated conversations on end-of-life care, racism and discrimination in healthcare settings.
- Worked with communities often underrepresented in engagement, including refugee groups, ethnically diverse communities and digitally excluded residents.

Through community engagement during 2025/26, Healthwatch Reading identified several recurring themes:

- Ongoing challenges accessing healthcare due to language barriers and inconsistent interpreter provision.
- Digital exclusion affecting some residents' ability to access services and use the NHS App.
- The importance of community-based approaches to prevention and early intervention.
- Experiences of racism and discrimination impacting confidence in healthcare services.
- Continued concerns around access to primary care and support services for vulnerable groups.

Examples of Impact

- Healthwatch evidence contributed to the introduction of a supervised toothbrushing programme expected to benefit approximately 1,800 children.
- Community Wellness Outreach evaluation findings demonstrated positive health impacts and informed future discussions on prevention services.
- Community feedback influenced local understanding of barriers relating to interpreter services and digital exclusion.
- Insights gathered from residents helped support planning discussions relating to the NHS 10-Year Plan and neighbourhood health models.

The report shows how community-led insight can inform service improvement and system-wide decision-making. Its findings provide valuable intelligence for commissioners, providers and partners across Reading.

Contribution to Reading's Health and Wellbeing Strategic Aims

Healthwatch Reading's work contributes to the Berkshire West Joint Health and Wellbeing Strategy priorities:

- *Reduce the differences in health between different groups of people*

Engagement with ethnically diverse communities, refugees, older people, children, families, and people facing language barriers has helped identify health inequalities and inform action to address them. Work on oral health, interpreter services, racism and digital exclusion directly supports this priority.

- *Support individuals at high risk of bad health outcomes to live healthy lives*

The Community Wellness Outreach evaluation showed that community-based health checks supported earlier intervention and improvements in residents' health and wellbeing.

- *Help children and families in early years*

Healthwatch Reading's oral health work informed the implementation of a supervised toothbrushing programme supporting approximately 1,800 children across Reading.

- *Promote good mental health and wellbeing for all adults*

Work on maternity mental health, suicide prevention discussions and end-of-life care contributes to improved wellbeing and support for residents.

Environmental and Climate Implications

There are no significant direct environmental or climate implications arising from noting this report. Engagement activities continue to utilise a combination of digital and community-based approaches to maximise accessibility and minimise unnecessary travel where appropriate.

4. Community Engagement

Community engagement is central to Healthwatch Reading's statutory role and underpins all aspects of its work. Through engagement, research, outreach, information and advice, Healthwatch Reading provides an independent public voice, ensuring that local people's views, experiences and priorities inform the planning, delivery and improvement of health and care services across Reading.

During 2025/26, Healthwatch Reading engaged with more than 8,489 residents through surveys, community conversations, focus groups, events, outreach activities, and information and advice services. Particular efforts were made to involve communities whose voices are often underrepresented in decision-making, including ethnically diverse communities, refugees and asylum seekers, older people, young people, people facing language barriers, and residents experiencing digital exclusion.

This engagement provided valuable insight into residents' experiences of accessing healthcare, navigating complex systems, using digital health tools, and overcoming barriers linked to inequality, language and discrimination. Feedback gathered throughout the year informed Healthwatch Reading's reports, recommendations and discussions with local health and care partners, helping services remain responsive to community need.

As an independent organisation, Healthwatch Reading enables people to share experiences and concerns that may otherwise go unheard. This insight provides an important source of evidence for decision-makers, helping to identify inequalities, understand barriers to access, and ensure that services are informed not only by performance data but also by the lived experiences of the people who use them. The practical value of an independent public voice is reflected in its ability to bring community perspectives into decision-making, helping partners respond to issues that matter most to local communities.

Residents' experiences continue to play a vital role in shaping Healthwatch Reading's work and influencing local discussions on service improvement.

One resident described difficulties accessing healthcare because interpreter support was not consistently available, making it harder to understand information and communicate with healthcare professionals. Through engagement with Healthwatch Reading, this experience contributed to wider discussions with providers about accessibility, communication and effective interpreter provision. It also informed Healthwatch Reading's ongoing work to promote equitable access to healthcare and reduce barriers for residents facing language difficulties.

Including lived experience alongside engagement data helps keep the voices behind the statistics visible and ensures that service improvement is informed by residents' real experiences. This highlights the importance of an independent public voice in bringing issues to light that may otherwise remain unseen, unheard or unreported. Without opportunities for residents to share their experiences independently, barriers affecting access, quality of care, and patient experience can be more difficult for services to identify and address.

5. Equality Implications

Healthwatch Reading's work is rooted in addressing health inequalities and ensuring that residents' voices are heard and acted on, particularly where people experience barriers to accessing services. During 2025/26, engagement and evidence-gathering highlighted inequalities affecting several protected and underserved groups, including:

- Ethnically diverse communities.
- Refugees, asylum seekers and migrant populations.
- Older people.
- Children and young people.
- Individuals facing language and communication barriers.
- People experiencing digital exclusion.
- People reporting experiences of racism and discrimination within health and care settings.

The Annual Report shows that inequalities in access, experience, and outcomes continue to affect many residents. Through targeted engagement, community outreach, information and advice, and partnership working, Healthwatch Reading has amplified the voices of people most affected by inequality and helped ensure their experiences inform service improvement and decision-making. By identifying barriers to care and highlighting the experiences of underserved communities, Healthwatch Reading contributes to local efforts to reduce health inequalities, improve accessibility and promote more equitable outcomes for residents.

The Annual Report highlights a range of equality issues and health inequalities affecting residents. However, as the report is presented for information only and does not introduce new policies, service changes or decisions, a full Equality Impact Assessment is not required.

6. Other Relevant Considerations

Healthwatch Reading continues to play a vital role in providing independent community insight and ensuring that residents' experiences are reflected in health and care decision-making. As the independent champion for people who use services, Healthwatch provides a trusted route for residents to share experiences, raise concerns, and influence decisions that affect their health and wellbeing.

During a period of significant change across health and care systems, including evolving approaches to public involvement and neighbourhood health, trusted and independent community feedback remains critically important.

Without an independent public voice, many of the issues identified through Healthwatch Reading's work—including language barriers, digital exclusion, experiences of discrimination and difficulties accessing services—may be less visible to decision-makers. Independent community insight helps ensure that the realities of people's experiences are understood alongside performance data, particularly for communities whose voices are less often heard through traditional engagement routes.

The findings highlight both opportunities and challenges for local communities, including health inequalities, language barriers, digital exclusion and variation in people's experiences of care. By gathering evidence directly from residents and sharing it with system partners, Healthwatch Reading helps strengthen accountability, improve service responsiveness and maintain public confidence that community voices are heard and acted on.

The report reinforces the importance of meaningful community engagement in the planning, delivery and evaluation of services, particularly for communities whose experiences may otherwise be overlooked.

7. Legal Implications

Healthwatch Reading undertakes its statutory functions under the Health and Social Care Act 2012, which established Healthwatch as the independent consumer champion for health and social care services. Its responsibilities include gathering and representing the views of local people, promoting community involvement in health and care services, providing information and advice, and carrying out statutory Enter and View activities.

The Health and Wellbeing Board is asked solely to receive and note the contents of this report. There are no additional legal implications arising from this recommendation, and no new legal powers, duties or delegations are required because of the Board's noting the report.

8. Financial Implications

Healthwatch Reading received statutory funding of £100,000 from Reading Borough Council during 2025/26, supplemented by additional project funding and Integrated Care System investment. Total income for the year was £130,667, with total expenditure of £137,443.

The difference between income and expenditure reflects planned investment in service delivery, community engagement and project activity during the reporting period and was met through existing organisational reserves. This enabled Healthwatch Reading to maximise opportunities to engage with communities, deliver additional projects and respond to emerging local priorities.

The report demonstrates the value generated through both statutory and additional funding, with community insight contributing to service improvement, prevention initiatives and action to address health inequalities across Reading. There are no direct financial implications arising from the Health and Wellbeing Board noting this report.

9. Timetable for Implementation

Healthwatch Reading has identified the following priority areas for 2026/27, informed by community feedback, local intelligence, emerging health system priorities and the experiences shared by Reading residents during 2025/26:

- **Enter and View activity in partnership with Adult Social Care** – undertaking visits to services to gather the experiences of residents, identify good practice and support improvements in the quality, safety and accessibility of care.
- **Understanding and supporting male carers** – exploring the experiences of male carers, identifying barriers to engagement and access to support, and working with partners to improve awareness, accessibility and service responsiveness.
- **Improving access to healthcare services for young people** – working through Healthwatch Youth to better understand young people's experiences of GP and other health services, ensuring their voices help shape future improvements.

Healthwatch Reading will remain responsive to emerging local and national developments and will adapt its work programme where necessary to address changing community needs and system priorities. Areas expected to influence activity during 2026/27 include:

- **Neighbourhood Health** – ensuring local communities are actively involved in the design and development of neighbourhood-based models of care.
- **Maternity Services** – gathering and amplifying the experiences of women, families and underserved groups to inform improvements in maternity care, safety and outcomes.
- **Experiences of Survivors of Domestic Abuse** – working alongside specialist organisations to better understand barriers to accessing health and support services and to identify opportunities for service improvement.

Healthwatch Reading will continue to review and refresh its priorities throughout the year to ensure its work remains aligned with the issues that matter most to local people and supports the strategic objectives of the wider health and care system and supports the strategic objectives of the wider health and care system, while ensuring that the voice of Reading residents remains central to service improvement and future service design.

10. Background Papers

- Healthwatch Reading Annual Report 2025/26. Available at:
<https://www.healthwatchreading.co.uk/post/healthwatch-reading-annual-report-2025-26>.
- Berkshire West Joint Health and Wellbeing Strategy.
- Health and Social Care Act 2012.

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Speaking up for better care

Healthwatch Reading Annual Report 2025/26

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Lead officer
Alice Kunjappy-Clifton

"Healthwatch Reading ensures local people's experiences shapes health and social care decisions. We engage with residents across the borough via surveys, focus groups and targeted engagements in neighborhood settings.

We continue to use our statutory powers to hold services to account and work constructively with partners to ensure residents' voices are heard and acted upon. Community insight has been shared with commissioners, service providers and system leaders, informing service discussions and improvement work.

I would like to sincerely thank everyone who has supported us during this period through sharing feedback, collaborating with us and working together to ensure the public voice truly matters."

A message from our chair

Since 2022, Healthwatch Reading has grown into a confident and influential statutory public voice ensuring local experiences shape design and delivery of local health and social care services.

Our journey has been one of a steady evolution—responding to a changing system, rising demand, and widening inequalities—while remaining firmly anchored in our purpose: **to listen, to represent, and to drive improvement.**

Since the pandemic, we prioritised reconnecting with communities reaching out to people who were distanced from services, experiencing inequalities and were at a greater risk of being unheard. We worked hard to rebuild trust, strengthen our presence, and create meaningful opportunities for people to share their experiences.

As our reach expanded, so too did our influence. Local experiences of accessing care, navigating complex systems, and understanding rights reinforced a fundamental truth: **lived experience is a powerful evidence for change.** Through this, we helped bring focus to key issues such as GP access, oral health inequalities, and barriers linked to language and communication.

Our progress comes at a pivotal time. In 2025, national proposals to bring public voice “in-house” within the NHS and the local authority structures marked a significant moment of change for Healthwatch and the wider system. While these changes may create opportunities for closer alignment, they also raise **important questions** about how the **independence** of public voice is preserved.

At Healthwatch Reading, we are clear: independence is essential to trust, credibility, and impact. It is what enables us to build relationships with communities, particularly those least likely to engage, and to raise difficult issues with honesty and integrity. As the system evolves, our commitment is to ensure that the public voice remains not only heard, but trusted, visible, and able to challenge constructively.

A message from our chair

This year we have focused on Speaking Up for Better Care. In a period of uncertainty, our role has never been more important.

We have continued to:

- Ensure people's voices are heard during system transition
- Challenge where progress is too slow or inequalities persist
- Support partners to embed meaningful community insight into decision-making
- Maintain confidence in the strength and independence of the public voice

Looking ahead, one principle will continue to guide us: **each voice matters**. Behind every experience is an opportunity to improve care—not only for individuals, but for communities across Reading. Healthwatch Reading remains committed to championing equity, strengthening accountability, and ensuring that lived experience shapes better, fairer care for all.

From listening to leading—and now speaking up in a time of change—we remain focused on what matters most: **making sure people's voices continue to shape the future of care in Reading.**



Reading Chair
Luke Howarth

“More recently, our role has matured further—from listening and amplifying voices to influencing change. We have worked closely with system leaders ensuring community insight informs decisions at a strategic level. Alongside this, we have continued to support individuals directly, helping them navigate services and making their voices heard when it matters most.”

About us

Healthwatch Reading is your local health and social care champion.

We ensure that NHS leaders and decision-makers hear your voice and use your feedback to improve care. We can also help you find reliable and trustworthy information and advice.



Our vision

To bring closer the day when everyone gets the care they need.



Our mission

To make sure that people's experiences help make health and care better.



Our values are:

Equity: We're compassionate and inclusive. We build strong connections and empower the communities we serve.

Collaboration: We build internal and external relationships. We communicate clearly and work with partners to amplify our influence.

Impact: We're ambitious about creating change for people and communities. We're accountable to those we serve and hold others to account.

Independence: Our agenda is driven by the public. We're a purposeful, critical friend to decision-makers.

Truth: We work with integrity and honesty, and we speak truth to power.

Our year in numbers

In 2025/2026 we supported more than 8489 people to have their say and get information about their care. We employed 4 staff and, our work was supported by 11 volunteers.



Reaching out:

2850 people shared their experiences of health and social care services with us, helping to raise awareness of issues and improve care.

3202 people came to us for clear advice and information on topics such as GP and, accident and emergency services.



Championing your voice:

We published 3 reports about the improvements people would like to see in areas like accessing interpreter services, tackling NHS overseas billing errors and evaluation of the Community Wellness Outreach project.

Our reports were well received and have made an impact with the community and service providers.



Statutory funding:

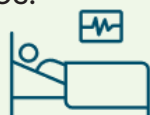
We are funded by Reading Borough Council. In 2025/26 we received £100,000, which is the same as last year.

A year of making a difference

Over the year we've been out and about in the community listening to your stories, engaging with partners and working to improve care in Reading. Here are a few highlights.

Spring

Collective insights from the end-of-life care community conversation, co-hosted by us, led to a series of webinars to address public responses.



The patient engagement programme, set up with Royal Berkshire Hospital, raised a need to address systemic racism and strengthen trust in healthcare..



Summer

Using our 'Thinking together' model, we celebrated our annual report launch and held the first local discussion on the NHS 10-Year Plan.



We continued working at system level on our previous projects – Language matters and Eligibility to NHS treatment, after which we published the latest updates to our website.



Autumn

Evaluation of the Community Wellness Outreach project enabled us to make recommendations that amplify local voices and reflect local needs.



Following the Government's 10-year NHS plan, we carried out a series of local engagements to gather experiences of accessing and using the NHS App.



Winter

Insights from our work contributed to the launch of a free supervised toothbrushing programme. This will support oral health of 1800 local children.



Our youth team insight and focus group participation highlighted the need for more accessible communication for the deaf community.



Thinking together and making a difference

Our joint Annual Report Launch with Healthwatch Wokingham Borough, in July 2025, hosted a **'Thinking Together'** community engagement model attended by over 90 attendees from different sectors such as the NHS, local authority, voluntary sector, Integrated Care Board (ICB), community leaders and system partners. This asserted the strong trust placed in **Healthwatch as an independent voice for local people.**

Our launch celebrated the **achievements and impact** of both Healthwatch work and introduced the first local discussions on the **NHS 10-Year Plan** and its emerging **Neighbourhood Health Programme**. This created an early space for attendees to consider what these changes could mean in practice for communities and local services.

Dr Priya Singh, Chair of Buckinghamshire, Oxfordshire, Berkshire West Integrated Care Board (BOB ICB) (now known as Thames Valley ICB) highlighted the importance of **neighbourhood working** and **partnership-based** approaches. Through presentations, guest speakers, our interactive live poll and Q&A sessions, attendees explored the **opportunities** and **challenges** of delivering **more joined-up, community-based care** through the emerging Neighbourhood Health Programme.



Thinking Together and making a difference

Our launch event took place shortly after the Government announced the closure of Healthwatch across England and plans to **bring public voice functions in-house** within NHS organisations and local authorities.

Since 1974, England has benefited from an **independent public voice** in health and social care. Closing Healthwatch will end more than 50 years of independent representation for local people.

This context strengthened discussions at the launch about **the role and importance of public voice in shaping care and services**, particularly within the emerging Neighbourhood Health Programme. Attendees widely recognised the importance and **continued need for independent public voice** at a time of significant system change.

Our launch event created an important valuable space for discussion, collaboration, networking and shared learning. Our live poll captured key themes and concerns, reinforcing system-wide interest in the future of public voice:

Loss of the independent voice

"No patient voice, no review, no accountability, no change, no co-production, no unity, no representation"

Loss of local knowledge and lived experience

"Views, opinions and voices will be lost"

Poorer quality of service and care

"Access issues, poor outcomes, organisation complacency"

Reduced trust in services

"Biased decisions – reduced trust in services, lack of accountability"

Less ability to influence change

"Services wouldn't receive constructive feedback missing the opportunity to improve"

Thinking Together and making a difference

Our launch event highlighted the **importance of involving local people** from the outset to ensure health and social care services reflect real needs and experiences. We showcased our work and demonstrated the **value and impact of public voice** in practice.

Our launch helped raise awareness of the Neighbourhood Health Programme and supported early thinking on more joined-up, community-based care. We have helped and continue to help ensure the **programme aligns with local needs** and reflects community views and feedback, ensuring **public voice is at the heart** of its development

Key impacts are set out in the infographic below, with this work continuing through ongoing engagement and partnership.

Event impact



- 1 We held the first local discussion on the NHS 10-Year Plan and the Neighbourhood Health Programme.
- 2 Greater recognition and understanding of the importance and impact of independent public voice and the vital work we do.
- 3 Stronger system-wide partnerships and increased engagement from councils, the NHS, and other organisations wanting to work with us; recognising our impact, trusted relationships and community connections.
- 4 Played a key role to ensure the Neighbourhood Health Programme reflects the needs, experiences and expectations of local people and communities. We are now consultants supporting its local planning, including sharing our "Thinking Together" engagement model to keep public voice at the centre of its development.

69 "Over [...] time, Healthwatch and yourself [Alice Kunjappy Clifton, Lead, Healthwatch Reading] directly have been both a support of Royal Berkshire NHS Foundation Trust as well as a critical friend when we needed to do better. I thank you personally for your support, approach and advocacy of our amazing teams at the Trust."

Steve McManus – Chief Executive Officer, Royal Berkshire NHS Foundation Trust

Thinking Together and making a difference



"Please convey to your team my thanks for taking both the time and effort of putting on yesterday's meeting which showcased Healthwatch annual reports for Reading and Wokingham [Borough].

Annual reports are often seen as "must do brochures" rather than documents that can point to best practice, examples of great quality health and care, or as signposts to potential or actual health and care issues that are facing the community.

The range of voices that you managed to attract to your meeting as well as the healthy numbers in the audience, are a testament to the importance of Healthwatch as an organisation that champions patient voice.

Each of the speakers brought a valuable set of learning to the proceedings. It was good to get a helicopter perspective of the 10-year plan and the Dash review, and these were complimented so well by the local reports from Healthwatch officers, demonstrating how Healthwatch has been able to address strategic issues in a practical way.

I particularly enjoyed listening to the beginnings of how we need to develop integrated neighbourhood partnerships – and these will be informed and complemented also by the important work being carried out in the public health domain.

I'm glad that you included Nick Fellows who brought us a very innovative community vision for working in the borough. This alongside the other volunteer organisations will help to address the current health inequalities that we see across the whole of the UK not just in our area.

I can understand that the future of Healthwatch as an organisation is held in the balance, whilst our government decide on how patient voice should be heard and acted on. In that interim period, we value the work of all the voluntary sector organisations, Healthwatch included, who stand in the gap for us.

We need to stand together as voluntary sector organisations in order to support the ongoing work of Healthwatch and to ensure that this valuable work is not lost in the government scramble to rationalise or save money."

Douglas Findlay – Health Innovation Oxford and Thames Valley

Thinking together and making a difference



"The launch event was incredibly valuable and well organised, with a high calibre line up of relevant speakers.

It was particularly helpful to be there amongst this diverse group, not only for the opportunity to get my message across, but to learn from others about critical developments in the sector.

What I was able to take away, in relation to Neighbourhood Health plans, enabled me to become more engaged and ensure colleagues were better informed, leading to positive action on our part that will hopefully help to shape new services for the communities we work with and ensure their needs are both heard and responded to."

Nick Fellows – Chief Officer, The Wokingham Volunteer Centre and Chair, Community Vision 2035 (Wokingham Borough)



"Attending the Healthwatch launch event and participating in discussions around the NHS 10-Year Plan reinforced my absolute belief that meaningful positive change and outcomes happen when we genuinely listen to the community who use services and involve them in shaping solutions.

I have been consistently impressed by the way Healthwatch Reading and Healthwatch Wokingham [Borough] bring people together, residents, partners and decision-makers to ensure the public voice is heard and responded to.

The positive outcomes we have seen through an approach of collaboration clearly demonstrate the real value of partnership working and the difference it can make to local communities.
Thank you Healthwatch!"

Denise Challis – Chair, Royal Berkshire Maternity and Neonatal Voices Partnership

Thinking Together and making a difference



"What stood out most was not only the depth of insight from local communities, but also the strong presence of health and social care professionals. Their attendance reflected clear support for Healthwatch as an independent voice, even where it provides constructive challenge and scrutiny of services.

I have a unique perspective, having been directly involved on the ground in mobilising the contracts when they transferred to The Advocacy People. From that mobilisation through to seeing the genuine change being achieved by our teams of paid staff and volunteers, it has reinforced for me how essential it is that people have the opportunity to speak to someone who is independent and objective. In a period of uncertainty, this is more important than ever because services are stronger, fairer and more effective when they are shaped by the people who use them."

Sarah Deason – Chief Operating Officer, The Advocacy People



"One of the key things I took away from the Annual Report launch event was the importance of ensuring that the public voice remains central within healthcare and social care. Feedback from patients, carers, families, and communities provides an essential perspective that professionals and organisations may not always see through data or operational reporting alone.

I reflected on how valuable lived experience is in shaping services that are compassionate, inclusive, and responsive to people's needs. Hearing examples and discussions at the event reinforced that engagement should not simply be a formality, but an ongoing conversation where people feel their views genuinely influence decisions and outcomes."

Stephen John – Head of Operations, The Advocacy People

Working together for change

The Advocacy People hold the service contract for seven Healthwatch; Hampshire, Portsmouth, Reading, Somerset, Southend, West Berkshire and Wokingham Borough.

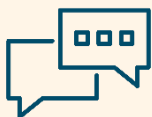


This year, we've worked with seven Healthwatch under The Advocacy People's infrastructure across Hampshire, Portsmouth, Reading, Somerset, Southend, West Berkshire and Wokingham Borough to achieve the following:



A collaborative network of local Healthwatch:

The Advocacy People have provided consistent infrastructure, governance, and operational support to the seven hosted Healthwatch, enabling them to work both locally and collectively. This includes shared leadership, senior guidance, and coordination across contracts. We have created space for collaboration, ensured consistency where needed, and supported each service to retain its distinct local voice.



A big conversation:

The seven local Healthwatch hosted by The Advocacy People have worked closely together in the last year. We have been proactive in our learning objective which was to understand the changing landscape for Healthwatch in response to Government proposals announced last July to transfer the functions of local Healthwatch to Integrated Care Boards and Local Authorities.



Building strong relationships to achieve more:

The Advocacy People supported the seven Healthwatch to lead meaningful community conversations by providing practical tools, coordination, and strategic oversight. This included enabling shared knowledge, supporting engagement planning, and facilitating the exchange of approaches and learning. We ensured local teams were equipped to respond to community priorities while linking these insights into a broader, coherent narrative at a regional level.

Working together for change

We've worked with neighbouring Healthwatch to ensure people's experiences of care in Reading are heard at the Integrated Care System (ICS) level, and they influence decisions made about services at BOB ICB (now Thames valley ICB). Below are some examples of our work this year.

Maternity and mental health:



We continued pushing forward maternity and mental health conversations with key focus on addressing maternal mental health and reducing suicide risk within the first year after childbirth. We have now progressed this locally with the Reading Suicide Prevention Group and across Pan Thames Valley to help ensure support systems are joined up and gaps in provision are identified.

We also continued raising feedback and concerns with the ICB and RBH about postnatal care, women not feeling listened to, and the need for stronger mental health support during and after pregnancy. In response, the ICB has increased awareness across primary care and will be delivering sessions with Thames Valley Primary Care Networks to improve conversations and engagement with women about their mental health needs.

Patient Participation Group (PPG) charter:



The PPG Inclusivity Charter was created by Healthwatch in Berkshire West for PPGs in Reading, Wokingham Borough and West Berkshire after an incident at a PPG meeting showed the need for clearer expectations on how people should behave and work together.

The charter, available to PPGs across Berkshire West, sets out simple shared rules to support respect, inclusion and good communication to ensure meetings are safe, welcoming and open to everyone to take part.

We continue to support PPGs across the area by sharing learning and good practice as they develop locally. Our aim is to make sure patient voices are not just heard but really help shape how services listen, learn and improve.

We have also highlighted some of our other outcomes achieved this year in the report sections below.

Making a difference in the community

We bring people's experiences to healthcare professionals and decision-makers, using their feedback to shape services and improve care over time. Here is an example of our work in Reading this year:



Improving care over time

Change takes time. We work behind the scenes with services to consistently raise issues and bring about change.

Local voice shaped local health services – oral health programme for 1800 children across Reading

Healthwatch Reading, a member of the **Oral Health Board** which oversees the strategy and implementation of the Supervised Toothbrushing programme, was delighted to see the **launch of a new free supervised toothbrushing programme** that will support **1,800 children across Reading** to help tackle rising levels of tooth decay.



The programme, launched in January 2026, will run in early years educational settings for 3–5-year-olds, children's centres and in special needs schools up to the age of 10.. In line with our recommendations, the programme also provides:

- Specialist support for children with additional needs
- Sensory-friendly toothbrushes and toothpaste
- Information translated into multiple languages and easy-read formats



“a recent report from Healthwatch Reading revealed several barriers to dental care, including limited awareness of dental services among parents and language barriers”.

British Dental Journal* (9th January edition)

Making a difference in the community

We bring people's experiences to healthcare professionals and decision-makers, using their feedback to shape services and improve care over time. Here is an example of our work in Reading this year:



Creating empathy by bringing experiences to life

Hearing personal experiences and their impact on people's lives helps services better understand the issues people face.

Since 2024 we have been working on the issue of eligible adults, and children being billed for free NHS treatment. Based on our recommendations, the overseas billing webpages were updated for clarity and a draft factsheet explaining NHS overseas billing was produced.

At the trust's request, we have signed off final changes to the trust's website and the draft factsheet.



Getting services to involve the public

By involving local people, services help improve care for everyone.

We co-hosted a "Dying well" community conversation in partnership with Reading Borough Council. Residents, carers, voluntary organisations, and professionals attended to share end-of-life care experiences and reflect on how support could be improved locally.

Collective insights led to tangible system-wide action.. A series of public webinars was designed to respond to public priorities of earlier, clearer, and culturally sensitive information. As a result:

- Residents received information before reaching a crisis point.
- Communities were supported to engage in earlier and more open conversations about dying.
- Understanding of choice, rights, and early planning was strengthened.
- Importance of clear, consistent, and culturally appropriate communication was reinforced.

Listening to your experiences

Services can't improve if they don't know what's wrong. Your experiences shine a light on issues that may otherwise go unnoticed.

This year, we've listened to feedback from all areas of our community. People's experiences of care help us know what's working and what isn't, so we can give feedback on services and help them improve.

69

"I welcome the opportunity[to do a health check in the community] because they were able to identify health issues like high cholesterol and my blood sugar was showing as borderline diabetes. I would not have known this if the check was not available to me"

Community wellness outreach evaluation participant feedback.



Digital futures: local voices about the NHS App

Last Autumn, we gathered the voice of our community to better understand how the NHS App is locally used.

According to the NHS 10 Year Plan, the NHS App will become the main ‘front door’ to NHS services. Our joint project explored how people in Reading and Wokingham Borough use the NHS App, and why some people do not use it.

What did we do

- We gathered residents' views and experiences using online and paper surveys, and informal conversations and discussions at community events.
- Analysed the feedback to gain insights into the App usage and barriers accessing/using it.
- Shared our early findings with the Integrated Care Board (ICB).

Some key findings:



Two thirds of the surveyed residents across Reading and Wokingham Borough report using the NHS App.

One-third of surveyed residents in Reading and Wokingham Borough do not use the NHS App.

Multiple healthcare apps and digital platforms are causing confusion and frustration amongst residents.

Our impact so far

In the community

- Improved understanding of the NHS App, including how it is used to access NHS health services and managing care.
- Increased awareness of available local support and guidance for using the NHS App and other NHS digital services.

Digital futures: what local voices told us about the NHS App

In the community (cont)

- Greater confidence in using the NHS App, with reduced confusion and improved ability to engage with digital health tools.
- Supported residents to better manage their health, appointments and engagement with healthcare services.
- Improved understanding of patients' rights, data use and future changes in healthcare services (NHS 10-year plan).
- Increased recognition of the value and importance of sharing feedback and how it influences local health and social services.

The ICB:

- Welcomed our early findings, response confirmed barriers identified reflect wider national feedback.
- Recognised that digital services designed to improve access to care should not create new inequalities.
- Recognised our findings helped reinforce system-wide understanding of lived experiences and importance of addressing digital exclusion.
- Clarified and confirmed system responsibilities:
 - NHS England responsible for NHS App platform and national communications
 - Local NHS organisations for supporting App access and use.
- Response confirmed willingness to continue working with Healthwatch to explore solutions that build confidence, trust, and digital inclusion.



“We would welcome a discussion with you and colleagues to review your emerging findings in more detail and to explore where collaborative action, particularly around community-based confidence building and trust, would add value ahead of your final report”.

**Dr Nick Broughton FRCPsych, Chief Executive
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB &
NHS Frimley ICB**

Addressing systemic racism and strengthening trust in care

Turning lived experiences into action against racism.

Feedback and lived experiences from borough residents highlighted the impact of racism and discrimination on people's health, access to services, and overall wellbeing. People told us that racism is being experienced in everyday life, in the community and within health and care settings affecting safety, trust and confidence in services.

What did we do:

- Raised concerns with Royal Berkshire Hospital (RBH) about racism affecting patients and staff from the borough.
- Worked closely with RBH to support on improvements needed to addressing racism, which included:
 - understanding the system-wide triage approach to support hospital staff experiencing racism
 - understanding RBH's "Up the Anti" programme
- Identified a clear need for a broader approach to address racism across Berkshire West following our work with RBH, feedback from local people and national evidence.
- As no single organisation can address this alone, we recommended a collective approach involving key partners– local councils, the Integrated Care Board, NHS trusts, Thames Valley Police and community leaders.
- Recommended a community conversation with key partners to share experiences, identify solutions, and agree on a collective action,.

What difference did it make

- Elevated local dialogue around the ongoing impact of racism on services across Reading.
- Encouraged direct action to tackle these issues through a commitment to anti-racist policy.
- Our recommendation for a broader community conversation on racism and inequality is now being taken forward. The event, currently in development, will involve the NHS, local authorities, community groups and other partner organisations.

Evaluation of Community Wellness Outreach(CWO) Project

Residents value health checks in community settings and want the project to continue running with added improvements.

We evaluated the impact and effectiveness of the project by collecting feedback from participants who had their health checks in community settings.

Key things we heard:

81%

of respondents visited their General Practice due to CWO checks.



"I was not aware that GPs do health checks". "Grateful for the check – without it could have been very ill".

54%

saw clinical changes such as new medication, dosage increase, further/continued monitoring.



"My BP is well managed". "Dosage of my medication was increased. Was also given a new medication"

92%

saw an improvement in their health since the CWO check ranging from a little to very much.



"Eat healthy lost 3 stone, I drink less".
"Stopped smoking and improved diet – cut down on red meat significantly".

Evaluation of Community Wellness Outreach(CWO) Project (continued)

What difference did this make?

- Local public voice was heard and passed on to decision-makers.
- Raised awareness of the project.
- Allowed local people, including those who are seldom heard, share their project experiences.
- Helped discovery of project strengths such as easy access, community settings, inclusivity, early issue identification, care quality and professionalism, information and advice given.
- Developed improvement suggestions to the project, including additional and frequent checks, follow-up and ongoing monitoring, improved capacity, inclusion and access.



Reading Borough Council

“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.”

Beverley Nicolson, Integration Programme Manager, Commissioning & Transformation, Directorate of Community & Adult Social Care Service (DCASC)

Language matters, continuous follow-up

Feedback from residents highlighted the need to move from awareness to more consistent delivery and accountability.

We kept building on the strong foundations we created. Fresh insights and feedback reinforce that accessing interpreter services remains a challenge.

Key things we heard:



Difficulties accessing interpreters in a timely way.



“Feel better to have [health check] in the community because translator available, not like at the GP”



Variable quality and consistency in provision of services.



“Sometimes they provide a translator, sometimes they don't. Hard to know (mostly not), will bring someone to translate for me”



Continued reliance on telephone interpreting that does not always meet people's needs



“Translation was done on the phone, and this was difficult for me as I don't hear very well. I use hearing aids”

We continued raising the issue at system level, including the ICB and primary care partners, for visibility and priority in the access and inequalities discussions.

What difference did this make?

- Greater awareness of language barriers across the system.
- Community feedback confirmed that accessing interpreter services is still challenging.
- Developed understanding that the issue is system-wide and persistent.
- The issue requires ongoing focus rather than a one-off intervention.

Hearing from all communities

We're here for all residents of Reading. That's why, over the past year, we've worked hard to reach out to those communities whose voices may go unheard.

Every member of the community should have the chance to share their story and play a part in shaping services to meet their needs.

This year, we have reached different communities by:

- **Working collaboratively with grassroot organisations** like St Barnabas Food Pantry, Reading GOLDERS Luncheon Club and Reading City of Sanctuary Café allowed us to capture lived experiences from deprived socioeconomic backgrounds and build trust and relationships with local communities.
- **Going beyond technology barriers:** in-person community engagements across Reading, including The Weller Centre, Whitley Wood and Hexham Road Community Centres, and Berkshire MS Therapy Centre, helped us gather local voices and share them with decision-makers.
- **Going beyond language barriers:** working with volunteer interpreters at community centres, such as the Forgotten Gurkha Centre, enabled us to hear and amplify local voices that may have gone unheard.



Empowering residents to help shape local health services

Golders Luncheon Club members spoke to us about digital services confusion caused by too many Apps and unfriendly triage systems.

There was also a reluctance to feedback demographic information believing this would not change anything. We explained the value of demographic information in identifying health inequality trends, provision of targeted resources and delivery of inclusive healthcare.

What difference did this make?

- Feeling of reassurance, willingness to provide demographic information.
- Improved understanding of public contribution towards healthcare development.
- Increased confidence of local voice and identity in shaping local health services.

Helping the Forgotten Gurkha community access healthcare services

Working with the Forgotten Gurkha Centre, we heard that members still struggle to access healthcare services due to language barriers.

To help, we agreed to meet the centre members, listen to their experiences and answer any questions they may have.

What difference did this make?

- A significant gap in knowledge and awareness of accessing interpreter and digital services, including the NHS App, was identified.

We have been invited to raise awareness of:

- Availability of interpreter services while accessing healthcare services.
- The NHS App and other digital health services.

Improving understanding of Digital Healthcare systems

Working with the over-50s lunch club at Whitely Wood Community centre highlighted the frustration with digital healthcare systems.

Older people who are digitally excluded felt left behind and abandoned. We listened to their problems, provided face-to-face guidance and advised them to visit their GP surgery in-person for further help with the NHS App.

What difference did this make?

- Community members felt listened to, included and supported.
- Helped raise awareness of the NHS App.
- Members felt confident and connected while accessing healthcare services.

Helping local diverse and refugee communities access healthcare

Local community members told us they struggled to book GP appointments, talk with the doctors and use the NHS App due to language barriers.

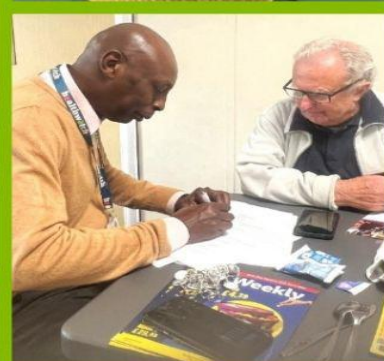
We informed community members about the availability of translation and interpreter services while booking and attending appointments. We also created an NHS App information sheet in multiple languages. The sheet was published on our website for easy availability.

What difference did this make?

- Local voice was heard and acted on.
- Improved awareness of access to interpreter services.
- Easy NHS App information availability.
- Availability of NHS App information in multiple languages helped overcome language barriers while accessing information and digital tools.

Hearing from communities in pictures

Engagement activities of the year



Healthwatch Youth

Our Healthwatch youth team is made up of 4 fantastic volunteers who live and study in Reading and Wokingham Borough.

Healthwatch Youth continued to champion the views of young people locally, so that services can improve to better meet their needs.

This year, the Healthwatch Youth team has been actively involved in:

- Promoting our NHS App project through community and university networks, including a pop-up stand at The University of Reading, university societies, such as the Autistic Students Society and Wokingham Baptist Church.
- Helping with our volunteering recruitment programme by attending recruitment events in Wokingham Borough.
- Supporting and promoting recommendations from our previous *Empowering Young Women: Improving Sexual Health Awareness and Services* report, contributing to ongoing improvements in sexual health service.

Impact of our sexual health project

Findings and recommendations from last year's *Empowering Young Women: Improving Sexual Health Awareness and Services* continue to influence sexual health service improvements, with action taking place this year:

✓ Young people shaping services

The Florey Clinic invited Healthwatch Youth to take part in a focus group on local sexual health services. The team shared their views, helping to shape future service developments and highlighted accessibility barriers, including the need for more accessible communication for the deaf community.

✓ Reaching more young people

Following our project recommendation, the clinic delivered a social media campaign that reached approximately 75,000 young people, increasing awareness of sexual health information.

✓ Supporting future improvements

Our project findings identified low awareness of HIV prevention services and PrEP (Pre-Exposure Prophylaxis) amongst young women. This helped inform the development of 'PrEP on Wheels' service for 16–18-year-olds. Launching in September 2026, it will improve access to HIV prevention medication. Healthwatch Youth will continue to support this project and the clinic's future service developments.

Healthwatch Youth

We have 4 fantastic volunteers who currently make up our Healthwatch Youth team who live and study in Wokingham Borough and Reading.

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"Thank you for coming in to meet with us last Friday, it was great to meet you and really useful to have the focus group [...]. It's always so beneficial for us to hear the voices of young people first hand so we can help create an accessible and approachable service based on their feedback."

Florey Clinic team (The Florey Sexual Health and Contraceptive Services)



Florey Clinic team:
Emily King and Paula Lane

Healthwatch Youth team:
Bethany, Chloe, Jeanet and Leia

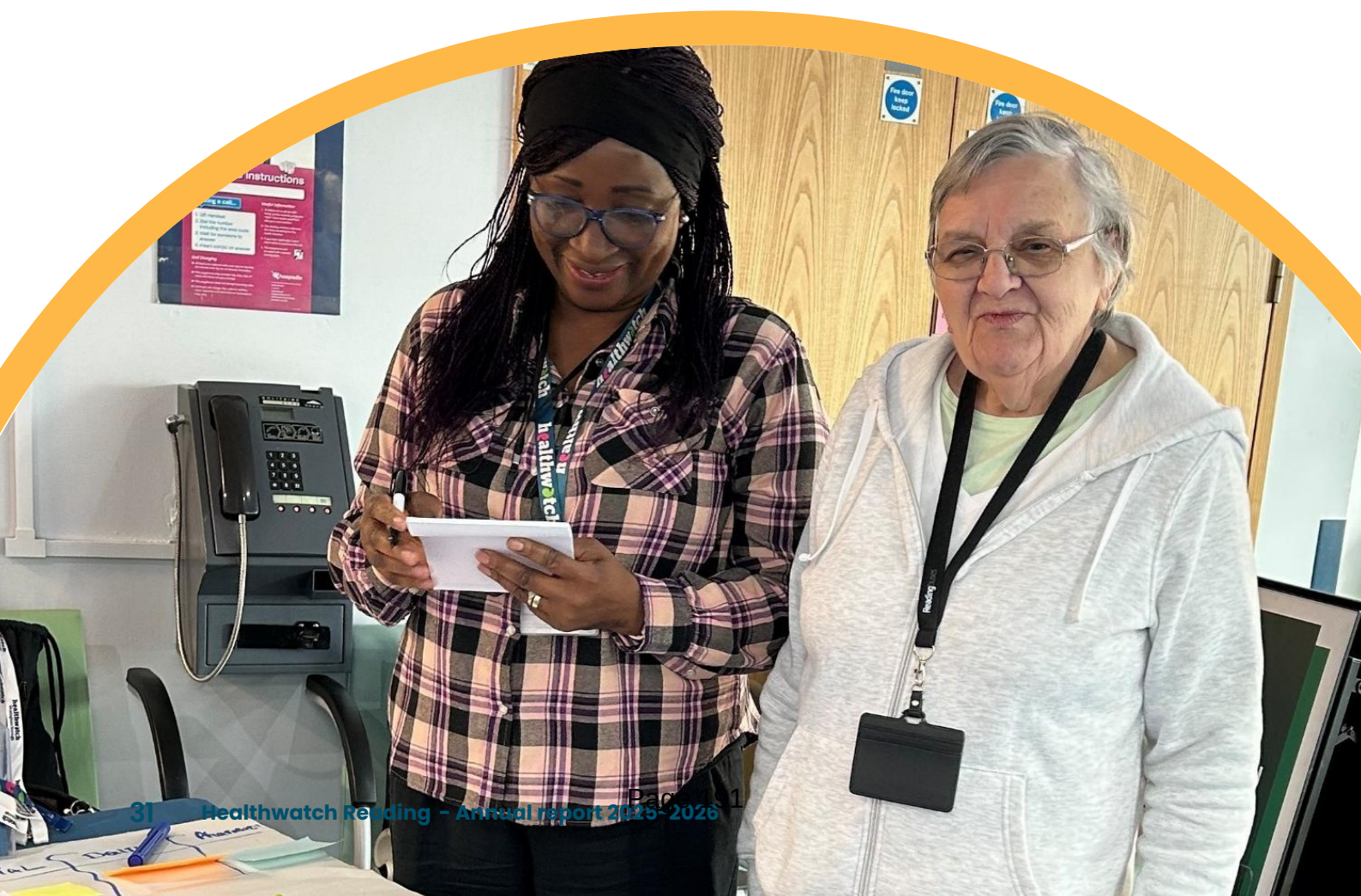
Information and signposting

When you're struggling to find an NHS dentist, looking for help about how to make a complaint, or need advice about a good care home for a loved one – we're your first port of call.

This year 3202 people have reached out to us for advice, support or help finding services. These conversations also help us to understand where, and how, your care can be made better.

This year, we've helped people by:

- Providing up-to-date information people can trust
- Helping people access the services they need
- Supporting people to look after their health
- Signposting people to additional support services



Treating patients with respect and empathy

Our involvement has helped towards attitude change of frontline staff.

SO felt “very bad” and “stressed” by how the frontline staff queried her about a request made by her doctor. This was done in presence of other patients.

SO believes, the intrusive questioning and subsequent responses were heard by other patients. The incident left her feeling unwelcomed, and worried if it could happen again. She wished, she never engaged with the staff.

We raised the issue with SO’s practice manager. SO told us, following our intervention, her concerns were successfully addressed, and frontline staff attitude has also changed.



“Everything changed.” “Thank you so much because when you spoke to them that made a big difference”.

Temporary resident pathway for urgent care

Access to urgent medical support prior to full GP registration.

An overseas student struggled to book a GP appointment following an emergency surgery. She was left housebound, in pain, and without any follow-up care plan.

We raised concerns about the risks created when urgent care pathways are not clearly understood or consistently applied highlighting the temporary resident process.

The student was able to secure an appointment the very same day, and her registration was quickly reviewed.



“I’m happy to report that after my partner’s visit to surgery, I was able to get into the system and check for available appointments within 15 minutes, thanks entirely to your intervention. We had tried twice before and were unsuccessful, so your help has been a huge relief.”

Better information and guidance for residents on the NHS App

Helping Reading residents and communities have access to clearer, accessible and easy to understand support.

The joint NHS App project carried out by Healthwatch Reading and Healthwatch Wokingham Borough has directly strengthened our understanding of the **local digital health needs**.

Through our **community engagement** across ethnically diverse communities and a varied spectrum of age groups across Reading, we were able to better understand the barriers people face when using the NHS App, particularly the difficulties with navigation and a lack of clear, relevant, easy-to-understand information and guidance on the App.

Analysis of **local feedback identified key gaps** in both national and local NHS App support materials. These included limited availability of translated and easy-read resources, and inconsistencies in how NHS App updates were being communicated at a local level.

To address the gaps identified, we added the information and advice webpage developed by Healthwatch Wokingham Borough, enabling us to provide residents and communities with consistent, accessible information both online and through face-to-face engagement.

Working together and using these resources also enabled us to promote NHS App updates more consistently, helping us reach more people through our website, newsletters, social media, and community engagement sessions.

Overall, the project has strengthened our work on digital inclusion and helped us better **support people and the communities in Reading** to access and use NHS digital services with greater confidence.



“This work continues, with ongoing engagement between Healthwatch and system partners to support improvements in digital access, inclusion, and patient experience.”

Alice Kunjappy-Clifton, Lead officer Healthwatch Reading

Showcasing volunteer impact

Our fantastic volunteers have given 236 hours to support our work. Thanks to their dedication to improving care, we can better understand what is working and what needs improving in our community.

This year, our volunteers:

- Visited communities to promote our work and helped us overcome language barriers with their excellent translation/interpretation skills.
- Collected feedback, lived experiences and encouraged their communities to share their views to help shape local health services.
- Our advisory board members played an important role in setting and maintaining the strategic direction of Healthwatch Reading.
- Advisory board members also ensured Healthwatch Reading adheres to its principles and purpose, and operates in a moral and ethical way in the service of the local community.



At the heart of what we do

From finding out what residents think to helping raise awareness, our volunteers have championed community concerns to improve care.



Errol
Advisory Group member

"Becoming a volunteer and an advisory group member for Healthwatch was one of my best decisions. The work they do with limited resources is nothing short of incredible."

Errol, a community activist and an IT professional provides advice on how best we can serve the community. He measures universal wealth by the quality of health.

"Healthwatch as an organisation are able to advocate for everyone whose voice needs to be heard. This amplification of concerns to those who can affect change is a critical instrument for those in need and wanting to be heard. The Healthwatch team embody service and humility which is remarkable especially in these challenging times."

"I chose to volunteer with Health watch because I love to support people for genuine reasons and Healthwatch is the best option because it empowers individuals to have their voices heard helping to improve health services and uplift communities."

Durga helped us reach out to the Nepali community with her valuable interpretation skills.

"This has given me the opportunity to meet people of different ages and backgrounds and to listen to their life experiences, giving me a deeper understanding of the challenges they face and the importance of making everyone's voice heard."



Durga
Community volunteer

Be part of the change.

If you've felt inspired by these stories, contact us today and find out how you can be part of the change.



www.healthwatchreading.co.uk



0118 214 5579



info@healthwatchreading.co.uk

Your Feedback



Public Health and Wellbeing, Reading

"The 2024 report 'CORE20PLUS5 Exploring the oral health of children aged under ten years in Reading; Norcot, Church and Southcote Wards' was well received by public health system partners and wider stakeholders in Reading including council members and local communities. It brought evidence-based clarity and a focus on the widely recognised need of poor oral health amongst local children. The report was appropriately challenging and has had a timely galvanising effect on our local system. Reading Borough Council public health team has been able to respond with the additional capacity of a Public Health registrar and a public health practitioner who have led the implementation of the Supervised Toothbrushing programme and the establishment of a multi-agency Oral Health Board which provides governance for a needs assessment process and associated innovative prevention work."

Martin White, FFPH, Consultant in Public Health
Public Health and Wellbeing | Directorate Communities and Adult Social Care

Thames Valley Integrated Care Board (ICB)

The ICB has worked closely with the Reading and Wokingham Healthwatch to improve access to NHS dental services, particularly for adults and children with additional needs. Healthwatch's work with these patients has provided valuable information about their experience of accessing and using NHS services with the local NHS then designing solutions to improve access to and responsiveness of the services.

Hugh O'Keeffe
Head of Pharmacy, Optometry and Dentistry
Thames Valley ICB

Your Feedback



Reading Borough Council

"This[Dying well] report helps us better understand how we can improve information and signposting for people approaching the end of life and has informed our series of Webinars to build a compassionate community to support Dying Well."

Beverley Nicolson, Integration Programme Manager, Commissioning & Transformation, Directorate of Community & Adult Social Care Service (DCASC)

Community Pharmacy Thames Valley

"Healthwatch are our eyes and ears for those unable to speak for themselves. Thank you – and we hope that we can continue the great work that you have started."

David Dean, Chief Executive Officer

Reading Community Learning Centre

"One of my key reflections from the discussions on the NHS 10-Year Plan was the importance of ensuring that the voices of local communities are not only heard but actively shape services and decision-making. Through RCLC's involvement in projects such as CPAR Project and CareWell with the University of Reading, we have seen first-hand the value of meaningful engagement with women whose experiences are often overlooked. Strong partnership working between communities, voluntary organisations, Healthwatch, researchers and statutory services helps create more inclusive, responsive and effective services. When people are genuinely listened to, their lived experiences can become a powerful catalyst for positive change."

Aisha Malik, Chief Executive Officer

Your Feedback



Golders Luncheon Club

"Many thanks to you[Engagement officer, Healthwatch Reading]. and your colleagues again for taking the time to come to the Golders lunch. To share the information about Healthwatch, and best of all, you eat lunch with us."

Leader, Golders Luncheon Club, Reading

Utilivu

"Collaborating with Healthwatch Reading has been and is vital to our mission to tackle health disparities. Through our joint initiatives, their consistent support for our annual conference and contributions to our Thursday Grassroots Community Conversations, we successfully bridge the gap between communities and healthcare providers. It is a powerful partnership that transforms authentic community feedback into tangible, lasting improvements."

Eva Wangui, Manager, Utilivu Women's Group

Alliance For Cohesion and Racial Equality(ACRE)

"ACRE values its strong partnership with Healthwatch Reading, built on a shared commitment to improving care for our communities. We applaud their role as an independent champion putting people at the heart of services. Our thanks go to Alice Kunjappy-Clifton for her action-focused leadership, Tariq Gomma for his unwavering support, and Zainab Koroma for her insightful health discussions. Together, we continue to create a meaningful impact across Reading."

George Mathew, Chief Executive Officer

Finance and future priorities

We receive funding from Reading Borough Council under the Health and Social Care Act 2012 to help us do our work.

Our income and expenditure:

Income		Expenditure	
Annual grant from Government	£100,000	Expenditure on pay	£105,512
Additional income	£30,667	Non-pay expenditure	£12,792
		Office and management fee	£19,139
Total income	£130,667	Total Expenditure	£137,443

Additional income is broken down into:

- £9,000 received from Reading Borough Council for evaluation of Community Outreach Project
- £5,000 received from Reading Borough Council for Dying Matters event

Integrated Care System (ICS) funding:

Healthwatch across Berkshire West also receive funding from our Integrated Care System (ICS) to support new areas of collaborative work at this level, including:

Purpose of ICS funding	Amount
BOB ICB Capacity Building Funds continue to contribute to extend the reach of Healthwatch engagement across Berkshire West	£16,667

Finance and future priorities

Over the next year, we will keep reaching out to every part of society, especially people in the most deprived areas, so that those in power hear their views and experiences.

We will also work together with partners and our local Integrated Care System to help develop an NHS culture where, at every level, staff strive to listen and learn from patients to make care better.

Our top three priorities for the next year are:

- 1. Enter and view** work with local adult social care to conduct 'Enter and view' sessions across Reading.
- 2. Men as carers** male carers generally do not access services at early opportunities. We will be listening to these hidden carers and the issues they encounter.
- 3. Access to services (Healthwatch Youth)** work with young people to look at ways to get access to services such as GP services.

Statutory statements

Healthwatch England, 2 Redman Place, Stratford, E20 1JQ
The Advocacy People, PO Box 375, Hastings, East Sussex, TN34 9HU.

Healthwatch reading uses the Healthwatch Trademark when undertaking our statutory activities as covered by the licence agreement.

The way we work

Involvement of volunteers and lay people in our governance and decision-making.

Our Healthwatch Board consists of three members who work voluntarily to provide direction, oversight, and scrutiny of our activities.

Our Board ensures that decisions about priority areas of work reflect the concerns and interests of our diverse local community.

Throughout 2025/26, the Board met 4 times and made decisions on all of our activities and reports. We ensure wider public involvement in deciding our work priorities.

Methods and systems used across the year to obtain people's experiences

We use a wide range of approaches to ensure that as many people as possible can provide us with insight into their experience of using services.

During 2025/26, we have been available by phone and email, provided a web form on our website and through social media, and attended meetings of community groups and forums.

We ensure that this annual report is made available to as many members of the public and partner organisations as possible. We will publish it on our website and publicise the report via our newsletters and social media channels.

Statutory statements

Responses to recommendations

We had zero providers who did not respond to requests for information or recommendations. There were no issues or recommendations escalated by us to the Healthwatch England Committee, so there were no resulting reviews or investigations.

Taking people's experiences to decision-makers

We ensure that people who can make decisions about services hear about the insights and experiences shared with us.

For example, in our local authority area, we take information to **Health and Wellbeing board, the Adult and Children Education committee (ACE), and Reading Integrated Partnership.**

We also take insight and experiences to decision-makers in the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System and work with other Healthwatch within this area to ensure voices are heard from all parts of the community. For example, we have a seat at the System Quality Group and BOB ICB Health Inequalities Board. We also share our data with Healthwatch England to help address health and care issues at a national level.

Healthwatch representatives

Healthwatch Reading is represented on the Reading Health and Wellbeing Board by Alice Kunjappy-Clifton, Lead Officer, Healthwatch Reading.

During 2025/26, our representative has effectively carried out this role by sharing our work and future workplans, as well as asking questions from the public perspective and ensuring the public voice is considered in decision-making.

The 3 Berkshire West Healthwatch (Healthwatch Reading, Healthwatch West Berkshire and Healthwatch Wokingham Borough) delivered through representation at place level which was and continues to be shared between Alice Kunjappy-Clifton (Lead Officer, Healthwatch Reading and Healthwatch Wokingham Borough), Fiona Worby (Lead Officer, Healthwatch West Berkshire) and Jamie Evans (Area Director, Healthwatch in Berkshire West).

Statutory statements

Enter and view

We did not undertake any Enter and View visits during the year, as alternative methodologies were better suited to our priorities—particularly engaging with communities through focus groups and targeted conversations.

For 2025/2026, our focus will be on ensuring that our primary care recommendations are acted upon, alongside gathering views to inform our wider project work. At present, we do not anticipate that these areas will require the use of the Enter and View methodology. However, there are plans to undertake a joint Enter and View visit in the coming year (2026/27).

2025 – 2026 Outcomes

Our Annual Report (April 2025 to March 2026), showcases the outcomes of our projects and the tangible impact of our work. It highlights how our efforts have contributed to improving services and amplifying the voices of the communities we represent.



Healthwatch Reading
Oxford Road Community Centre,
344 Oxford Road,
Reading, RG30 1AF



www.healthwatch.readingco.uk



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info@healthwatchreading.co.uk



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[@healthwatchreading](https://www.instagram.com/healthwatchreading)



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 2026/27¹ 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

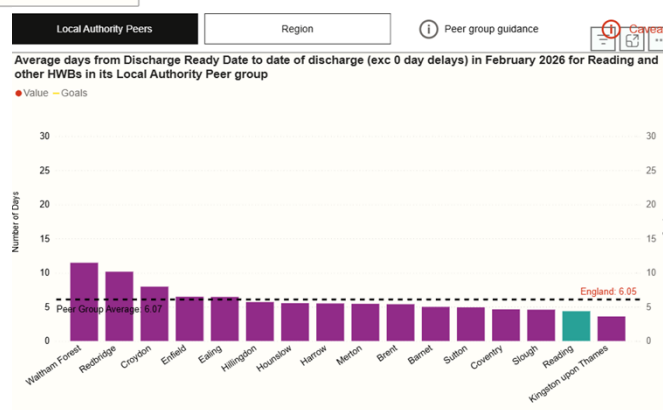
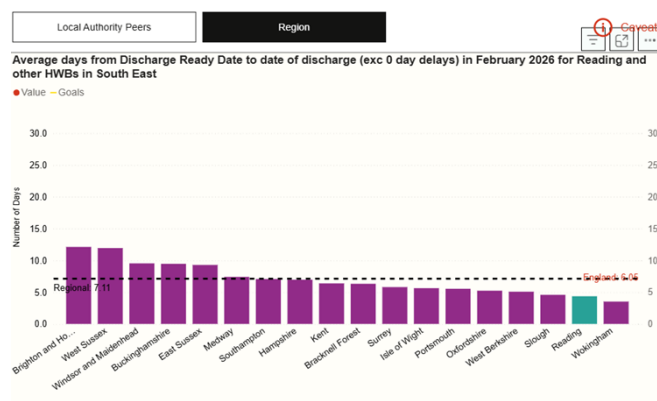
An overview of the BCF targets and performance compared to the previous period are shown in this table:

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.

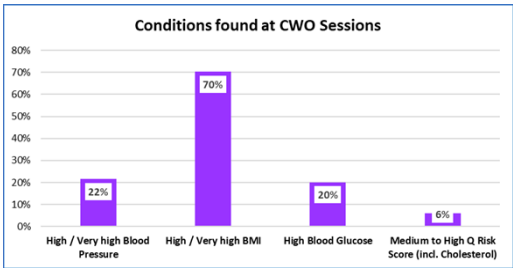
3.3. **Community Wellness Outreach**

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.

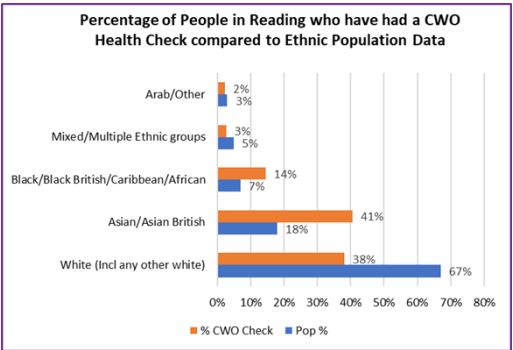
Since April 2025, 75% of appointments were booked through the website <https://rva.org.uk/community-wellness-outreach/> and 25% were drop-ins, which clearly demonstrated the need for a drop-in option for this service.

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.



an

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 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.

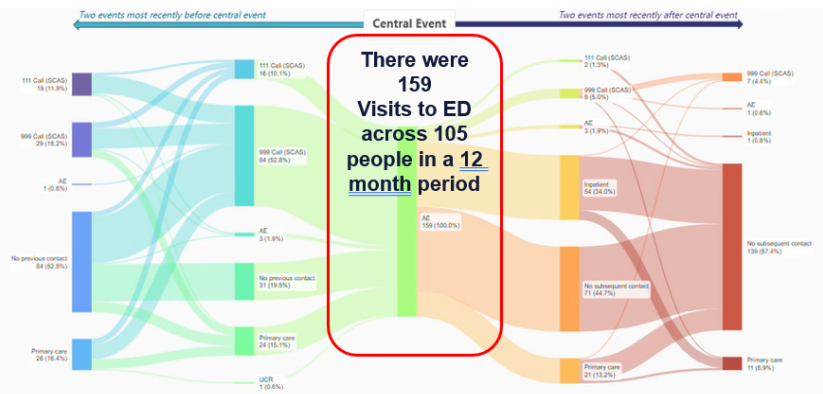
The Problem

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 2026/27² 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				Checklist
5. Income & Expenditure				
Selected Health and Wellbeing Board:		Reading		Complete:
Source of Funding	2025-26		DFG EOY Actual Expenditure	
	Planned Income	Updated Total Income for 25-26		
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;

	Projected c/fwd to 2026/27	
2025/26 Reserves and Underspend 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 Scheme 44 on Plan (Project c/fwd)
Sub-Total:	598,321	
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

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Better Care Fund 2026-27

Narrative return

Submission details

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

<i>Adapt as necessary</i>	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.

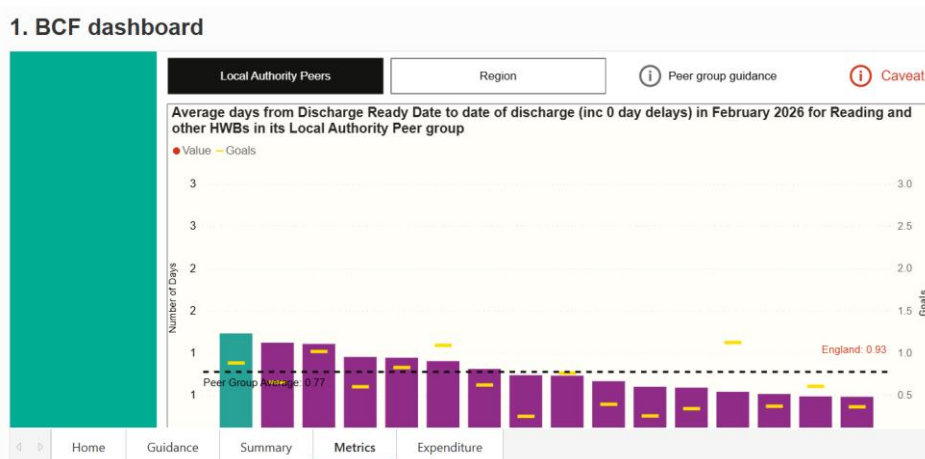
The BCF is therefore an important enabler of integrated planning in Reading. It helps partners maintain shared accountability, sustain neighbourhood capacity, and direct investment towards areas of greatest system pressure and local need. It also helps ensure that funding complements rather than duplicates 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.

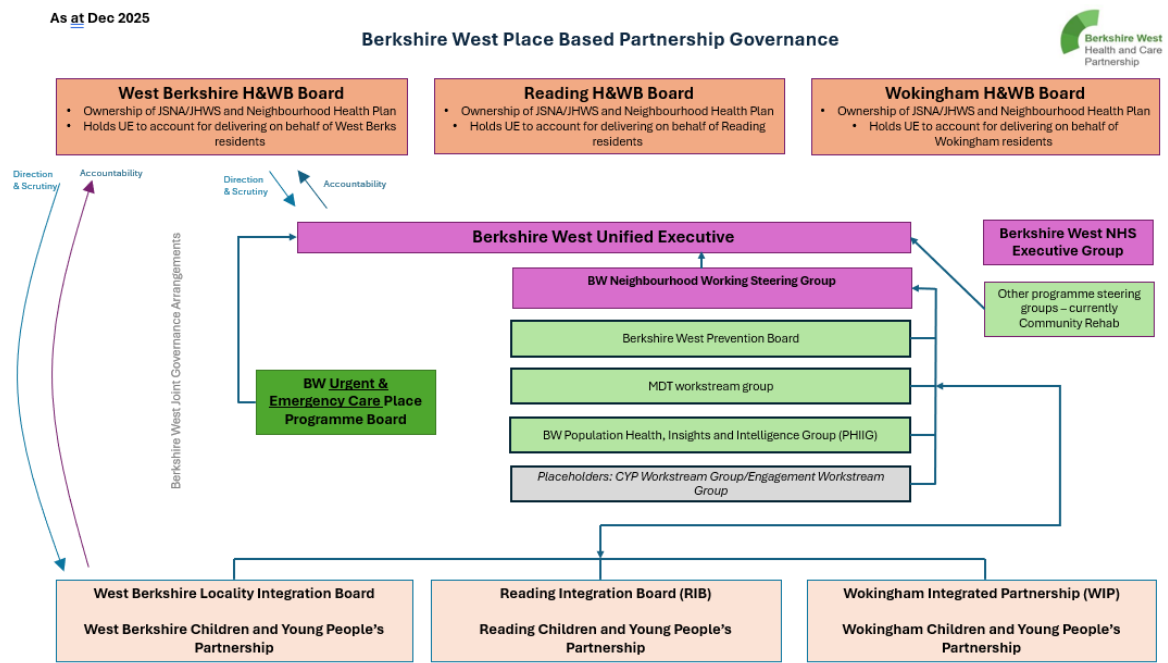
Overall strategic oversight is provided via Reading's HWB arrangements (including delegated authority briefing and sign-off where applicable), supported by place-based partnership governance (for example, the Reading Integration Board and Berkshire West Prevention Board), that brings together senior 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.

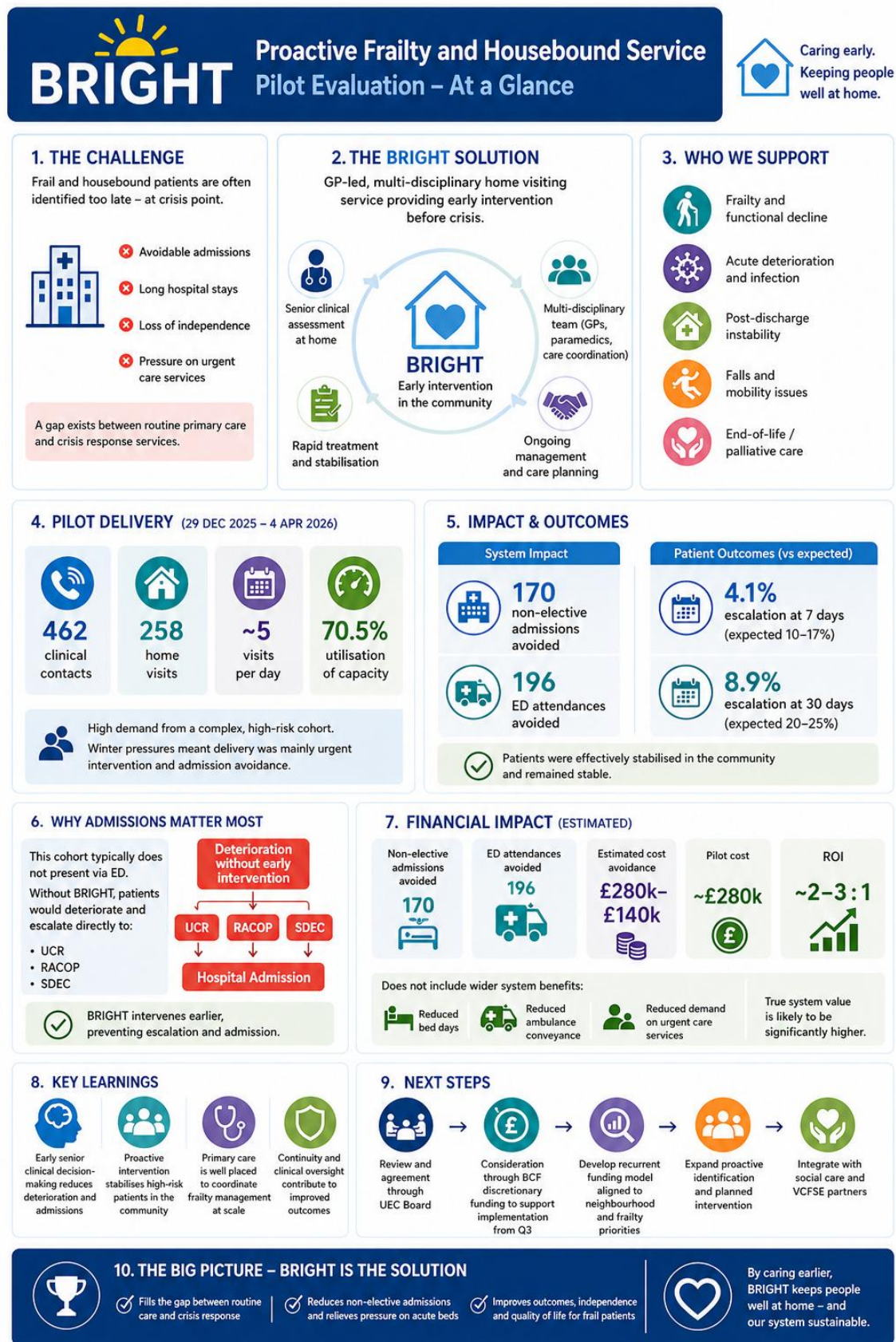
Impact is assessed through a combination of scheme-level monitoring and whole-system metrics. A shared performance dashboard tracks delivery against the national BCF metrics (including non-elective admissions for those aged 65+ and delayed discharges), alongside local indicators such as long-term admissions 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



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Appendix 2: Reading HWB - BCF 2026-27 Numerical Template (Final)

Better Care Fund 2026-27 Numerical Template

Data Sharing Statement

Data Sharing Statement

Please see below important information regarding data sharing and how the data provided during this collection will be used. This statement covers how NHS England will use the information provided.

Purpose of data collection

NHS England is collecting data on behalf of Better Care Fund (BCF) partners to fulfil statutory duties, including improving healthcare quality, efficiency, and transparency. The data supports operational and strategic planning, financial management, workforce planning, and system feedback, as mandated by the NHS Act 2006 and relevant regulations.

Type and scope of data

Patient-level data, including identifiable information like NHS numbers, is not required.

Data includes finance, activity, workforce, and planning information as specified in the national guidance documents.

The BCF numerical template is categorised as "Management Information," and aggregated data, including narrative sections, will be published on the NHS England website and gov.uk.

Access, sharing, and publication

The BCF numerical template is categorised as 'Management Information' and data submitted will be published in an aggregated form on the NHS England website and gov.uk. This will include a narrative section. Please also note that all BCF information collected here is subject to Freedom of Information requests.

Internal Access: Data will be accessed by NHS England national and regional teams on a "need-to-know" basis and may be shared internally to support statutory responsibilities.

External Sharing: Data and information from this numerical template and associated narrative return may be shared with partner organisations and Arm's Length Bodies (ALBs) including BCF partners (i.e. Ministry of Housing, Communities and Local Government (MHCLG), Department of Health and Social Care (DHSC) and NHS England) for joint working and policy development.

Publication: Local Health and Wellbeing Boards (HWBs) are encouraged to publish local plans. Until publication, recipients of BCF reporting data (including those accessing the Better Care Exchange) cannot share it publicly or use it for journalism or research without prior consent from the HWB (for single HWB data) or BCF national partners (for aggregated data).

Storage and security

Data will be securely stored on NHS England servers. Shared data will be minimised and handled per confidentiality and security requirements.

The BCF template is password-protected to ensure data integrity and accurate aggregation. Breaches may require resubmission.

Data analysis and use

NHS England will analyse data submissions for feedback, reporting, benchmarking, and system improvement.

Triangulation with other data may be conducted to support deeper analysis and insights and inform decision-making.

Concerns

For any questions about data sharing, please contact your regional Better Care Managers or the national Better Care Fund team england.bettercarefundteam@nhs.net



Better Care Fund (BCF) 2026-27 Numerical Template

1. Guidance

Overview

The numerical return is designed to capture planned BCF spend, goals and assurance statements. Together with the narrative return these will enable local areas to demonstrate how they meet the national funding conditions, in line with the published BCF 2026-27: <https://www.gov.uk/government/publications/better-care-fund-framework-2026-to-2027/better-care-fund-framework-2026-to-2027>.

Completed numerical returns are due by Tuesday 19 May 2026 (noon)

Submissions should be sent to the national BCF team at england.bettercarefundteam@nhs.net, as well as to regional Better Care Managers.

This guidance provides an overview of how to complete this numerical return. Further guidance is provided in the BCF Planning Principles guidance and and supporting documents which can be found on the Better Care Exchange - <https://future.nhs.uk/bettercareexchange/view?objectID=70716560>

Functional use of the template

We are using the latest version of Excel in Office 365, an older version may cause an issue.

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell
Pre-populated cells

This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

2. Cover

The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. To view pre-populated data for your area and begin completing your template, you should select your HWB from the top of the sheet.

Governance and sign-off

National condition one (refer to tab 6) outlines the expectation for the local sign off of plans. Plans must be jointly agreed and be signed off in accordance with organisational governance processes across the relevant ICB and local authorities. Plans must be accompanied by signed confirmation from local authority and ICB chief executives that they have agreed to their BCF plans, including the goals for performance against headline metrics. Please enter date of expected sign off if not yet signed off. **This accountability must not be delegated.**

Data completeness and data quality:

- Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells in this table are green should the template be sent to the BCF team: england.bettercarefundteam@nhs.net (please also copy in your better care manager).
- The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear red and contain the word 'No' if the information has not been completed. Once completed the checker column will change to green and contain the word 'Yes'.
- The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
- Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'. Please ensure that all boxes on the checklist are green before submission. Please contact your regional BCF team if you have any issues.

3. Income

This sheet should be used to specify all funding contributions to the HWBs BCF plan and pooled budget for 2026-27. This section will be pre-populated with the NHS minimum contributions, Disabled Facilities Grant (DFG) and Local Authority Better Care Grant (LABCG). For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your better care manager).

Additional Contributions

This sheet also allows local areas to add in additional contributions from both the NHS and local authority. You will be able to update the value of any additional contributions (local authority and NHS) income types locally. If you need to make an update to any of the funding streams, select 'Yes' in the boxes where this is asked and cells for the income stream below will turn yellow and become editable. Please use the comments boxes to outline reasons for any changes and any other relevant information as this will ensure section is marked as complete.

Unallocated funds

Plans should account for full allocations meaning no unallocated funds should remain once the template is complete.

4. Expenditure

Please see tab '4a, Expenditure guidance' for further information.

5. Metrics

For 2026-27, local authorities, integrated care boards (ICBs) and HWBs will be expected to monitor performance and improvement for the four metrics listed in the Metrics Handbook <https://future.nhs.uk/bettercareexchange/view?objectID=277641413>, available on the Better Care Exchange:

It is a national requirement for partners to set local goals in relation to the following two metrics:

- Non elective admissions to hospital for people aged 65 and over per 100,000 population
- Average length of discharge delay for all acute adult patients

HWBs are also encouraged to set goals for the metric on long-term admissions to residential and nursing homes for people aged 65 and over per 100,000 population.

We also expect HWBs to monitor and drive improvements for the metric on the proportion of people aged 65 and over discharged from hospital with reablement provided partly or solely by local authorities who remained in the community within 12 weeks of discharge.

Further details on the metrics, can be found below:

1. Non-elective admissions to hospital for people aged 65 and over per 100,000 population. (monthly)
 - This is a count of non-elective inpatient spells at English hospitals with a length of stay of at least 1 day, for specific acute treatment functions and patients aged 65+
 - This requires inputting of both the planned count of emergency admissions. The population figure is pre-populated using the latest available mid-year estimates.
 - This will then auto populate the rate per 100,000 population for each month

Source statistics: <https://digital.nhs.uk/supplementary-information/2026/non-elective-inpatient-spells-at-english-hospitals-occurring-between-1-april-2020-and-30-november-2025-for-patients-aged-18-and-65>

2. Average number of days from Discharge Ready Date to discharge (all adult acute patients). (monthly)

- This is calculated as the sum of all bed days between the Discharge Ready Date and discharge (bed days lost) for patients discharged in a given month, divided by the total number of patients discharged in that month. In completing the table for 2026-27 we ask areas to set out these two components and sheet automatically calculates the average figure:
- In a given month, the total number of patients discharged on the same day as their Discharge Ready Date, divided by the total number of patients discharged in that month.
- The sum of all bed days between the Discharge Ready Date and discharge (bed days lost) for patients discharged in a given month, divided by the total number of patients delayed by at least 1 day and discharged in that month.

Source statistics: <https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/>

3. Long-term admissions to residential and nursing care homes for people aged 65 and over per 100,000 population

- Admissions data is taken from the Client Level Data (CLD) source published on a quarterly basis and presents admissions as a rolling 12-month total, calculated to the end of each quarter and reported as a rate per 100,000 population.
- Population are based on a calendar year using the latest available mid-year estimates.

Any improvement planned in reablement can be noted in the narrative template but does not need to be included in this numerical template.

For missing pre-populated actuals data from November 2025 to date, please check the BCF dashboard on the DHeXchange which will have more recent data as it becomes available.

6. National conditions

This section requires local authorities, ICBs and HWBs to confirm whether the three BCF national conditions and planning requirements detailed in the published BCF 2026-27 guidance will be met. The assurance statements in this section refer to specific planning requirements, supplementing the information provided in the narrative template and this numerical template.

This sheet requires the local authorities, ICBs and HWBs to confirm 'Yes' or 'No' to the assurance statements. Should 'No' be selected, please note the actions in place towards meeting the requirement and outline the timeframe for resolution.

In summary, the national conditions are as below:

- **National condition 1:** ICBs and local authorities must develop joint plans, agreed by health and wellbeing boards, outlining how ICBs and local authorities intend to use BCF funding, to deliver more integrated and preventative care, linked to the wider development of neighbourhood health and social care services.
- **National condition 2:** ICBs and local authorities must comply with all national grant and funding conditions and deliver in accordance with their approved return. ICBs must maintain the NHS minimum contribution to adult social care and pool NHS BCF contributions into a section 75 (of the NHS Act 2006) pooled fund.
- **National condition 3:** ICBs and local authorities must comply and engage with BCF planning, governance and reporting requirements including adherence to any assurance and oversight processes.

Better Care Fund 2026-27 Numerical Template

2. Cover

Version 1.0

Please Note:

- The BCF numerical template is categorised as 'Management Information' and data from them will be published in an aggregated form on the NHS England website and gov.uk. This will include any narrative section. Some data may also be published in non-aggregated form on gov.uk. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the Better Care Exchange) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners (MHCLG, DHSC, NHS England) to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Governance and Sign off

Health and Wellbeing Board:	Reading
Confirmation that the plan has been signed off by Health and Wellbeing Board ahead of submission - Plans should be signed off ahead of submission.	Yes
If no indicate the reasons for the delay.	
If no please indicate when the HWB is expected to sign off the plan:	

Submitted by:	Beverley Nicholson
Role and organisation:	Integration Programme Manager, Reading Borough Council
E-mail:	beverley.nicholson@reading.gov
Contact number:	07812 461464
Documents submitted (please select from drop down)	
In addition to this template the HWB are submitting the following:	Narrative

Complete:

Yes
Yes
Yes
Yes

Yes
Yes
Yes
Yes
Yes

	Role:	Professional title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	Organisation
Health and wellbeing board chair(s) sign off	Health and wellbeing board chair	Cllr	Rachel	Eden	Rachel.Eden@reading.gov.uk	
	Health and wellbeing board chair					
Named accountable person	Local authority chief executive	Mrs	Jackie	Yates	jackie.yates@reading.gov.uk	
	ICB chief executive 1	Dr	Nick	Broughton	nick.broughton1@nhs.net	Thames Valley Integrated Care Board
	ICB chief executive 2 (where required)					
	ICB chief executive 3 (where required)					
Finance sign off	LA section 151 officer	Mr	Darren	Carter	darren.carter@reading.gov.uk	
	ICB finance director 1	Mr	Richard	Chapman	Richard.chapman@nhs.net	Thames Valley Integrated Care Board
	ICB finance director 2 (where required)	Mr	Daniel	Leveson	daniel.leveson@nhs.net	Thames Valley Integrated Care Board
	ICB finance director 3 (where required)					
Area assurance contacts	Local authority director of adult social services	Mrs	Melissa	Wise	melissa.wise@reading.gov.uk	
	DFG lead	Ms	Carla	Thomas-Bellamy	Carla.Thomas-Bellamy@reading.gov.uk	
	ICB place lead 1	Ms	Rachael	Corser	rachael.corser@nhs.net	Thames Valley Integrated Care Board
	ICB place lead 2 (where required)	Ms	Helen	Clark	helen.clark23@nhs.net	Thames Valley Integrated Care Board
	ICB place lead 3 (where required)					
	Director for Adult Social Care Commissioning, Transformation & Performance	Ms	Lara	Fromings	Lara.Fromings@reading.gov.uk	Reading Borough Council, Adult Social Care

Please add any additional key contacts who have been responsible for completing the plan

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Better Care Fund 2026-27 Numerical Template

3. Income

Selected HWB:

Reading

Complete:

Local authority contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Reading	£1,535,942
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum local authority contribution (exc local authority BCF grant)	£1,535,942

Local authority better care grant (LABCG)	Contribution
Reading	£3,321,794
Total Local authority better care grant	£3,321,794

Are any additional local authority contributions being made in 2026-27? If yes, please detail below	Yes
---	-----

Yes

Local authority additional contribution	Contribution	Comments - Please use this box to clarify any specific uses or sources of funding
Reading	£305,000	Local Authority contribution
Reading	£773,593	C/fwd project and revenue underspend
Reading	£70,900	DFG C/fwd for cases assessed but not yet started
Total additional local authority contribution	£1,149,493	

Yes

NHS minimum contribution	Contribution
NHS Thames Valley ICB	£15,360,094
Total NHS minimum contribution	£15,360,094

Are any additional NHS contributions being made in 2026-27? If yes, please detail below	No
---	----

Yes

Additional NHS contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total additional NHS contribution	£0	
Total NHS contribution	£15,360,094	
	2026-27	
Total BCF pooled budget	£21,367,323	

Yes

Funding contributions comments
For any useful details please use the text box below (for no additional comments, insert 'NA')

The carried forward funding is allocated against a range of integration projects to enable improved access to services and flow, and the left shift to supporting prevention in and with our communities, combined with revenue funding. These projects and grants are supporting us in achieving the better care fund objectives and metric targets, improving outcomes for our residents and embedding learning from our community outreach schemes to inform the development of neighbourhood working. The Disabled Facilities Grant underspend is included here and is allocated against DFG funded works that had not been completed at end of year, and this fund is managed by our Housing Directorate.

Yes

Better Care Fund 2026-27 Numerical Template

4. Expenditure

Selected Health and Wellbeing Board:

Reading

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

Checklist

Column complete:

Yes

Yes

Yes

Yes

Yes

Number	Category of scheme	Description of scheme	Source of funding	Adult Social Care Spend	Expenditure for 2026-27
1	Discharge support and infrastructure	Short Term/Hospital Discharge Team	NHS Minimum Contribution	Yes	£2,138,622
2	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Reablement - Local Authority In-house Community Reablement Team	NHS Minimum Contribution	Yes	£2,196,778
3	Discharge support and infrastructure	OT/SW Support to Hospital Discharge to Assess team	NHS Minimum Contribution	Yes	£160,218
4	Discharge support and infrastructure	Step Down Beds - Discharge to Assess	NHS Minimum Contribution	Yes	£357,807
5	Discharge support and infrastructure	Step Down Beds - (Physiotherapy)	NHS Minimum Contribution	Yes	£92,144
6	Long-term home-based social care services	Care Packages - Mental Health	NHS Minimum Contribution	Yes	£143,575

Number	Category of scheme	Description of scheme	Source of funding	Adult Social Care Spend	Expenditure for 2026-27
7	Long-term home-based social care services	Care Packages - Physical Support	NHS Minimum Contribution	Yes	£891,191
8	Long-term home-based social care services	Care Packages - Memory and Cognition	NHS Minimum Contribution	Yes	£552,629
9	Assistive technologies and equipment	Technology Enabled Care (TEC,) Equipment, Aids and Appliances	NHS Minimum Contribution	Yes	£270,500
10	Discharge support and infrastructure	Independent Mental Health Advocacy	NHS Minimum Contribution	Yes	£36,050
11	Wider local support to promote prevention and independence	Falls Prevention Service	NHS Minimum Contribution	Yes	£274,778
12	Wider local support to promote prevention and independence	Integration Board Projects (Front Door Service, Community support and Social Prescribing Digital Platform)	NHS Minimum Contribution	Yes	£385,621
13	Evaluation and enabling integration	Care Act Duties - Brokerage, Commissioning, Safeguarding, Assessments	NHS Minimum Contribution	Yes	£422,187
14	Wider local support to promote prevention and independence	Carer's Services Contribution to Care Act costs - Closing the Gap (NHS)	NHS Minimum Contribution	Yes	£208,060
15	Wider local support to promote prevention and independence	Carer's Services Contribution to Care Act costs - Closing the Gap (LA)	Additional LA Contribution	Yes	£305,000

Number	Category of scheme	Description of scheme	Source of funding	Adult Social Care Spend	Expenditure for 2026-27
16	Evaluation and enabling integration	Project Management Office (Incl. Performance Reporting / PHM)	NHS Minimum Contribution	Yes	£173,544
17	Discharge support and infrastructure	Hospital to Home Service to support vulnerable people to return home safely and prevent readmission	NHS Minimum Contribution	Yes	£10,000
18	Evaluation and enabling integration	ICB Contingency	NHS Minimum Contribution	No	£1,236
19	Evaluation and enabling integration	ICB Project Management Office	NHS Minimum Contribution	No	£92,245
20	Wider local support to promote prevention and independence	ICB contribution to Integrated Neighbourhood Working Fund / Berkshire West Schemes	NHS Minimum Contribution	No	£247,421
20a	Wider local support to promote prevention and independence	LA contribution to Integrated Neighbourhood Working Fund / Berkshire West Schemes	Additional LA Contribution	No	£109,172
21	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	BHFT - Community Reablement Team. Contribution to BW Place Costs	NHS Minimum Contribution	No	£1,139,250
22	Support to carers, including unpaid carers	Support and Advice Services for Young People with Dementia (YPWD), Alzheimers DCA, Stroke Association	NHS Minimum Contribution	No	£162,025

Number	Category of scheme	Description of scheme	Source of funding	Adult Social Care Spend	Expenditure for 2026-27
23	Evaluation and enabling integration	Connected Care	NHS Minimum Contribution	No	£323,892
24	Urgent community response	Care Homes / RRaT	NHS Minimum Contribution	No	£669,984
25	Wider local support to promote prevention and independence	Speech & Language Therapy - Eating and Drinking referral service	NHS Minimum Contribution	No	£65,061
26	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Out of Hospital Care Home in-reach	NHS Minimum Contribution	No	£130,753
27	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Out Of Hospital - Community Geriatrician	NHS Minimum Contribution	No	£137,858
28	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Intermediate Care (including integrated discharge to assess service)	NHS Minimum Contribution	No	£1,083,879
29	Evaluation and enabling integration	Health Hub - Acute Single Point of Access to Community Health Services.	NHS Minimum Contribution	No	£498,335
30	Urgent community response	Out Of Hospital - Intermediate Care, rapid response, reablement and part year night sitting service (linked to scheme 51 for remainder of year)	NHS Minimum Contribution	No	£313,738

Number	Category of scheme	Description of scheme	Source of funding	Adult Social Care Spend	Expenditure for 2026-27
31	Evaluation and enabling integration	Street Triage service supporting Reading Rough sleepers	NHS Minimum Contribution	No	£177,185
32	Discharge support and infrastructure	Additional D2A beds (4, scale up to 10)	Local Authority Better Care	Yes	£395,170
33	Discharge support and infrastructure	Hospital to Home Service Top-up, to support vulnerable people to return home safely and prevent readmission	Local Authority Better Care Grant	Yes	£64,000
34	Discharge support and infrastructure	Bed & Breakfast / And Blitz Cleans to enable discharge back to usual place of residence	Local Authority Better Care	Yes	£70,000
35	Discharge support and infrastructure	Hospital Discharge support TEC	Local Authority Better Care	Yes	£50,000
36	Discharge support and infrastructure	Hospital / CRT delivering extended hours / Bank Holidays	Local Authority Better Care	Yes	£30,000
37	Evaluation and enabling integration	Workforce Development	Local Authority Better Care	Yes	£20,000
38	Discharge support and infrastructure	Hospital Discharge support Minor Works	NHS Minimum Contribution	Yes	£100,030
39	Long-term home-based social care services	Homecare capacity and waitlist management	NHS Minimum Contribution	Yes	£236,529
40	Discharge support and infrastructure	Additional SW/OT posts to support hospital discharge assessments and right-sizing of packages	NHS Minimum Contribution	Yes	£371,880
41	Discharge support and infrastructure	Complex Cases - high cost placements (including MH)	NHS Minimum Contribution	Yes	£783,909
42	Personalised budgeting and commissioning	Brokerage Staffing	NHS Minimum Contribution	Yes	£41,080

Number	Category of scheme	Description of scheme	Source of funding	Adult Social Care Spend	Expenditure for 2026-27 (£)
43	Disabled Facilities Grant related schemes	Adaptations, including statutory DFG grants	DFG	Yes	£1,535,942
44	Evaluation and enabling integration	Project spend c/fwd for projects running into 2026/27	Additional LA Contribution	Yes	£598,321
45	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Community Reablement Services - Care Packages	Local Authority Better Care Grant	Yes	£2,692,624
46	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Contribution to wider social care intermediate care services	NHS Minimum Contribution	No	£261,700
47	Wider local support to promote prevention and independence	Magic Notes - digital enabler	NHS Minimum Contribution	Yes	£50,000
48	Wider local support to promote prevention and independence	Social Prescribing	NHS Minimum Contribution	Yes	£30,000
49	Wider local support to promote prevention and independence	Policy and Engagement & Prevention	NHS Minimum Contribution	Yes	£85,000
50	Wider local support to promote prevention and independence	Optimising Care team to improve flow and prevent admissions	Additional LA Contribution	No	£90,000
51	End of life care	Night Sitting Service for Care and End of Life (Part Year - new contract)	NHS Minimum Contribution	No	£43,402
52	Wider local support to promote prevention and independence	Hoarding Service	Additional LA Contribution	Yes	£47,000

4a. Expenditure Guidance

Guidance for completing expenditure sheet

1. Please enter spend information in the bottom table starting cell B30 including the category of spend which is a dropdown containing the categories listed in the table below. You must also enter scheme-level detail for the line of spend in 'Description of Scheme' with the appropriate level of information keeping this relatively succinct, for example 'Community Health Rehabilitation' or 'MSK services' or 'Integrated Crisis and Rapid Response' would be sufficient. Please also enter source of funding which determines the total spend appearing in the source of funding table at the top. Ensure a 'Number' is entered in the 'Expenditure for 2026-27 (£)' so that the validation boxes can be marked as complete.
2. Please ensure 'Adult Social Care Spend' is marked 'Yes' when the money is spent on Adult Social Care across any funding source.

Scheme Types

Number	Category of scheme	Description
1	Assistive technologies and equipment	Using technology in care processes to support self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Housing related schemes	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
3	DFG related schemes	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place.
4	Wider support to promote prevention and independence	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and wellbeing.

Number	Category of scheme	Description
5	Short-term home-based intermediate care (rehabilitation, reablement and recovery services)	Short-term (up to 6 weeks), therapy-led services in the person's usual residence (home or care home), following the 'Home First' principle. For adults 18+ to regain independence post-illness/injury/discharge (step-down) or prevent admissions/long-term care (step-up). Person-centred, with initial assessment and regular reviews; led by registered therapists (physiotherapists, occupational therapists, speech/language therapists) plus support from unregistered workers and other professionals (nurses, doctors, social workers). Outcomes: better function, confidence, wellbeing; less carer reliance and long-term care demand. Domiciliary social care (personal care, domestic help) included only within a rehab/reablement-focused package.
6	Short-term home-based social care (excluding rehabilitation, reablement and recovery services)	Short-term domiciliary social care (e.g. personal care, help with domestic tasks, voluntary sector support), except where it is provided as part of a package that also includes rehabilitation, reablement and/or recovery services.
7	Long-term home-based social care services	Ongoing social care services (e.g. personal care, help with domestic tasks), helping people continue to live at home and maintain independence.
8	Long-term home-based community health services	Ongoing health services provided in people's own homes or in other non-residential community-based settings.
9	Bed-based intermediate care (short-term bed-based rehabilitation, reablement or recovery)	Short-term (up to 6 weeks), therapy-led services in a community bed-based setting (e.g. community hospital, care home bed or designated facility). For adults 18+ to regain independence post-hospital stay (step-down) or prevent avoidable admission/long-term residential care (step-up from community). Person-centred, with initial assessment and regular reviews; led by registered therapists (physiotherapists, occupational therapists, speech/language therapists) plus multi-disciplinary support (unregistered workers, nurses, doctors, others as needed). Where safe and appropriate, transition to home-based intermediate care is required to continue recovery at usual residence. Outcomes: improved function, confidence, wellbeing; reduced acute admissions, readmissions and long-term social care demand. May include mixed health and social care interventions.

Number	Category of scheme	Description
10	Long-term residential or nursing home care	Ongoing care provided in a residential care home or nursing home for people who need more intensive or specialised support than can be provided at home.
11	Discharge support and infrastructure	Services and activity to enable discharge. Examples include multi-disciplinary/multi-agency discharge functions or Home First/Discharge to Assess process support/ core costs.
12	End of life care	Schemes specifically designed to provide care and support for people nearing the end of life.
13	Support to carers, including unpaid carers	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
14	Evaluation and enabling integration	Schemes that monitor or evaluate the impact of integrated care schemes. Schemes or services that enable integrated care, such as (but not necessarily limited to): - Joint commissioning arrangements - Integrated care planning - Helping people navigate services - Workforce development or recruitment and retention
15	Urgent Community Response	Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
16	Personalised budgeting and commissioning	Various person centred approaches to commissioning and budgeting, including direct payments.
17	Other	This should only be selected where the scheme is not adequately represented by the above scheme types.

Better Care Fund 2026-27 Numerical Template

5. Metrics for 2026-27

Selected Health and Wellbeing Board:

Reading

5.1 Non-Elective admissions

Non elective admissions to hospital for people aged 65 and over per 100,000 population	Rate	Apr 25 Actual	May 25 Actual	Jun 25 Actual	Jul 25 Actual	Aug 25 Actual	Sep 25 Actual	Oct 25 Actual	Nov 25 Actual	Dec 25 Actual	Jan 26 Actual	Feb 26 Actual	Mar 26 Actual
		1,440	1,575	1,395	1,485	1,462	1,327	1,462					
		320	350	310	330	325	295	325					
	Population of 65+*	22,227	22,227	22,227	22,227	22,227	22,227	22,227					
	Rate	Apr 26 Plan	May 26 Plan	Jun 26 Plan	Jul 26 Plan	Aug 26 Plan	Sep 26 Plan	Oct 26 Plan	Nov 26 Plan	Dec 26 Plan	Jan 27 Plan	Feb 27 Plan	Mar 27 Plan
		1,354	1,453	1,255	1,323	1,413	1,174	1,345	1,341	1,251	1,327	1,071	1,327
		301	323	279	294	314	261	299	298	278	295	238	295
	Population of 65+	22,227	22,227	22,227	22,227	22,227	22,227	22,227	22,227	22,227	22,227	22,227	22,227

Complete:

Yes

Source: <https://digital.nhs.uk/supplementary-information/2025/non-elective-inpatient-spells-at-english-hospitals-occurring-between-01-04-2020-and-30-11-2024-for-patients-aged-18-and-65>

5.2 Discharge delays

Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	Apr 25 Actual	May 25 Actual	Jun 25 Actual	Jul 25 Actual	Aug 25 Actual	Sep 25 Actual	Oct 25 Actual	Nov 25 Actual	Dec 25 Actual	Jan 26 Actual	Feb 26 Actual	Mar 26 Actual
	0.85	0.88	1.32	0.92	0.81	1.11	1.16	1.20				
	76.5%	77.7%	73.2%	76.5%	73.4%	73.1%	68.0%	75.4%				
	3.6	4.0	4.9	3.9	3.0	4.1	3.6	4.9				
Proportion of adult patients discharged from acute hospitals on their discharge ready date	Apr 26 Plan	May 26 Plan	Jun 26 Plan	Jul 26 Plan	Aug 26 Plan	Sep 26 Plan	Oct 26 Plan	Nov 26 Plan	Dec 26 Plan	Jan 27 Plan	Feb 27 Plan	Mar 27 Plan
	0.60	0.51	0.63	0.78	0.59	0.84	0.87	0.93	0.81	0.95	0.88	0.90
	83.3%	86.1%	81.3%	79.9%	80.5%	75.1%	76.4%	75.4%	74.3%	73.9%	75.3%	74.6%
	3.60	3.66	3.38	3.90	3.00	3.38	3.69	3.78	3.16	3.64	3.55	3.57

*Dec Actual onwards are not available at time of publication

Yes

Yes

Source: <https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/>

5.3 Admissions to residential and nursing care homes

		Rolling 12 month total until end of quarter date indicated							
		Actual Ending 31- 12-2024	Actual Ending 31- 03-2025	Actual Ending 30- 06-2025	Actual Ending 30-09-2025	2026-27 Plan Ending 30-06-2026	2026-27 Plan Ending 30-09-2026	2026-27 Plan Ending 31-12- 2026	2026-27 Plan Ending 31-03-2027
Long-term admissions to residential and nursing care homes for people aged 65 and over per 100,000 population	Rate	737.8	688.4	620.9	557.9	589.4	557.9	557.9	652.4
	Number of admissions	164	153	138	124	131	124	124	145
	Population of 65+*	22,227	22,227	22,227	22,227	22,227	22,227	22,227	22,227

*Population of people aged 65 and above are based on the latest available mid-year estimates from the ONS

Yes

Better Care Fund 2026-27 Numerical Template
6: National Condition Planning Requirements

Health and wellbeing board

Reading



HM Government



National Condition	Planning requirement	Assurance statement	Yes/No to assurance statement	Where the planning requirement or assurance statement is not met, please note the actions in place towards meeting the requirement	Timeframe for resolution	Complete:
National Condition 1: effectively support the delivery of integrated and preventative care ICBs and local authorities must develop joint plans, agreed by health and wellbeing boards, outlining how ICBs and local authorities intend to use BCF funding to deliver more integrated and preventative care, linked to the relevant areas of neighbourhood health and social care services.	ICBs and local authorities must have considered how to use the BCF most effectively to support the delivery of more integrated and preventative services, particularly supporting those with more complex health and social care needs. This must include setting out how the funding will be used to develop the quality, efficiency and outcomes from intermediate care.	Named ICB and local authority chief executives and named HWB chair must confirm that BCF expenditure is agreed and aligned with wider strategic objectives for neighbourhood health and social care.	Yes			Yes
National Condition 2: comply with expenditure and grant conditions ICBs and local authorities must comply with all national grant and funding conditions and deliver in accordance with their approved return. ICBs must maintain the NHS minimum contribution to adult social care and pool NHS BCF contributions into a section 75 (of the NHS Act 2006) pooled fund.	The NHS minimum contribution to adult social care must be met and maintained by the ICB in line with the published BCF allocations. This represents an increase of 4.4% in each health and wellbeing board area. Local authorities must comply with the grant conditions of the Local Authority Better Care Grant and the DFG, including the pooling of funding.	ICBs and local authorities confirm compliance with BCF national grant and funding conditions, and that they will deliver in accordance with approved spend and BCF numerical return, including maintaining the NHS minimum contribution to adult social care. ICBs and local authorities confirm they will pool funds through Section 75 agreements by 30th September 2026.	Yes Yes			Yes Yes
National Condition 3: - effective governance, reporting and engagement ICBs and local authorities must comply and engage with BCF planning, governance and reporting requirements including adherence to any assurance and oversight processes.	ICBs, local authorities and health and wellbeing boards are required to engage with BCF reporting, oversight and support processes	ICBs and local authorities confirm full compliance with BCF planning and reporting requirements and will adhere to the BCF oversight and support processes.	Yes			Yes

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Appendix 3: Reading HWB - BCF 2025-26 EOY Report (Final)

Better Care Fund 2025-26 EOY Reporting Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements for 2025-26 (refer to link below), which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health and Social Care (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE).

<https://www.england.nhs.uk/long-read/better-care-fund-planning-requirements-2025-26/#introduction>

<https://www.gov.uk/government/publications/better-care-fund-policy-framework-2025-to-2026/better-care-fund-policy-framework-2025-to-2026>

As outlined within the planning requirements, quarterly BCF reporting will continue in 2025-26, with areas required to set out progress on delivering their plans by reviewing metrics performance against goals, spend to date as well as any significant changes to planned spend.

The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF plans and progress on wider integration.

BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICBs, local authorities and service providers) for the purposes noted above.

In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

BCF reports submitted by local areas are required to be signed off HWB chairs ahead of submission. Aggregated data reporting information will be available on the DHSC BCF Metrics Dashboard and published on the NHS England website.

Note on entering information into this template

Please do not copy and paste into the template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells/Not required

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut and paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy and paste', please use the 'Paste Special' operation and paste Values only.

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric goals from your BCF plans for 2025-26 will pre-populate in the relevant worksheets.
2. HWB Chair sign off will be subject to your own governance arrangements which may include a delegated authority.
3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2025-26 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.

<https://www.england.nhs.uk/long-read/better-care-fund-planning-requirements-2025-26/>

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, an outline of the challenge and mitigating actions to support recovery should be outlined. It is recommended that the HWB also discussed this with their Regional Better Care Manager.

In summary, the four National conditions are as below:

National condition 1: Plans to be jointly agreed

National condition 2: Implementing the objectives of the BCF

National condition 3: Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC) (and section 75 in place)

National condition 4: Complying with oversight and support processes

4. Metrics

The BCF plan includes the following metrics (these are not cumulate/YTD):

1. Emergency admissions to hospital for people aged 65+ per 100,000 population. (monthly)
2. Average number of days from Discharge Ready Date to discharge (all adult acute patients). (monthly)
3. Admissions to long term residential and nursing care for people aged 65+ per 100,000 population. (quarterly)

Plans for these metrics were agreed as part of the BCF planning process outlined within 25/26 planning submissions.

Populations are based on 2024 mid year estimates, please note this has been updated from the Q2 template to match the DHSC metrics dashboard.

Within each section, you should set out how the ambition has been reached, including analysis of historic data, impact of planned efforts and how the target aligns for locally agreed plans such as Acute trusts and social care.

The bottom section for each metric also captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.

The metrics worksheet seeks a short explanation if a goal has not been met - in which case please provide a short explanation, including noting any key mitigating actions. You can also use this section to provide a very brief explanation of overall progress if you wish.

In making the confidence assessment on progress, please utilise the available metric data via the published sources or the DHSC metric dashboard along with any available proxy data.

https://dhexchange.kahootz.com/Discharge_Dashboard/groupHome

5. Income & Expenditure

This section requires confirmation of an update to actual income received in 2025-26 across each fund, as well as spend to date at Q3. If expenditure by activity has changed since the original plan, please confirm that this has been agreed by local partners. If that change in activity expenditure is greater than 5% of total BCF expenditure, please use this box to provide a brief summary of the change.

On the 'DFG' row in the 'Source of Funding' table, 'Updated Total Income for 25-26' this should include the total funding from DFG allocations that is available for you to spend on DFG in this financial year 2025-26. 'EOY Actual Expenditure' should include total amount that has been spent at year-end, even if the application or approval for the DFG started in a previous quarter or there has been slippage.

The template will automatically pre-populate the planned income in 2025-26 from BCF plans, including additional contributions. Please enter the update amount of income even if it is the same as in the submitted plan. Note that the extra £50m DFG top-up that had been introduced at the start of the year is now included in the total DFG amount therefore please include this in your total actuals expenditure.

Please also use this section to provide the aggregate End of Year Spend. This tab will also display what percentage of planned income this constitutes.

Better Care Fund 2025-26 EOY Reporting Template

2. Cover

Version 1.0 [unlocked]

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Checklist

Complete:

Yes

Yes

Yes

Yes

Yes

Yes

Health and Wellbeing Board:	Reading
Completed by:	Beverley Nicholson
E-mail:	beverley.nicholson@reading.gov.uk
Contact number:	07812 461464
Has this report been signed off by (or on behalf of) the HWB Chair at the time of submission?	Yes
If no, please indicate when the report is expected to be signed off:	

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'.

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Income & Expenditure	Yes

For further guidance on requirements please refer back to guidance sheet - tab 1.

[<< Link to the Guidance sheet](#)

Better Care Fund 2025-26 EOY Reporting Template

3. National Conditions

Selected Health and Wellbeing Board:

Reading

Confirmation of Nation Conditions

National Condition	Confirmation	If the answer is "No" please provide an explanation as to why the condition was not met in the quarter and mitigating actions underway to support compliance with the condition:
1) Plans to be jointly agreed	Yes	
2) Implementing the objectives of the BCF	Yes	
3) Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC) and Section 75 in place	Yes	
4) Complying with oversight and support processes	Yes	

Checklist

Complete:

Yes

Yes

Yes

Yes

4. Metrics for 2025-26

Selected Health and Wellbeing Board:

Reading

For metrics time series and more details:

[BCF dashboard link](#)

For metrics handbook and reporting schedule:

[BCF 25/26 Metrics Handbook](#)

4.1 Emergency admissions

Plan		Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	1,489.2	1,552.2	1,601.7	1,543.2	1,340.7	1,358.7	1,529.7	1,660.1	1,547.7	1,565.7	1,457.7	1,579.2
	Number of Admissions 65+	331	345	356	343	298	302	340	369	344	348	324	351
	Population of 65+	22,227.0	22,227.0	22,227.0	22,227.0	22,227.0	22,227.0	22,227.0	22,227.0	22,227.0	22,227.0	22,227.0	22,227.0

Assessment of whether goal has been met in Q4:	On track to meet goal
You may use this box to provide a very brief explanation of overall progress if you wish.	Performance in 2025/26 was very positive with the end of year position being a rate of 16,570 per 100,000 against our target of 18,226, 9% below our maximum target for the year. Our target for 2026/27 has been set at 5% below our actuals for this year, given our positive improvement against both this and the sub-targets, and the additional community based support to build strength and confidence and raising awareness of health and wellbeing, working closely with our VCSE partners, alongside developing our Falls Prevention Team, and investing in our Reconditioning Programme, Community based exercise sessions and Technology Enabled Care.

4.2 Discharge Delays

Original Plan

	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	0.69	0.51	0.63	0.82	0.63	0.84	0.87	0.97	0.81	0.95	0.88	0.90
Proportion of adult patients discharged from acute hospitals on their discharge ready date	83.3%	86.1%	81.3%	79.9%	80.5%	75.1%	76.4%	74.5%	74.3%	73.9%	75.3%	74.6%
For those adult patients not discharged on DRD, average number of days from DRD to discharge	4.13	3.66	3.38	4.08	3.24	3.38	3.69	3.78	3.16	3.64	3.55	3.57

Assessment of whether goal has been met in Q4:

Not on track to meet goal

You may use this box to provide a very brief explanation of overall
progress if you wish.

We have improved discharge rates compared to 2024/25 but due to complexity of some cases, and delays in hospital discharge that are not social care related, e.g. transport, medications, the target has not been achieved this year. We have a commissioned "Hospital to Home" service through a voluntary and community sector partner which has positively impacted on discharge rates, along with reconditioning, reablement and Technology Enabled Care programmes to avoid readmissions and build strength and confidence. Our overall position at year end was average proportion of people discharged on discharge ready date 72.5% and for those not discharged on their discharge ready date, the average number of days delay was 4.16. Our targets for 2026/27 have been informed by the actual performance this year and we continue to work with our system partners in Acute services to improve data quality. It is of note that the DH Exchange Dashboard shows that in February (*latest data available*), Reading performed better than the England average for average days delayed and better than the majority of regional and peer local authority groups.

4.3 Residential Admissions

Actuals + Original Plan		2023-24 Full Year Actual	2024-25 Full Year CLD Actual	2025-26 Plan Q1 (April 25- June 25)	2025-26 Plan Q2 (July 25- Sept 25)	2025-26 Plan Q3 (Oct 25-Dec 25)	2025-26 Plan Q4 (Jan 26-Mar 26)
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	551.8	679.4	252.4	224.1	183.0	220.2
	Number of admissions	120.0	151.0	56.1	49.8	40.7	48.9
	Population of 65+*	22227.0	22227.0	22227.0	22227.0	22227.0	22227.0
Assessment of whether goal has been met in Q4:		On track to meet goal					
You may use this box to provide a very brief explanation of overall progress if you wish.		Having had a steep rise in admissions over the last two years, we are pleased to have achieved a positive outcome in 2025/26, supported by home care, reablement services, our voluntary and community social enterprise sector and community health support. Our Technology Enabled Care service and effective use of our disabled facilities grants, alongside falls prevention has enabled people to remain at home with the right levels of support and enabled connection with community teams and activities to maintain health and wellbeing, and reduce isolation and loneliness. Our target for 2026/27 has been set with a 4% reduction on the overall actuals for this year as we expect to see a continuation of this positive impact within our communities. We note the use of Client Level Datasets by BCF team on the planning templates going forward and report that we have been monitoring admissions on a monthly and quarterly basis this year on our actual Long- Term admissions. Our aim for the year was to have no more than 880 admissions, per 100,000 population and we achieved this with 722 admissions per 100,000 population (18% below the maximum target). We did not monitor against CLD rolling 12 month average and will be doing this from April 2026 onwards. Our targets for 2026/27 have been based on CLD actuals for 2025/26.					

Better Care Fund 2025-26 EOY Reporting Template

5. Income & Expenditure

Checklist

Complete:

Selected Health and Wellbeing Board:	Reading		
	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
Minimum NHS Contribution	£14,886,847	£14,886,847	
Local Authority Better Care Grant	£3,321,794	£3,321,794	
Additional LA Contribution	£866,221	£1,483,435	
Additional NHS Contribution	£0	£0	
Total	£20,665,048	£21,282,262	
			% of Planned Income
End of Year Actual Expenditure		£20,437,769	96%
If expenditure by activity has changed since the original plan, please confirm that this has been agreed by local partners. If that change in activity expenditure is greater than 5% of total BCF expenditure, please use this box to provide a brief summary of the change.		Change was increased c/fwd from previous year and was 3% of total BCF planned expenditure, which was agreed with all parties and included in the Section 75 Framework Agreement. The additional DFG Income of £104,480 received in February was included on the DFG Income line on this End of Year template. The balance of funds are c/fwd on continuing projects and some new schemes, such as Magic Notes, into 2026/27 and beyond and to support the development of neighbourhood working models.	

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Better Care Fund 2024-25 EOY Reporting Template

6. Year End Impact Summary

Selected Health and Wellbeing Board:

Reading

Checklist

Complete:

Confirmation of Statements		
Question statements	Confirmation	If the answer is "No" please provide an explanation:
Overall delivery of BCF has improved joint working between health and social care	Yes	
Our BCF schemes were implemented as planned in 2025-26	Yes	
The delivery of our BCF plan 2025-26 has had a positive impact on the integration of health and social care in our locality.	Yes	

Yes

Yes

Yes

Highlight success and challenges within reference to the most relevant enablers from SCIE logic model:	
Logic model for integrated care - SCIE	
Success and Challenges	Narrative
2 key successes observed towards driving the enablers for integration	Success 1: Building an integrated Falls & Frailty workforce The Falls Prevention Team is now fully in post and recruitment to care coordinator roles completed, which strengthens system capacity to deliver integrated falls work. Falls training has been embedded as mandatory induction for adult social care staff—supporting shared standards and consistent capability across the workforce. Delivery is described as collaborative working with partners (including work with libraries, care homes, VCSFE, trusted assessor roles and linking with Technology Enabled Care TEC team), reinforcing joined-up prevention and pathway development. Success 2: Digital platform developments Thames Valley Shared Care Record System (Connected Care) and JOY Connected Care Insights and PHM capacity has improved coordination and decision-making across partners. A single, transparent view accessible to all partners (e.g. primary care, community, acute) supports faster, better-informed decisions and system-wide conversations, reducing silos and improving pathway coordination, as well as enabling targeted approaches for “rising risk” cohorts such as frailty. JOY continues to scale and mature as a shared, cross sector social prescribing and navigation platform, with ongoing workshops for VCS organisations and improved ability to directly upload services—supporting a more complete, diverse and current community offer. A Berkshire West cross sector steering group has been established (Reading Voluntary Action, and Involve (both VCSE infrastructure partners) alongside representatives from Reading, Wokingham and West Berkshire councils, to review the form and function of the JOY digital platform and shape a specification for future procurement, considering enablers for neighbourhood working and write back to the system. This collaborative approach demonstrates shared governance and system alignment around digital enablers.

Yes

2 key challenges observed towards driving the enablers for integration

Challenge 1: Discharge Delays

Discharge performance remains off target, with discharge on discharge-ready date (DRD) below the annual average target and delays driven by recurring multi-agency blockers such as, transport, medications, equipment delays (also impacted by switching equipment providers mid-year), court of protection processes and family expectations.

Contributing to our ability to flag issues around discharge delays has been the lack of robust and timely national discharge datasets. This impacted alongside local system changes, switching providers of the BCF Metric data from the Commissioning Support Unit to the locality based business intelligence team, and changes to our acute hospital's data processes in relation to DRD and discharge delay reporting, which in year impacted by weakening system oversight and learning.

Challenge 2: Referrals to Community Reablement

Community reablement referrals have been at a lower rate than expected but there have been significantly more cases that were double up/ more complex, which have utilised capacity. An action plan is in place reviewing referrals into the community reablement team, and identifying opportunities to switch to a full intake model, which will further support admission avoidance.

Yes

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Evaluation of Berkshire West

Community Wellness Outreach Health Check

EXECUTIVE SUMMARY

This report describes a clear case for continued expenditure on the CWO programme. The programme is successful at raising awareness of CVD and reaching communities who would not otherwise access a health check (especially global majority communities). There is tentative evidence of improved health and value for money. The report recommends a more focused service, which is closely embedded into a neighbourhood health model, and which puts a greater focus on follow up support (e.g. lifestyle and physical activity interventions).

The programme runs from January 2024 to 30th June 2026. The evaluation covers the period January 2024 – September 2025, with the patient data study (in particular), focused on the early part of the programmes (March 2024-April 2025). **Many of the issues highlighted in the evaluation have already been addressed and improved, prior to this report being finalised.**

Targeting & locations

- 57%¹ of checks have been delivered to target populations. Reading and West Berkshire are more successful at targeting – in Wokingham targeting was initially more challenging, but remedial action was taken.
- All three locations have encouraged a disproportionately high number of people from the global majority to access the health check.
- There are two approaches to encouraging take up which have been especially valuable: (i) West Berkshire's approach to phoning patients (ii) Reading's collaboration with voluntary organisations.
- Feedback regarding locations for health checks is complex: (i) Those who had a health check at a venue they were attending for another reason (e.g. homeless

¹ This figure comes from the running report: a monitoring report which gathers data from the three locations on a monthly basis. A separate patient data study (drawing on connected care data and delivered by Nuffield Department of Primary Care Health Sciences, University of Oxford) states that 89% of checks were delivered to the target cohort - this figure works on the assumption that the target cohort is IMD1-6. In West Berkshire, the target cohort was 1-6 for 18 months from January 2024 – June 2025 (this includes the period covered by the patient data study). In June 2025, the target cohort in West Berkshire reverted to IMD 1-4. In Reading and Wokingham the target cohort has been IMD 1-4 throughout.

drop in lunch, community learning centre, Gurkha village hall) indicated that the location was critical: they would not have had a health check elsewhere. (ii) Among those who attended more generic locations (e.g. libraries and church halls), a majority (although not all) were relaxed about where the health check was delivered, as long as it was accessible and offered privacy. In fact some were confused / frustrated that they had not been able to access a health check at their GP surgery.

Patient experience and CVD awareness

- Patient feedback across all three sites is overwhelmingly positive (interviews n=23, focus groups / survey in Reading n=16, free-text responses in the patient survey n=391). People value the thoroughness of the check, the amount of time they have to discuss issues, the attitude, empathy and expertise of the staff.
- Most patients who needed language support were able to access it in a way that suited them.
- The running report suggests that around 85% of patients feel that the health check increased their awareness and understanding, with survey respondents suggesting that their knowledge has increased by about 33 percentage points.

Clinical impact

- The running report shows that nearly 70% of people accessing the checks had a high BMI. Nearly half had high cholesterol and 20-25% had high blood glucose or high blood pressure.
- The running report suggests that around 25% of people were referred to their GP following the health check.
- Data regarding benefits to people aged 18-39 is tentative. However the scoping review makes clear that a focus on these younger adults would be valued.

Behaviour change

The evidence of behaviour change is promising, although not entirely conclusive.

- The running report suggests that weight management is the most common referral for lifestyle support (following by social prescribing and mental health support). Smoking cessation and loneliness referrals are less common.
- 75% of survey respondents (n=391) indicated that they had made a lifestyle change, with 97% of those indicating that they felt the change would be maintained in 2 years' time. The lifestyle changes (listed in order of frequency, with the most common change listed first) were: improved food and nutrition,

increased activity / exercise, reduced alcohol consumption, improved mental wellbeing / reduced stress, reduced smoking.

- However in-depth conversations with the 23 people who took part in interviews suggests that people are finding it hard to make a meaningful change in their health outcomes. They would value more follow up to ensure they can generate and maintain lifestyle changes. The scoping review promotes a focus on lifestyle support (and finds that investment in physical activity services can result in a return of £7.78 for every £1 spent).

Partnership working and comparing the models

Details of the three models are available in the full report. Notable *differences* in delivery are highlighted below:

Figure 1 Differences between the models

Differences between the models	
Reading	• Delivery contracted to voluntary sector and RBH • Higher levels of voluntary sector collaboration to recruit participants + open access to all adults 18+ • Check delivered by nurses • Additional follow up support through social prescribers on site, and 'Give it a go' programme. • Focused on IMD 1-4
West Berkshire:	• Delivery contracted to Solutions4Health • Phone call follow up to recruit participants • Check delivered by health care assistants • Focused on IMD 1-6 for the first 18 months, then IMD 1-4
Wokingham:	• Delivered in-house • Focused on IMD 1-4

- Stakeholders feel very pleased with the quality of partnership working, and the sustainable working relationships which have been developed. They would value more input from primary care colleagues if possible.
- Whilst it has been challenging to implement a suitable digital solution for transferring data to primary care, stakeholders now feel satisfied with the arrangements. They would however prefer that follow-on referrals and lifestyle support is co-ordinated through the Joy App, across all three sites.
- The evaluation has been unable to uncover strong evidence to justify the use of qualified nurses to deliver the health checks. However there is likely to be value in having clinical oversight (e.g. a nurse-led team of health care assistants, or a nurse 'on-call' during the delivery of health checks).

Areas for improvement

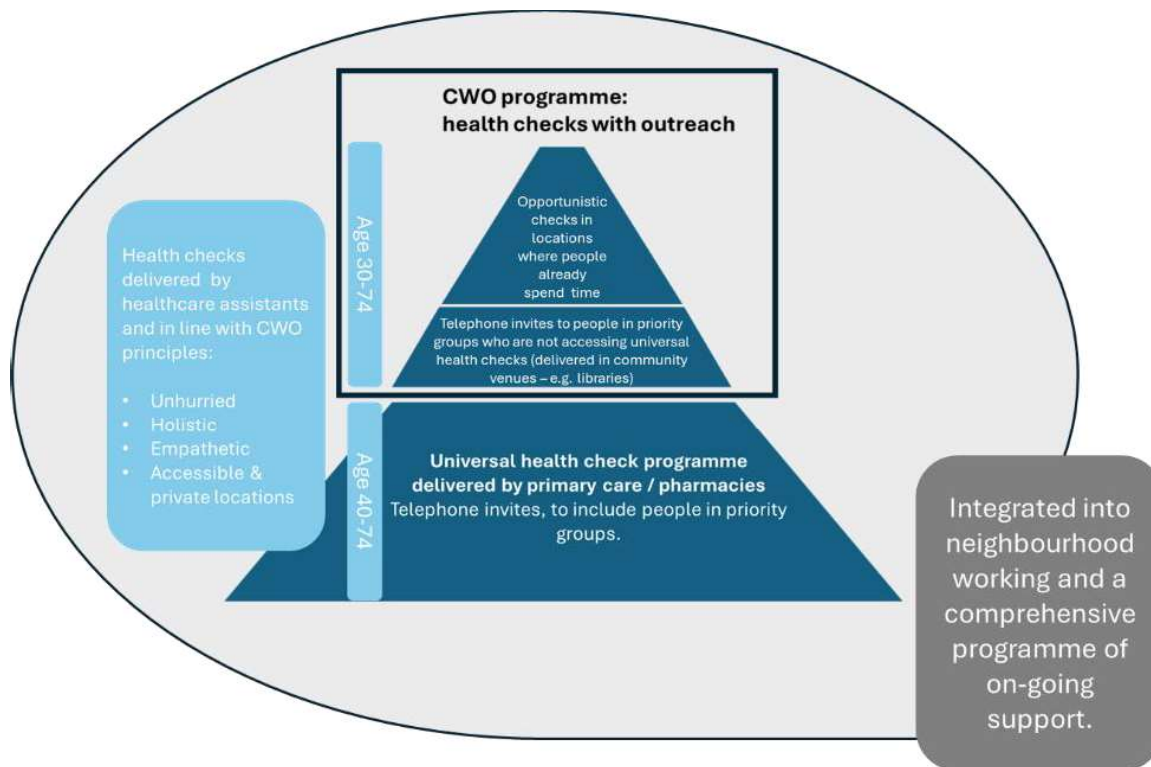
- **High priority:** Improved targeting and risk stratification – this is likely to include more effective / accurate Connected Care lists, combined with community-led engagement and telephoning key cohorts. Even more focus on informal, opportunistic invites, and an overall programme of targeted awareness-raising.
- **High priority:** Improved data recording. The success of the programme relies on accurate recording of blood pressure, HbA1c and patient outcomes. Improvements to point of care testing and accuracy of recording is key. For example, it is important to make sure the full systolic and diastolic readings (rather than simply noting that it falls within the ‘normal’ range). There may also be value in reviewing the codelist template and ensuring there is an on-going plan to regularly verify data entry and data recall.
- **High priority:** Better follow up support for those who are making lifestyle changes.
- **Medium priority:** Even more flexibility in terms of time slots (e.g. evenings and weekends). Balance the location of deliver to ensure optimum access and value for money. Likely to involve (a) a greater focus on opportunistic checks in locations where the target cohort will be (e.g. work place appointments, support groups and drop-in lunches) (b) a more modest focus on targeted outreach invites (and where these are used, they should be by telephone). It is acceptable for a greater proportion of health checks to be delivered at GP surgeries or pharmacies, as long as they are accessible, offer privacy, are unhurried and empathetic.
- **Low priority:** There may be value in offering follow up support for the small number of people who have trouble interpreting their personalised risk report.

Future service

Overall approach

The future CWO programme would be integrated into neighbourhood working and ideally focus on delivering a smaller programme of opportunistic health check delivery in locations which target communities frequent. This assumes that more checks are moved to primary care and pharmacies, delivered using CWO programme principles (non-judgemental, adequate time, delivered by healthcare assistants). Alongside these two ‘extremes’ of delivery, there would ideally be a small programme of additional support for those who can travel to a health check location, but are unlikely to attend a ‘medical’ setting.

Figure 2 Summary of an 'ideal' model



Targeting

The services would ideally improve targeting through even better collaboration between primary care, CWO colleagues and Connected Care. This work would be complemented with a programme of awareness raising, telephone invites and local relationship building, with an especial focus on those groups who will only access a health check when it is delivered in a location which is familiar and routine for them to attend (e.g. Mosque, Community Learning Centre).

Staffing

It would focus on recruiting healthcare assistants with the attitudes and behaviours which patients have valued so strongly (empathy, non-judgemental, patience). This model would reduce the amount of nursing presence (however nursing oversight in some form would ideally be maintained). The role of social prescriber would be maintained and expanded (to support follow up lifestyle and behaviour change activities), and the use of community champions to help recruit patients would be explored, especially where voluntary sector presence is low.

Age

The service would consider lowering the entry age to 30, but pilot this in high-deprivation areas only, due to limited evidence of benefits for those under 40.

Support for lifestyle changes

There would be improvement to the post-health check support to ensure easy / immediate access to social prescribers, consistent availability of lifestyle programmes, tailored gym/swim sessions, informal peer encouragement, and regular progress reviews (cholesterol, blood sugar).

Digital solutions and data recording

All sites would migrate to the Joy App for better referral monitoring and broader patient access to support options.