



Neighbourhood Working

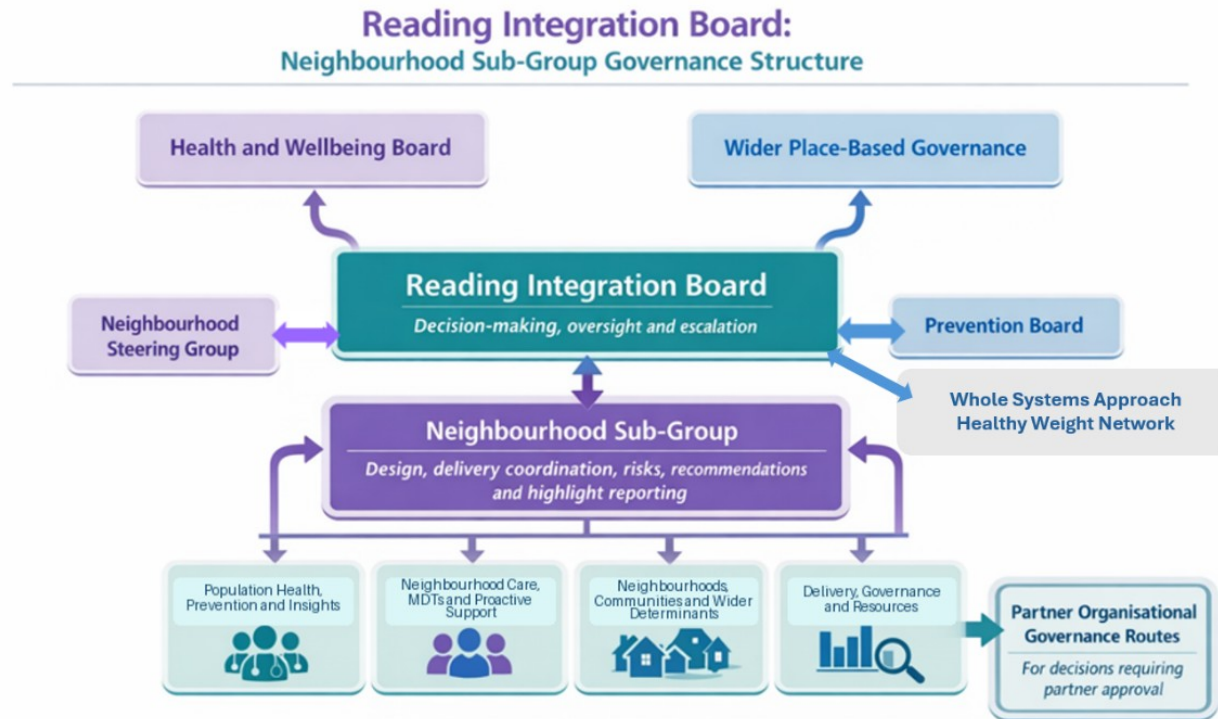
Update report to Reading Patient Voice Group

21st October 2026

Bev Nicholson, Integration Programme Manager

RIB Neighbourhood Sub-Group update

A Reading neighbourhood health subgroup has been established with Terms of Reference agreed. The aim of the group is to shape the local model, support development of Neighbourhood Plans, and avoid duplication with the Berkshire West task and finish group for Multi-Disciplinary Team (MDT) working and other pan Berkshire West groups.



Early discussion has confirmed the need to balance a consistent core offer across Reading with flexibility for neighbourhood-specific priorities.



What has been agreed...

- The group is focused on developing a practical Neighbourhood Health Plan that reflects local need, community insight and system priorities, incorporating learning to date from the Accelerator programme and Community Wellness Outreach, BHFT's Community First as well as successful schemes Terms of Reference have been agreed.
- **Purpose and alignment:** The subgroup will focus on the Reading local model while maintaining clear links with the Berkshire West workstreams.
- **Neighbourhood footprints:** Reading is likely to need four or five neighbourhoods, with boundaries shaped by community identity, service delivery and local intelligence. This work has started through Public Health and Healthwatch, working with the Community Health Champions and the Engagement Report will be shared with the sub-group to inform development of Neighbourhood Plans.
- **System partners:** Housing, public health, VCSE partners, primary care collaborative (including Pharmacy, Optometry and Dental– POD), community nursing, representatives of community voice groups, social care and are all central to effective neighbourhood working.
- **Meeting frequency:** Monthly meetings will be aligned to Reading Integration Board cycles to support timely updates, decisions and escalation. *(Thursday afternoon, second week of each month is currently most popular day/time).*



RIB Neighbourhood Sub-Group Progress

The plan is taking shape, with delivery dependencies still to resolve

- Neighbourhood Health will support Reading's three agreed priorities: Healthy Neighbourhoods, Best Start in Life, and All-Age Mental Health and Wellbeing. The aim is to develop the draft chapters for the Neighbourhood Health Plan by the end of October; bearing in mind competing pressures across the system.

Progress across the four workstreams

- **Evidence:** Partners need to validate draft Chapters 1 and 2 and agree priority themes.
- **Care:** Chapters 3, 4, 5 and 7 are in development. All-age mental health is a potential shared priority, and proactive care for frailty and complex needs is progressing.
- **Communities:** Chapters 8 and 9 are in development. Trained community conversation leaders will gather resident insight to inform priorities and delivery.
- **Delivery:** RIB oversees progress, reporting to the Berkshire West Neighbourhood Steering Group, ICB and Health and Wellbeing Board.

Immediate priorities and risks

- Clarify the Reading proactive care cohort, referrals, workforce and adult social care capacity, funding timing and evaluation. Align VCSE provision to avoid duplication.
- Use the October workshop to align workstreams, resolve dependencies and agree the route to a consolidated plan. Strengthen children and young people's representation and confirm future governance.
- Need to ensure opportunity for wider stakeholder engagement and routes to review and contribute to the developing plan once drafted.



Learning from SE Accelerator

The outcomes of the home visits clearly showed that this joint initiative resulted in effective actions being taken to support the 10 people seen (see summary below). One person felt they needed no further support and one person declined having initially agreed to contact. Some people required multiple aspects of support. All the cases had their Care Plans and ReSPECT forms reviewed. Some people were known to the Parish Nurse already but that was not reflected in the system. Majority of the needs identified involved Social Care / VCSE support.

SE Neighbourhood Accelerator: Home Visit Pilot - Summary Dashboard

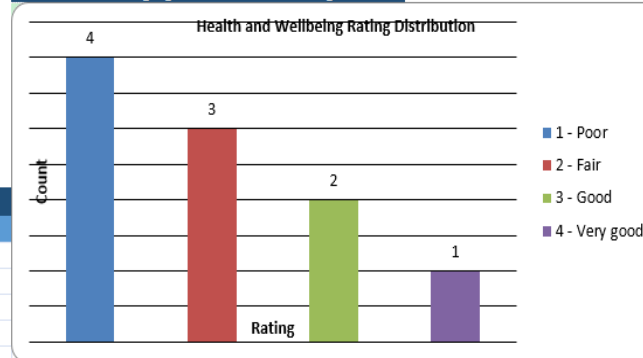
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Consent for records held: Yes	10
Consent for anonymised case study: Yes	10
Engaged with groups/community support: Yes	4
Follow-up required: Yes	4
Refusals to engage recorded	1

Health and Wellbeing Rating	
1 - Poor	4
2 - Fair	3
3 - Good	2
4 - Very good	1

ACTIONS TAKEN / REFERRALS MADE

Action category	Patients	Patient records
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Community / voluntary / group support	2	Patient 2, Patient 11
OT / home assessment referral	1	Patient 1
Housing management referral / advocacy	1	Patient 6
Therapy-dog support continued	1	Patient 2
Service engagement / records check	1	Patient 3
No further action / engagement declined	2	Patient 5, Patient 10

Confidence Managing Health and Wellbeing



Neighbourhood Health Workshop

Reading's draft vision is for everyone in Reading to have the opportunity to live a healthy, fulfilling and independent life, stay connected and access the right support as early as possible, wherever they live.

Partners at the Health and Wellbeing Board workshop on 23rd September 2026 discussed what residents should notice as a result:

- Help comes earlier, so fewer needs escalate.
- Support is joined up, and people tell their story fewer times.
- It is easier to connect with local services, activities and trusted community groups.
- People facing the greatest inequalities get a better experience and better outcomes.
- People feel more independent and connected and have a stronger sense of belonging.

Our priorities

Following feedback from multi-agency stakeholders, voluntary sector groups and Healthwatch, we envisage Neighbourhood Health as a key mechanism through which Reading will deliver the three priorities already confirmed by the Health and Wellbeing Board:

- **Healthy Neighbourhoods.** The priority most closely aligned to Integrated Neighbourhood Teams, covering adults with complex and long-term needs, prevention and joined-up local services.
- **Best Start in Life.** Integrated Neighbourhood Teams (INTs) for children and families, built around Family Hubs and linked to Best Start programmes, SEND reform and wider children's services.
- **All-Age Mental Health and Wellbeing.** Prevention, early help and mental health and wellbeing built into wider integrated teams, working with communities, schools, employers and families.



Our workstreams for developing the Neighbourhood Health Plan for Reading

#	Name	Workstream leads	Summary of purpose	Chapter leadership
1	EVIDENCE: Population Health, Prevention and Insights	Izzy Braithwaite	Understand need, inequalities and priority populations; develop the evidence base and data and intelligence arrangements, neighbourhood profiles, develop outcomes framework and ensure prevention focus.	1. Introduction, vision, principles & strategic context (WS3 as co-lead) 2. Population need and case for change 6. Priority populations and strategic priorities (WS 2 as co-lead) 12. Data, digital and health intelligence 13. Outcomes and evaluation (content lead), join with WS4
2	CARE: Neighbourhood Care, MDTs and Proactive Support	Natasha Ramnarine, Lucy Cunningham	To design the future care model and how neighbourhood health services will operate in Reading.	4. Future Model of Care 5. Three Reform Agendas 7. INTs and MDTs
3	COMMUNITIES: Neighbourhoods, Communities and Wider Determinants	Rachel Spencer, Alice Kunjappy-Clifton, Dayna White	Develop the Reading neighbourhood model (beyond NHS transformation), community engagement, development and wider determinants approach.	3. Our neighbourhood model (focus on footprints, assets, and wider determinants sections) - lead, with WS 2 as co-lead 8. Wider integration and system alignment (with WS 2 as co-lead) 9. Communities and inequalities
4	DELIVERY: Implementation, Governance and Resources	Bev Nicholson, Anu Holman	To design and agree the governance, commissioning, financial, workforce arrangements needed to implement Neighbourhood Health in Reading.	10. Governance 11. Commissioning and finance 13. Outcomes and evaluation (delivery and performance lead) 14. Implementation and delivery



Workstream 1 Progress

Workstream 1: Understanding Need and Place

Purpose: Build a shared evidence base describing Reading's neighbourhoods, population needs and inequalities.

- **Progress:** Early drafts of Chapters 1 and 2 have been developed using Joint Strategic Needs Assessment evidence and initial Health and Wellbeing Board workshop feedback.
- **Current focus:** Strengthening the high-level quantitative picture, incorporating adult social care evidence and using interim Connected Care neighbourhood profiles while the fuller population health dashboard is developed.
- **Key dependency:** Maintaining a clear boundary with Workstream 3, which will provide deeper community insight and shape the response to wider determinants.
- **Next steps:** Partners to review the draft chapters, correct gaps and agree the core evidence and priority themes at the October workshop.

Board message: The evidence base is taking shape; the immediate priority is to validate it across partners and turn data into a clear, shared account of place, informing the development of a dashboard to show progress in addressing identified needs.



Workstream 2 Progress

Workstream 2: Neighbourhood care, MDTs and proactive support

Purpose: Translate the evidence into a focused set of neighbourhood priorities and practical models of integrated delivery.

- **Progress:** The first workstream meeting identified all-age mental health as a potential cross-cutting priority, alongside family hubs and best-start approaches. Chapters 3, 4, 5 and 7 are being developed using the Berkshire West paper and emerging local evidence.
- **Delivery development:** The Berkshire West Proactive Care Service is progressing, targeting people with frailty and complex needs through coordinated health, adult social care, housing, VCSE and primary care support.
- **Key risks:** The Reading cohort, referral volumes, adult social care capacity, workforce requirements, funding timing and evaluation framework require clarification. Existing VCSE provision must be aligned to avoid duplication or increased demand without additional capacity.
- **Next steps:** Use the all-age mental health needs assessment, bring wider partners into chapter development and confirm the proactive care operating and evaluation model.

Board message: Priority-setting is moving forward, but sustainable delivery depends on agreed pathways, capacity, resourcing and measurable outcomes.



Proactive Care Model: Frailty and Complex Care focus

The service at a glance

Keep-well support for a defined high-need cohort before crisis

1 Identify

Connected Care /
System Insights
PNG 10–11 + recent
hospital use

2 Validate

Clinical review of
need,
existing services and
priorities

3 Active PCS

~1,000 pts
proactive caseload
management

4 Intervene

Clinical + social + VCSE
action
home visit where
needed

Core team

Frailty GPs
SCDM

Prescribing
paramedics

Care
coordination

Geriatrician
Clinical Lead

ASC + VCSE
links

PCA Remote Monitoring

Separate high-risk cohort, with pts stepping up
into PCS when need increases and stepping down
again when stable.

What is different?

Not SDEC, not UCR and not routine GP visiting.
Active caseload management before pts tip into
crisis.



What are we trying to achieve?

Clinical / system

Fewer ED attendances and non-elective admissions
Less repeat hospital use / avoidable escalation
Reduced UCR / SDEC escalation where appropriate
Length of stay / bed days tracked

Social care / VCSE

Need identified and addressed
ASC reassessment / reconnection where required
Carer, practical and community support
Loneliness / social isolation outcomes

Evaluation

Matched comparator using System Insights
Patient and carer experience
3, 6, 9 and 12-month review points
Refine cohort / resource based on evidence

Year 1: measurable reduction in urgent / emergency care use, with learning built in from day

1.



Workstream 3 Progress

Workstream 3: Neighbourhoods, Communities and Wider Determinants

Purpose: Embed resident insight, community assets and wider determinants in the neighbourhood plan and its delivery.

- **Progress:** Chapters 8 and 9 are in development, with stakeholder sessions being arranged to map existing routes for resident, patient and community voice and capture case studies of neighbourhood working already under way.
- **Engagement:** Community conversation leaders have completed training and will gather resident insight over the coming month. Learning will be shared at a celebration and feedback event ahead of final plan consideration by the Health and Wellbeing Board.
- **Approach:** Public engagement will use the accessible “healthy neighbourhoods” narrative, while retaining alignment with the national neighbourhood health framework. Equity will be embedded throughout, supported by an appropriate Health Observatory checklist.
- **Next steps:** Confirm stakeholder session dates, secure accessible local venues and resources, connect community insight to governance and decision-making, and explore a wider neighbourhood launch event.

Board message: The engagement infrastructure is in place; the next task is to convert community insight into visible influence over priorities, design and delivery.



Community Conversations – what did we find out?



Connection



Trust &
Inclusion



Communicatio
n



Place

Many of the resources that support healthy neighbourhoods already exist.

The priority is helping people connect with them and with each other.

Workstream 3 – Learning from Engagement

Healthy Neighbourhoods Community Conversations Pilot 03/06/2026

What residents told us

- Healthy neighbourhoods are built on **connection, trust, safety, inclusion and clear communication**.
- Reading has strong community assets—faith groups, cafés, libraries, local businesses, activities and informal networks—but awareness and access are inconsistent.
- Key barriers include **social isolation, limited time, low trust, poor visibility of support, transport challenges and unequal access between communities**.
- Proposed neighbourhood footprints did not always feel recognisable; participants favoured **smaller, locally meaningful areas**, with North, South, East, West and Central suggested.

Learning from the pilot

- Community conversations work best with **up to six participants, 2–3 focused questions, trained facilitators, two note-takers and dedicated time management**.
- Accessibility, consent, inclusive facilitation and transparent communication about how feedback will be used are essential.

Proposed next steps

- Map and promote existing community assets through **clear, trusted local communication channels**.
- Train Community Health Champions and community leaders as facilitators, supported by Public Health and Healthwatch note-takers.
- Confirm resources and schedule wider community conversations.
- Feed emerging insight into the **Neighbourhood Working Group and Berkshire West Neighbourhood Steering Group**, including further work on neighbourhood footprints.

Board message: The next phase of engagement should ensure community insight directly informs neighbourhood development and resource planning.



Complexities around defining footprints - no perfect solution?

1 Differently aligned geographies / 'layers'

GP catchments, PCNs, wards, schools, housing and community identities do not align neatly.

2 Different purposes

The geography needed for community insight may differ from clinical or specialist arrangements.

3 Flexible at the boundaries

Residents and services will cross boundaries; rigidity could add complexity.

4 Identity and equity

Population balance must be considered with identity, deprivation, transport and access.

5 Evidence and legitimacy

Further primary care and community input is needed before final endorsement.

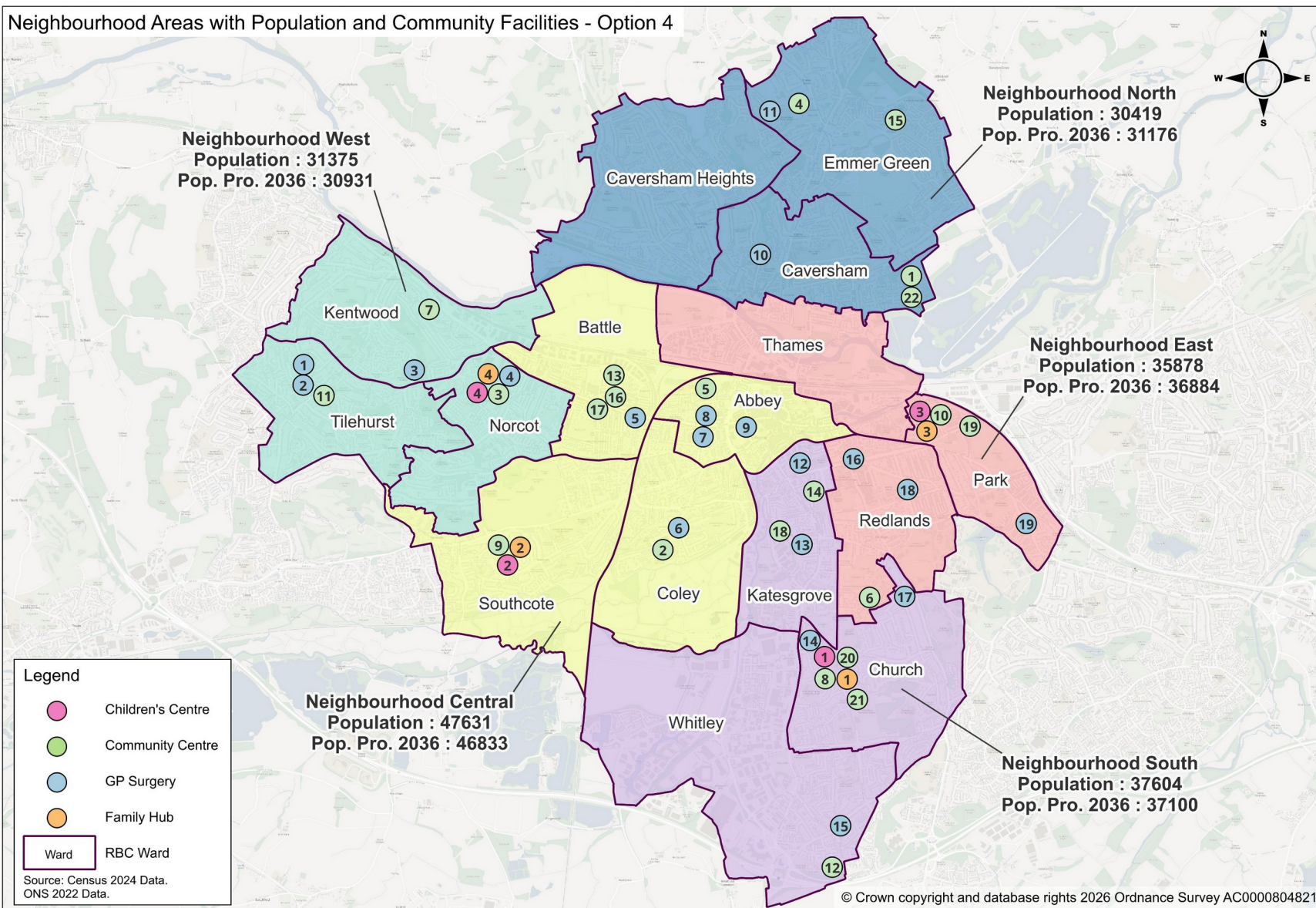
6 Implementation risk

New geography should simplify joint action, not create another organisational layer.

Key principle to test: a common core geography, with purposeful flexibility across its edges.

Emerging footprint recommendation

Neighbourhood Areas with Population and Community Facilities - Option 4



Workstream 4 Progress

Workstream 4: Delivery, governance, resources and infrastructure

Purpose: Establish the governance, leadership and enabling conditions required to deliver neighbourhood working at scale.

- **Progress:** The workstream has met once. The current accountability route is through the Reading Integration Board, with onward reporting to the Integrated Care Board and Health and Wellbeing Board.
- **System alignment:** Engagement with Primary Care Network clinical directors is progressing, with broad support for working within the agreed neighbourhoods. Messaging is focused on practical benefits while providing reassurance that current local work does not change general practice or PCN structures.
- **Key enablers:** Workforce, finance, culture and new ways of working will require phased short-, medium- and long-term planning. Better Care Fund and Thames Valley Innovation Fund resources are supporting elements of delivery. Engagement with Moorhouse/NAPC support can be used where workstreams need challenge or comparative expertise.
- **Gaps and next steps:** Strengthen children and young people's representation; confirm future governance as the ICB context develops; use the October workshop to align workstreams, resolve dependencies and agree the route to a consolidated plan.

Board message: Governance is established, but the programme now needs stronger alignment of leadership, workforce, finance and partner representation to move from planning to sustained delivery.



Other programmes linked to Neighbourhood Working

Community Health and Wellbeing Workers – supporting whole households in specific areas of deprivation

Creating enabling environments for CHWW to be truly community-centred

Optimizing impact of CHWW Programmes as an EXAMPLE of how the 'descriptors' can be used to help create enabling environments for any community-centred approach



CHWWs are part of a neighbourhood health ecosystem – to optimize impact, they will need to

- Follow the evidence base: 30 years experience: RTC outcomes coming soon
- Tackle wider determinants: gain trust & connect people into community support & activities
- Dovetail with community development: identifying & nurturing needs & strengths
- Upwards influence: using insights & community ideas to influence & inform neighbourhood health pathways & activities

SO THE BIG QUESTION?

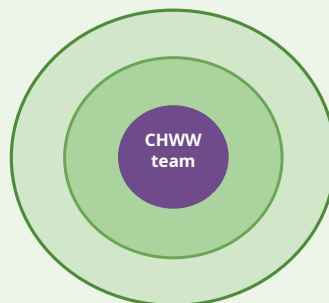
Not only “How do we support implementation of CHWW programmes?”
But “How can we help create the conditions to optimized the impact of CHWWs by embedding it in wider community development & engagement?”

WHAT WE HEARD

- 1 Build on what is already there**
Map and design with community assets, VCSE infrastructure and existing community roles.
- 2 Connect, do not duplicate**
Clarify interfaces with connectors, champions, social prescribers, local area coordinators and community development.
- 3 Trust, support & sustainability**
Multi-year investment, with measures that reflect the time needed for development work & to build trust
CHWW JDs incorporates community development but also support & infrastructure to enable system influence
- 4 Integrate insight with action**
Ensure support & infrastructures enables routes for community insight & actions to shape priorities, co-design solutions and inform decisions within neighbourhood health

THE ENABLING ENVIRONMENT

A strong CHWW model needs a receptive system around it



SYSTEM CONDITIONS

Governance • leadership • resources • mechanisms to act on insight

RELATIONSHIPS & LEVERS

NHS • local authority • VCSE • integrated teams • community development

DELIVERY & TRUST

Evidence-based model • supported workforce • strong community relationships

KEY TENSIONS TO HOLD

- 1 Delivery organisation vs enabling environment**
- 2 Programme delivery vs system transformation**
- 3 Outward reach vs inward receptivity**

CHWW leads cannot create a receptive system alone.

WHAT CAN NETWORK MEMBERS AND PARTNERS DO?

1

Inform

Use local insight to shape priorities and design.

2

Champion

Make community voice visible and influential.

3

Connect

Link CHWWs with services, groups and assets.

4

Collaborate

Create space to solve local issues together.

5

Embed

Build formal routes into governance and decisions.

6

Learn & act

Remove barriers and use learning to improve.

The impact of CHWWs depends not only on the model itself, but on the strength of the neighbourhood health system that surrounds it.



Thank you – Any questions?

- Opportunities to engage
- Key themes to feed back
- Timelines
- What else?

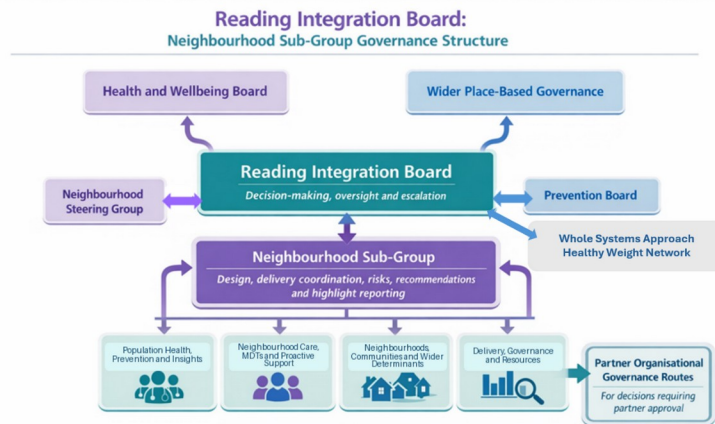
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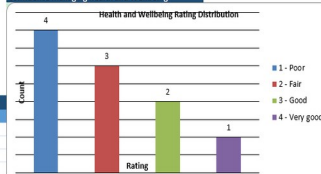
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Proactive Care Model: Expected outcomes

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Primary Care Alliance CIC | Proactive Care Service



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Communication



Place

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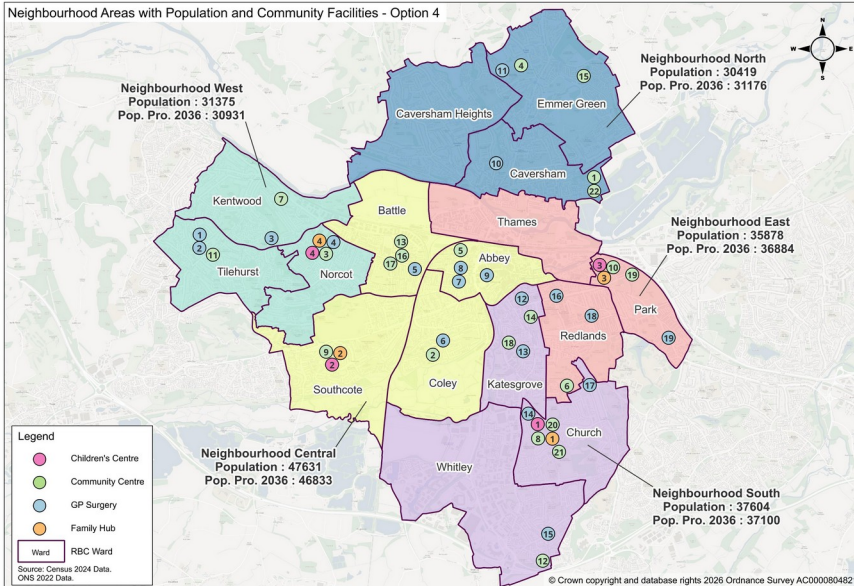
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