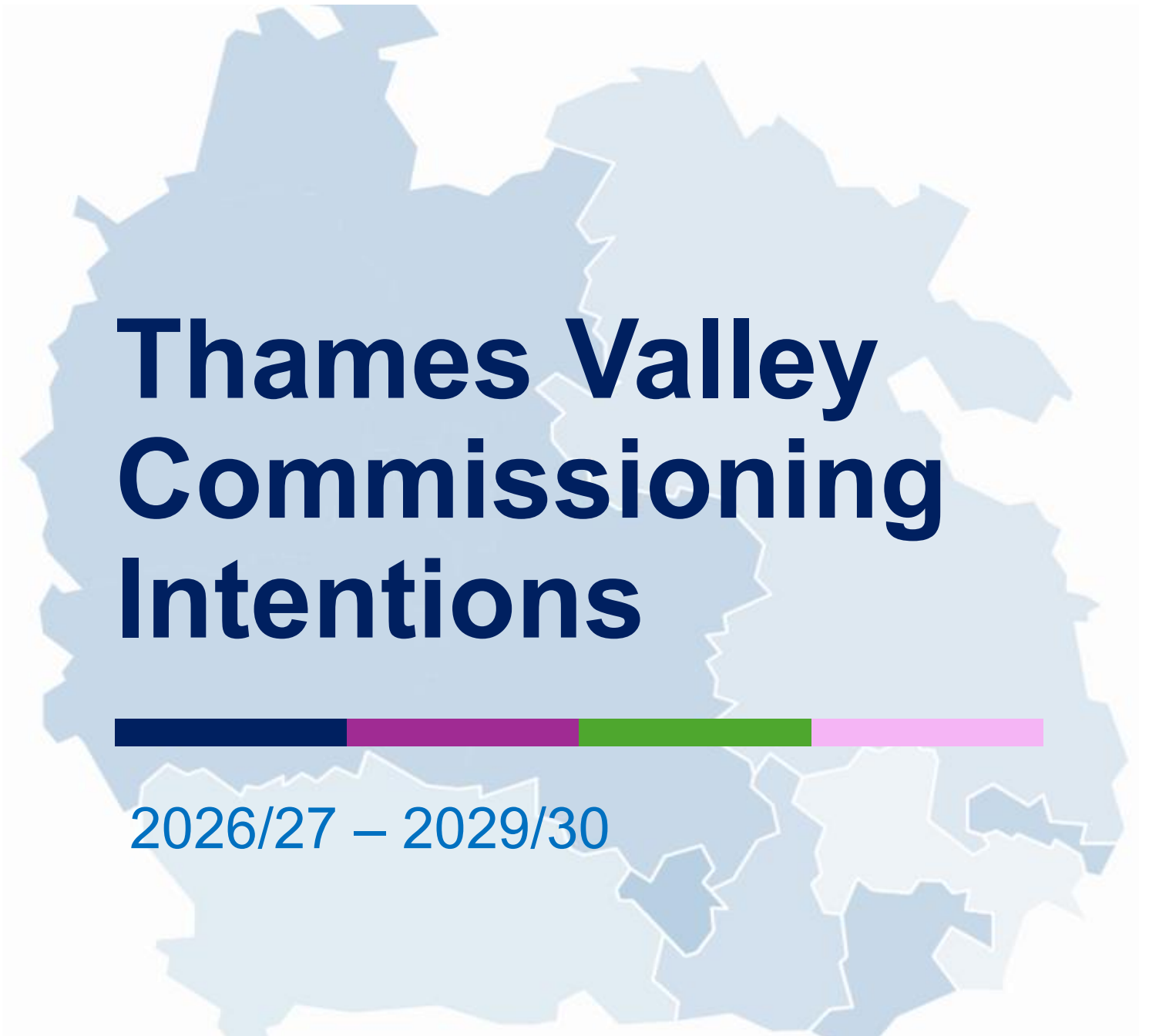

Thames Valley Commissioning Intentions

2026/27 – 2029/30

Contents

Introduction

Thames Valley Integrated Care Board will be formally established in April 2026 to serve the 2.5 million people who live across Berkshire, Buckinghamshire and Oxfordshire. It will exist to improve the health of the Thames Valley population by identifying how best to use the health budget of £5.6 billion to improve outcomes, reduce the inequalities people face and ensure that everyone can access consistently high-quality services, whichever neighbourhood they live in.

We will work as a strategic commissioner, determining across the Thames Valley what services should be delivered and what outcomes they should achieve. We will be guided by the principle of maximising value – achieving the best possible outcomes for our population, at the lowest possible cost. We will also be driven by a focus on equity, seeking to ensure that all our residents experience equity of access and outcome.

To deliver our vision of equitable outcomes at neighbourhood level, within a system which maximises healthcare value, we will need to set in train a series of changes to how we organise and deliver care. In line with the Government's 10 Year Health Plan, we will focus on shifting care out of hospital and into the community, investing in prevention and mainstreaming digital and data enabled services to improve access and experience. To narrow health inequalities, we will differentially invest in improving the outcomes and experience for our residents who are currently experiencing the poorest outcomes.

We have worked at pace to distil a wealth of feedback from our partners across health, local government, VCSE and the wider Thames Valley system; insights from our residents on what needs to change, alongside input from our teams across the existing BOB and Frimley ICBs, who have come together to define a shared vision for the future.

Across these different groups, there is strong consensus of a Thames Valley health and care system which improves population outcomes, narrows stark inequalities and makes services more accessible and easier to navigate. There is also universal recognition of the need to actively build a proactive and preventative new model of care which integrates services around our residents and delivers as much as possible locally in the neighbourhood settings where they live.

As we prepare to commission healthcare services on a Thames Valley basis from April 2026, this document sets out the outline strategic objectives which will frame our commissioning decisions over the next three years. It covers the following areas:

- **Where we are** – what we know about our population's health today and in the future; the quality and performance of our existing provision and our financial context.
- **Where we are going** – our strategic objectives to deliver improved value, build neighbourhood health and prioritise prevention.
- **How we will work** – measuring what matters; investing in change and working in partnership.

1 Where we are

What we know about our population, our services and the sustainability of our health and care system

01 Understanding our population and communities

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01 Understanding our population and communities

What do we know about our Thames Valley population?

To ensure that our commissioning intentions are grounded in insights about our population and their health, we have assessed the needs of the Thames Valley population today and modelled how it is likely to change over time, identifying our underserved communities and surfacing the often-hidden inequalities that are present.

To do this, we have analysed:

- **Joint Strategic Needs Assessments** (JSNAs) from across the Thames Valley geography to identify key themes.
- Our **population's health profile and residents' individual needs** using the Johns Hopkins Segmentation methodology to understand the current population needs across different population segments, grouped according to patterns of similar need.
- **Shared care record data** using our Thames Valley and Surrey (TVS) population health analytics and intelligence platform and Connected Care System Insights to generate insights and projections.

From this work, we have identified three key headlines:

- Our population is generally less deprived compared to the rest of England and is generally in good health.
- We have areas of considerable deprivation, such as Slough, Reading, Oxford City, Banbury, High Wycombe and Aylesbury and there are also many smaller areas of deprivation which can lead to hidden inequalities across our geography.
- Our most deprived populations have significantly lower life expectancy and healthy life expectancy than our less deprived areas, which is also reflected in their higher prevalence of long-term conditions.

What we know about inequality

We serve a geography and population who are generally in good health. The current Thames Valley population of nearly 2.5 million people is older than the national average, with 19% of the population aged 65 years or older. Life expectancy and healthy life expectancy are higher across our geography than the UK average. However, this masks hidden inequalities and there is significant difference in both life expectancy and healthy life expectancy between the most and least deprived communities.

Figure 1 shows this variation at local government level. For example, in the neighbouring local authorities of Slough and Windsor and Maidenhead, there is nearly a nine-year gap in healthy life expectancy and a four-year gap in life expectancy. Even these figures mask greater inequalities experienced at community level; in neighbouring wards in Oxford, which are only a few bus stops apart, there is a ten-year difference in life expectancy, emergency hospital admission rates are more common, and obesity prevalence is higher. These factors all risk poorer health outcomes.

Deprivation

Overall, 45% of the Thames Valley registered population live in the 20% least deprived areas nationally. Whilst the Thames Valley has areas of great affluence, it also has wards which feature in the 20% most deprived nationally.

The ‘Core20’ population refers to the 20% most deprived of the national population, as defined by the national Index of Multiple Deprivation (IMD). The most deprived areas of the Thames Valley can be found in Reading, Oxford, Slough and Banbury.

Only 3% of our local population live in IMD Quintile 1 (greatest deprivation), whereas this jumps to 16.3% when including both IMD Quintiles 1 and 2. High Wycombe and Aylesbury in Buckinghamshire are two example areas experiencing high levels of deprivation without fitting into the national Core20 definition.

	Males		Females	
	Life expectancy	Healthy life expectancy	Life expectancy	Healthy life expectancy
Windsor and Maidenhead	81.3	67.5	85.1	68.9
Oxfordshire	81.3	67.0	84.9	68.3
West Berkshire	81.3	67.2	84.6	68.1
Buckinghamshire	81.2	65.1	84.9	65.9
Reading	78.8	66.4	83.2	62.6
Wokingham	82.5	70.9	85.6	71.2
Bracknell Forest	81.0	64.9	84.9	66.3
Slough	77.1	58.7	82.0	59.8
Gap	**5.4**	**12.2**	**3.6**	**11.4**

Figure 1. Life expectancy and healthy life expectancy 2021-2023 for TV local authority areas (years)

Place name	1 - Most deprived 20% Nationally	2	3	4	5 - Least deprived 20% Nationally
Wokingham	0%	4%	3%	9%	82%
Buckinghamshire (Phoenix & The Chilterns)	0%	2%	7%	33%	56%
Buckinghamshire (Arc)	0%	1%	12%	18%	67%
South Oxfordshire	0%	3%	11%	19%	67%
West Oxfordshire	0%	6%	8%	28%	59%
Royal Borough of Windsor and Maidenhead	0%	5%	14%	19%	59%
Buckinghamshire (South of Bucks)	0%	2%	15%	32%	48%
Vale of White Horse (Oxfordshire)	1%	0%	6%	33%	60%
Buckinghamshire (North of Bucks)	0%	1%	12%	42%	42%
West Berkshire	1%	2%	14%	40%	40%
Bracknell Forest	0%	6%	25%	27%	41%
Buckinghamshire (Aylesbury)	1%	22%	12%	26%	36%
Cherwell (Oxfordshire)	6%	9%	22%	33%	30%
High Wycombe	0%	18%	32%	18%	30%
Oxford	12%	16%	21%	25%	27%
Reading	7%	30%	22%	14%	25%
Slough	8%	53%	23%	14%	1%
Total	**3%**	**12%**	**15%**	**23%**	**45%**

Figure 2. Proportion of population living in each deprivation quintile by place across Thames Valley geography

Figure two shows that, in Oxford, Aylesbury, Slough and Reading, between 20-60% of the population live in the 40% most deprived areas nationally. This contrasts with Wokingham where 82% of the population live in the 20% least deprived areas nationally. However, given the aggregation of this data, across the Thames Valley there are significant pockets of deprivation and poorer outcomes which can be hidden in the general picture.

Data also shows that within the Thames Valley, deprivation and inequality can significantly impact people’s lives:

- **School Readiness -** Across the Thames Valley, school readiness varies significantly, with some areas falling well below the national average. For example, in Slough, only 65% of children achieved a good level of development by the end of reception, and 69% in Reading. In comparison, the national average across England is 71%. In contrast, more affluent areas report higher rates of school readiness, highlighting inequalities even within small geographical areas. Local authority JSNAs also note that children eligible for free school meals consistently perform worse in early years development; the percentage of children in Oxfordshire and West Berkshire performing worse than the national average.

- **Access to healthcare -** Across our JSNAs we see that people living in areas of higher deprivation tend to access healthcare later in the progression of disease. This delay often results in poorer health outcomes and increased healthcare costs. For instance, the Berkshire East JSNA highlights that delayed engagement with services in deprived areas can lead to significant additional costs, especially for long-term conditions such as diabetes and cardiovascular disease. From other local analysis we can see that people who live in the most deprived areas are twice as likely to be readmitted to hospital within 30 days of discharge than those in more affluent areas.
- **Progression of Ill Health -** Data from the JSNA summaries show that individuals in the most deprived wards of Slough and Reading develop serious health conditions 10-15 years earlier than those in more affluent areas such as Windsor or Wokingham. This includes earlier onset of chronic diseases such as chronic obstructive pulmonary disease (COPD), hypertension and mental health disorders.
- **Emergency Service Usage -** Across the Thames Valley we see higher emergency service usage for those living in the most deprived areas. For example, in Berkshire, the 2% of the population living in the most deprived areas – particularly in Slough and parts of Reading and Oxford – are disproportionately higher users of emergency services. This includes increased A&E attendances and ambulance callouts, often linked to unmanaged chronic conditions and lack of access to primary care. Children and young people living in the most deprived areas in Buckinghamshire have higher rates of emergency admission to hospital for chest infections and accidents. In Leys in Oxford, emergency hospital admissions for all causes are the highest in Oxfordshire and emergency hospital admissions for self harm are three times higher than Oxfordshire and England averages.

In addition to looking at deprivation we have also explored areas of other health inequalities such as Health Inclusion Groups; the ‘Plus’ element of the Core20Plus programme.

Throughout the Thames Valley system, we have identified groups such as carers, homeless, people with learning disabilities, formerly in military service, refugees and asylum seekers and prisoners. These individuals face multiple intersecting risk factors for poor health, including poverty, discrimination, complex trauma, and substance dependence, which lead to higher rates of illness, shorter life expectancies, and barriers to accessing healthcare services.

Inclusion health groups are hard to quantify as they often remain unrecorded / coded in the data. Current data suggests that these communities account 8% of our population.

Findings suggest that the average age of death for people experiencing homelessness is 43 for women and 45 for men, much lower than the national average of closer to 80. In addition, within the homeless population, the number of people with a mental health diagnosis in 2021 was 82%, they are 34 times more likely to have tuberculosis and six times more likely to present with heart disease. This has a profound onward impact on their health service utilisation, resulting in this group being six times more likely to attend A&E, four times more likely to be admitted into hospital and three times as long to have a long inpatient stay in hospital.

Prevalence

In the Thames Valley overall, prevalence for conditions such as cancer and atrial fibrillation are above the national average, with cardiovascular disease prevalence growing at a quicker rate, as outlined in figure 3. When controlling for age and sex, prevalence is significantly higher in deprived areas for a wide range of long-term conditions. For example, at small community level (LSOA):

- COPD is more than three times as common in the most deprived versus least deprived areas (3.25% vs 0.97%) and diabetes is over twice as likely (9.98% vs 4.64%).
- We also see slightly lower rates of cancer diagnosis in deprived areas. This aligns with national trends that people from the most deprived areas are often diagnosed at a later stage of disease progression.

Conditions		Cardiovascular disease						Respiratory diseases		Other			
		AF	CHD	HF	HYP	PAD	S/TIA	Asthma	COPD	Obesity	Cancer	Dementia	Depression
Buckinghamshire	Arc	2.9%	3.2%	1.1%	15.3%	0.5%	2.1%	6.0%	1.1%	8.8%	4.8%	0.8%	1.2%
	Aylesbury	2.0%	2.7%	0.8%	13.5%	0.4%	1.5%	6.7%	1.3%	11.9%	3.4%	0.7%	1.5%
	High Wycombe	1.6%	2.5%	0.7%	13.1%	0.4%	1.6%	6.3%	1.1%	11.5%	2.9%	0.7%	1.3%
	Phoenix & The Chilterns	2.8%	3.1%	1.0%	15.4%	0.4%	1.9%	6.9%	1.1%	7.7%	4.9%	0.8%	1.0%
	South of Bucks	2.8%	3.4%	1.1%	16.2%	0.5%	2.0%	6.2%	1.3%	9.8%	4.6%	1.0%	1.3%
	The North of Bucks	2.8%	3.0%	1.1%	16.6%	0.5%	1.7%	6.8%	1.4%	10.1%	4.5%	0.6%	1.8%
Oxfordshire	Cherwell	2.2%	2.5%	1.0%	13.7%	0.5%	1.9%	6.4%	1.4%	12.7%	4.3%	0.7%	1.1%
	Oxford	1.3%	1.6%	0.6%	9.1%	0.3%	1.2%	4.7%	1.0%	7.3%	2.7%	0.5%	1.0%
	South Oxfordshire	2.7%	2.6%	1.1%	14.8%	0.5%	1.9%	6.9%	1.4%	10.8%	4.8%	0.8%	1.2%
	Vale of White Horse	2.6%	2.7%	1.1%	15.2%	0.5%	2.4%	6.8%	1.5%	13.0%	4.8%	0.8%	1.1%
	West Oxfordshire	3.0%	2.9%	1.3%	17.2%	0.5%	2.1%	7.1%	1.5%	12.8%	5.3%	1.1%	1.2%
Berkshire West	Reading	1.4%	1.8%	0.8%	12.0%	0.3%	1.2%	5.4%	1.1%	10.6%	2.6%	0.5%	1.1%
	West Berkshire	2.4%	2.5%	1.1%	15.3%	0.4%	1.7%	7.2%	1.5%	11.6%	4.2%	0.8%	1.0%
	Wokingham	2.2%	2.3%	1.0%	13.5%	0.3%	1.5%	6.3%	1.0%	8.8%	3.9%	0.8%	0.9%
Berkshire East	Bracknell Forest	1.9%	2.4%	0.8%	14.4%	0.4%	1.4%	6.1%	1.2%	12.8%	3.5%	0.6%	1.9%
	RBWM	2.3%	2.8%	1.2%	13.8%	0.4%	1.7%	5.8%	1.1%	9.3%	4.0%	0.9%	1.4%
	Slough	1.0%	2.6%	0.8%	12.4%	0.3%	1.1%	5.4%	0.9%	16.1%	1.9%	0.4%	1.5%
National		**2.2%**	**3.0%**	**1.1%**	**14.8%**	**0.6%**	**1.9%**	**6.5%**	**1.9%**	**12.8%**	**3.6%**	**0.8%**	**1.5%**

Figure 3. Disease and condition prevalence by Thames Valley area compared with average deprivation (IMD)

Understanding our population according to need and use of healthcare resources

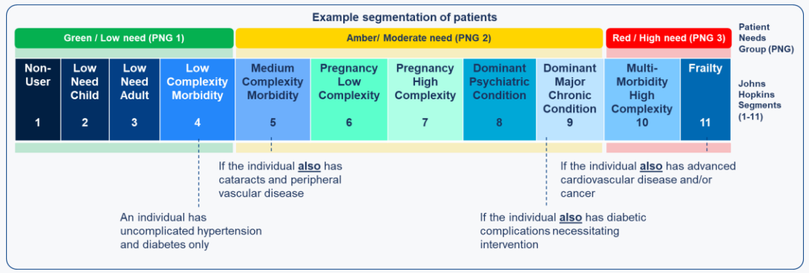
Using John Hopkins Segmentation

Across Thames Valley, we can understand more about our patients' needs and how people use our healthcare services through linking data across our acute, mental health, community and primary care services. This is collated in the Thames Valley and Surrey (TVS) shared care record.

Using the Johns Hopkins ACG (adjusted clinical groups) system we can describe cohorts of patients based on the complexity and acuity of their healthcare needs. This approach is an analytical technique to help understand how disease and morbidity are distributed within a population.

The purpose of the approach is to group segments of a population who share similar needs and will benefit from the similar types of intervention or treatment. The resulting analysis can inform the design of care to help achieve the aims of improved quality, better outcomes and lower cost.

We have understood and modelled our population according to the 11 Johns Hopkins patient needs group (PNG) segments which allows a better understanding of variation and resource use across different points of delivery, and to forecast how healthcare trends could impact future resource need.



What segmentation of our population tells us

- As people get older, their complexity and level of need also both increases as shown by the green, yellow and red groupings shown in figure four.
- Using QOF (Quality and Outcomes Framework) registers it is possible to see this trend more clearly, that people in the higher need groups have greater prevalence of comorbidities and conditions such as hypertension, cancer, coronary heart disease and COPD compared to patients in the Moderate Need group.
- This analysis outlines the case for us to support our Thames Valley population to stay well, and slow the progression of ill health, and where possible develop models of care that provide more proactive, accessible support that reduces people's need for our most acute services.

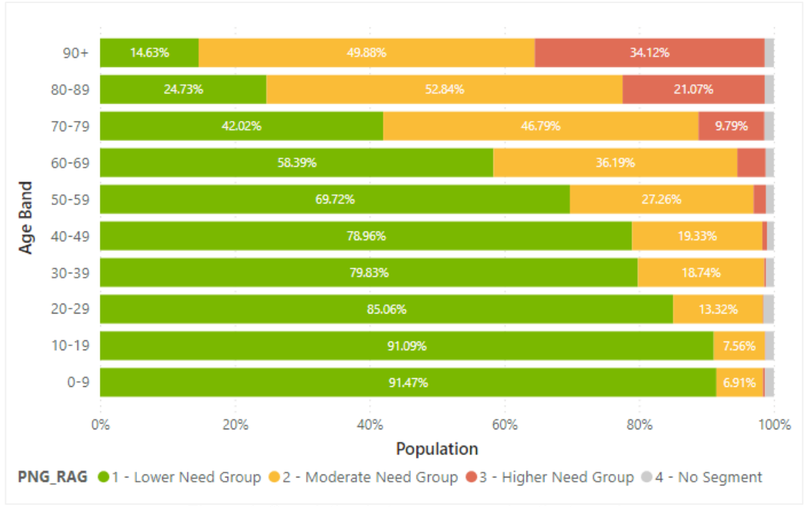


Figure 4. Correlation between age and patient need

Age band	Non-User	Low Needs	Low Complexity Morbidity	Medium Complexity Morbidity	Pregnancy Low Complexity	Pregnancy High Complexity	Dominant Psychiatric Condition	Dominant Major Chronic Condition	Multi-Morbidity High Complexity	Frailty
0-17 Pop: 411k Total cost: £340m	£3.1m	£163.8m	£76.5m	£37.5m	£199K	£8K	£19.4m	£26.6m	£12.8m	
	21.2k	401.1k	60.9k	18.1k	128	11	6.0k	13.6k	1.7k	
	0.9%	17.7%	2.7%	0.8%	0.0%	0.0%	0.3%	0.6%	0.1%	
	0.1%	6.3%	3.1%	1.5%	0.0%	0.0%	0.7%	1.0%	0.5%	
18-64 Pop: 1.1m Total cost: £1.3bn	£7.2m	£156.6m	£245.4m	£216.3m	£77.5m	£22.4m	£126.1m	£299.0m	£158.6m	
	67.8k	694.8k	315.5k	108.2k	24.2k	4.1k	41.6k	97.6k	13.6k	
	3.0%	30.7%	13.9%	4.8%	1.1%	0.2%	1.8%	4.3%	0.6%	
	0.2%	6.3%	9.1%	7.9%	2.7%	0.7%	4.2%	10.3%	5.6%	
65+ Pop: 314k Total cost: £1.2bn	£6.8m	£31.4m	£106.2m	£293.6m			£26.9m	£239.0m	£298.1m	£148.6m
	7.8k	56.8k	92.8k	108.9k			8.1k	54.0k	35.5k	11.3k
	0.4%	2.5%	4.1%	4.8%			0.4%	2.4%	1.6%	0.5%
	0.2%	1.1%	3.7%	10.3%			0.9%	8.3%	10.6%	4.7%

Proportion of pop. | Population of segment | Proportion of spend

Figure 5. Population profile and resource utilisation baseline as modelled for 2023/24

24% of the population who are in the medium and high complexity segments account for **70% of all resource use** in the Thames Valley.

Even more starkly, the **2.7% of the population** who have the most acute needs account for **21% of all resource use.**

02 Understanding our financial context

Thames Valley ICB (TV ICB) will receive in the region of £5.6 billion in 2026/27 to provide a broad range of primary, secondary and specialised services for our population.

- Having financially sustainable organisations is a fundamental requirement for all health systems. This priority is best achieved through partnership focussing on maximising the value that can be delivered for our population from our finite funding envelope.
- Recent analysis has concluded that the ongoing resource commitments for the Thames Valley health system exceed the level of national funding allocated to the system and, without action to reduce costs, we will breach our statutory duties to break even.
- Integrated Care Boards have a statutory duty to remain within their allocated annual funding envelope and so, as we progress, we will need to enact appropriate changes to ensure that we only commission within the funding envelope we have. We must allocate our resources optimally to meet the needs of our population both today and in the future.
- Historically our system's deficit position has been managed on an annual basis and has been supported in part by national deficit support funding. This funding is now being phased out and the system will need to take collective action to recover this position and return to sustainable financial balance.

Current commissioning landscape

The commissioning environment across the system has changed significantly in recent years, often focused on short-term planning and in-year financial performance. This, coupled with the legacy arrangements from Clinical Commissioning Groups, has led to different funding and service models commissioned across Thames Valley, contributing to variation in the outcomes experienced by our population.

Analysis of existing contracts and block arrangements

As part of an NHS England exercise, we have analysed the existing block contract arrangements in our system that were established as part of the national response to the Covid-19 pandemic. Whilst this contractual environment was necessary, over time it has worked to loosen the direct connection between activity and payment.

We are collaborating with provider colleagues to re-establish a common, agreed view of the current activity and services, within the overall contract envelope. This will be crucial in enabling the system to have an aligned view of services being delivered across our system within our current financial baseline, alongside a clear picture of the income flows into and out of the Thames Valley system.

2025/26 planned spend breakdown

- Figure 6 shows the basis of how the funding for 2025/26 has been planned to be allocated for the existing Thames Valley geography.
- This includes acute, mental health, community, specialised and primary care services to address the needs of our population.
- The chart provides a breakdown per sector and, while the actual spend throughout the year may vary slightly, it shows that we plan to spend a significant amount on services provided in the acute sector.
- 46% of the total budget is allocated to hospital providers, with 10% to primary care, 9% to community services and 9% to mental health services.
- Of the total funding received, most is spent on services within the Thames Valley across NHS, independent sector, local authority, voluntary sector and primary care.
- Approximately £0.5 billion is spent on services for our residents which are delivered outside of the Thames Valley system.

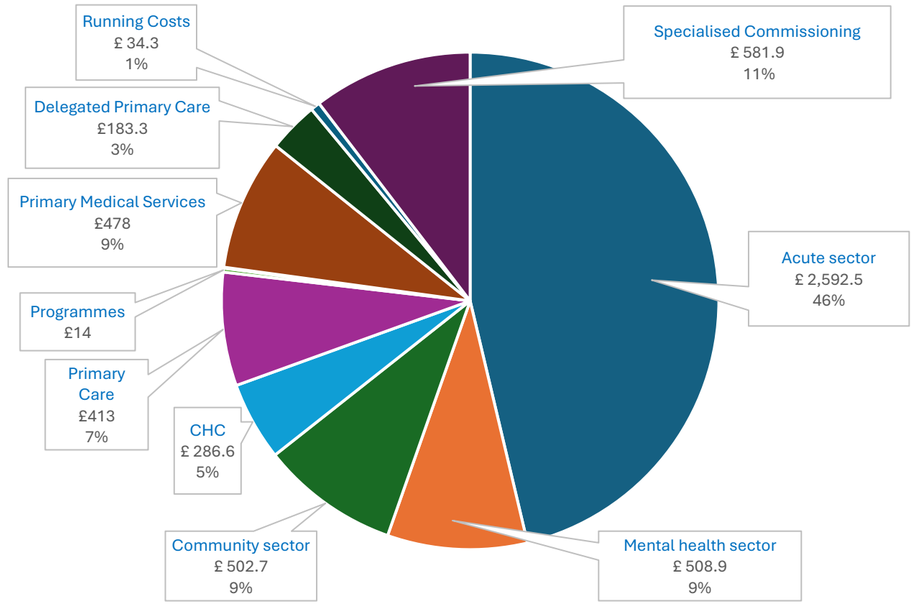


Figure 6. Thames Valley geography planned expenditure 25/26 (in £ millions)

03 Reviewing existing provision

Over the past four years since the pandemic, the Thames Valley system has taken steps to recover services and meet rising demand.

Primary care
Primary care is delivering more than ever before. Two years ago, around 1 million appointments were provided each month across Thames Valley; by mid-2025 this has grown to around 1.3 million. Appointments are offered in both face-to-face and virtual formats, with around half delivered on the same or next day.

Urgent and emergency care (UEC)
Our urgent and emergency care systems have absorbed a rise of 25% in attendances. This has been supported by the development of co-located and community urgent care centres and the development of Same Day Emergency Care (SDEC) models of care.

Elective care
In elective care, two years ago, there were over 10,500 patients waiting more than 52 weeks for treatment; that number is now 6,500. We have nearly eliminated waiting times over 65 weeks across Thames Valley and some providers now treat around 80% of patients within 18 weeks.

These are important signs of recovery, but the overall picture remains challenging and there is significant variation in performance, access to and quality of provision across the Thames Valley.

Planned care and diagnostics

Despite tackling long waits, the elective waiting list has grown to over 240,000 patients.

Within our total waiting list, **40% of patients** are concentrated in just **five specialties** – ophthalmology, gynaecology, ENT (ear, nose and throat), dermatology and gastroenterology. Ophthalmology alone accounts for more than one in ten patients on the list.

Diagnostic waiting lists are rising, with nearly 40% of patients waiting over six weeks for an endoscopy compared to the national ambition of 1%. The improvements across a range of services show that sustained effort delivers results, but demand continues to outpace capacity. Restoring the 18-week standard and sustaining urgent and emergency care access will require a fundamental reconfiguration of elective services, stronger provider collaboration, and a step-change in diagnostic productivity.

Cancer

Cancer remains one of the leading causes of early mortality in the region.

Progress has been made in diagnosing more cancers at an early stage and ensuring 80% of suspected cancer patients receive a diagnosis within 28 days. Yet the 62-day cancer standard is not consistently achieved, largely due to capacity in endoscopy, imaging and specialist surgery. Frimley Health NHS Foundation Trust is achieving above the 75% standard for 62-day treatment, but Buckinghamshire Healthcare NHS Trust and Oxford University Hospitals NHS Foundation Trust remain below this.

Primary care

Primary care access has improved, but capacity does not always align with population need.

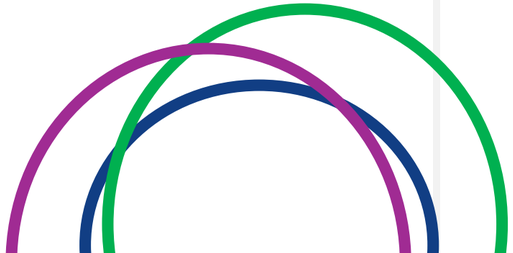
- Across Buckinghamshire, Oxfordshire and Berkshire West, 60% of appointments are face-to-face and 52% are same or next day. In Berkshire East and Frimley, 54% of appointments are either same or next day appointments. This slightly higher number reflects the increased use of virtual appointments to improve access.
- Primary care coverage is also uneven. GP supply varies widely, from 47 per 100,000 people in Berkshire West to 60 in Oxfordshire. The areas with the lowest GP staffing often overlap with the areas of greatest deprivation, compounding inequalities.
- We know that health and social need is greater in poorer areas, but GP surgeries serving deprived parts of England receive on average 9.8% less funding per needs-adjusted patient than practices in more affluent areas. This has been addressed in the Frimley system but has not yet been addressed in Buckinghamshire, Oxfordshire or Berkshire West.

- Practice nursing is also stretched, with Thames Valley averaging 4,576 patients per nurse, 20% more than the 3,821 national average. These gaps mean that despite more appointments being provided overall, patients in some communities still struggle to access timely care. These challenges reinforce the case for investment in primary care workforce, new roles, and integrated neighbourhood teams.
- On cardiovascular disease, hypertension case-finding and lipid management have improved but remain below our ambition. Expanding proactive case-finding through primary care networks and community pharmacies could make a significant difference. For example, increasing blood pressure detection coverage and lipid management to the 80% national ambition could prevent hundreds of heart attacks and strokes.

Urgent and emergency care

Across the Thames Valley we have invested in and improved our urgent and emergency care pathways but the service model and impact for our population have been inconsistent.

- Urgent Community Response (UCR) services and virtual wards are reducing admissions for frail patients and those with acute needs, but coverage and consistency need to improve to make these alternatives to admission universally available. For example, across Thames Valley there are 25 virtual ward beds per 100,000 population but the admission to these beds varies from 28-44 per 100,000, and, although high, occupancy can vary.
- Same Day Emergency Care (SDEC) pathways are also in place on several acute sites and showing impact, yet capacity is uneven. Scaling these to achieve increased system capacity will be critical to absorbing further demand without increasing bed occupancy.
- Emergency departments have made significant progress in reducing ambulance handover delays, but sometimes long waits, corridor care and reliance on escalation beds remain a feature in times of pressure. Closer alignment between ambulance triage, UCR, and SDEC is needed to ensure patients are treated in the most appropriate setting. Embedding “front door” streaming to alternatives, and recovery loops into neighbourhood teams, will be key to a sustainable future.
- Average length of stay has reduced, and Thames Valley has one of the lowest criteria-to-reside occupancy figures nationally. However, variation between places persists, and discharge delays remain a recurring constraint. Consistent discharge processes and standards delivered in partnership with councils and community providers, will be required to sustain flow. Seven-day discharge is not yet a reality across all providers. Standardising weekend and bank holiday discharge processes and increasing Criteria Led Discharges will be essential to avoid bottlenecks and maintain patient flow.
- Integration between physical and mental health crisis pathways remains incomplete. Improving access to 24/7 crisis alternatives, particularly for children and young people, is a continuing priority.
- Workforce capacity across urgent care is fragile, particularly in emergency medicine, acute medicine and community nursing. New preventive and anticipatory community and neighbourhood models, leveraging digital solutions and a wider multidisciplinary team will be needed.



Mental health and neurodiversity

Mental health services in Thames Valley are performing strongly but significant challenges remain.

- Access to children and young people (CYP) mental health, perinatal and maternal mental and individual placement and support (IPS) services have all increased (Nov-24 to Jul-25) and our share of the national ambition for CYP mental health access has been achieved.
- Adults joining waitlists for ADHD or Autism assessments today may face waits of multiple years, while children are waiting well over a year - delays that can significantly impact development and wellbeing.
- NHS Talking Therapies completed courses of treatment have increased (Nov-24 to Jul-25) and the percentage achieving reliable improvement has increased but is below plan, as is the percentage achieving reliable recovery.
- Active inappropriate adult acute mental health out of area placements have reduced (Nov-24 to Jul-25) and average length of stay for adult acute mental health beds has also reduced and current performance (Jul-25) is good (well below the baseline for Dec-23 to Nov-24, from which we were asked to reduce).
- 52% of people with severe mental illness (SMI) across the Thames Valley have had a full physical health check (Q1 2025/26) which is below plan and the SE Region target of 60%.
- Oxford Health has the second-highest national number of children and young people waiting over 52 weeks for speech and language therapy. Across Buckinghamshire, Oxfordshire and Berkshire West, around 20% of community long waits are in mental health services. Reducing these waits is a priority if we are to deliver genuine parity of esteem.
- Thames Valley performs well on the percentage of annual health checks carried out for persons aged 14 years or over on the QOF Learning Disability Register.

Summary

Across the Thames Valley system we have many areas of excellence and innovative practice, where people are getting timely support, in a local place, with a professional who understands them and addresses their needs appropriately.

We also know that there is considerable variation in both access, outcome and experience and recognise that many of our residents experience long waits to be seen and treated, delays in diagnosis and challenges when trying to access care.

What we have heard from our population

We believe that the best health and care services are **shaped by the people who use them**. We are committed to listening, involving our communities, and using their experiences and ideas to guide our decisions.

Our commissioning intentions have been **informed by insight** from our residents gathered over recent years, which have identified several key themes.

Accessing services

People across our communities continue to face challenges accessing timely care, whether it is long waits for GP and dental appointments, urgent and planned hospital care or navigating complex systems. Transport, digital exclusion, and affordability remain key barriers, identifying the importance of inclusive and equitable access to services.

People who do not speak English as their first language often find it hard to register with a GP or use health services because of language barriers. Online appointment systems can be difficult for people who struggle with communication, highlighting the need for staff to be trained in how to make adjustments for people with learning disabilities or other support needs.

> *Access to the right care and knowing "the system" is difficult. There seems to be an expectation that patients will always just know which services are best for them.*

Preventative health

There is strong support for more joined-up, person-centred care. People understand the value of focussing on prevention, early intervention, and support for families from the very start of life. Holistic approaches that consider lifestyle, mental health, and social needs are seen as essential to improving long-term health outcomes.

> *We need to move from a firefighting 'illness' service to a proper proactive 'health' service.*

> *"Prevention with communities is key. Look at what works and expand it.*

Integrated services

Integration needs to address wider determinants of health; integration should go beyond clinical care to include housing, transport, education, leisure, mental health and social care. Holistic approaches are seen as essential to improving long-term health outcomes. Parents want more joined-up early years support across local authority and NHS services, including health visitors, children's centres, and mental health services working together with their families.

> *Integrated teams providing more 'joined up' care and support and working proactively are a really positive idea along with more of a focus on prevention.*

Digital enablement

People appreciate the convenience of booking appointments, ordering prescriptions, and accessing test results online, especially when platforms work across devices. However, they have asked for better integration between GP, hospital, and pharmacy systems.

Many want one simple, joined-up platform which is easy to use and inclusive, offering options for those with limited digital access, different languages, or accessibility needs.

However, there are other people where digital exclusion remains a significant concern, particularly for elderly patients, neurodiverse individuals, carers, and those without internet access or digital devices.

> *No one should be left behind… there should always be a route for people who do not have a smart phone or computer."*

What we have heard from our partners

To inform the development and focus of these commissioning intentions we have **engaged with partners across the Thames Valley**. Through this, we heard from local authorities, NHS providers across all sectors, primary care leads, place-based leadership teams from all four places, public health and the voluntary, community and social enterprise (VCSE) about their ambitions for our system and how we might work together to achieve them.

Ambition for change is unanimous across our partners. There is a common recognition that we will need to work differently if we are to maximise the impact for our populations sustainably.

There is a commitment to working closely and collaboratively together to see the change delivered. Through the engagement several common messages have been repeated that we will reflect in our commissioning approach.

Focus on outcomes

There is clear consensus across the system that we must shift our focus onto improving a small number of outcomes for our population and narrowing gaps in life expectancy and healthy life expectancy.

Commission to deliver the three shifts

It is recognised that more of the same will not deliver the national and local ambitions. To achieve the change, we must be bold in the way we commission new models of care and de-commission services where value is questioned.

Focus on addressing inequalities

There is consensus that we must commission for equitable outcomes, with targeted investments shifted to communities experiencing greatest inequalities. This will impact on our population's health and reduce the gap in outcomes experienced by those living in our most and least deprived areas.

Local responsibility for service design

In line with national direction and local ambition for improved population health, there is a desire for more local decision making on how services could be improved, designed and delivered best for local populations, particularly as neighbourhood models, collaborations and partnership models develop.

Transparent, evidence-led decision making

We must build our vision of the future, and the changes required based on robust evidence that is shared openly with partners and stakeholders. Decision making must be rooted in a fair and transparent framework.

Work together as one system

We encourage honest and challenging conversations, to understand different system perspectives and priorities and continue to work collectively as one system leadership group towards shared goals for the system and our population.

Modelling future demand and patterns of healthcare usage

Demographic changes over the next five years

As we look forwards, we can forecast significant growth in demand and pressure on our services. Whilst the overall population of Thames Valley is expected to grow by 1.1% in the next five years, the population of people over 65 is expected to grow at a rate of 12.6%, faster than other age groups.

As demonstrated previously, we know that our 65+ population has significantly higher needs, meaning the growth of this group will have a disproportionate impact on the resources required to support them. Additionally, planned housing developments across the Thames Valley in each local authority, will place additional pressure on the health and care services.

In many of these areas we know that demand is outstripping capacity, for example in primary care.

With no change our system is not sustainable

Local modelling has shown that, if current trends in disease and prevalence continue, people's health in the Thames Valley will deteriorate.

As described earlier, the number of people with moderate and high needs will increase due to the onset or progression of preventable conditions and the number of people with the most acute needs. Those who need the most support from health and care professionals will double, as shown below in the frailty segment in figure 7.

If no action is taken to address these changes it is anticipated that the 5% of the population with the most acute needs will use approximately 30% of all healthcare resources in the Thames Valley within five years.

In the same timeframe, if no action is taken, demand would increase for all services - bed days are estimated to rise by 8%, mental health contacts will rise by 21%, A&E attendance is estimated to increase by 18%, and community contacts are expected to increase by 55%.

Collectively the impact from demographic and non-demographic growth factors drives a 46% increase in costs by 2029/30. This position is not sustainable and would push the system cost well past the expected financial allocation for the Thames Valley population.

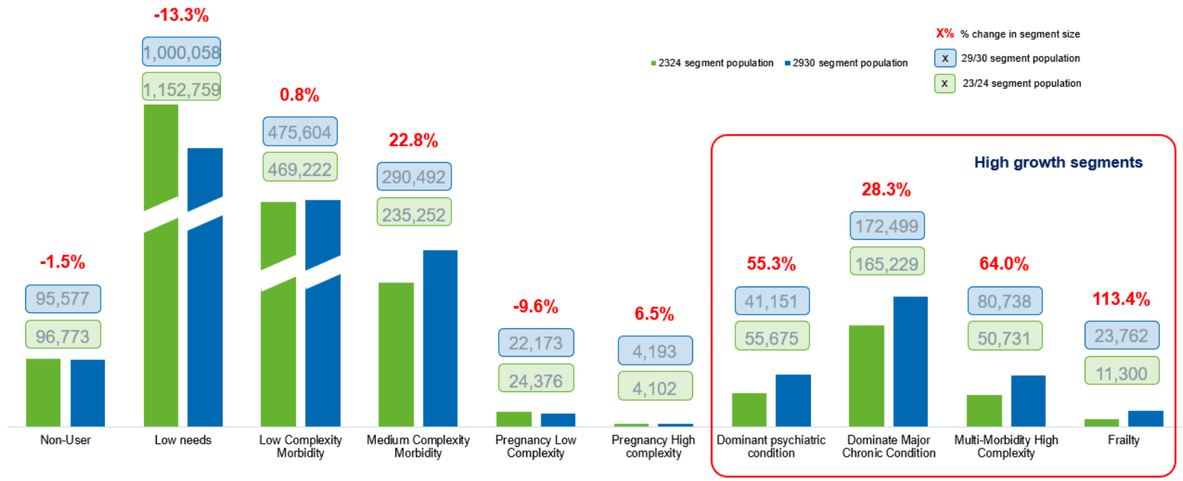


Figure 7. Population change by segment over the next 5 years, assuming current trends continue.

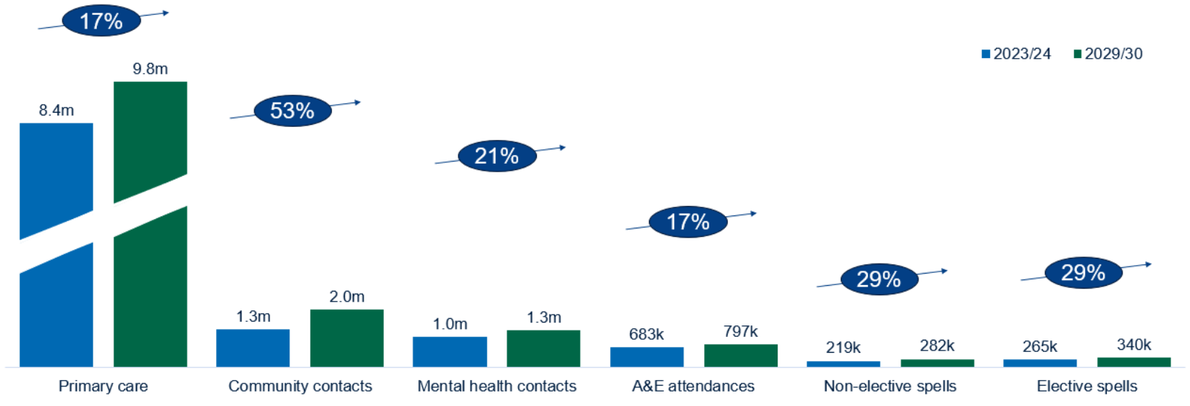


Figure 8. Forecasted increase in activity volume by point of delivery from 23/24 to 29/30

Why we must commission differently

Across the Thames Valley NHS system there is much to celebrate. Our population health data shows much of our population is in better health than the national average. Performance against many of the national standards has been improving, meaning better access, shorter waiting times, faster diagnosis for our residents, and teams across the geography are driving forward change and improvements. However, backed by data and modelling, we can also clearly see the set of challenges which are present in our geography.

We face three main challenges:

Inequality and unwarranted variation

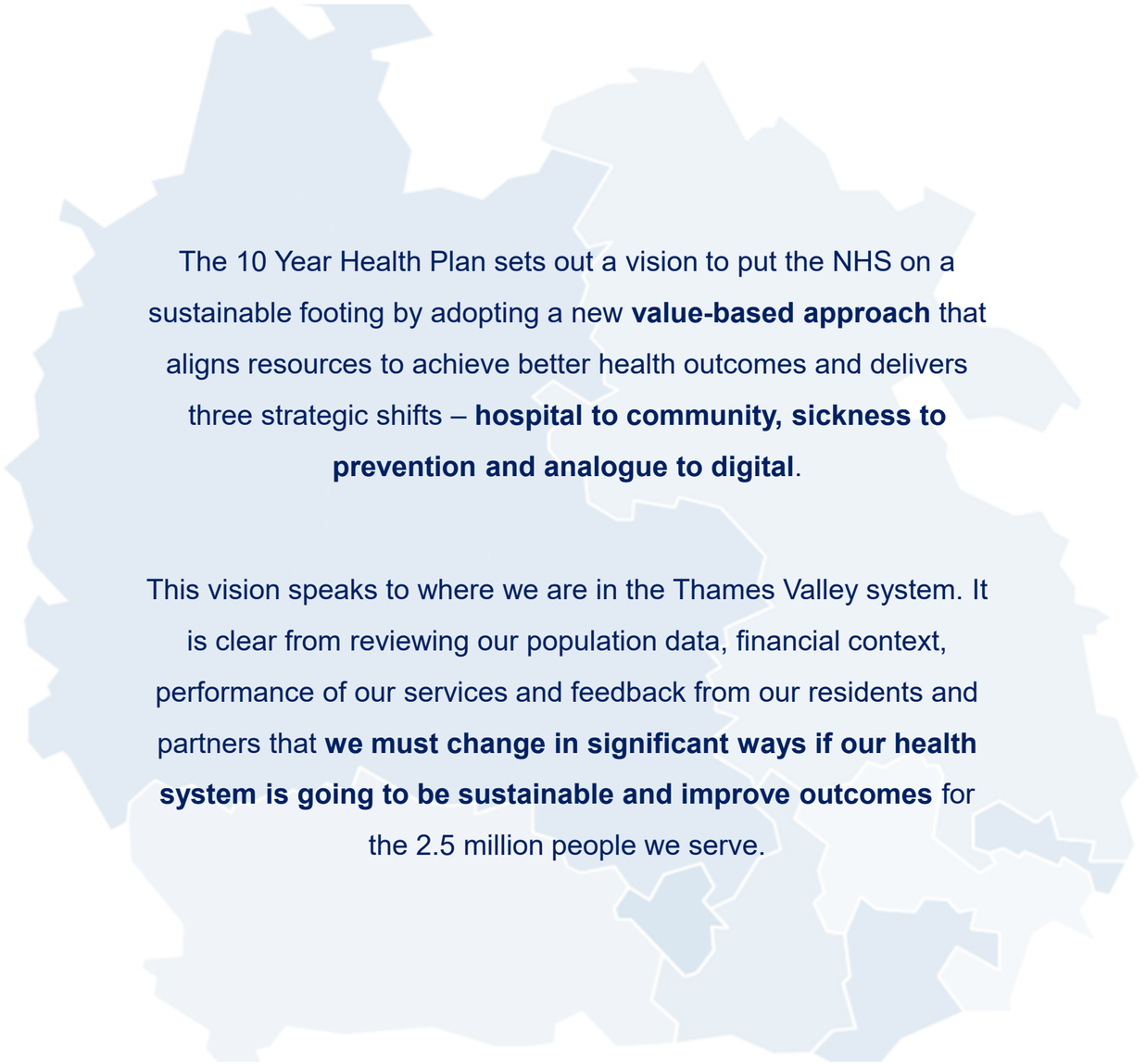
- Within the Thames Valley, there are stark inequalities in life expectancy and healthy life expectancy, with factors such as deprivation significantly impacting healthcare outcomes.
- There is unwarranted variation across our services, with varying levels of provision, performance and quality across different postcodes and providers. This impacts on how our communities access services, the outcomes these services achieve and the differential experience our residents can have when seeking support and care.

Rising demand

- Across the Thames Valley, due to an aging population and the changing prevalence of disease, there are growing pressures on our services.
- As we model forwards, demographic changes mean that the system will become unable to meet the changing needs of the population within the resources available.

Unsustainable and outdated models of care and delivery

- Our residents have told us that they want to be able to access joined up, easy to navigate and modernised services as close to their homes as possible.
- Given our starting place, where our resource commitments have previously exceeded the level of national funding allocated, we will need to take bold decisions about the way in which we fund and deliver services, including by decommissioning some services.



The 10 Year Health Plan sets out a vision to put the NHS on a sustainable footing by adopting a new **value-based approach** that aligns resources to achieve better health outcomes and delivers three strategic shifts – **hospital to community, sickness to prevention and analogue to digital**.

This vision speaks to where we are in the Thames Valley system. It is clear from reviewing our population data, financial context, performance of our services and feedback from our residents and partners that **we must change in significant ways if our health system is going to be sustainable and improve outcomes** for the 2.5 million people we serve.

2 Our strategic objectives

The three strategic objectives that will guide our commissioning over the next three years

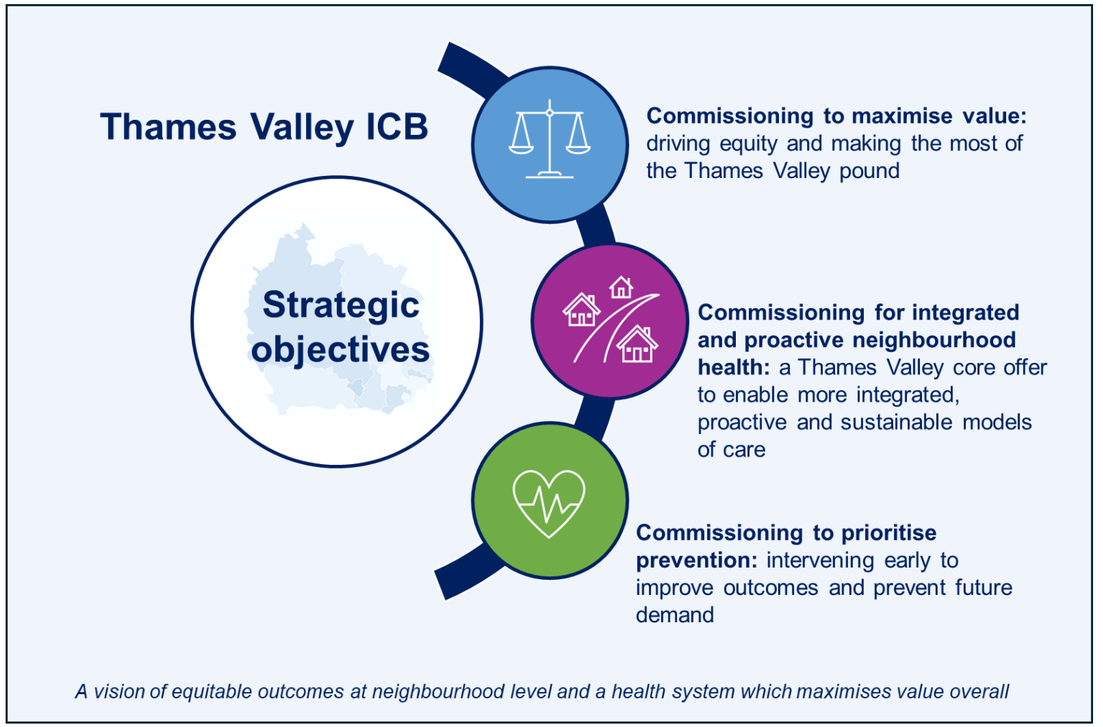
01 Commissioning to maximise value

02 Commissioning for integrated and proactive neighbourhood health

03 Commissioning to prioritise prevention

Our strategic objectives

To meet the challenges outlined in section one, the Thames Valley Integrated Care Board is developing a new commissioning strategy for the Thames Valley. It will be framed by three principal areas of focus and effort, which we introduce in this section. Ahead of the formation of the organisation in April 2026, we will work to refine and develop these objectives with our residents, partners and teams to identify the best ways of delivering our vision of more equitable outcomes at neighbourhood level and a system that maximises value for our residents overall.



01 Strategic objective 1: Commissioning to maximise value

Context

The 10 Year Health Plan states that the NHS is in critical condition, with demographic change and population ageing set to place more demand on an already stretched service. To meet these challenges, deliver for the population and achieve a viable future, it is necessary to *"put the NHS on a sustainable footing by adopting a new value-based approach, that aligns resources to achieve better health outcomes."*

As we have set out, the Thames Valley data shows widening gaps in healthy life expectancy, rising demand in long-term conditions such as diabetes and frailty, and high-cost variation in service models. This highlights the urgent need to shift commissioning levers from a focus on volume and activity towards a focus on value. To achieve this, we must address the current state where we are facing:

- **An overly complex commissioning landscape**: The Thames Valley ICB will inherit a commissioning baseline of over 1,000 service contracts, which all have varying degrees of specificity, relevant and up to date service specifications, measurement and evaluation approaches and ability to track impact. Many of these are legacy contracts, with commissioning variation present across our geographies, which is contributing to inequity of access.

  In recent years, reliance on block arrangements for NHS providers has also created limited visibility of actual costs, activity, and performance plans. This has hindered productivity improvement and made it harder to hold partners to account for delivery.
- **A focus on inputs and activity:** Too often, commissioning in our system has focused narrowly on activity and inputs rather than outcomes and value. By masking what is truly important, this contributed to persistent inequalities, variable patient experience, and inefficient use of resources.
- **Variation in provision and sustainability**: Whilst the system has many high performing services delivering excellent outcomes, there is considerable variation in provision, which is giving rise to significant inequity and varying levels of performance, quality and sustainability of services across organisations and geographies. Reasons for this include legacy commissioning arrangements, funding approaches and sub-scale or unsustainable services.
- **Marginal investment in the changes we want to see**: Whilst we have invested in reducing inequalities and developing innovation, these initiatives often lack sustainable funding models to enable the significant and large-scale change we need.

What is healthcare value?

At its core, value-based commissioning is about maximising the benefit our health and care system delivers for the people of Thames Valley with the finite resources available to us. In the context of healthcare, value can be defined as the health, wellbeing, and equity we generate for our population per unit of resource invested. It is not simply about delivering more activity or meeting service targets; rather, it is about ensuring that every pound we spend produces meaningful, measurable improvements in outcomes that matter to people and communities.

Traditional approaches to commissioning have focused on service delivery such as the number of appointments delivered, procedures carried out, or beds filled. While these metrics capture activity, they do not capture value. High activity can still coincide with poor outcomes, persistent inequalities, or inefficient use of public funds. Value-based commissioning reframes this by shifting the focus from volume to impact. It asks:

- What outcomes did we achieve?
- How equitably were they delivered?
- How efficiently did we use our resources?
- What experience did people have when they accessed care?

How we will maximise value

To guide our commissioning decisions, the Thames Valley ICB will adopt a more rigorous and transparent definition of value that goes beyond traditional cost-effectiveness analysis. Building on international evidence, we will conceptualise value using the following equation:

$$Value = \frac{Outcomes\ that\ matter\ to\ people\ and\ populations}{Total\ resources\ used\ to\ achieve\ them}$$

Within this:

- Outcomes include improvements in health status (such as reduced morbidity or increased life expectancy) but also extend to patient-reported outcomes (quality of life, functional status), patient and carer experience, access, equity, and broader social and economic benefits.
- Resources encompass not only direct financial expenditure but also workforce capacity and capabilities, infrastructure, time, and opportunity costs.

Crucially, value is not a single metric but is composed of multiple dimensions. Decisions about what counts as "value" must be informed by evidence, co-produced with clinicians and communities, and responsive to local context.

How we will commission differently

To effectively commission in a different way, we must identify and commit to principles and an approach centred on evidence-based work to identify and track value.

- **Defining what good looks like -** Applying this value equation means commissioning will be explicitly tied to the outcomes we want to achieve and the resources we deploy to achieve them. It will require us to define what “good” looks like for our population. For example, reducing the gap in healthy life expectancy between our most and least deprived neighbourhoods, improving diabetes control in primary care, or increasing the proportion of people with mental health needs who access support early and locally.
- **Basing decisions on evidence –** We will build the intelligence and analytical capability needed to track and report against these measures. This will include routinely integrating clinical data, patient-reported outcomes, population health insights, and cost data into commissioning decisions. Over time, we will establish benchmarks for value across key services and pathways, allowing us to compare performance, incentivise improvement, and make transparent decisions about where to invest, scale, or disinvest.
- **Working to the principles of allocative efficiency –** Value-based commissioning (VBC) is about ensuring that every pound of the £5.6 billion Thames Valley budget generates the greatest possible benefit to patients, communities, and the whole care system.

Creating our value- based commissioning approach

We will seek to:

- **Define metrics of value** that go beyond life expectancy and quality of life, incorporating patient experience and measuring gaps between patient groups to highlight inequities.
- Use **routinely-collected data and population health analytics** to continually assess how we are performing as a health system.
- Support local decision making with transparent, **evidence-based decision support frameworks** that weigh multiple criteria like outcomes, resources, and patient needs at the neighbourhood- and place-level.
- **Incentivise providers** through longer-term contracts that reward value, such as bundled or population-based payments and shared savings from efficient care delivery.
- Embed **continuous monitoring** into how we work using a cycle of evaluation, reinvestment, and (where necessary) disinvestment from low-value services.

Key programmes of work

Commissioning to maximise value is a practical way we can make the most of the Thames Valley pound for the 2.5 million people we serve. Our early priorities for this work will be to complete a:

Thames Valley Commissioning and Contracting Review

- We will conduct an in-depth review of all existing contracts to understand where we currently are in terms of commissioning.
- We will review all contracts and service specifications that transfer into the new Thames Valley ICB from April 2026 from the current BOB and Frimley ICBs. Currently there are over 1,000 clinical services contracts held by the two ICBs.
- This will inform a commissioning reset that we will work through with providers, consolidating towards fewer contracts that are more outcome focused alongside reducing unwarranted variation in service access and delivery for our population.

Decommissioning Programme

- Working with providers we will track the cost of services in greater detail to understand and re-base the cost of services. This should establish a transparent line between core, funded activities, and discretionary or other spending.
- We will identify service areas where there may be duplication, out-dated modes of delivery, or benefits to service consolidation that will improve quality. We will also look across geographies and decommission selectively where there is a significant imbalance of resource investment for marginal outcome improvement.
- We will develop a Thames Valley decommissioning framework with prioritisation criteria, engagement process, value assessment and equality and quality impact assessment.
- This will inform a selective decommissioning programme, which will ultimately enable re-investment of money saved, into the commissioning of better value healthcare services within our finite resources.

Commissioning for equity

Addressing unwarranted variation in service provision and outcome

- We will address unwarranted variation in our commissioning approach to ensure equitable access to and experience of services, as well as equitable health outcomes.
- We will tackle variation in provision and access in primary care and ensure we commission a core offer consistently across the geography.
- We will tackle inconsistency of offer. For example, there is inconsistent funding of women's services across Thames Valley, so we will review the provision of community women's health services to deliver high quality, equitable care. From April 2026 we will fund Women's Health Hubs across the geography.
- We will also address pathways with significant variation, commissioning a Thames Valley neuro-rehab pathway by assessing variation and supporting more consistent and accessible rehabilitation in community settings.
- Where the performance challenges identified in the previous section persist, e.g. cancer pathways, 4-hour standard, elective recovery, we will explicitly build improvement actions into our commissioning intentions, ensuring delivery is aligned with national standards.

Investing for equity

- We will allocate funding according to need to commission for equitable outcomes at neighbourhood level. We will evaluate existing funding approaches and move away from using small pots of money to address inequalities, towards more systematic differential allocation based on need.
- This will include providing additional funding for primary care in areas of greatest need. GP practice funding is weighted using the Carr Hill formula and way the formula is calculated tends to mean lower funding is allocated for a general practice operating in a more deprived area.
- Following the approach of Frimley ICB, we will provide additional funding to correct this imbalance across the whole of the Thames Valley from April 2026.
- We will review and commission equitable provision of hospice services.

Commissioning changes to services and pathways

Thames Valley Clinical Services Review

A key principle of value-based healthcare is to concentrate volume in fewer locations to maximise economies of scale, improve outcomes and reduce costs. We will mobilise a Thames Valley Clinical Services Review to optimise our approach to clinical service delivery across the Thames Valley.

- Over time, we will move away from funding everything everywhere on a historical precedent basis. Instead, by working with providers, we will identify opportunities to streamline the service offer and delivery model across locations.
- We will work with our provider collaboratives to review fragile and low volume services, high volume low complexity services, maternity services, specialised provision and use of community hospitals.
- In light of the New Hospital Programme in Frimley and estate challenges across providers we will work with provider collaboratives to optimise service configuration across the geography. We will also explore lead provider models for certain specialties creating centres of excellence and ensuring we balance population access with economies of scale.
- We will review all existing flows and payment volumes to independent sector and out of system providers to examine current state and identify future options that support our principles of equity and sustainability. This will include opportunities to repatriate out of area activity into the Thames Valley.

Leveraging specialist networks

- We will take account of the opportunities offered by the delegation of specialised commissioning to commission pathways that integrate tertiary, secondary and primary care where most effective, such as the BOB Integrated Severe Asthma Care pilot.
- Through Thames Valley Cancer Alliance (TVCA) we will commission cancer services planned and delivered at regional scale to reduce duplication with shared diagnostic and treatment capacity. This will enable improved workforce planning, cross-boundary centre of excellence operating at scale, and commissioning service redesign. We will narrow screening uptake between the most and least deprived quintiles to within 5%, embed tailored outreach programmes in underserved communities, and achieve demonstrable improvement in survival rates for ethnic minority, deprived and rural populations.

How we will get there

Delivering a shift to value-based commissioning will require a structured and disciplined approach to build capability, key processes and different ways of working.

The Thames Valley Value Lab

We are partnering with experts from the University of Oxford through the National Institute for Health and Care Research (NIHR) Applied Research Collaboration (ARC) Oxford & Thames Valley to support the development of a shared capability focussed on value analytics, evidence synthesis and decision-making support. By bringing together ICB leaders, academic researchers, VCSE and NHS providers, we will create a 'Value Lab' to support decision making and underpin our value-based approach to commissioning.

This new centre will be responsible for helping to:

- Identify value priorities by engaging communities and clinicians
- Effectively prioritise using multi-criteria decision analysis (MCDA) approaches, a framework that allows us to systematically weigh multiple outcomes, stakeholder preferences, and costs when prioritising investment.
- Translate priorities into measurable outcomes,
- Design innovative value-based payment models,
- Conduct ongoing monitoring and evaluation to track outcomes and performance,
- Ensure we have the right evidence to inform commissioning and decommissioning decisions.

Using insights and evidence from the Value Lab we will create a structured framework for identifying and decommissioning low-value services.

To make our new value-based approach work, we need to create a robust system for measuring outcomes, costs, and population needs. A new commissioning intelligence framework will enable us to integrate data from different sources and identify how services can be better aligned with population needs. This process will allow us to reduce inefficient uses of resources and reinvest in more services that better meet the needs of our communities.

The data and analysis will be shared openly with partner organisations to allow a collective understanding of challenges, opportunities and expected benefits.

The Thames Valley Innovation Fund

To support the shift towards value-based commissioning, we will create an innovation fund to help us seed fund change, track and evaluate impact and reinvest savings. Our approach to this is set out further in section three.

02 Strategic objective 2: Commissioning for integrated and proactive neighbourhood health

Context

The 10 Year Health Plan aims to end hospital by default care by 2035, with hospitals focussing on specialist and emergency care. Most health and care will be delivered locally, proactively and joined up, through a revitalised neighbourhood service designed around people's needs, with prevention and integration at its core.

The plan also states that ICBs will build new neighbourhood health services, being responsible for commissioning the best, most appropriate neighbourhood providers in their footprint. To enable this, ICBs will need to actively cultivate strong providers who can deliver care in the integrated and proactive ways set out in the plan.

We know from analysing our system and listening to our residents and our partners that currently, across the Thames Valley, we have a current state defined by:

- **Inconsistent provision –** The services we have vary by place, and where we have similar services there is often variation in what, where, and how support is offered and received. Sometimes this variation responds to need but often the variation is unwarranted and leads to inequity of offer.
- **Fragmented service commissioning –** Often we have multiple services and providers supporting the same groups and people. This siloed approach results in a poor experience for the patient and is often an inefficient use of resource and staff time and adds unnecessary complexity for residents.
- **Poor coordination of care for those who need it most –** Many patients experience multiple assessments, overlapping care plans and appointments based on partial information, with professionals often not able to understand a person's holistic needs, resulting in avoidable hospital attendance or admissions.
- **Limited understanding of the inequalities gap –** Our understanding of the inequalities people experience is often incomplete and fragmented, which makes targeted support to some of our most vulnerable communities more challenging.
- **Digital infrastructure not always facilitating easily accessible joined-up care –** whilst we have some excellent examples of digitally enabled care, these are not evenly spread across pathways and localities.
- V**ariable staff experience –** Staff experience, as a key indicator of productivity, is not improving and there is significant variation for ethnic minority staff across sectors, organisations and clinical teams.

How we will commission for neighbourhood health

As we prepare to commission on a Thames Valley-wide basis, we are keen to move from this current state towards one where our residents can access care in their local communities, delivered by multi-disciplinary teams, including professionals, working in a patient-centred way. Whilst design and delivery will vary by locality, we will commission consistently, which means that wherever our residents live and whoever provides their services, they will be able to expect the same level of service, working to a consistent and Thames Valley-wide outcomes framework.

Using our commissioning levers, we will:

1. **Define a core Thames Valley neighbourhood offer** and work with partners and residents to develop a shared vision for neighbourhood care and a set of core specifications, working to identify the high-level pathways to be delivered across our localities and the outcomes they should deliver.
2. **Develop a neighbourhood outcomes framework** which we will track across the Thames Valley, with a view to better understanding equity of access, quality of provision and value for the population.
3. **Cultivate strong providers** by understanding what is working well and assessing how best to incentivise and spread new models of care. Whilst we will not prescribe detailed delivery models, with local design led at place and neighbourhood level, we will focus on developing updated specification and contractual mechanisms to enable and support the building of effective models of neighbourhood care. Over time, we will look to delegate budgets to provide more levers for locally led change.
4. **Support effective data-led change** – We will support neighbourhood development with tailored population data packs, that will be developed with partner organisations to ensure a rich picture of population health is developed and used as the foundation for integrated working.

What we will do

Over the coming months, we will review our existing services, funding streams and work with teams across our geographies to jointly develop the outline of a core neighbourhood offer which, over time, we will move to commission across the whole of the Thames Valley.

This will also be supported by new contractual forms set out in the 10 Year Health Plan – working with single neighbourhood providers and the multi-neighbourhood providers. **We expect this work will include the following key areas on the following four pages.**

Key areas that we will focus on

Ensuring effective frailty and care coordination for residents with complex needs

- As part of the move to integrated neighbourhood working, we will coordinate with partners to review frailty provision across the Thames Valley and commission a new integrated pathways where necessary to ensure consistent assessment, proactive management, and reduce avoidable admissions.
- Coordinate outreach and proactive planning and interventions for frail people, prioritising deprived neighbourhoods and care homes where frailty often occurs earlier.
- Linking closely with any changes to the urgent care pathway, assessment and care will be undertaken virtually wherever appropriate, with face-to-face access required. We will target support to minimise digital exclusion. We will strengthen anticipatory care planning in primary care, ensuring personalised plans are in place for people living with frailty
- We will expand virtual wards and urgent community response so higher acuity patients can be managed at home, using AI and digital tools to support remote monitoring across all places.
- Expand Urgent Community Response (UCR) services to deliver a two-hour response to crises in the community, preventing avoidable admissions.
- Implement comprehensive geriatric assessment (CGA) in community and acute settings to standardise care and reduce variation. Working with partners, increase dementia diagnosis capacity and ensure early identification, MDT support and connections to formal and informal support is accessible to people, families and carers.
- Develop integrated frailty units and pathways across acute and community providers to enable rapid assessment, treatment, and discharge. Increase same-day emergency care (SDEC) access for older people, avoiding unnecessary overnight admissions.
- Improve links between frailty pathways and end-of-life care including our hospice partners, reducing late hospital admissions. Expand falls prevention services and strength/balance programmes in the community to reduce injury and admission risk.
- Embed pharmacy-led medicines optimisation for people with frailty and polypharmacy to reduce adverse drug events.
- Intermediate care and reablement: invest in local step-up and step-down care and support, prioritising a home-first approach, particularly where hospital admission rates are highest. Linking formal care and reablement to community-led initiatives that create resilience and improve wellbeing and independence.

Integrated Urgent Care

- We will work with our providers to develop one integrated urgent care service specification for each place in line with national requirements, tailored to local need. This will include:
- Reduced number of same day access points.
- Deliver an integrated end-to-end UEC pathway to support patients in the right setting, first time.
- In optometry and pharmacy, expanded urgent care pathways and the growth of Pharmacy First consultations will make same-day access to advice and treatment the norm.
- Ensuring seven-day urgent care services are available across Thames Valley, offering same-day access to primary, community and voluntary sector services
- Maintaining flow out of our acute beds and ensure consistent delivery of 7 day a week discharge services and ensuring patients are discharged in a timely manner.
- Supporting our emergency departments to meet national standards, rapidly offload ambulances, reducing extended waits in emergency departments and eliminate reliance on escalation spaces.
- Embedding a “recovery loop” with neighbourhood health teams following up all emergency episodes to reduce recurrence.

Pilot pathway approaches

- Our commissioning will support transformation of services and pathways to provide a streamlined patient journey and more efficient use of resources. This will include faster diagnostics and optimising use of Community Diagnostic Centres (CDC) to accelerate diagnosis and treatment. For example, new pathway approaches such as breathlessness and maximising the use of new facilities such as the CDC in Slough.
- Expand urgent dental care access – deliver against the national commitment for 700,000 additional appointments to better meet local need.
- Explore integrated pathway commissioning for long term conditions, such as diabetes. This organises multi-disciplinary teams and resources around a population health management approach focused on caring for people with a particular condition.
- New contracting and funding mechanisms will be explored to support this change, which could include the piloting of ‘year-of-care’ payments outlined in the 10 Year Health Plan.

Expanded community workforce

- Ensuring we maximise and expand the skills available to us in our community settings including through leveraging the expertise of our hospital workforce, more effectively embedding our VCSE support, pharmacists working to the top of their licence, advanced practitioners, delegated healthcare task opportunities maximised.
- Close demand - capacity gaps in community nursing and address critical shortages (e.g. daily home insulin delivery) to reduce immediate safety risks and unlock left-shifted models of care.

Digitally enabled neighbourhood care

- Assessment and care will be undertaken virtually wherever appropriate, with face-to-face access where clinically required and patient requested. Targeted support to minimise digital exclusion.
- We will expand the Virtual Hospital model, extending acute expertise into the home through hospital-at-home, virtual wards, proactive digital monitoring, and multidisciplinary support underpinned by Home First.
- We will ensure that most referrals and communications across general practice, pharmacy, optometry and dentistry are made via NHS electronic referral systems, improving safety, timeliness and coordination.
- Ability to proactively identify those for systematic case-finding, early detection, and management of hypertension, atrial fibrillation, and high cholesterol.
- Direct-to-test and digital-first models will be standard in diagnostics and long-term condition management.
- A joint electronic care plan will be in place for those requiring coordination, supported by rollout of remote monitoring across all places.
- We will be early adopters of new NHS App functionality, using it as a primary access point and patient-held care record, rationalising local portals where duplication exists.
- Apps and digital platforms will be used to connect individuals with community support and self-care resources.

Commissioning integrated neighbourhood working

- Progress Neighbourhood Health Centre and primary care estates development – work with partners on estates planning to create additional community clinical space, and develop some community hospitals into prevention-focused hubs
- We will build on existing work across the Thames Valley and invest further in neighbourhood teams, developing a core specification, outcomes framework and delegating authority to coordinate local models of delivery. We will learn from the two national neighbourhood health pilot sites in Buckinghamshire and East Berkshire, informing the commissioning and delivery of neighbourhood health services going forward.
- General practice will continue to drive up the proportion of patients with long-term conditions such as hypertension who are managed to evidence-based standards.
- Community pharmacies will expand their role in prevention through blood pressure checks, smoking cessation and other commissioned services.
- Optometrists will contribute by managing urgent eye conditions in the community and preventing unnecessary hospital referrals.
- In dentistry, we will prioritise preventive interventions and support for families and children, including increased uptake of fluoride varnish.
- Over time as these models develop, we will look to align and delegate budgets which we will oversee through outcomes-based commissioning approaches.
- In line with the 10 Year Health Plan vision of redesigned outpatient care, we will work to expand integrated Multidisciplinary Team (MDT) approaches across primary and secondary care, such as the integrated paediatric MDT model in Berkshire West which has reduced outpatient appointments by over 30% where implemented. We will extend this and establish CYP MDTs across Thames Valley, including a primary care-led MDT in Slough to integrate paediatric and mental health expertise at neighbourhood level.

03 Strategic objective 3: Commissioning to prioritise prevention

Across the Thames Valley many population indicators show a trend of deteriorating health. However, in many cases the onset and progression of the conditions and disease are preventable. These trends are not universal across our population and are seen most starkly in areas of deprivation.

Evidence shows that prevention activity can make a significant improvement, and research shows well planned prevention activities have a high return on investment.

Across the Thames Valley, we want to maximise the years people spend in good health. It is clear that we must act to prevent the onset or progression of disease through earlier identification of people at risk and the provision of more proactive support to those identified to be at highest risk.

Already in the Thames Valley we have many areas of good practice to build on including Community Health and Wellbeing Workers in Oxford, Buckinghamshire's lipid optimisation programme to reduce CVD using a population health management (PHM) based approach to identify the people at greatest risk earlier and primary care teams in East Berkshire achieving consistently high levels of adherence to lipid lower therapies. However, these models have not been consistently applied to all relevant populations.

How we will commission to prioritise prevention

As we prepare to commission on a Thames Valley-wide basis, we are keen to move from this current state where good practice is not evenly spread and many of residents are getting sicker from preventable conditions towards a system that has actively invested in prevention and spread what works.

Using our commissioning levers we will focus on three preventative priorities:

1. **Improving cardiovascular health**
2. **Reducing obesity and diabetes**
3. **Improving children and young people's mental health**

The prevention activity required to influence each of these areas will also impact more widely on individuals' health. The modifiable factors, particularly impacting the Cardiovascular health, weight and diabetes, are factors that strongly link with other diseases including chronic kidney disease and various many cancer types.

It is therefore vital that the work of prevention is not seen as the work of one organisation type, or professional group, but the shared work of all partners and individuals working to support the Thames Valley population.

Prevention focus areas 1: cardiovascular health

- Our commissioning intentions will give priority to cardiovascular disease (CVD), as the leading cause of premature mortality in Thames Valley
- According to the national CVD Prevent audit, our footprint across BOB ICB falls in the lowest quartile for patients with recorded hypertension, whose blood pressure reading (in the last 12 months) is at an appropriate treatment threshold. In March 2025, for example, the ICB had only 68.9% of patients achieving this standard against a national target of 80%. When reviewing lipid management, the number of patients with no recorded CVD but known to be at high risk and currently being treated with lipid lowering therapy, lags (at 59%) behind peers and the national target of 65%.
- UCL Size of the Prize modelling quantifies that a further 81,000 people in BOB require urgent action to mitigate their risk and prevent 251 heart attacks and 375 strokes.
- In contrast, as of March 2025, Frimley ICB GP practices were achieving above the national average in five of seven CVD Prevent priority metrics across hypertension, cholesterol and AF management; Frimley is regularly in the top half or quartile of the national ICB Prevent audit. However further improvement is required to meet national ambition targets, and size of the Prize analysis indicates up to 230 heart attacks and 300 strokes could be saved in Frimley.
- Across the Thames Valley, improvement is still required to sustain performance including case-finding efforts identify more patients with hypertension. By targeting CVD prevention through a more robust approach to case finding and the monitoring of patients with CVD, system population health analysis suggests a potential cost avoidance of more than £150 million may be achievable over a five-year period.
- Other behaviour factors drive ongoing ill health and vary significantly across population cohorts. Smoking prevalence is 20.6% in our most deprived areas compared with 9% in our least deprived.

How we will improve: cardiovascular health

- We will learn from best practice within the Thames Valley and from other national and international examples to increase early detection rates and better management of CVD conditions. Our data-led approach will use the Core20Plus principles with a particular focus on:
  - Optimising primary care capacity, as part of wider neighbourhood developments, to improve case finding, early detection and the effective management of conditions – with targeted support where required.
  - Strengthening the role of community pharmacy to support more pharmacy-led management of hypertension and lipid management.
  - Enabling the use of population health management approaches to target CVD prevention activities at people and communities at greatest risk
- Support proactive community engagement and empowerment in our at-risk communities to increase awareness and understanding of the importance of effective self-management of CVD conditions and making healthy choices. Working with local authority and VCSE partners across the system to achieve coordinated impact.
- Ensure smoking cessation services are embedded across acute, mental health and maternity services
- We will commission and sustain integrated heart failure pathways spanning primary, community, and secondary care, with specific investment in community heart failure nursing to address underfunding and inequities.
- We will commission quality improvement support through CVD Champions to drive best practice, expand digital and population health management tools for risk profiling, and develop a standardised community cardiology model across the system.

Outcomes we will track

- Greater use of community pharmacy in the management of hypertension and lipid management
- > 80% of patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 month
- > 65% of patients with no GP recorded CVD and a GP recorded QRISK score of 20% or more, treated with lipid lowering therapy.
- Decrease in the variance in prevalence of CVD conditions between the least and most deprived population of the Thames Valley.

Prevention focus areas 2: reducing obesity and diabetes

- There are over 153,000 registrations of diabetes in the Thames Valley and a further 161,119 who are categorised as having pre-diabetes. There has been a 13% increase in the number of people with early onset type 2 diabetes in the last 24 months. Aligned with national data, within the Thames Valley people of Black, Asian, and Mixed ethnicities have a significantly higher prevalence of type 2 diabetes when compared to White ethnic groups.
- All people with diabetes should expect to have all eight care processes checked annually. In BOB there is considerable variation in how well practices are completing these checks (90% to 11% attainment) indicating a significant inequality between practice populations.
- In the Thames Valley nearly two in three adults are overweight or obese (BOB 62.1% / Frimley 63.1%). In children, nearly one in three are overweight or obese by the end of year 6 (BOB 31.3% / Frimley 33.7%). It is estimated that 55% of children who were obese will continue to be obese into adolescence – which brings further health consequences and challenges.
- 38% of those who are obese have pre-diabetes or type 2 diabetes, 55% have hypertension, chronic kidney disease (CKD) and coronary heart disease (CHD).
- 26% of those who are obese live within deprivation decile 1-5.
- Due to shared genetic, lifestyle and socioeconomic factors, children born to parents with type 2 diabetes have a high risk of developing the condition – up to 75% increased risk if both parents have it. This is not only because of genetics but also because families are likely to share the same eating and exercise habits.
- Across BOB weight management services are currently inconsistent and aligned to legacy contracts. We spend approximately £1.5m on tiers 1-4 with a further approximate £2 million on NHS Right to Choose tier 3 pathways which include weight medications costs.

How we will improve: obesity and diabetes

- We will work in collaboration with our public health partners to focus efforts on our children and young people through a whole-family, holistic approach to healthy weight and diabetes education that addresses cultural and socioeconomic factors.
- Ensure continued funding for Complications of Excess Weight clinic at Oxford University Hospitals; evaluate impact and explore efficiencies across Thames Valley. Consider new technologies and develop transition pathways with adult services.
- We will enable primary care to increase the number of patients with diabetes who receive all eight care process each year, ensuring any abnormal results are acted upon quickly. This will prevent people from progressing into higher need/higher cost segments and improve outcomes by reducing the complications of diabetes such as CVD events, renal failure, blindness and amputations.
- The current attainment for all eight care processes in BOB and Frimley is 67% and 70% respectively. To reduce variation and equity of care for patients we will aim for all practices to achieve at least 70% attainment of the eight care processes and see an overall improvement in glycaemic control on the National Diabetes Audit.
- We will conduct a strategic review of our weight management services with the intention to align and commission services which have a holistic approach (moving away from the tiered model), fit the needs of our population, provide value, quality and defined outcomes.
- Confirm pathways that promote joined-up, community-based care, and supports people to avoid seeking hospital-based services unless clinically necessary. This should seek to remove existing gaps between current service provision and include simpler access to medication for weight loss for eligible cohorts. It should reduce unwarranted variation across Thames Valley weight management services ensuring that every citizen residing in the area, who is overweight or living with obesity, can access the appropriate and timely support for them to manage their weight.
- Ensure that weight management services are integrated within key long term condition pathways such as diabetes, CVD, sleep apnoea, cancer, women's health and respiratory.

Outcomes we will track

- All practices to achieve at least 70% attainment of the eight care processes and see an overall improvement in glycaemic control on the National Diabetes Audit.
- Increase in referrals to weight management services
- Increase in patients completing treatment within weight management programmes
- Increase in patients reaching programme specific weight loss targets
- Increase in referrals to the National Digital Weight Management services (we are below NHSE target)
- Longer term – decrease in obesity prevalence
- Decrease in the variance in prevalence of obesity and diabetes between the least and most deprived population of the Thames Valley.

Prevention focus areas 3: children and young people's mental health

- A recent report, supported by the Oxford Health Biomedical Research unit, summarises that more than one in five children and young people experience a common mental health problem, such as anxiety or depression. This is almost double the figure for 2017.
- Three quarters of mental health problems are established by the age of 24 and these conditions have been shown to have a long-term impact if the right support is not available. Poor mental health has been shown to have an impact on school attendance, employment, loss of earnings, and increased costs to the public sector, notably in the health and care sector.
- Since 2021 the population of children and young people (CYP) in the Thames Valley has grown at rate of 0.83% (slightly above national average of 0.66%). However, growth in demand for CYP mental health services has been growing at a significantly higher rate (32%).
- There has been a significant increase in acuity and complexity of need in young people requiring support from CYP MH services. This includes complex eating disorders, autism and adverse life events resulting in demand in acute hospital settings, inpatient settings and/or social care.

How we will improve: improving children and young people's mental health

- To enable earlier detection and provide more proactive support of people with Mental Health problems, the Thames Valley ICB will:
- Continue to support the roll out the Mental Health Support Teams (MHST) in schools from approximately two thirds coverage in 2025 to achieve full coverage of the Thames Valley population by 2029/30.
- Complete the consistent roll out of a needs-led and person-centred approach. The changes will lead to more appropriate matching of support level to need, the earlier identification of mental health needs, a reduction in avoidable escalation, and a targeting of resources to communities living in areas of greatest deprivation

Outcomes we will track

- Increase the coverage of mental health support teams (MHSTs) in schools across the whole Thames Valley
- Decrease the variance in access trends to children and young people's mental health services between the least and most deprived population of the Thames Valley.

How we get there

3

How we will work with our population and partners to make this vision a reality

01 Introduction

How will we make our vision a reality?

To deliver our vision of equitable outcomes across every Thames Valley neighbourhood, within a system that makes the best use of resources, we will need to change what we fund, what and how we measure, and how we work together across the system.

This will be a journey we co-produce with partners, but we anticipate it will include the following key aspects:

- A **Thames Valley Innovation Fund** to seed fund the changes we want to see
- A new approach to **measuring what matters**
- New strategic **partnerships** and deepening existing **collaborations**

02 Thames Valley Innovation Fund

To support the ambitions set out in this document, it is clear we need a significantly different set of services and model of care across the Thames Valley, alongside an ability to test new approaches and scale what works.

These changes will not happen overnight and will require us to commission purposefully for the changes we want to see. To support this, we will set up the Thames Valley Innovation Fund which we will use to:

- Seed fund change, working with partners, our population and our teams to prioritise interventions, pilot new payment approaches and evaluate impact. The fund will be held on behalf of the system, and we will define the approach and governance model with partners over the coming months.
- Work with the Value Lab, together with community stakeholders, to help identify high-performing solutions that can be scaled up through targeted resources.
- Create a reinvestment pipeline – committing to removing low value activities and moving money to support evidence-based offers, again tracking delivery, impact and cost
- Attract wider partner and private-sector investment (e.g. through social-impact bonds) to make additional resources available for testing and scaling new services.

For year one, we will invest the growth funding that the Thames Valley health system receives within its allocation to set up the fund and are in active discussions to provide match funding to increase the size of the pot from April 2026.

03 Measuring what matters

Why this is important

As system partners, we need a shared, trusted way to know three things at once:

- that today's care is safe and efficient;
- that service changes made over the recent months are working;
- that longer-term investment is improving outcomes and narrowing gaps

A single measurement framework - fed by a single data ecosystem - gives everyone the same facts at the same time, from board to place to neighbourhood. It underpins transparent commissioning and the use of finite resources so that we achieve the best outcomes for our population, fairly, at the lowest sustainable cost.

It is expected all providers, practices and local authorities will provide data into the TVS Shared Care Record. We will work collaboratively to ensure data is of high quality and that health and care staff are aware of the benefits.

The problem it solves

Different programmes and organisations have used different definitions, creating multiple versions of the numbers and debate. Insight has often arrived too slowly to correct course before performance or quality risks grow.

Measures have not been routinely broken down by deprivation, ethnicity and geography, making it hard to see and close gaps that matter most. The result is duplication, unclear accountability, and missed opportunities to move capacity to where it has the greatest impact.

We also have a key challenge of maintaining good quality services now, whilst transforming how we deliver care This will require a different set of outcome metrics so that we reduce inequalities and improving the overall health of the population we serve.

To track these intentions, we will create a measurement framework for both current performance and quality metrics, and key, longer term metrics. The framework is our common method, shared tool and built-in evaluation approach for **"measuring what matters"** most to support organising for delivery, making informed decisions and ensuring we best allocate our resources for impact.

- **Common method**. A small, stable core of clearly defined measures - access, quality and safety, experience, prevention, productivity and inequalities - used consistently at system, place and neighbourhood.
- **Shared tool (single data ecosystem).** Linked data from all our partners, national datasets, wider determinants and from residents all feeds into a single ecosystem. Boards see the high-level picture; places and providers can drill down; neighbourhood teams see variation across primary care networks and actionable lists.
- **Evaluation built in.** Evaluation approaches that enable us to track the impact of interventions underway, as well as working with partners to undertake robust evaluations of large-scale intervention. There will be transparent and collaborative mechanisms for decommissioning, commissioning new services and to support neighbourhood working.

04 Working in partnership

Shared commitment from system leadership

At our recent system leadership event, partners across Thames Valley reaffirmed their intent to work together on the major challenges facing health and care. Leaders recognised that no single organisation can deliver the scale of change required, and agreed to a collective focus on reducing inequalities, strengthening prevention, and shifting care closer to home. This provides a strong mandate for joint action across ICB, providers, local authorities and wider partners.

Clear roles across system, place and neighbourhood

The ICB will set the overarching commissioning strategy, define shared outcomes, and allocate resources transparently. Places will translate these priorities into local delivery plans, working with partners to shape services that reflect their communities. Neighbourhoods will be where change is most visible - integrated teams delivering joined-up, personalised care around people and families. This layered approach ensures decisions are taken at the most appropriate level while maintaining accountability for system-wide outcomes.

Developing wider partnerships

Delivering better health and care will require partnerships beyond traditional NHS boundaries. We will strengthen collaboration with the VCSE sector to reach communities most at risk of poor outcomes, with public health teams to embed prevention at scale, and with universities to support innovation, workforce development and evaluation. We will also seek opportunities to work with business and social investors to augment NHS resources and accelerate transformation.

Taking this forward together

Partnership cannot be a one-off exercise. We will establish regular forums for system partners to shape priorities, align resources and monitor delivery. We will commit to resolving differences transparently, avoiding duplication, and sharing risks and benefits fairly across the system. By doing so, we will create the conditions for collective ownership of challenges and shared pride in success.

Public and community engagement

Our vision will only succeed if it reflects what matters most to local people. We will be open about the choices we face and involve and engage residents in shaping neighbourhood models and priorities. This will include co-production with communities experiencing the inequalities, ensuring their voices are central to design and decision-making. We will also build stronger feedback loops, so that people can see how their views have influenced change and hold us to account for delivery.

Next steps

These are outline commissioning intentions produced in the initial phase of the planning process that set out the strategic direction of commissioning for the Thames Valley system.

We will work with the providers and system partners during the next phase of the planning process to refine our analysis and modelling, further clarify our intentions, and ensure planning alignment. This will include engagement through online platforms inviting public feedback and suggestions. We will also run engagement sessions with partners to gather a range of perspectives to ensure that our commissioning approach is transparent, collaborative, and focused on delivering the best possible outcomes for everyone in Thames Valley.

As a result of this process and other potential factors, including the organisational development of the new ICB and greater alignment across our ICB teams, there may be a requirement to adapt or revise these commissioning intentions. We will continue to engage with providers and partners on any required changes over coming months.

Appendix

National Access and Quality Standards

Context

In addition to the transformative focus of these commissioning intentions, providers are expected to deliver all required operating plan targets and continue to pursue internal improvement programmes as part of their business-as-usual activities. This appendix provides an overview of these requirements but please note this should not be seen as an exhaustive list.

National guidance and access standards

We expect all Providers to meet the requirements set out in the national operational planning guidance:

- Providers should ensure they deliver within the context of the national 10 Year Health Plan: NHS England Fit for the Future: 10 Year Health Plan for England
- Providers should ensure they deliver the national operational planning guidance for 2026/27 when published.
- Providers should ensure they meet the requirements set out in the national elective reform plan: NHS England Reforming elective care for patients
- Providers should ensure they meet the requirements set out in the national Urgent and Emergency Care plan: NHS England Urgent and emergency care plan 2025/26
- Providers should ensure they deliver within the context of the national neighbourhood health plan: NHS England Neighbourhood health guidelines 2025/26 – this will be updated with any further neighbourhood health planning guidance received.

Quality expectations

We expect all providers to prioritise the patient voice by:

- Ensuring patient feedback is actively sought and acted on through a range of mechanisms.
- Striving to meet the national requirements to respond to at least 85% of complaints within the target timeframe.
- Ensuring FFT is embedded into patient pathways.
- Ensuring patients and families are involved in incident learning responses.

We expect all providers to:

- Use all available quality and performance metrics to identify areas of good practice and areas that need improvement, these should include PROMs and PREMs in line with National guidance
- Engage with the National Audit programme and monitor clinical outcomes in line with the 10 year plan
- Provide the ICB quality intelligence in line with contractual obligations and the ICB quality assurance framework.
- Adopt a systematic and organisational approach to continuous quality improvement
- Report patient safety incidents via LFPSE, have a Patient Safety Incident Response Plan in place that is regularly reviewed and updated in response to themes and trends identified and in line with the ICB PSIRF policy.
- Work in collaboration with the ICB if quality metrics for services are consistently not being met to facilitate timely improvement of services for our population. If improvement is not seen within services, the ICB may take an increased oversight approach in line with National oversight framework and contractual methods. ICB's may escalate in line with national escalation framework.

We expect all providers to:

- Be compliant with best clinical practice guidelines e.g. NICE, Royal Colleges, NHSE and if not to ensure a rationale for deviation is provided.
- Undertake robust quality impact assessments balancing the risks across safety, quality, equality, performance, finance, workforce and service sustainability. Ensuring that system impact and cumulative effects of decisions are considered.
- Strive to meet the NHS thresholds for C-dif and Gram negative infections, enabled by a focus on supporting the national UK 5-year action plan for antimicrobial resistance 2024 to 2029 - GOV.UK .
- Have a robust process for ensuring compliance with CQC, NHSE, MHRA, HSSIB, MNSI and other external bodies recommendations and proactively engage with external partner organisations, regulators and the ICB to escalate quality and safety concerns, including whistleblowing.
- Have executive board level oversight of quality, safety, patient experience, infection prevention and control that is facilitated through clear governance structures.
- Support the move to prevention, by promoting vaccination and screening within the workforce and population, identifying opportunities within pathways in both primary and secondary care.

This document has been jointly created by Buckinghamshire, Oxfordshire and Berkshire West ICB, and Frimley ICB.

From 1 October 2025 we have been operating in a 'cluster' arrangement, as a shadow organisation in readiness for the formal establishment of Thames Valley ICB from 1 April 2026.