NHS
Thames Valley

Board Meeting of the Thames Valley Integrated Care Board – Meeting in Public

Agenda
Wednesday 16 September 2026 – between 11am and 1.15pm

Via Microsoft Teams

Chair: Priya Singh

The quorum for meetings of the board will be seven members, including:

a) Either the Chair or Deputy Vice Chair
b) Either the Chief Executive or Chief Finance Officer
c) Either the Chief Medical Officer or the Chief Nursing Officer
d) At least two Non-Executive members
e) At least two Partner Members

Timing	No.	Item	Action	Delivery	Lead
11am	1	Welcome, apologies for absence and Chair's introduction	-	Verbal	Chair
	2	Conflicts of Interest and declarations of any interests relating to this agenda	Note	Paper	Chair
	3	Minutes of the Board meeting held on 15 July 2026	Approve	Paper	Chair
		Operating Context			
11.05am	4	Chief Executive Officer's report	Note	Paper	Nick Broughton, Chief Executive Officer
11.15am	5	Office of the Pan-ICB Commissioning (OPIC) - update	Note	Verbal	Sam Burrows, Chief System Development and Engagement Officer Caroline Reid, Regional Director of Commissioning
11.30am	6	Quality, Performance and Finance Reports	Note	Paper	Rich Chapman, Chief Finance Officer and Sarah Bellars, Chief Nursing Officer
11.40am	7	Winter Readiness	Approve	Paper	Sam Burrows, Chief System Development & Engagement Officer

Timing	No.	Item	Action	Delivery	Lead
		Strategic Commissioning			
11.50am	8	Strategic Commissioning Sprint Programme and Commissioning Intentions Development	Note	Paper	Hannah Iqbal, Chief Strategy & Commissioning Officer
		Building Conditions for Success			
12.05pm	9	Maternity Services in the Thames Valley	Note	Paper	Sam Burrows, Chief System Development & Engagement Officer Sarah Bellars, Chief Nursing Officer Lalitha Iyer, Chief Medical Officer
12.35pm	10	Advise, Alert, Assure (AAA) Board Committee Reports • Audit • Remuneration • Quality, Performance & Finance • Commissioning & Population Health • System Delivery Committee	Note	Paper	Committee Chairs
12.45pm	11 12 13	Governance: Board Assurance Framework Fit and Proper Person Test Annual Board Return Designated Body Annual Report and Statement of Compliance	Note Approve Note	Paper Paper Paper	Caroline Corrigan, Chief People & Corporate Affairs Officer Lalitha Iyer, Chief Medical Officer
		Annual General Meeting			
12.55pm	14	2025-26 Annual Reports and Accounts for BOB ICB and Frimley ICB	Note	Slides	Sam Burrows, Chief System Development & Engagement Officer
		Other items of Business			
1.05pm	15	Public Questions		Verbal	Chair
1.10pm	16	Any other Business	-	Verbal	Chair
1.15pm	17	Close	-	Verbal	Chair
		Date of next meeting: 18th November 2026			

Thames Valley ICB Board Declarations of Interest Register Sept 2026

Surname	First Name	Job Title	Interest	Description of Interest	Type of Interest			Actions agreed with Line Manager to mitigate risk
Bellars	Sarah	Chief Nursing Officer	Son works for FHFT	Son worked for FHFT , currently as a student nurse	Declarations of Interest – Other	Indirect	Indirect	do not discuss work with my son
Bellars	Sarah	Chief Nursing Officer	Daughter works for Thames Valley ICB	Daughter works in the EPRR Team.	Declarations of Interest – Other	Indirect	Indirect	My daughter is in another directorate
Blackmore	Sara	Partner Member - Local Authority	Royal Borough of Windsor and Maidenhead	I am employed by the Royal Borough of Windsor and Maidenhead as Director of Public Health. This includes membership of the Royal Borough of Windsor and Maidenhead Health & Wellbeing Board.	Declarations of Interest – Other	Non-Financial Professional	Indirect	Executive Leadership team and Administration of Royal Borough aware of my LA partner member role on the ICB Board.
Blue	Ilona	Non-Executive Member	General Dental Council	Lay Council Member	Declarations of Interest – Other	Non-Financial Professional	Direct	I do not anticipate any direct conflicts of interest as I do not expect the ICB or its audit committee to engage in direct discussions/decisions related to individual dental professionals; or dental education establishments. My role in GDC does not involve any direct decisions about individual professionals as these are handled through independent hearing panels.
Blue	Ilona	Non-Executive Member	Accent Housing Group Limited and Accent Capital plc	Non-executive director of Accent Housing Group and Director of Accent Capital plc (the latter is a financing vehicle for Accent Housing)	Declarations of Interest – Other	Non-Financial Professional	Direct	I don't anticipate any direct conflicts, but should any discussions arise relating to any Accent housing interests in the TV patch I would flag my interest and if necessary recuse myself from any discussions/decisions.
Blue	Ilona	Non-Executive Member	NB Solutions	Director (I own 4% and my husband Robert Nichols owns the remainder) of NB Solutions. My husband is the sole employee.	Declarations of Interest – Other	Financial	Direct	I do not anticipate any conflicts of interest. NB Solutions' clients could sell into the NHS but my husband would not be directly involved in such commercial arrangements and I do not expect the ICB to be directly engaged with third party suppliers to provider organisations in the patch. My lack of direct involvement in any such commercial arrangements mitigates the risk of conflict.
Blue	Ilona	Non-Executive Member	Active Travel England, an executive agency of the Department for Transport	Non-executive director, Audit Chair and Deputy Chair	Declarations of Interest – Other	Non-Financial Professional	Direct	No conflicts anticipated
Blue	Ilona	Non-Executive Member	Network Rail, an arms' length body of the Department for Transport	Independent advisor to the Audit & Risk Committee and the Treasury Committee	Declarations of Interest – Other	Non-Financial Professional	Direct	None anticipated
Broughton	Nick	Chief Executive	Oxford Academic Health Partners (formerly Oxford Academic Health Science Centre)	Board Member	Declarations of Interest – Other	Non-Financial Professional	Direct	Standing declarations – actions to be taken as deemed appropriate if conflict identified.
Broughton	Nick	Chief Executive	Thames Valley Academic Health Science Network	Member	Declarations of Interest – Other	n-Financial Professio	Direct	Standing declarations – actions to be taken as deemed appropriate if conflict identified.
Broughton	Nick	Chief Executive	Charlie Waller Trust (mental health charity)	Trustee	Declarations of Interest – Other	Non-Financial Personal	Direct	Standing declarations – actions to be taken as deemed appropriate if conflict identified.
Broughton	Nick	Chief Executive	Green Templeton College, Oxford University	Associate Fellow	Declarations of Interest – Other	Non-Financial Professional	Direct	Standing declarations – actions to be taken as deemed appropriate if conflict identified.
Broughton	Nick	Chief Executive	Thames Valley Cancer Alliance	Interim Chair	Declarations of Interest – Other	Non-Financial Professional	Direct	Standing declarations – actions to be taken as deemed appropriate if conflict identified.
Broughton	Nick	Chief Executive	James's Place (Charity)	Trustee	Declarations of Interest – Other	Non-Financial Personal	Direct	Standing declarations – actions to be taken as deemed appropriate if conflict identified.

Broughton	Nick	Chief Executive	NHS England	National Priority Programme Director for Mental Health, Learning Disabilities, and Neurodevelopmental conditions (part time seconded role)	Declarations of Interest – Other	Financial	Direct	Standing declarations – actions to be taken as deemed appropriate if conflict identified.
Burrows	Sam	Chief System Development & Engagement Officer	Eightway Solutions Ltd	My spouse is the owner and operator of the company Eightway Solutions Ltd.	Declarations of Interest – Other	Indirect	Indirect	Sought advice from the Governance team and communicated to Line Manager. Will ensure that if this conflict of interest has the potential to become direct this will be immediately disclosed in order to identify further mitigations.
Chapman	Rich	Chief Finance Officer			Nil Declaration			
Corrigan	Caroline	Chief People & Corporate Affairs Officer			Nil Declaration			
Emms	Julian	Partner Member - Acute	CEO of a combined Community and Mental Health trust in Berkshire	Healthcare	Declarations of Interest – Other	Non-Financial Professional	Direct	Identifying /declaring any conflict as and when it might arise
Gavriel	George	Primary Medical Services Partner Member	Swan GP Ltd	Director and Shareholder	Declarations of Interest – Other	Financial	Direct	Standing Declaration - actions to be taken as deemed appropriate if conflict identified
Gavriel	George	Primary Medical Services Partner Member	Buckinghamshire Primary Care Provider Collaborative	Director of Partnersip Board	Declarations of Interest – Other	Financial	Direct	Standing Declaration - actions to be taken as deemed appropriate if conflict identified
Gavriel	George	Primary Medical Services Partner Member	Gavriel Professional Services Ltd	Director and Shareholder	Declarations of Interest – Other	Financial	Direct	Standing Declaration - declare at all meetings. Actions to be taken as deemed appropriate if conflict identified
Gavriel	George	Primary Medical Services Partner Member	Boehringer Ingelheim	External Consultant	Declarations of Interest – Other	Financial	Direct	Standing Declaration - declare at all meetings. Actions to be taken as deemed appropriate if conflict identified
Gavriel	George	Primary Medical Services Partner Member	Buckingham Community Hospital league of Friends	Director and Shareholder	Declarations of Interest – Other	Non-Financial Professional	Direct	Standing Declaration - actions to be taken as deemed appropriate if conflict identified
Gavriel	George	Primary Medical Services Partner Member	RCGP - Thames Valley Leaderhip and Management Course	Course Organiser and Facilitator	Declarations of Interest – Other	Non-Financial Professional	Direct	Standing Declaration - actions to be taken as deemed appropriate if conflict identified
Gavriel	George	Primary Medical Services Partner Member	Thames Valley Professional Support and Wellbeing Service	Spouse - Associate Director	Declarations of Interest – Other	Indirect	Indirect	Standing Declaration - actions to be taken as deemed appropriate if conflict identified
Gavriel	George	Primary Medical Services Partner Member	FedBucks	Shareholder on behalf of Swan GP Ltd and employed as part of Buckinghamshire Primary care Provider Collaborative role	Declarations of Interest – Other	Non-Financial Professional	Direct	Standing Declaration - actions to be taken as deemed appropriate if conflict identified
Iqbal	Hannah	Chief Strategy and Commissioning Officer			Nil Declaration			
Iyer	Lalitha	Chief Medical Officer	Gren Investments LTD	Director	Declarations of Interest – Other	Non-Financial Professional	Direct	Declared via Board register of interests and will be managed in line with ICB policy.
Iyer	Lalitha	Chief Medical Officer	Cumbria Homes LTD	Director	Declarations of Interest – Other	Non-Financial Professional	Direct	Declared via Board register of interests and will be managed in line with ICB policy.
Iyer	Lalitha	Chief Medical Officer	Globe Management Consultants LTD	Director	Declarations of Interest – Other	Non-Financial Professional	Direct	Declared via Board register of interests and will be managed in line with ICB policy.
Iyer	Lalitha	Chief Medical Officer	Thames Hospice	I have accepted a role as a clinical trustee at the Thames Hospice in Maidenhead. it is anticipated that the start date will be the 7/7/25 . It is an unpaid voluntary role. This was with the permission of the CEO.	Declarations of Interest – Other	Non-Financial Personal	Indirect	I will recuse myself out of any decision making for the commissioning of services for the Thames Hospice.

Khan	Sajjad	Non-Executive Member	Oxford University Hospitals/Buckinghamshire Healthcare Trust	Son is currently employed as a Foundation Year (F1/F2) doctor within Oxford University Hospitals NHS Foundation Trust (OUH) and Buckinghamshire Healthcare NHS Trust (BHT).	Declarations of Interest – Other	Non-Financial Personal	Indirect	Interest declared on the ICB Register of Interests. If any specific item on an agenda presents a potential overlap, I will notify the Chair and Governance Lead prior to the meeting.
Khan	Sajjad	Non-Executive Member	States Consulting Ltd	Director and Shareholder	Declarations of Interest – Other	Financial	Direct	No work currently being done within healthcare or public sector
Khan	Sajjad	Non-Executive Member	National Council for Voluntary Organisations (NCVO)	I have been appointed as an independent member of the Finance and Commercial Committee for the NCVO.	Declarations of Interest – Other	Non-Financial Professional	Indirect	In line with the COI policy.
McCarthy	Lance	Chief Executive - FHFT	Frimley Health NHS Foundation Trust	I am the Chief Executive of Frimley Health NHS Foundation Trust, an acute and community provider in the Frimley Health system.	Declarations of Interest – Other	Non-Financial Professional	Direct	Will excuse myself if there is a conflict of interests in any agenda items.
Nadeem	Safina	ED & I System Lead	Lancashire Cricket Foundation	ED & I System Lead	Declarations of Interest – Other	Non-Financial Professional	Indirect	
Nadeem	Safina	ED & I System Lead	Purple Infusion Ltd	ED & I System Lead	Declarations of Interest – Other	Non-Financial Professional	Indirect	
Nadeem	Safina	ED & I System Lead	University of Surrey on Wellbeing Initiatives for NHS	Co-investigator on a research project	Declarations of Interest – Other	Non-Financial Professional	Indirect	
Nolan	Tim	Non-Executive Member	Labour Party	Member	Declarations of Interest – Other	Non-Financial Professional	Direct	Standing declarations – actions to be taken as deemed appropriate if conflict identified
Reeves	Martin	Partner Member - Local Authority	Oxfordshire County Council	I am the Chief Executive of Oxfordshire County Council which is an integral part of the Thames Valley ICB footprint with significant pooled budget and joint commissioning arrangements across health and social care (childrens, adults and public health)	Declarations of Interest – Other	Non-Financial Professional	Indirect	Conflict registered with Oxfordshire County Council. Delegation used to other senior, chief officers if deemed appropriate and absent myself from any decision-making meetings if necessary.
Reeves	Martin	Partner Member - Local Authority	Thinking Place	I am an Advisor (non-remunerated and with no Director/fiduciary responsibilities) to Thinking Place.	Declarations of Interest – Other	Non-Financial Professional	Direct	Whilst it is highly unlikely that the Thames Valley ICB will commission this type of consultancy support, if Thinking Place is engaged in any activity with places across the region, I will declare my non-pecuniary interest and not be involved in any procurement related to Thinking Place.
Reeves	Martin	Partner Member - Local Authority	National Health Equity Advisory Board	I sit on the Board which is chaired by Professor Sir Michael Marmot. This is in a voluntary capacity and has no director or fiduciary responsibilities.	Declarations of Interest – Other	Non-Financial Professional	Direct	Highly unlikely to have any impact on the ICB and I am not involved in decision-making on the grants but will declare interest for any offered within our region.
Shepherd	Gareth	Non-Executive Member			Nil Declaration			
Singh	Priya	Chair	National Council for Voluntary Organisations	Appointed November 2020 - Chair of Board of Trustees	Outside Employment			
Singh	Priya	Chair	Society for Assistance of Medical Families	Appointed January 2018 - Executive Director	Outside Employment			
Singh	Priya	Chair	PG Mutual Insurance	Non-Executive Director	Declarations of Interest – Other	Financial	Indirect	Manage in accordance with COI policy.
Singh	Priya	Chair	CAF Nominees	Charitable Trustee	Declarations of Interest – Other	Non-Financial Professional	Direct	
Singh	Priya	Chair	Regulatory Oversight Board (Cricket Regulator)	Non Executive Director	Declarations of Interest – Other	Non-Financial Professional	Indirect	In line with the COI policy.
Thomas	Huw	Place Clinical Lead RBWM	Claremont and Holyport practice	Partner in the practice	Declarations of Interest – Other	Financial	Direct	Will be managed in accordance with policy

Thomas	Huw	Place Clinical Lead RBWM	Maidenhead Primary Care Network	Practice is a member of Maidenhead PCN	Declarations of Interest – Other	Financial	Direct	Will be managed in accordance with policy
Thomas	Huw	Place Clinical Lead RBWM	Frimley Health NHS Foundation Trust	Spouse employed by Trust as Clinical Nurse Specialist	Declarations of Interest – Other	Indirect	Indirect	Will be managed in accordance with policy
Thomas	Huw	Place Clinical Lead RBWM	East Berkshire Primary Care	Work on sessional basis for East Berkshire Primary Care. Member of the EBPC Council EBPC provide out of hours care and other primary care services.	Declarations of Interest – Other	Financial	Direct	Will be managed in accordance with policy
Thomas	Huw	Place Clinical Lead RBWM	Holy Trinity Primary School, Cookham	Governor at school	Declarations of Interest – Other	Indirect	Indirect	Will be managed in accordance with policy
Thomas	Huw	Place Clinical Lead RBWM	Royal Borough of WIndsor and Maidenhead	Practice subcontracted to provide opiate substitute prescribing services for the Royal Borough of Windsor and Maidenhead	Declarations of Interest – Other	Financial	Direct	Manage in accordance with policy

NHS
Thames Valley

Minutes
Thames Valley ICB
Board meeting – Meeting in Public
Wednesday 15th July 2026 – 10.30am-12.41pm
MS Teams

Name	Role	Attendance
Members		
Priya Singh	Chair	Present
Nick Broughton	Chief Executive Officer	Present
Rich Chapman	Chief Finance Officer	Apologies
Lalitha Iyer	Chief Medical Officer	Present
Sarah Bellars	Chief Nursing Officer	Present
Caroline Corrigan	Chief People and Corporate Affairs Officer	Present
Sam Burrows	Chief System Development and Engagement Officer	Present
Hannah Iqbal	Chief Strategy and Commissioning Officer	Present
Ilona Blue	Senior Independent Director and NEM for Audit, Risk & Finance	Present
Sajjad Khan	Vice-Chair and NEM for Commissioning & Population Health	Present
Tim Nolan	NEM for Remuneration, Culture, Quality & Safety	Present
Gareth Shepherd	NEM for Digital, Technology & AI	Present
George Gavriel	Primary Medical Services Partner Member	Present
Huw Thomas	Primary Medical Services Partner Member	Present
Sara Blackmore	Local Authority Partner Member	Apologies
Martin Reeves	Local Authority Partner Member	Apologies
Lance McCarthy	NHS Trust or Foundation Trust Partner Member	Apologies
Julian Emms	NHS Trust or Foundation Trust Partner Member	Apologies
Attendees		
Zina Etheridge	Chief Executive, Buckinghamshire Council – Local Authority rep	Present
Oliver White	Director of System Financial Sustainability	Present
Safina Nadeem	EDI Advisor	Present
MJ Steijger	Head of Governance	Present
Kelly Sutherland	Senior Corporate Office Manager	Present – minuting

	Board Business
1.	**Welcome and Apologies for Absence** The Chair, Priya Singh, opened the meeting and welcomed attendees, including members of the public who had registered to join the meeting. Apologies were received from Sara Blackmore, Rich Chapman, Julian Emms, Lance McCarthy and Martin Reeves. The Chair thanked Zina Etheridge, Chief Executive of Buckinghamshire Council who attended in place of Martin Reeves and Ollie White, Director of System Financial Sustainability, who attended in place of Rich Chapman for this meeting.
2.	**Declarations of Interest** The Conflicts of Interest register was noted. As there were two mental health items on the agenda, Nick Broughton reminded the Board of his role as National Priority Programme Director for Mental Health, Learning Disability and Neurodevelopmental Conditions.
3.	**Minutes of the meeting held on 20th May 2026** The minutes of the Board meeting held in public on 20th May 2026 were agreed as a correct record.
4.	**Mental Health in Schools Team** The Chair welcomed Yani Chocaligum, Pete Saunders, Sophie Graham and Caitlin Perryer from Berkshire Healthcare who were part of the Mental Health in Schools (MHST) team. Sarah Bellars, Chief Nursing Officer had invited them to present to the Board after attending one of their team meetings, where she was struck by their positive results, professionalism and enthusiasm. During the presentation and in response to subsequent questions, the following main points were noted: • The Mental Health in Schools team launched in 2021 with a pilot run in 4 schools. In 2025, further funding was secured to enable expansion with MHST2, ensuring that 30 out of 36 local schools were now regularly engaging with the team.

- The team worked closely with schools to promote their service and to train staff to better understand mental health. In one school this led to referrals increasing five-fold. The success of the team has meant fewer children and young people were being referred to Child and Adolescent Mental Health services (CAMHs) because anxiety and low mood referrals could be addressed by the MHST. MHST met every fortnight with CAMHs colleagues to enable referrals if they identify that individuals do require higher level support.
- Pete Saunders shared that photos of the whole team were shared in all schools in Bracknell Forest, so that the school community would be familiar with the team.
- The team were able to offer effective early intervention to children and young people, delivering assessments within 2 weeks of initial referral and beginning appropriate treatment within 3-4 weeks.
- The team held regular consultations with schools to discuss the needs of their students, usually every 3-4 weeks for secondary schools and every half term for primary schools. This strong feedback loop proved extremely valuable.
- Evidence based treatment methods were used to support both school staff and students.
- Caitlin and Sophie, Education Mental Health Practitioners, explained how they were able to train for this role that attracted psychology graduates, as well as ex-teachers or ex-teaching assistants. There was an undergraduate and a postgraduate diploma available and Sophie appreciated that she was able to work within the service whilst studying, with a consistent national training programme and secure a job at the end of it.
- It was noted that the Royal Borough of Windsor and Maidenhead also had a MHST, which was hosted by the local authority and was looking to expand with a second team.
- In response to a question about how the MHST engaged with young people from more vulnerable groups, it was reported that the Bracknell team had reached out to local traveller and eastern European communities and would also be attending an upcoming Bracknell Pride event. The Bracknell East team had a monthly Equality, Diversity and Inclusion (EDI) group where they considered how best to support young people with protected characteristics. It was also noted that the MHST in Slough had visited local mosques to raise awareness of their offer.

The Chair thanked Yani, Pete, Sophie, and Caitlin for joining the meeting to share a valuable insight into their work and the impact it had on young people in Bracknell. The Board would be interested to hear about the wider rollout of MHST across the Thames Valley and the continued success of the Berkshire Health MHST in future.

Operating Context

5. **Chief Executive Officer's Report**

Nick Broughton, Chief Executive Officer introduced his report, highlighting that Berkshire Health Foundation Trust had recently been approved as an Advanced Foundation Trust. He also reported that an urgent ten-point plan had been published by NHS England as a result of Baroness Amos' Maternity review – the ICB was working with Trusts across Thames Valley to implement the plan. The Board noted that the Thames Valley ICB Oversight Annual Assessment Meeting took place on 12th June 2026 which was attended by the Chief Executive and the Chair. It was a positive meeting, recognising that the merger of the two legacy ICBs had been very complex and noting areas of focus for improvement. The assessment letter would be appended to the minutes of the meeting.

ACTION: Kelly Sutherland

Nick Broughton invited Ollie White to provide an update on the ICB's invoice backlog and the following main points were noted:

- Clearing the invoice backlog was a priority for the Finance team, supported by the entire organisation. Progress had been made – the total number of invoices being approved now exceeded new invoices coming in.
- The team was prioritising the most outstanding invoices and urgently paying suppliers who had highlighted cashflow issues.
- The invoice process was being reviewed, with a view to introducing better automation. The target was to clear the backlog and introduce a new process by the end of August.

	• Thanks were extended to the Care Associations in Berkshire, Buckinghamshire and Oxfordshire who had supported the ICB in their communications with providers across the region. It was noted that the Thames Valley Value Lab had launched on 2nd July. This was an important collaboration between the ICB and Oxford University and the launch provided great insight into different methods of tacking population health inequalities. Nick Broughton emphasised that the ICB was very keen to harness local academic expertise. A Non-Executive member thanked the Chief Executive for his report and suggested that it might be helpful to structure the Chief Executive's report according to the ICB's agreed strategic objectives and enablers. Nick Broughton agreed to take this suggestion away for further consideration. **ACTION: Nick Broughton/Caroline Corrigan** *The Board noted the Chief Executive Officer's report.*	
6.	**Out of Area Placements – Mental Health** Sarah Bellars, Chief Nursing Officer introduced a report on Out of Area Placements – Mental Health. The NHS England Medium-Term Planning Framework (MTPF) October 2025 set out targets to reduce the numbers of unwarranted Out of Area Placements (OAP). The primary objective under this framework was to eliminate inappropriate out of area placements for mental health patients by March 2028. Ideally when mental health patients were admitted they should be placed in a location where they could maintain contact with carers, friends and family and their community mental health support. Sometimes, due to lack of local capacity they might need to be placed out of area, which was classified as 'unwarranted'. Sarah Bellars explained that it was often female Psychiatric Intensive Care Unit (PICU) beds locally which were oversubscribed. This pressure was being mitigated & supported by additional investment this year to commission a female PICU with some high dependency beds. This was being delivered and overseen via the Thames Valley Mental Health Provider Collaborative. The Board noted that as part of the Thames Valley planning submission a system wide ambition to reduce inappropriate OAPs to 0 across the 3-year period had been agreed. In April and May 2026, a less than 5 OAPs per month target had been achieved. This target would gradually reduce further to 2 OAPs per quarter in 2027-28 and then 0 by the end of 2028-29. Nick Broughton highlighted that this was now one of 5 priority areas for NHS England this year and welcomed the news that progress was being made in reducing the number of OAPs. *The Board noted the Out of Area Placements – Mental Health report.*	
7.	**SEND Reforms Update** Sarah Bellars, Chief Nursing Officer introduced a report on SEND Reforms Update which outlined recent work undertaken across the system to produce SEND reform plans for each Local Area Partnership. Thames Valley has eight local authorities and plans had to be submitted by 19th June. ICB staff were deployed to support the development of these plans, which focussed on reducing the number of children with Education and Health Care Plans (EHCP) by increasing early intervention for children in schools by offering enhanced support, upskilling school staff ,and collaborative working. The 'Expert at Hand' model would continue to be developed over the summer months and it was hoped that this initiative would deliver improved outcomes for children and young people. The outcome of the plan submission was still to be confirmed. Zina Etheridge, CEO, Buckinghamshire Council thanked the ICB for supporting the production of the SEND reform plans, which had to be completed at pace and were crucial for local authorities in terms of funding decisions that would be made. There was a discussion about the governance diagram included in the report and the need to clarify the role and responsibilities of the ICB. Sarah Bellars gave assurance that the ICB was clear about its responsibilities, and she would discuss the diagram further with partners to ensure that accountability was understood. *The Board noted the report and the risks identified for process and delivery.*	

8.	**Quality, Performance and Finance Reports** The Board considered the Quality and Finance reports, noting that the Finance report was a more limited high-level report due to the prioritisation of resources to address the invoice backlog mentioned earlier. The report showed that at month 2 the ICB's finances were tracking to plan and the finance team were focussed on robust controls, cost improvement plans, and risk mitigations to ensure plan delivery. In response to a question about the allocation of capital, it was noted that the ICB's capital programme had been tested as part of the wider financial plan submission. There was a significant lag between capital investment being agreed and services going live. With regards to community diagnostic centres (CDC), it was noted that the way they were commissioned would be changing, which would provide more visibility on their impact. The Slough CDC was now fully operational and Frimley Health Foundation Trust hoped to double utilisation over the coming year. Sarah Bellars, Chief Nursing Officer, provided an overview of the Quality report, highlighting that an action plan was in place to address a complaints backlog and work was being commissioned to review the complaints process and staffing structure, in order to identify new ways of working. It was also noted that a new national Quality Strategy for NHS-funded Care had been published yesterday and Sarah Bellars would bring back a report to a future Board meeting to consider the detail. **Action: Sarah Bellars** The report also noted that recent CQC inspection reports for maternity services at Oxford University Hospitals (OUH) and Horton hospital in Banbury had resulted in Good ratings and that the Amos report published at a similar time was not as favourable in its findings about patient experience. It was helpful to see these reports together and the ICB would work with OUH to implement a 10-point plan aimed at improvements in patient experience and staff experience. NHSE had emphasised the need for shared clinical leadership on Quality and Sarah Bellars confirmed that and Dr Lalitha Iyer, Chief Medical Officer, worked closely on Quality issues. A question was raised about the annual LeDer report which was recently published and how the ICB would take learning from that report. This was important for the ICB's duties in reducing health inequalities as the annual LeDer report highlighted that people with learning disabilities or autism were dying 19 years earlier than the general population. Sarah Bellars explained that the ICB's LeDer group were considering the report and would identify any actions to take forward as a result. Dr Lalitha Iyer, Chief Medical Officer, advised that when the ICB was commissioning any clinical programmes, data for those with learning disabilities and autism would be considered to understand any specific barriers to care. *The Board noted the Quality and Finance reports.*	
	Strategic Commissioning	
9.	**Neighbourhood Health Update** Sam Burrows, Chief System Development and Engagement Officer, presented a report highlighting the key themes which emerged from the recent Neighbourhood Health Programme visit, from Dr Claire Fuller, National Priority Programme Director for Neighbourhood Health and her team. ICB, system partner, and regional representatives were involved in the discussions and were able to demonstrate positive work in establishing neighbourhoods, whilst recognising when a consistent approach was needed across the whole Thames Valley population. The importance of agreeing neighbourhood geographies was a recurring theme, as well as the need to strengthen relationships between commissioners and providers to redesign care pathways effectively. It was noted that Buckinghamshire and Oxfordshire had made significant progress in defining neighbourhood footprints and aligning them with place governance. Zina Etheridge, CEO for Buckinghamshire Council, reminded the Board that Neighbourhood Health was not only about health care and offered to help other areas who were finding it more challenging to identify appropriate neighbourhood geographies. It was noted that Health and Wellbeing Boards had a key role to play in driving change and that local authorities had significant experience around decommissioning and tackling variation in access which would be helpful to share.	

	A more detailed understanding of which areas were already progressing well with Neighbourhood Health and the challenges that were being worked through in other areas would be useful for the Board. Sam Burrows explained that he wanted to bring an analysis or 'heat map' back to Board after the summer so that this could be explored further. **ACTION: Sam Burrows** The Board noted that a follow-up action plan, which consolidated the feedback from the visit into a single programme of work for the system would be developed and agreed. To support delivery of these priorities, the ICB would appoint a strategic development partner to work alongside Places and system partners, providing expertise, challenge and facilitation to accelerate implementation of neighbourhood health across the Thames Valley. *The Board noted the report and approved the next steps.*	
10.	**New Hospital Programme** Sam Burrows, Chief System Development and Engagement Officer shared slides highlighting the recent engagement activity around the New Frimley Park Hospital programme, following publication of the proposed site on 16th June 2026. Thames Valley ICB and Frimley Foundation Health Trust had launched a joint community engagement programme to enable the active involvement of local people in this work. Several events had already been held including an online webinar and further events were planned, including community pop ups, visits to local schools, focus groups facilitated by Healthwatch, as well as engagement events for FHFT's staff. A Joint Health Overview and Scrutiny Committee on the new hospital would also be held later this week. It was noted that the planning application process would also provide further opportunities for the public to feed into the proposals. Sam Burrows was also keeping neighbouring ICBs Surrey & Sussex and Hampshire & Isle of Wight updated with regards to the community engagement programme. Sam Burrows was asked if there was support from NHS England as Frimley Park Hospital was part of the first wave of the New Hospital Programme. He reported that all 10 local MPs had worked constructively alongside the ICB and FHFT. Lance McCarthy of FHFT, David Radbourne from Southeast region and Sam Burrows met regularly with the national team, who challenged them to ensure that decision-making and the engagement strategy was robust and had offered support in liaising with local MPs and Government throughout the process. It was noted that the new hospital represented a £2billion investment in the area, at a time when buildings were no longer fit for purpose . *The Board noted the New Hospital Programme Update.*	
	Building Conditions for Success	
11.	**Lord Mann Review and Actions** Safina Nadeem, EDI Adviser, presented the findings and recommendations of the Lord Mann review into antisemitism, anti-muslim hatred, and racism in the NHS and advised that an initial assessment had been undertaken to consider the implications for Thames Valley ICB. The review's recommendations had been mapped against the Beyond Boundaries Antiracism Framework, identifying that the existing framework provided a strong foundation for implementation, with only a small number of enhancements required to explicitly reflect the recommendations made by Lord Mann. A programme of activity was already underway including the relaunch of staff networks, refresh of recruitment and leadership initiatives, a planned Board development session on antiracism and a review of e-learning and other training once NHSE release additional updated materials. A question was raised about establishing a baseline within the ICB in the absence of a staff survey last year. Safina Nadeem explained that there was still a lot of intelligence available via staff networks and confirmed that the national staff survey would go out in October, with the results available in December or early new year.	

	There was a discussion about the ICB's role in driving the Mann recommendations forward across the system. It was recognised that it was important for the ICB to build the right culture and to model behaviour as individual leaders, as an employer, and through strategic commissioning. The ICB could use its commissioning role to influence across the system, respectful of the role and work of partners and other organisations. *The Board noted the report and approved the approach.*	
12.	**Frimley Health NHS Foundation Trust Delegation Agreement** Sam Burrows, Chief System Development and Engagement Officer reminded the Board that as part of the ICB Change Delivery Programme, a number of functions would be delegated to Frimley Health Foundation Trust (FHFT) - Medicines Optimisation, All Age Complex and Continuing Care, Thames Valley primary care workforce training and education hub, Berkshire Community Equipment Hub, and the associated Finance support staff for the first two functions. This arrangement between the ICB and FHFT would enable the ICB to fulfil its changed role as a strategic commissioner and deliver the required operational running cost reductions set by NHS England. The ICB would remain accountable for the performance outcomes of the delegated functions, therefore it was proposed that a Joint Committee to be chaired by Nick Broughton, Thames Valley ICB Chief Executive Officer, would be established to oversee performance and assess any risks to delivery. It was noted that the FHFT Board had already agreed the Delegation Agreement and the associated governance arrangements, including the establishment of this Joint Committee. It was noted that it was important that clear baselines for the performance and costs of these functions were agreed and understood by both parties at the outset. Sam Burrows assured the Board that after the first quarter of Thames Valley ICB's operation, there was a robust snapshot of operational delivery and associated finance for these functions, which would underpin the ongoing monitoring of their performance once FHFT hosting begins from 1st September 2026. *The Board noted the governance which supports the delivery of the arrangement between the ICB and FHFT.* *The Board approved the establishment of the Joint Committee between the ICB and FHFT.*	
13.	**Board Assurance Framework and Board Governance Update** Caroline Corrigan introduced the Board Assurance Framework (BAF), explaining that the BAF would enable the Board to hold itself to account for, and mitigate any risks to, the ICBs Strategic Objectives. The Board had previously approved a risk appetite statement and principal risks and controls had now been aligned against this. Each of the Board Committees would oversee different elements of the BAF risks. Ilona Blue, Chair of the Audit Committee, welcomed this early iteration of a Board Assurance Framework. She asked for assurance that the totality of the ICB's risks had been captured and requested that headline descriptions should include the actual risk as this supported discipline. She also questioned whether Cyber risks should be aligned to the Commissioning and Population Health Committee. It was also noted that it might be helpful to have a more general risk for day-to-day operational effectiveness. *The Board approved the Board Assurance Framework on the basis that that it would be further iterated before being presented to Audit Committee, before returning to the Board.*	
14.	**Alert, Advise & Assure (AAA) Reports** Tim Nolan, Chair of Finance and Performance Committee, conveyed his thanks to Finance staff from both BOB and Frimley ICBs and the new Thames Valley ICB for closing the 2025-26 financial year successfully. In his capacity as Chair of the Remuneration Committee, Tim Nolan highlighted that the Committee had been assured that the staff consultation and resulting reorganisation was on track. It was also noted that the Fit and Proper Person Test assurance for Board Members had been completed and submitted.	

	Sajjad Khan, Chair of the Commissioning and Population Health Committee, was pleased to report that their first meeting had been very positive. He noted that Thames Valley ICB was one of only 12 ICBs that had ringfenced funding for innovation – alongside Committee partners, he hoped that the ICB could grow the size of its innovation fund as well as its organisational capabilities. *The Board noted the AAA reports.*	
	Other Items of Business	
15.	**Public Questions** There were none.	
16.	**Any Other Business** There was none.	
17.	**Close** The meeting closed at 12.41pm.	
	Date of Next Meeting 15th July 2026	
END 12.41pm		

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

To: Dr Priya Singh, Chair, Thames Valley ICB
Dr Nick Broughton, Chief Executive, Thames Valley ICB

13 July 2026

Dear Nick and Priya,

Annual assessment of Buckinghamshire, Oxfordshire and Berkshire West, and Frimley Integrated Care Boards' performance in 2025/26

I am writing under section 14Z59 of the NHS Act 2006, as amended by the Health and Care Act 2022, which requires NHS England to conduct an annual performance assessment of each Integrated Care Board (ICB) including Buckinghamshire, Oxfordshire and Berkshire West (BOB) ICB and Frimley ICB, which were both dissolved at 31st March 2026.

Recognising the joint leadership and clustering arrangements that were in place during 2025/26 we have considered both ICBs together but have drawn out separate points pertaining to each statutory organisation where appropriate.

This has been a particularly challenging year for ICBs, marked by significant system-wide pressures and continued organisational change. In parallel, ICBs have been required to adapt to an evolving operating model, while maintaining a clear focus on statutory duties, system leadership and delivery for local populations.

Against this backdrop, I recognise the complexity of the task facing organisations and the sustained effort required to balance immediate operational pressures with longer-term strategic priorities. I also acknowledge the additional burden created by structural changes, and the need to maintain stability and continuity across systems during a period of transition.

In reaching this assessment, I have considered evidence from annual reports and accounts, available performance and assurance data, feedback from partners and stakeholders, and the discussions my team and I have held with ICB colleagues over the course of the year.

While this annual assessment is a statutory requirement, I have sought to ensure that it is balanced and proportionate, recognising both the need to assess performance against statutory responsibilities and the realities of the organisational change that has taken place during the year.

I remain committed to working constructively with you, building on learning from the year, and supporting ICBs as roles, responsibilities and arrangements continue to evolve.

I would like to thank you, your Board and your wider team for your leadership and continued commitment during a demanding period of change. My team and I look forward to continuing to work with you in the year ahead.

Yours sincerely,

David Radbourne
Director of Strategy and Transformation, NHS England South East

Cc:
Anne Eden, Regional Director NHS England South East
Karen Geoghegan, Regional Director of Finance, NHS England South East
Dan Bradbury, Regional Chief Operating Officer, NHS England South East
Andrea Lewis, Regional Chief Nurse, NHS England South East
Chris Tibbs, Interim Regional Chief Medical Director, NHS England South East
Alison Barnett, Regional Director of Public Health England South East
Lawrence Tyler, Deputy Director of System Coordination, NHS England South East
Charlotte Wood, Head of System Coordination, NHS England South East

Our assessment starts by recognising the complex and challenging journey undertaken by the ICBs during 2025/26: successfully engaging with key stakeholders to develop proposals for operating over a new Thames Valley geography and navigating a difficult transitional process while continuing to deliver on statutory duties. This letter sets out achievements that the successor ICB should be proud of as well as the continued priorities.

Section 1: ICB performance assessment

BOB ICB

The ICB undertook a detailed analysis of the population to provide a clearer understanding of health needs, service use and associated costs in early 2025 (Carnall Farrar work), and alignment was made in 2025/26 with local health and wellbeing strategies alongside partnership working to address improvements in population health and reduction in health inequalities. Recognising the considerable investment made by the ICB on this work, the new Thames Valley ICB should ensure the intelligence created helps to build the foundations for stronger strategic commissioning discussions going forwards.

From reviewing key oversight framework metrics, the ICB should be proud of BOB being rated in the highest performing quartile against the safety domain in the oversight framework and against the key system performance indicators of 18-weeks RTT and GP satisfaction – both performing above national target and demonstrating a year-on-year improved position.

Many metrics relating to population health and inequality remained stable – this means that areas the ICB performed well in remained strong, although areas of challenge did not show significant improvement or where improvement was made, the ICB was still under-performing both regionally and nationally. There are a couple of notable exceptions - referrals to digital weight management services per 100k people living with obesity where the ICB moved from quartile 4 to 2, and % of people on GP learning disability registers to receive an annual health-check that moved from 12.53% in Q1 to 79.4% in Q4.

The prevention agenda requires ongoing focus, with cardiovascular disease (CVD) being an area of under-performance despite work done to strengthen care as laid out in the ICB annual report. Against this year's national priorities and success measures as described in the operational planning guidance: Increase the percentage of patients with hypertension treated according to NICE guidance, and the percentage of patients with GP recorded CVD whose cholesterol levels are managed to NICE guidance whilst the ICB saw small improvements across the year (based on latest data from December 2024 to December 2025) of 2.18% and 2.6% respectively, the BOB geography remained behind both the system and national position.

Against Mental Health and Learning Disability and Autism metrics, the ICB delivered a mixed but improving end-of-year performance position, with strong achievement in a number of community and planned care measures, including CYP access above plan, Talking Therapies on or above plan, Perinatal access above plan, IPS above plan, MHST coverage meeting the national target. However, this is offset by continuing pressure in more complex operational areas, particularly long CYP waits, variable crisis responsiveness and ongoing adult inpatient flow issues. Overall, this suggests the ICB has had good capability in planned and community service delivery, but more limited capability in resolving system flow and urgent care pressures at pace. However general performance is exceeding or in line with regional peers.

Frimley ICB

Frimley ICB laid out in their annual report that they worked collaboratively with staff, partners and communities to improve their performance towards national objectives as well as locally identified priorities to address inequalities and shift towards prevention. Across a number of population health and inequality metrics the ICB were in the upper two quartiles, although there were areas of challenge in closing the myocardial infarction and stroke admission deprivation gap, and worsening performance against peers in the proportion of cancers identified at stage 1 and 2 (slope index of inequality).

Conversely to BOB ICB, Frimley outperformed regionally and nationally against the success measures for CVD management from the operational planning guidance and we would welcome the new ICB thinking through how learning can be applied to the wider Thames Valley geography.

Against Mental Health and Learning Disability and Autism metrics, Frimley ICB's end-of-year position was mixed, with a number of MHLDA measures performing at or above plan, including Talking Therapies, perinatal access, IPS, Annual Health Checks and SMI physical health checks, while average length of stay was on target and most Learning Disability and Autism inpatient metrics were on plan. However, this is offset by continuing concerns in a small number of key areas, particularly inappropriate out of area placements, very long CYP community waits, and wider SEND-related delivery pressures.

With respect to maternity services, neonatal death rates have remained high, however stabilised and adjusted perinatal mortality rates have declined over the past 4 years. Neither ICB had safety concerns relating to 2025/26 perinatal mortality events identified through surveillance systems, including MOSS. Actions have been taken to improve services and address inequalities including the introduction of a standard operating procedure for language support, antenatal education in service users' first languages, mandatory training in equity and cultural awareness, and the Genetic Risk Equality Project, which promotes culturally sensitive care and improved access to genetic services.

For safeguarding, the respective ICB teams came together to work as one team in 2025/26 and have retained their safeguarding workforce with minimal reductions to meet their statutory responsibilities. They demonstrate a drive for a consistent approach and parity of safeguarding responses across the local authority areas covered.

Financial budget management

BOB ICB

The ICB's financial performance in 2025/26 saw achievement of a breakeven position; it maintained strong financial control and remained within its running cost allowance putting in place effective financial management and robust governance arrangements and keeping a focus on value for money. The ICB performed better than average (in the second quartile) for planned surplus/deficit as a proportion of allocation and its combined financial score and was in quartile 1 for its variance to financial plan (0.0%) seeing only a drop in quarters two and four for implied productivity growth against the national average. This is a task made more

impressive by the fact the ICB was part of the Investigation and Intervention regime in the previous financial year.

Frimley ICB

Frimley ICB delivered its agreed 2025/26 financial and efficiency plans. The ICB performed better than average (in the second quartile) for planned surplus/deficit as a proportion of allocation and its combined financial score and was in quartile 1 for its variance to financial plan (0.0%) seeing only a drop in quarters 2 and 3 for implied productivity growth against the national average.

As we look ahead to 2026/27, despite Thames Valley submitting a breakeven plan, continued focus is required to progress all contracts though to signature status, particularly for agreements affected by the disaggregation of Frimley ICB, to support financial certainty and clear accountability. Thames Valley ICB also has an underlying deficit which presents a recurrent financial risk requiring sustained action and reduced reliance on non-recurrent mitigations. The ICB's 2026/27 recurrent allocation is 1.85% below fair shares target reinforcing the need for contract management grip, and a close focus on efficiency delivery and productivity.

Section 2: ICB Capability assessment

Against a backdrop of significant reform which included the national requirement for ICBs to reduce running costs by 50%, financial pressures, industrial action and sustained demand placing strain on NHS services, both ICBs maintained a grip and sought to strengthen collaboration with providers, partners and voluntary services to improve productivity and use shared resources effectively. Feedback from the Health and Wellbeing Boards was generally positive, noting active engagement, support in developing approach to the neighbourhood health agenda, and funding of community wellbeing outreach services and inequalities projects, though there was some concern about continued engagement in context of operating across the wider Thames Valley geography.

From October 2025, the ICBs began operating under a formal clustering arrangement whilst also establishing a Joint Transition Programme to design the new Thames Valley ICB, establish joint governance and operating models and support a safe transition to the new organisation on 1 April 2026. In addition, the new ICB has also stepped forward to host the region-wide Office for Pan-ICB Commissioning from April 2027. The clustering arrangement also allowed closer working in advance of the formal creation of Thames Valley ICB, for example the System Quality Group (SQG) supporting the governance of quality across the geography.

The ICB should be proud of how it has navigated the change process – the disaggregation of Frimley ICB was one of the most complex changes undertaken by an ICB across the country for April 2026. Financially, there remain some issues with contract agreements linked to the disaggregation of Frimley ICB, which need to be resolved, and with the payment of invoices (including those relating to CHC) following the ISFE2 implementation and ICB merger.

Inevitably the change process continues in terms of establishing a new operating model and we are pleased to hear a commissioning and population health committee has been

established to oversee the development of strategic commissioning capability. We should note that the BOB and Frimley ICB cluster did not develop a single five-year plan narrative as part of the planning process, however the reasons why are recognised – there had been a clear view to establish the new Thames Valley geography first in order to have legitimacy to engage with partners at this scale. Lots of good work has progress in parallel – the innovation fund, the neighbourhood agenda and lead provider arrangements, but it remains important the ICB engages with partners to develop a clear overarching five-year plan, which in turn can drive commissioning intentions for 2027/28 onwards. We know that the ICB has a clear ambition to deliver excellent outcomes for patients, in turn becoming one of the best health systems in the country, which should be central to the five-year plan. As part of strengthening strategic commissioning capability, the ICB should ensure that it quantifies this ambition, is clear on the outcomes it wants to improve and how this will be monitored.

We are sighted on some operational and capacity issues that have presented as part of the transition process, these include with All Age Continuing Care (AACC) services and with the management of complaints, subject access requests and freedom of information requests. We ask that the new ICB continues to focus on the development of these areas as part of new arrangements.

Conclusion

In forming this assessment, I have sought to take a balanced and proportionate view of your performance, recognising both what has been delivered and the complexity of the operating environment in which ICBs continue to function. I am encouraged by progress towards a more mature system of integrated care, with decision-making increasingly informed by, and responsive to, the needs of local people and communities.

NHS England acknowledges the pace of change across systems and is committed to working with you in your new geography, supporting continuity, learning from predecessor organisations, and continued improvement as the new ICB develops and embeds its responsibilities.

I ask that you share this assessment with your board and senior leadership team and consider publishing it alongside your annual report at a public meeting. In line with our statutory responsibilities, NHS England will also publish a summary of the outcomes of all ICB annual performance assessments.

NHS Thames Valley

Chief Executive and Chief Officers' Report

Context

1. This report provides an update to the Board on recent developments, items for assurance or escalation pertaining to the work of the ICB within the broader Thames Valley geography.

2. The report shares highlights from the work of the Chief Executive, the executive team, the Integrated Care Board (ICB) and its partners, together with key issues that are not reported elsewhere on the Board agenda.

3. This report is presented in a new style, framed around the ICB's strategic objectives and enabling factors, to provide clearer alignment between the work of the Chief Executive and Chief Officers and the Board's agreed priorities.

Thames Valley ICB: Mission, strategic objectives and enablers
Our mission – [why we exist]
We are here to improve population health outcomes and reduce unwarranted variation at scale.
Our strategic objectives – [how we will drive change]
1. We will **improve population outcomes** by **prioritising prevention and proactive care**, using data to effectively manage risk and prevent worsening health.
2. **We will drive equity** for communities experiencing the worst outcomes by **redistributing resources** to drive improvement and improving our understanding of hidden need.
3. **We will reduce unwarranted variation** in quality (experience, safety and effectiveness), service provision, cost, productivity, using our collective levers to address risk, drive improvement and maximise value.
Our enablers – [How we will work]
• **Improvement focused** – We will be a dynamic, improvement focused organisation, applying improvement cycles and a clear measurement framework to ensure future-focused commissioning that drives population outcome improvement
• **Insight led, AI & data literate** – We will be insight led, using user experience and population data to drive our strategy and actions. We will grow our collective capability in AI and equip all our teams with analytical tools as part of their everyday work
• **Investing in our people** – We will build commissioning capability and confidence, so that we can commission confidently for outcomes, creating a culture where our teams are empowered to tackle the complex problems facing our population and health system
• **Partnering for innovation** – We will partner across our system and beyond to drive innovation, working together to reshape our system landscape and partnering to generate investment and innovation to drive improvement

4. Today's agenda includes updates on the quality, performance and finance, winter readiness, commissioning intentions and maternity services in the Thames Valley. The Board will also receive committee assurance reports and consider key governance matters, including the Board Assurance Framework, Fit and Proper Person Test Annual Board Return and Designated Body Annual Report and Statement of Compliance, together with the 2025/26 Annual Reports and Accounts for BOB ICB and Frimley ICB.

5. Alongside updates aligned to the ICB's strategic objectives, the report will continue to include relevant system leadership and operating context where this supports the Board's understanding of the wider environment in which the ICB is working. This may include senior appointments across partner organisations, changes to national or regional governance and reporting arrangements, regional collaboration updates, and significant publications or policy developments that may inform future strategy and delivery.

Our Strategic Objectives

*We will **improve population outcomes** by **prioritising prevention and proactive care,** using data to effectively manage risk and prevent worsening health*

Chief Finance Officer

2026/27 Financial Year

The reported position at month 4 is break even with a forecast break even to year end. However, this position contains some very material risks.

Material cost pressures are emerging within:

- Medicines optimisation in NCSO (No Cheaper Stock Obtainable) and price concessions
- All Age Continuing Care where Continuing Healthcare is showing a £4.7m adverse variance YTD
- Community equipment, Terminations of Pregnancies and Complex Care
- ADHD Right to Choose activity (£2.1m adverse variance YTD)

Actions are in place to mitigate these pressures as far as is possible, and to identify and to deliver compensating cost-out efficiency in-year.

£8.6m of reserves having been committed YTD, with a remaining £23m of reserves available. However, if the current expenditure run rate is not addressed then it is likely that these reserves will be insufficient to deliver a break-even position at year end.

The reserves available include prior year benefits and unutilised specialist commissioning and other reserves, which the ICB would not normally be entitled to access, but the need for this was notified to NHSE as a pre-requisite condition for the submission of a balanced plan for the year.

Full detail is provided in the Month 4 Finance pack

Additionally, HIOW and Surrey and Sussex ICBs have submitted a claim under the terms of the South Frimley transfer MOU for the transfer of a material allocation to them from TV where they consider that their national allocation does not cover costs of services to the population for which they are responsible. This matter will be considered by the Board.

The Directorate is working rapidly to populate its new structure to mitigate capacity challenges.

Chief Medical Officer

Medicines Optimisation

- **Critical Vacancies within Delegated Function**- Recruitment for 9 whole time equivalent critical posts, targeted at the highest-risk gaps within the team. These posts are deliberately shaped around future operating model priorities, specifically medicines safety/quality, formulary and prescribing committee processes, single national formulary alignment, and place-based/community pharmacy support.

- Budget Cost Pressures- April–May shows a £4m net cost pressure against the same period last year, concentrated in three areas: GLP1s, Cardiovascular and Appliances/Continuous Glucose Monitors. A large share of this is price-driven rather than demand-driven. The increases in price concessions and

the impact on the Medicines Optimisation budget have been raised nationally through Pharmacy and Finance networks.

- **Cost Improvement Plan (CIP)**- The 2026-27 Primary Care Prescribing Cost Improvement Plan is targeting £14.5m of savings — rebates, ScriptSwitch, generic/biosimilar switching, SGLT2i and DPP4i optimisation, best-value inhalers, appliances/woundcare, primary care prescribing variation, and the ONS discharge service. Delivery to date is encouraging: many schemes are risk-rated as being low and reporting good progress through Q1 — ScriptSwitch, generic prescribing, SGLT2i and inhaler switching are all tracking either on or ahead of plan

- **Medicines Board and wider governance**: a diagnostic review of medicines governance across the ICB has been undertaken, benchmarking against the NHSE strategic commissioning framework and legacy structures. On the back of this, approval has been given to establish a Thames Valley Medicines Board.

Chief People & Corporate Affairs Officer

WorkWell Programme: The WorkWell programme is a national scheme which is focussed on supporting people aged 16 to 64 with health-related barriers to remain in, return to, or access good work through personalised support plans. We continue to mobilise successfully across the Thames Valley geography. Delivery remains on track against national requirements including the KPI for 6,850 successful placements in the scheme, with strong partnership engagement and governance arrangements in place to support implementation across the Thames Valley.

- Place-based mobilisation is progressing well, with governance arrangements agreed in Buckinghamshire and local delivery discussions continuing across Oxfordshire and Berkshire.

- Strong collaboration has been established across NHS partners, local authorities, Department for Work and Pensions (DWP), Voluntary, Community and Social Enterprise (VCSE) organisations and employment support providers to support an integrated delivery model and a streamlined access route for residents.

- Opportunities to align WorkWell with neighbourhood and primary care models are being explored to strengthen local access, integration and referral pathways.

- Stakeholder engagement and system readiness activity continues to support a coordinated and effective service launch.

The immediate focus is the submission of the WorkWell Delivery Plan to DWP in September, information governance requirements, and maintaining mobilisation and implementation readiness across all Places.

Equality, Diversity & Inclusion Advisor

Equality Impact Assessments (EqIAs): EqIAs are embedded into the consideration and development of services and interventions, helping to identify inequalities, barriers to access and groups at greater risk of poorer outcomes. This will support targeted prevention and proactive care, ensuring resources are focused where they can have the greatest impact.

Equality Diversity and Inclusion Conference (EDI) - 11 November 2026: The Thames Valley ICS Equality, Diversity and Inclusion Conference will take place on 11 November 2026, bringing together partners from across the system to share good practice, strengthen collaboration and support delivery of the EDI agenda.

Thames Valley ICS Mirror Board: Applications for the Thames Valley ICS Mirror Board will close on 18 September 2026, with a good response from system partners; further representation from local government and the voluntary sector would be welcomed.

We will drive equity *for communities experiencing the worst outcomes* ***by redistributing resources*** *to drive improvement and improving our understanding of hidden need.*

Chief Finance Officer

The financial strategy is progressing, with a headline figure of £59m to be allocated to support preventative, proactive and neighbourhood care models in pathway transformation.

This sum will not all be deliverable through growth funding and there is a concomitant requirement to identify resources consumed by activity which is of lower comparative value and take action to decommission or reduce the breadth of provision in order to release resource for investment in transformation.

More detail will be covered in the Board agenda item concerning Commissioning Intentions.

Chief System Development and Engagement Officer

Neighbourhood Development Programme: This month marks the start of the Thames Valley Neighbourhood Development Programme which is a critical opportunity for our system wide partnership to influence, design and implement the neighbourhood architecture of the Thames Valley. This will be the engine room of our 'left shift' endeavour and will mark a fundamental next step in ensuring that more care is delivered closer to home whilst resolving outstanding questions on local decision making and accountabilities.

Following the visit of Professor Claire Fuller, NHS England's National Priority Programme Director for Neighbourhood Health, on 23 June, Thames Valley was recognised as a good system in neighbourhood and partnership working, with strong examples of practice across the geography. The visit provided valuable external validation and an opportunity to build on existing strengths and build a consistent approach across Thames Valley.

We have identified a strategic development partner to support partnerships accelerate the development of Neighbourhood Health Plans for each Health and Wellbeing Board. We will also develop a mature governance and outcomes framework that links resident outcomes in neighbourhoods, to Health and Wellbeing Boards, Health and Care Partnerships and the Thames Valley system. Professor Fuller's letter and the accompanying single-page summary are included in the appendix.

Maternity Review: The Board will hear further details today about our planned review of maternity services in the Thames Valley which will inform our future approach to commissioning and delivering such services. This is a critical priority for the organisation following the recent reviews which have been undertaken into maternity care across the country and more locally.

New Hospital for Frimley Park – Engagement: We continue to run a far-reaching public engagement programme to hear the views of local people regarding the proposed redevelopment of Frimley Park Hospital and the associated new model of care. Over 5,000 responses have now been received from members of the public with a wide range of views expressed. The second phase of this engagement work has now commenced, and we look forward to further conversations with residents around the opportunities this multi-billion-pound investment in our health services will present.

Winter Planning: Our work to prepare for delivering high-quality services throughout the winter period has progressed well over the summer. The Board will be presented with a summary of our Winter Plan today, including the assurance statements which will give confidence to local people and partners of a robust NHS service they can rely on.

Chief Strategy and Commissioning Officer

Primary Care In August, we saw the completion of a £500k capital investment at KEY Medical Practice in Kidlington to provide additional clinical space and increased primary care capacity. The investment was funded through the NHS England Utilisation and Modernisation Fund (UMF), which supports the conversion of non-clinical space into clinical accommodation to maximise the use of existing healthcare estates.

The UMF programme has supported a number of smaller estates improvement schemes across the system, with the KEY Medical Practice project providing a particularly powerful example of its impact. Delivered in partnership with NHS Property Services (NHSPS), the scheme refurbished and repurposed previously vacated and underutilised space within the practice to create new consultation rooms. The project has increased clinical capacity, improved utilisation of the existing estate, and enhanced the practice's ability to meet growing patient demand, demonstrating how targeted capital investment can deliver tangible benefits both for patients and primary care services.

We will reduce unwarranted variation *in quality (experience, safety and effectiveness), service provision, cost, productivity, using our collective levers to address risk, drive improvement and maximise value.*

Chief Executive Officer

Neighbourhood health: an international exploration The King's Fund has published new research on neighbourhood health, drawing on international examples from Brazil's Family Health Strategy and New Zealand's Healthy Families programme. The research highlights the importance of community knowledge, leadership and relationships in shaping effective neighbourhood-based models of care. While the current focus in England is on improving access to clinical services and reducing pressure on hospitals, the international evidence suggests that neighbourhood health has the potential to support broader transformation in how health and care systems work with people and communities to improve population health. Although these examples are not intended as a blueprint for replication, they provide useful insight as the NHS develops its approach to neighbourhood health and considers the conditions needed for these models to thrive.

A key element of the planning process is the deconstruction of block contracts, which when completed will provide transparent intelligence on the commitment of our resource, which will facilitate more informed decision making in pursuit of value and productivity. This cannot be completed by the ICB alone and must be done in collaboration with system partners.

Chief People & Corporate Affairs Officer

Change Delivery Programme – A brief update is provided in the sections below

TV ICB Structures The project continues to progress to plan, with significant movement through the "Filling of Posts" process and further progress in workforce transition planning and policy harmonisation.

- To date, 502 colleagues from a baseline of 725 have received clarity on their future position, including 214 colleagues transferring to Frimley Health Foundation Trust (FHFT) on 1st September, 243 colleagues being matched into roles and 45 colleagues identified as being at risk.
- The second voluntary redundancy (VR) process is ongoing, with 42 applications currently being progressed.
- A shared approach to developing a single set of People Policies has been agreed with Executive and Trade Union colleagues. Policies have been reviewed and categorised to support implementation, ranging from those aligned to national policy through to those requiring further development to reflect emerging legislative changes.

Organisational Development Key organisational development milestones have been achieved in the current reporting period, including completion of Phase 1 of the Ways of Working programme and establishment of governance arrangements for the new Commissioning Delivery Boards. Preparations are also underway for the organisation's first all-staff conference in October and our inaugural NHS staff survey in the autumn, both of which will support greater staff engagement, organisational insight and culture development across Thames Valley ICB.

Thames Valley Delegated Functions (Transfer to FHFT) Project. The Delegation Agreement for transferred functions has now been agreed and signed off. The relevant governance arrangements to support the new arrangements have been established.

Governance and Operating Model Project. The Governance team has published an updated Functions and Decisions Map for the new organisation.

Functions Done Once Across the South-East and CSU Closure coherence Project. Engagement continues as functions are identified that can be delivered on a pan ICB model. Leads are being agreed and alignment being undertaken with the new Thames Valley ICB Commissioning Boards to support decision making.

- CSU close down - We continue to be concerned about the speed of development of some CSU transfers, particularly those relating to GP and Corporate IT and Procurement.

- We continue to engage with the Office of the South East ICBs Sub Committee to provide direction on the various work streams.

System leadership and operating context update

- **South Central Ambulance Service NHS Foundation Trust and South East Coast Ambulance Group Chief Executive appointment:** Simon Ashton has been appointed as Group Chief Executive for South Central Ambulance Service NHS Foundation Trust (SCAS) and South East Coast Ambulance Service NHS Foundation Trust (SECAmb), joining both organisations on Monday 5 October 2026. Ahead of his start date, he will be released from his current role for one day a week during September to support induction across both Trusts, including service visits and engagement with colleagues. Interim Chief Executive arrangements will remain unchanged during this period. The Board is asked to note the appointment and the opportunity it presents to strengthen collaboration, shared learning and improvement through the group model.

- **Oxford Health NHS Foundation Trust:** Grant Macdonald, Chief Executive of Oxford Health NHS Foundation Trust, will retire in September 2026. Dr Michael Holland has been appointed as the Trust's next Chief Executive and will take up the role on 7 September 2026. Grant has made a significant contribution to Oxford Health and wider system partnership working during his time as Chief Executive and prior to that as the trust's chief operating officer for mental health services.

- **Slough Borough Council:** Will Tuckley left his position as Slough Borough Council's Chief Executive in August. Dr Dave Smith will succeed him.

Regional Governance: The South East Regional Team has advised that the proposed approach to ICB oversight meetings for 2026/27 will be to hold mid-year reviews, followed by the annual assessment in Q1 of 2027/28. The mid-year review meetings are already scheduled for Q2 and will therefore be retained, while the Q1 meetings currently scheduled for August will be cancelled. Where specific points of escalation arise, additional meetings will be arranged on an as required basis to ensure timely discussion and resolution.

Regional Transition Board: As the new ICB and NHS England regional operating models continue to take shape, the Regional Transition Board has been formally closed, with learning from its work informing the next phase of regional collaboration. Over the past year, the Board has brought together senior leaders from across the system to maintain collective oversight during a significant period of organisational transition, strengthen collaboration between NHS England, ICBs and providers, support alignment on key transformation priorities and provide a forum for constructive challenge, shared learning and system problem-solving. The contribution of colleagues, including the Regional Delivery Unit, has been instrumental in enabling this work. Looking ahead, a broader strategic steering group will be established to bring together senior leaders from NHS England, ICBs, provider organisations, primary care and HINs, focusing on a smaller number of shared regional priorities where collective leadership, delivery support and system-wide insight can add greatest value.

Nick Broughton
Chief Executive
NHS Thames Valley ICB

Date: 9 September 2026

NHS England

ICB Chief Executive
ICB Chair

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

9 September 2026

Dear Priya and Nick

Neighbourhood Health – Thames Valley

Thank you to you and your team for meeting with us to discuss progress following the recent Neighbourhood Health Readiness Visit.

We appreciated the continued openness and constructive engagement from you and your colleagues. The follow – up discussion provided an opportunity to further review progress and consider the system's trajectory as neighbourhood health continues to develop.

There are a number of strong examples of good practice across Thames Valley.

These include:

- **Using Population Health Management to target neighbourhood action**

  Population Health Management is being used as a practical foundation for neighbourhood planning and delivery across Thames Valley. Shared data and analytics are combined with local intelligence and community insight to understand population need, identify people at risk of deterioration and target proactive interventions.

- **Targeted prevention and action on health inequalities**

  Thames Valley has used preventative outreach to reach groups who are less likely to engage with traditional services. An earlier programme in Berkshire West delivered 12,500 enhanced health checks focused on inequalities groups. The programme identified significant levels of previously unrecognised cardiovascular risk, with 85% of participants reporting improved awareness of their CVD risk and 75% reporting subsequent lifestyle changes. The next phase is being commissioned through the Thames Valley Innovation Fund, with a focus on prevention and earlier detection.

- **Buckinghamshire: building the infrastructure for neighbourhood working**

  Buckinghamshire provides an example of a partnership that has built a comprehensive infrastructure around neighbourhood working. Services include proactive frailty support, Community Health and Wellbeing Workers and MDTs for complex individuals and children and young people.

- **Oxfordshire: embedding neighbourhood working**

  Oxfordshire provides an example of neighbourhood working being embedded within wider partnership arrangements. Oxfordshire has several mature and embedded Integrated Neighbourhood Teams, a strong primary and secondary care interface network, experienced primary care providers operating at scale, evidence of reduced discharge delays and a focus on joint commissioning and inclusive planning. This provides a foundation for further development of proactive neighbourhood care for frail and complex residents, alongside work with children and young people and prevention.

- **Berkshire West: developing proactive INTs through test and learn**

  Berkshire West is developing a proactive neighbourhood model by bringing existing resources and services together around agreed population cohorts and pathways. The emerging model includes PCN-cluster INTs, multi-agency review and escalation, and proactive home visiting initially focused on the 1,000 highest-need patients.

Taking together the visit and follow-up process, alongside the subsequent system and Place level self - assessments, the accompanying single page summary provides an agreed reflection of the system's current position.

We would encourage you to share the agreed single page summary with your Board and system partners to support local oversight of neighbourhood health priorities, agreed next steps and future delivery.

As discussed, the key areas of focus over the coming months are to:

- Agree/validate neighbourhood footprints and develop a Neighbourhood Health Plan for each HWB, with explicit approach to managing LGR and other boundary changes.
- Baseline partnership maturity; agree governance and leadership arrangements; clarify ICB/partnership/neighbourhood roles.
- Identify priority cohorts and early adopters; agree minimum expectations and develop local delivery models.
- Establish common intelligence requirements and improve data-sharing gaps; use PHM to identify priorities and cohorts.

- Agree core measures, baseline and reporting approach; align with NHF requirements and Place plans.
- Identify early adopter pathways/schemes; develop commissioning and contracting options; align BCF and other resources with neighbourhood priorities.
- Identify priority pathways and interface barriers; agree improvement actions with providers.
- Confirm operating model, governance and work programme; establish Neighbourhood Commissioning Board as a lean strategic commissioning forum.

Thank you again for the time and commitment shown by you and your teams throughout both the visit and follow-up process. We look forward to continuing to work with you as neighbourhood health develops across Thames Valley.

Yours sincerely

Professor Claire Fuller MRCGP DRCOG MBBS
National Priority Programme Director – Neighbourhood Health

Annex:

Single slide summary

NHS Thames Valley ICB

8 September 2026

ICB at a glance			
ICB CEO	Dr Nick Broughton (substantive)	**Local authorities**	8 upper-tier/unitary; LGR live in Oxfordshire footprint
ICB Chair	Dr Priya Singh	**Providers**	Acute: OUH, Royal Berkshire, Frimley Health (boundary-spanning), Buckinghamshire Healthcare. Community/MH: Berkshire Healthcare, Oxford Health.
Registered population	approx. 2.49 million	**Self-reported**	1 (OUH, Requires Improvement)
Places	4 (East Berkshire presented as one footprint at the visit; whether it operates as one Place or three not fully resolved); eight HWBs; only Bucks and Oxon coterminous	**Workforce**	Legacy Frimley GBP 27k surplus on an underlying system deficit
Footprint	Berkshire, Buckinghamshire, Oxfordshire; affluent ageing shires with sharp urban deprivation (Slough, Oxford City, Reading)	**Pilots and designations**	NNHIP pioneers in system ; 1 Neighbourhood Health Service Site recorded, hours unevidenced

Place level maturity score

Place (fill = maturity)	Buckinghamshire	SCORE: 60	Oxfordshire	SCORE 55	Berkshire West	SCORE 51	Berkshire East	SCORE 50
Population	553,100		725,292		~510,000 (3 LAs)		502,080 (3 LAs)	
HWB sign-off	Y (footprints agreed; BCF allocated)		Y (NbHs through HWB)		N (shared strategy)		Place partnership governance set	
NbH footprints / PCNs	6 neighbourhoods (2+ PCNs each)		3 planning units		3 planning units 17 PCNs / 43 practices		3 planning units 1 footprint; 41 practices / 11 PCNs	
HLE (M / F)	69.4 / 70.3		67.1 / 68.3		Reading 63.9 / 65.7 to Wokingham 70.9 / 71.2		Slough 60.1 / 61.8 to W and M 70.3	
GP federation	Fed Bucks		PML (~70% of practices), Oxford City Primary Care and Oxavia		Berkshire West Primary Care Alliance		Berkshire Primary Care Ltd	
MNP / integrator	Buckinghamshire Healthcare candidate		ICB MNP not confirmed		Not surfaced		Not surfaced	

Examples of practice surfaced across Places

- **Berkshire West (App 83):** Virtual Ward cared for 3,093 adults, 93 per cent avoiding an unnecessary hospital admission (NNHIP application).
- **Buckinghamshire (App 68):** Lipid Optimisation Programme reviewed 1,500+ patients in a year, 62 per cent up-titrated (NNHIP application).
- **Berkshire East / Frimley (App 52):** mature frailty model delivering 20 to 30 per cent reductions in hospital activity for targeted cohorts (NNHIP application).

Five Goals (RAG vs England; see Annex B for scores)

G1 Health outcomes	G2 GP access and experience	G3 Planned care	G4 Urgent and emergency care	G5 Patient and staff satisfaction

Strongest: G5 staff satisfaction (top-quartile on every NSS 2025 theme, engagement 7.26 rank 1/42 QNQ). Weakest and most polarised: G2 GP access (QNQ Frimley bottom-quartile across GPPS 2025; whole-ICB overall satisfaction 73.5 per cent, preferred-HCP 40.1 per cent). G4 strength on UCR and virtual wards offset by both legacy systems bottom-quartile on the 0 to 14 A and E attendance share.

Enablers (Section 4)

Enabler (fill = rating)	Key point
Data	Well evidenced and advanced: Connected Care (Graphnet) across all four Places, Johns Hopkins PNG segmentation in active clinical use (demonstrated at the visit), risk stratification and PHM analytics embedded
Workforce	3-year primary care / non-NHS MH plan in the 2026/27 submission; no Place-level neighbourhood workforce plan
Finance	Most challenging environment in CFO experience; underlying system deficit; 50 per cent running-cost reduction
Digital	Shared record across BOB and Frimley; legacy Frimley a national PHM incubator feeding the FDP
Estates	7 surgical hubs, 6 CDCs, 1 NHS Service Site; Wycombe hub and Slough centre (c. GBP 24.5m); NHC pipeline to confirm

Framework readiness: Stage 1 (foundations) and Stage 2 (NbH Plan)

Ref	Stage 1 minimum requirement (2026/27): Ref fill shows rating	Self-assessed score
S1	Reduce non-elective admissions via UCR and reablement	6.5
S2	Reduce variation; improve access to general practice	4.0
S3	Neighbourhood footprints agreed	6.5
S4	INTs for high-priority cohorts; devolved budgets	4.0
S5	Neighbourhood approach to elective pathways	5.25
S6	18-week community waits; eliminate 52-week waits	5.0
S7	BCF pooled funding plans confirmed with LAs	6.75
S8	Primary / secondary care interface (RTC)	4.25
S9	Organisational ownership of planned deliverables	5.25
S10	Data-sharing arrangements for patient identification	6.5
Stage 1 overall:		**54**

Step	Stage 2 NbH Plan: seven-step readiness - cell colour shows rating
1	National objectives via the three reform agendas
2	Support wider local goals and public service reform
3	Local objectives informed by JSNA
4	Confirm final geographies
5	Confirm organisational delivery responsibilities
6	Confirm governance and operational arrangements
7	Align other initiatives (Family Hubs, Pride in Place, MH hubs, employment)

Forward look - Key actions over next 6 months:

1. Agree/validate neighbourhood footprints and develop a Neighbourhood Health Plan for each HWB, with explicit approach to managing LGR and other boundary changes.
2. Baseline partnership maturity; agree governance and leadership arrangements; clarify ICB/partnership/neighbourhood roles.
3. Identify priority cohorts and early adopters; agree minimum expectations and develop local delivery models.
4. Establish common intelligence requirements and improve data-sharing gaps; use PHM to identify priorities and cohorts.
5. Agree core measures, baseline and reporting approach; align with NHF requirements and Place plans.
6. Identify early adopter pathways/schemes; develop commissioning and contracting options; align BCF and other resources with neighbourhood priorities.
7. Identify priority pathways and interface barriers; agree improvement actions with providers.
8. Confirm operating model, governance and work programme; establish Neighbourhood Commissioning Board as a lean strategic commissioning forum.

Forward look – Key actions over next 18 months

1. Plans embedded in planning, commissioning and delivery, with neighbourhood priorities routinely driving action.
2. Mature, exercised partnership arrangements with clear accountability and sustainable local capability.
3. Consistent INT/proactive care model operating across neighbourhoods, with learning and improvement embedded.
4. Integrated intelligence routinely drives neighbourhood planning, prioritisation, intervention and evaluation.
5. Outcomes routinely reported at neighbourhood/partnership level and used to drive improvement and resource decisions.
6. Early adopter models implemented, evaluated and ready for wider spread across Thames Valley.
7. Neighbourhood-facing pathways increasingly embedded, with improved access, reduced waits and specialist capacity released.
8. Neighbourhood working embedded in business as usual, with reduced reliance on external support and strong local capability.

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Thames Valley Integrated Care Board

Public Board

Title of Paper	Quality Exception Report – September 2026		
Agenda Item	6	**Date of meeting**	16 September 2026
Exec Lead	Sarah Bellars, Chief Nursing Officer		
Author(s)	Melanie Bessant, Deputy Chief Nursing Officer Jane Thomson-Smith, Associate Director of Quality and Clinical standards Alison Mcmilan, Interim Head of Patient and Public Experience		

Purpose	To Approve	☐
	To Ratify	☐
	To Discuss	☐
	To Note	☒

Link to Strategic Objective	*Please list which Objective this paper relates to here.*

Executive Summary	
The report provides high level surveillance of developing quality issues and a precis of current concerns. Areas acknowledged in the report are Complaints and Patient Experience, Learning from Patient Safety, LeDeR Programme update and positive assurance from recent inspections.	
Recommendation	The Board is asked to note the report and the assurance provided regarding ongoing quality oversight and improvement activity.

Conflict of interest identified
Yes ☐ No ☒
Detail

Reporting – has this paper been discussed at other meetings		
Committee Name	Date discussed	Outcome

NHS
Thames Valley

Quality Exception Report – Thames Valley ICB Public Board (September 2026)

Key Areas of Focus

Complaints and Patient Experience

Following the integration of the former Frimley complaints and PALS service into Thames Valley ICB, work has continued to stabilise services, improve oversight and reduce historic backlogs. Recovery actions are demonstrating positive progress, with a significant reduction in the number of older complaints awaiting resolution and improvements in timeliness of acknowledgement. Further work remains underway to achieve expected performance standards and establish a sustainable operating model.

Learning from Patient Safety Events

One Never Event was reported by a provider organisation during the reporting period. The provider has completed investigation processes, identified learning and implemented improvement actions. The ICB continues to monitor provider learning and assurance arrangements through established quality oversight mechanisms.

Services in Enhanced Oversight

Enhanced oversight arrangements remain in place for a small number of commissioned services where performance, quality or operational recovery plans are being monitored. Progress continues to be demonstrated against agreed improvement trajectories, with regular assurance meetings providing oversight of delivery and risk mitigation.

Learning Disabilities Mortality Review (LeDeR)

The LeDeR programme continues to address a historic backlog of reviews inherited from predecessor organisations. Actions have been implemented to improve review completion rates, strengthen processes and increase reviewer capacity. Whilst challenges remain due to the volume of cases, the quality of reviews remains strong and continues to provide valuable learning to support service improvement.

Positive Assurance

Recent regulatory inspections have provided positive assurance regarding the quality of care delivered across the system. During the reporting period:

- The Campion Unit at Berkshire Healthcare NHS Foundation Trust received a rating of **Good** across all domains, with inspectors highlighting person-centred care and a positive service culture.

- Thames Hospice was rated **Outstanding overall** by the Care Quality Commission, recognising excellent standards of caring, responsiveness and partnership working.

Conclusion

Quality surveillance continues to identify areas requiring focused improvement and oversight. Recovery actions are progressing across identified areas of concern, while recent CQC inspections provide positive assurance regarding the quality of care being delivered across the Thames Valley system. The Quality Oversight Committee will continue to monitor progress and escalate significant risks to the Board where required.

Recommendation: The Board is asked to note the report and the assurance provided regarding ongoing quality oversight and improvement activity.

NHS
Thames Valley

Thames Valley Integrated Care Board

Public Board

Title of Paper	Finance Report		
Agenda Item	6	**Date of meeting**	16 September 2026
Exec Lead	Rich Chapman		
Author(s)	Veronica Lowthian, Elaine Polton, William Stokes and Ambika Solanki		

Purpose	To Approve	☐
	To Ratify	☐
	To Discuss	☐
	To Note	☒

Link to Strategic Objective	

Executive Summary

The paper reports the month 4 finance position for Thames Valley ICB.

Finance

At month 4 the ICB is reporting on plan for both the year to date and the forecast outturn.

There are cost pressures within the following budget areas:

- **Urgent Emergency Care (UEC), Community and Long-Term Conditions (LTC)** adverse pressure £0.7m YTD and £0.7m FOT. There is a cost pressure YTD in the community equipment budget based on April & May data, the team are working with the provider to identify efficiencies to bring this back on plan. There is a pressure in the Termination of Pregnancies (TOPS) contract YTD with a forecast pressure of £0.7m, this appears to be a year-on-year increase in activity rather than price, the team are working on the analysis of the data.
- **Elective, Cancer and Diagnostics** £1.2m adverse YTD but on plan FOT. The YTD is driven by NHS London providers and Independent sector providers with small underspends elsewhere in the portfolio. The forecast remains on plan as Indicative Activity Plans (IAPs) are in place with these providers.
- **Mental Health, LD, CYP and Maternity** YTD adverse £1.3m and £3m FOT. The FOT is the ADHD RTC providers, and the YTD is a net of £2m ADHD RTC being mitigated with underspends elsewhere in the portfolio. The ADHD providers do have IAPs and Activity Query Notices (AQNs) will be issued but the ICB do not expect to be able to recover the full overspend.
- **All Age Complex and Continuing Care** YTD adverse £4.7m and FOT £6.9m adverse. This reflects the continued adverse pressure in some areas of the geography and ongoing operational capacity issues. The forecast has been calculated at £6.9m adverse as an AACCC infrastructure reset programme is expected to strengthen financial assurance and operational resilience therefore have a positive impact as we progress through 26/27.
- **Primary Care Prescribing** YTD adverse £1.6m and FOT £2.9m adverse. This is the impact of Price concessions / NCSO drugs. At M3 the budget was reported to plan with a £2.5m risk. The data is showing a continued cost pressure therefore at M4 this risk has been reflected in the FOT. A residual risk of £0.7m has been noted for additional impact of weight loss drugs.

The cost pressures at Month 4 have been fully mitigated by non-recurrent benefits.

Efficiency programme

The efficiency programme is targeting a CIP delivery of **£68m** against a required CIP delivery of **£65m** to allow for a contingency against slippage. Fully developed plans in delivery account for **£48.8m** (71.4%) of this target, with **£4.6m** against plans developed but not started and **£6.8m** with plans in progress. The remaining **£8.1m** remains opportunities without fully developed plans.

At Month 4, the programme has delivered £19.2m of savings against a planned £21.7m, resulting in a £2.5m adverse variance to plan, representing a deterioration of £0.4m from the £2.1m adverse variance reported at Month 3. This reflects savings delivery being behind the original financial plan, although part of the variance is attributable to the agreed phasing of scheme implementation.

When measured against the scheme implementation plan profile of £20.2m, savings delivery is £0.9m behind plan. The remaining £1.5m variance represents the net impact of under delivery against the original financial plan.
The principal areas contributing to the shortfall are:

- Mental Health, with savings of £0.2m delivered against a plan of £2.3m, an adverse variance of £2.1m.
- All-age Continuing Care, delivering £2.6m against a plan of £4.9m, an adverse variance of £2.4m.
- Community Healthcare, where no savings have been delivered against a planned £0.6m.

These adverse variances are partially offset by Primary Care Prescribing, which has delivered £7.5m against a plan of £4.7m, exceeding plan by £2.7m.

Capital

The ICB capital allocation for 26/27 is **£14.2m** and remains on track to be fully utilised by year end.

From 2026/27, NHS England's South East region will assume responsibility for making Minor Improvement Grant and UMF payments directly to GP practices. This change is intended to provide a clearer, more streamlined, and consistent approach to the administration of these funding streams.

Recommendation	The Board is asked to NOTE the report.

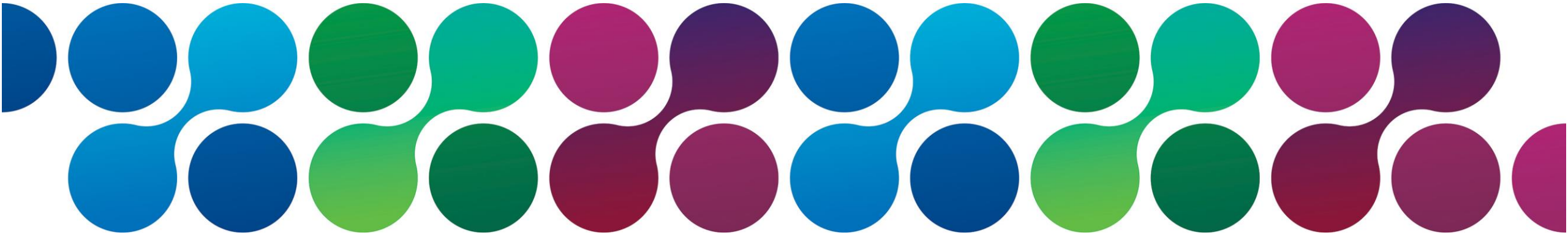
Conflict of interest identified
Yes ☒ No ☐
Members of the Committee have responsibility and/or accountability for performance portfolio included within the report

Reporting – has this paper been discussed at other meetings		
Committee Name	Date discussed	Outcome
Finance and Performance	27th August 2026	Noted

NHS
Thames Valley

Financial Performance Report

Thames Valley ICB Financial Position as at Month 4



Thames Valley ICB Position at M04

Year To Date & Forecast Outturn - break-even

Thames Valley ICB Month 04	YTD Budget	YTD Actual £m	YTD Variance	Annual Budget	Forecast Outturn £m	Forecast Variance
Allocation	(1,938.5)	(1,938.5)	0.0	(5,917.9)	(5,917.9)	0.0
Expenditure	1,938.5	1,938.5	0.0	5,917.9	5,917.9	0.0
Month 04 Financial Position (break even)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

ICBs are no longer required to report at system level and therefore Provider finances are no longer included within the monthly Integrated Finance Return.

Thames Valley ICB is reporting a break-even position at month 4 (YTD and FOT)

Portfolio Summary YTD & FOT

UEC, Community & Long Term Conditions

YTD overperformance in Community Equipment (£0.6m), the forecast remains on plan for this service as there is joint work with the local authority and the provider to identify efficiencies including increases in recycling and efficiency utilisation. The Termination of Pregnancies (TOPs) contract is showing an adverse variance YTD (£0.2m) and the **FOT is showing an adverse variance of (£0.7m)**. Initial investigation into this suggests year on year increase in activity, rather than price. Unable to apply AQNs etc on this type of service.

Elective, Cancer and Diagnostics

Acute providers were **reporting £1.2m YTD overspend**, primarily driven by adverse position with the Independent Sector (IS) providers (£0.9m) and NHS London providers (£0.6m). This is partially offset by favourable positions with in-system providers

The current forecast outturn for core Acute is in line with the annual budget as AQNs/AMPs are expected to bring current overspends back on plan.

Mental Health, LDA, CYP & Maternity

Overall **YTD pressure of £1.3m** across the portfolio, with ADHD RTC contracts and S117 showing adverse positions, these are partly mitigated by underspends within other areas of the budget. ADHD Providers have agreed IAPs therefore AQNs will be issued and the providers will be expected to deliver to the IAPs in 26/27 however, the ICB is still expecting to see further pressures where new providers come online. The **FOT is showing a £3m cost pressure.**

Thames Valley ICB Month 04	YTD Budget	YTD Actual £m	YTD Variance	Annual Budget	Forecast Outturn £m	Forecast Variance
Total Allocation	**(1,938.5)**	**(1,938.5)**	**0.0**	**(5,917.9)**	**(5,917.9)**	**0.0**
Portfolio						
UEC, Community and Long Term Conditions	241.1	241.8	(0.7)	723.2	723.9	(0.7)
Elective Cancer and Diagnostics	1,000.3	1,001.5	(1.2)	3,047.4	3,047.4	0.0
Mental Health, LDA, CYP and Maternity	199.3	200.6	(1.3)	600.7	603.7	(3.0)
All Age Complex and Continuing Care	93.3	98.0	(4.7)	280.0	286.9	(6.9)
Primary Care Prescribing and HCD	124.2	125.8	(1.6)	372.7	375.7	(2.9)
Primary Care and POD	258.1	257.2	0.8	788.7	788.7	0.0
Estates	1.4	1.4	(0.0)	4.3	4.3	0.0
Corporate	20.1	20.1	0.0	60.5	60.5	0.0
Other	0.6	0.6	0.0	1.6	1.6	0.0
Reserves	0.0	(8.6)	8.6	39.0	25.4	13.6
Total Expenditure	**1,938.5**	**1,938.5**	**0.0**	**5,917.9**	**5,917.9**	**0.0**
Month 04 Financial Position (break even)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

All Age Complex and Continuing Care

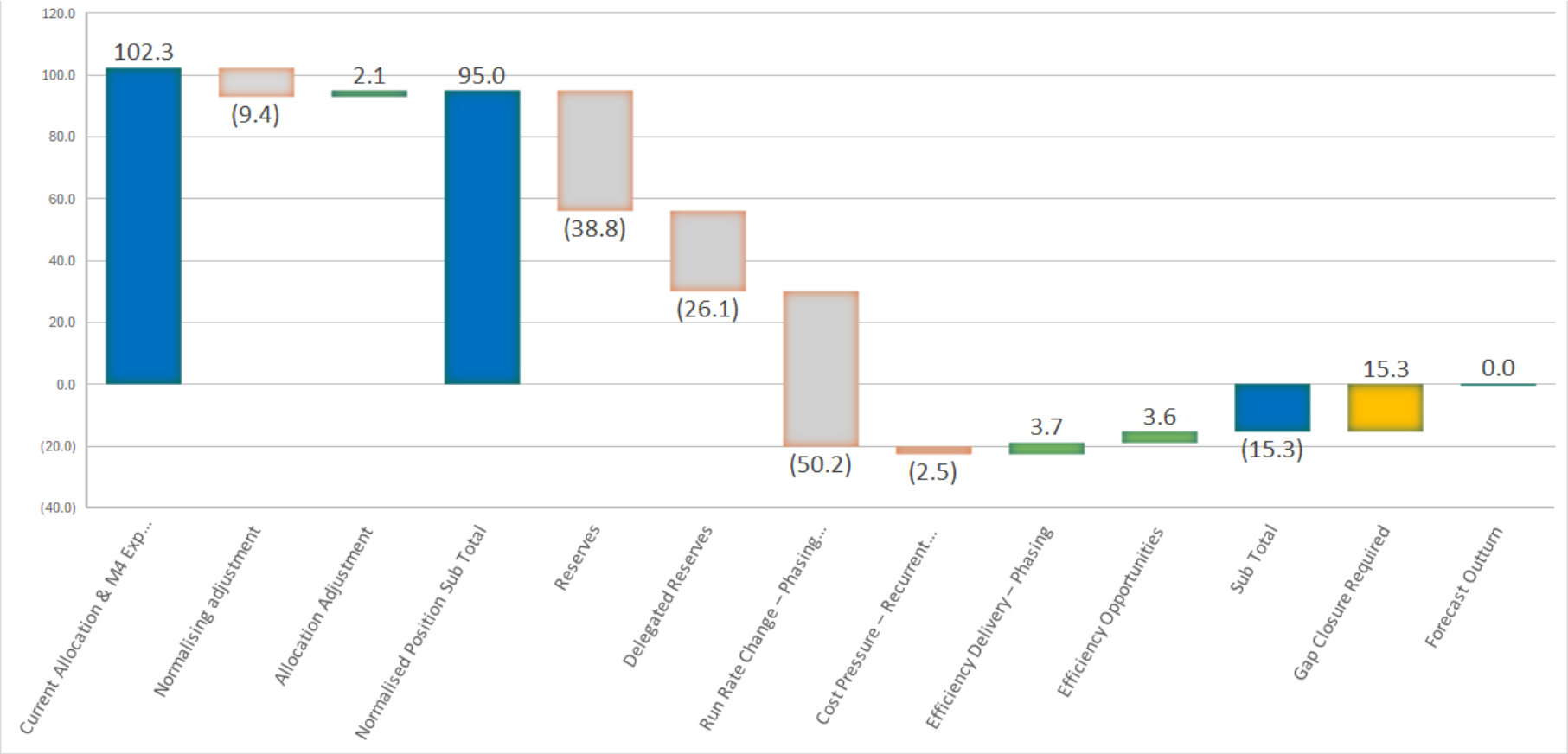
YTD **£4.7m adverse and FOT £6.9m adverse**. The budget is experiencing cost pressures due adverse movements compared to 25/26. The team have operational capacity issues, invoice backlog issues as a result of the closure of 2 ICBs to create the new TV ICB and database issues. A paper was sent to Execs on 10/8/26 requesting support for AACCC infrastructure reset to strengthen financial assurance, governance and operational resilience. This was approved.

Prescribing

YTD shows **a £1.6m adverse variance and £2.9m FOT adverse** the budget was on plan at month 3 with a £2.5m risk noted. The month 2 data shows cost pressures within the prescribing budget this is due to growth in endocrine system/weight loss drugs, cardiovascular medicines, appliances, and ongoing NCSO (No Cheaper Stock Obtainable) pricing pressures. Further analysis will be undertaken once 3–4 months of actual expenditure data is available to better understand the prescribing trends and refine the risk assessment.

The **YTD adverse** variances are fully mitigated by non recurrent benefits at Month 4. The ICB remains **on plan overall** YTD and FOT.

Run Rate Analysis



The ICB has a **starting surplus of £102.3m** based on a straight-line expenditure run rate and current allocation.

Following normalisation and allocation adjustments, this reduces to a **normalised surplus of £95.0m.**

After reflecting delegated reserves, phasing adjustments, undelivered efficiencies and cost pressures, the position moves to a **£15.3m deficit.**

This gap is expected to be closed through AMPs, further CIPs and mitigating actions, resulting in a break-even forecast outturn.

The following slide provides further detail on the movements shown in the waterfall.

The waterfall above shows the bridge between the current allocation & straight-line expenditure run rate, which is normalised and then has further expenditure/efficiencies and mitigating actions factored in to achieve a break-even forecast outturn.

Efficiencies

Budget Area	Executive Lead	YTD M4 Plan £m	YTD M4 Actual £m	YTD M4 Variance £m	Financial Plan £m
Acute	Hannah Iqbal	0.1	0.0	0.1	0.3
Acute IS	Hannah Iqbal	3.7	3.6	0.1	11.0
All-age Continuing Care	Sarah Bellars	4.9	2.6	2.4	14.8
Community Healthcare	Hannah Iqbal	0.6	0.0	0.6	1.7
Mental Health	Sarah Bellars	2.3	0.2	2.1	7.0
Primary Care (inc. Primary Co-Commissioning)	Hannah Iqbal	0.0	0.0	-0.0	0.0
Primary Care Prescribing	Lalitha Iyer	4.7	7.5	-2.7	14.2
Running Cost	Richard Chapman	5.3	5.3	-0.0	15.9
Other Programme	Richard Chapman	0.0	0.0	0.0	0.0
Total		21.7	19.2	2.5	65.0
Acute - Avoidance of anticipated demand growth - left shift, contract levers		9.3	9.3	0.0	28.0
2% Contract Efficiency		23.0	23.0	0.0	69.0
Total Delivery against Financial Plan Submission		54.0	51.5	2.5	162.0

The ICB's total efficiency requirement for 2026/27 is £162m, comprising £65m of ICB CIP savings, £69m of 2% Contract Efficiency requirements, and £28m of Acute Avoidance, Left Shift and Contract Lever efficiencies. At Month 4, year-to-date delivery is £51.5m against an equal twelfths plan of £54.0m, resulting in an adverse variance of £2.5m (4.5%).

Delivery of the £69m 2% Contract Efficiency programme and the £28m Acute Avoidance, Left Shift and Contract Lever programme are advised as remaining on track, with year-to-date targets achieved, providing assurance over £97m (60%) of the total efficiency requirement.

The £2.5m variance is primarily driven by under delivery in the Mental Health and All-age Continuing Care budget areas, together with implementation profiling differences. This has been partially offset by over delivery within Primary Care Prescribing.

Details of CIP plan development, delivery progress and associated risks are provided in the following slides.

At Month 4, the programme has delivered £19.2m of savings against a planned £21.7m, resulting in a £2.5m adverse variance to plan, representing a deterioration of £0.4m from the £2.1m adverse variance reported at Month 3. This reflects savings delivery being behind the original financial plan, although part of the variance is attributable to the agreed phasing of scheme implementation.

When measured against the scheme implementation plan profile of £20.2m, savings delivery is £0.9m behind plan. The remaining £1.5m variance represents the net impact of under delivery against the original financial plan.

The principal areas contributing to the shortfall are:

- Mental Health, with savings of £0.2m delivered against a plan of £2.3m, an adverse variance of £2.1m.
- All-age Continuing Care, delivering £2.6m against a plan of £4.9m, an adverse variance of £2.4m.
- Community Healthcare, where no savings have been delivered against a planned £0.6m.

These adverse variances are partially offset by Primary Care Prescribing, which has delivered £7.5m against a plan of £4.7m, exceeding plan by £2.7m.

Capital

Month 4 TVICB gross capital expenditure was £3.2m below plan, primarily due to the profiling assumptions made during the planning stage. **Operational Capital Schemes**: £4.3m of operational capital schemes are currently progressing through the Project Initiation Document (PID) process and are awaiting approval through the ICB governance framework.

CDEL Summary	Capital Plan YTD £'000	Capital Actual YTD £'000	Capital Variance YTD £'000	Capital Plan FY £'000	Capital Forecast FY £'000	Capital Variance FY £'000
Operational Capital-Minor Improvement Grant (MIG)	375	0	375	1,125	1,125	0
Operational Capital Digital	1,092	0	1,092	3,279	3,279	0
System Strategic Projects	1,291	0	1,291	7,199	7,199	0
Digital ARRS	0	0	0	513	513	0
IFRS 16 Impact	33	0	33	100	100	0
National Programmes - UMF	446	0	446	2,000	2,000	0
Total CDEL	3,237	**0**	**3,237**	**14,216**	**14,216**	**0**

Overall Capital Plan and Forecast outturn
The capital programme is designed to support TVICB in delivering its key strategic capital priorities. Capital expenditure as at Month 4 remains on track to fully utilise the **£14.2m** allocation by year end.

System Strategic Projects: PIDs for the System Strategic Projects programme remain in development.

National Programmes (UMF): The ICB continues to work closely with GP practices, and approximately 40% of PIDs have now been submitted to NHS England for approval.

Change in Process for GP Practice Payments Relating to Minor Improvement Grants and UMF Funding (2026/27)
From 2026/27, NHS England's South East region will assume responsibility for making Minor Improvement Grant and UMF payments directly to GP practices. This change is intended to provide a clearer, more streamlined, and consistent approach to the administration of these funding streams. Payments will be processed through the Primary Care Support England (PCSE) system, aligning the South East region with the approach already adopted across other NHS England regions. This will ensure a consistent national process for the payment of GP practice estates capital projects and improve standardisation across the organisation.

NHS
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Thames Valley Integrated Care Board

Title of Paper	2026/27 Winter Plan		
Agenda Item	7	**Date of meeting**	16 September 2026
Exec Lead	Sam Burrows, Chief System Development & Engagement Officer		
Author(s)	Debbie New, Associate Director Performance UEC – Ambulance Philip Kelley, Head of UEC, Delivery & Flow		

Purpose	To Approve	☒
	To Ratify	☐
	To Discuss	☐
	To Note	☐

Link to Strategic Objective	*Please list which Objective this paper relates to here.*

Executive Summary	
The Thames Valley Winter Plan attached is a consensus position of the 4 place winter plans that have been through local health & care partnership governance and approval with partners. The slide deck attached also presents in an alternative summary format. The Board Assurance Statement is also attached which requires Board approval and submission to NHSE by 30th September 2026. A regional exercise winter test event took place on Monday 14th September with over 30 members of the Thames Valley system in attendance.	
Recommendation	The Board approves the Winter Plan and associated Board Assurance Statement.

Conflict of interest identified
Yes ☐ No ☒
Detail

Reporting – has this paper been discussed at other meetings		
Committee Name	Date discussed	Outcome
N/A		

Thames Valley's Winter 2026/27 - Draft

1. Introduction and Purpose

This paper sets out the first draft of the Thames Valley Integrated Care Board (ICB) Winter Plan for 2026/27. It brings together, for the first time as one system, the winter plans developed independently by Buckinghamshire, Oxfordshire, Berkshire West and East Berkshire, and sets them against the assurance framework NHS England has prescribed for this winter.

The final version will be produced for 30th September recognising that some amendments may be required following with regional Winter Test Event on 14th September.

Each of the 4 Thames Valley geographies have developed individual winter plans and this document is the overarching plan for the whole of Thames Valley.

2. Learning from Winter 2025/26

Thames Valley enters this winter as one ICB but with four geographies still, in effect, reporting on four different winters – Buckinghamshire, Oxfordshire and Berkshire West from BOB ICB, East Berkshire as part of the former Frimley system.

2.1 What worked

- Established Urgent Community Response (UCR), Virtual Ward/Hospital@Home and discharge pathways supported admission avoidance and step-down in every geography.
- Removing the daily cap on Buckinghamshire's Clinical Assessment Service (CAS) during winter reduced the need to send patients to GP practices and safely managed more patients at home.
- Local dashboards, escalation routes and named ownership improved operational visibility in East Berkshire and Berkshire West alike.
- Targeted communications, Pharmacy First and vaccination outreach helped residents navigate services across all four places.
- Oxfordshire achieved zero growth in emergency admissions to general medical and gerontology wards – in fact a 4% reduction – and reduced ambulance conveyances from care homes by 18%, with a 26% reduction in emergency admissions from care homes.

2.2 What did not work well enough

- Workforce pressure, partner capacity, housing, equipment and care packages remained structural constraints in every geography
- Variation in pathway maturity and utilisation reduced the benefit of capacity that existed on paper: community pathways in East Berkshire, for example, had the referral volumes but not always the acute demand reduction to show for it.
- Data quality, attribution and baselines weakened assurance and made impact harder to evidence – a theme common to all geographies, where different systems (SHREWD, local dashboards, FDP) do not yet speak with one voice.
- Community pharmacy stock shortages, in Buckinghamshire, and a lack of face-to-face capacity behind an otherwise successful virtual Clinical Assessment Service, created some gaps.
- Funding sign-off delays pushed back recruitment in Buckinghamshire, meaning some discharge and care home bed schemes did not realise their full benefit before winter ended.

2.3 Therefore, for 2026/27

- **Reliability over ambition –** define the core model ensure embedded rather than adding further schemes
- **Evidence –** agree baselines, trajectories, dashboards and named data owners before winter starts, not during it.

- **Early action –** treat known constraints – workforce, care market capacity, funding sign-off – as planning assumptions to be built around, not late surprises.

3. One System, Four Geographies: The Shape of This Plan

Thames Valley's four geographies are not starting winter planning from the same place. Buckinghamshire, Oxfordshire and Berkshire West carry forward BOB ICB's shared governance, shared vaccination infrastructure and a common escalation vocabulary built around SHREWD. East Berkshire carries forward the former Frimley system's own winter model.

3.1 Universal offer, targeted protection

Across Thames Valley, the same winter offer will not necessarily produce equitable outcomes across a geography with significant internal variation. Slough carries materially greater deprivation and lower healthy life expectancy than neighbouring localities where high-need residents drive a disproportionate share of 999 calls, ED attendance and bed days. Oxfordshire's own data shows a comparable pattern between East Oxford and its wider county, and Buckinghamshire's Integrated Neighbourhood Team (INT) interventions are explicitly targeted at wards – Quarrendon in Aylesbury, Castlefield in Wycombe – with the greatest need.

The implication for this plan, adopted across all four geographies, is to plan for reliable access everywhere – NHS 111, primary care, community pharmacy, urgent treatment centres, UCR and Hospital@Home – and then show explicitly how communications, vaccination, proactive care and pathway capacity are tailored to higher-risk cohorts: frailty and multimorbidity, care homes, respiratory risk, high-intensity service users, and Core20 communities.

4. Local Delivery Plans

This section summarises the four geography plans..

4.1 Buckinghamshire

Buckinghamshire's plan is on behalf of all system partners including Buckinghamshire Council, Buckinghamshire Healthcare NHS Trust (BHT), FedBucks, Oxford Health NHS Foundation Trust, HealthWatch, Community Pharmacy Thames Valley, Buckinghamshire VCSE, South Central Ambulance Service (SCAS), Bucks Primary Care and Frimley Health NHS Foundation Trust. It is approved via the Bucks UEC Steering Group and UEC Board in August, then the Buckinghamshire Executive Partnership and Health and Social Care Committee (HASC) in September.

Learning From 2025/26

Type 1 A&E attendances at Stoke Mandeville remained consistently high through January–March 2026 with no sustained reduction; 4-hour performance was highly variable, with isolated days exceeding the 78% national standard but not sustained; bed occupancy remained consistently above optimal levels throughout the quarter. The Clinical Assessment Service (CAS), capped at 120 calls a day, had that cap removed through winter and this is credited as one of the most effective single interventions of the year.

2026/27 Priorities

- **UEC Vision Phase 2 –** increasing face-to-face capacity at Wycombe Urgent Treatment Centre as an extension of the CAS, with clinical assessment of walk-in patients and redirection to Pharmacy First where appropriate.
- **Care Homes –** a 24/7 Care Home Clinical Assessment Service (live since 1 April 2026), 23 Care Home Hub beds providing step-down capacity, and joint UKHSA outbreak-readiness work.
- **Discharge and flow –** Home First, Rapid Response and Intermediate Care (RRIC), the Emergency Medical Receiving Unit, an ED-based Admission Avoidance Social Worker, and dedicated homelessness discharge support from Buckinghamshire Council.
- **Neighbourhood interventions –** six Integrated Neighbourhood Teams delivering targeted schemes – Health on the High Street and Warm Spaces in Aylesbury/High Wycombe, Community Health and Wellbeing Workers in Quarrendon and Castlefield, a Pharmacy First resilience project in

Chiltern, and Proactive Frailty Clinics elsewhere – alongside an ambition for one CYP multidisciplinary team in every Thames Valley neighbourhood.

Risks flagged locally

- The ICB's own organisational consultation, which will see UEC place-based teams no longer part of the organisational structure, with changes likely during the summer
- Potential consultants' industrial action affecting urgent, community and emergency services.
- Weather variability – milder winters in recent years have reduced trauma/orthopaedic demand, but a colder winter would have a direct impact.

4.2 Oxfordshire

Oxfordshire's plan is framed around the continued shift towards integrated, community-based care through neighbourhoods – bringing primary care, acute providers, community services, mental health, the voluntary sector and councils together around shared outcomes.

Learning From 2025/26 & Current Pressures

Oxfordshire's winter picture reflected rising pressure across all parts of the UEC pathway, with sharp ED attendance growth at both John Radcliffe and Horton General Hospitals—particularly among walk-ins and children—and increased acuity linked to the summer heatwave. Community services absorbed significant demand: SPA call volumes rose 39% while maintaining near-target responsiveness, MIUs sustained 95%+ 4-hour performance, GP Out of Hours saw substantial activity spikes, and UCR consistently delivered over 95% two-hour responses. The system achieved notable gains, including an 18% reduction in ambulance conveyances from care homes, a 26% reduction in emergency admissions from care homes, zero growth in emergency admissions to general medical and gerontology wards, and improved ambulance handover times. However, pressures persisted: rising ED attendances, workforce challenges, increased complexity in community caseloads, mental health demand (including an 11% rise in CYP mental health attendances), and discharge delays driven by therapy capacity, social care availability, equipment, reablement flow and complex cases. Oxfordshire's learning emphasises the need for continued neighbourhood-based integration, strengthened Home First and intermediate care pathways, clearer discharge task visibility, expanded crisis mental health provision, and sustained investment in community-based alternatives to admission.

2026/27 Priorities

- **Acute hospital flow –** a 10% reduction in emergency admissions for frailty cohorts by 2029; a 10% reduction in ED attendances, admissions and primary care contacts for high-intensity users; ambulance handovers consistently under 45 minutes; elimination of corridor care.
- **Discharge –** no more than 0.6% of patients medically optimised for discharge (MOFD) for 21 days or more; continued work on the gap between people ready for reablement discharge (rarely waiting more than a day) and those needing more complex, specialist rehabilitation placements (currently waiting 8–18 days).
- **Mental health –** expansion of the 24/7 crisis team to full county coverage by November 2026, and continued work with SCAS on the 24/7 mental health crisis phone line to divert appropriate patients away from ED – against an 11% year-on-year rise in children and young people's mental health attendances.
- **SCAS 'stack' support –** extension of urgent community response support to South Central Ambulance Service from the current 4 hours a day to 12 hours, Monday to Friday, from 1 October 2026, building on 1,099 patients supported in this way between April and July 2026.

Risks flagged locally

- Continued demand growth after a pressured summer, with concern that the system will not have time to recover before winter demand builds further.
- The ICB's organisational consultation, with the impact on the winter plan not yet clear.

4.3 Berkshire West

Berkshire West's plan with system partners including Royal Berkshire NHS Foundation Trust (RBFT), Berkshire Healthcare NHS Foundation Trust (BHFT), Reading, Wokingham and West Berkshire Borough Councils, HealthWatch, Community Pharmacy Thames Valley, BW VCSE, Thames Valley ICB and SCAS.

Learning From 2025/26

Berkshire West entered winter 2025/26 under sustained pressure, with high bed occupancy, challenged ED flow, ambulance handover delays and significant strain on mental health services, affecting staff morale. Rapid mobilisation of pilots, strong cross-organisation collaboration through SPoA, effective use of D2A beds and P1 discharge, and locally commissioned VCSE support (including Hospital@Home) all worked well. However, workforce fragility, short-term financial arrangements, estates constraints, care home delays, data quality issues and prolonged mental health waits in ED remained unresolved risks. Sign-off processes slowed mobilisation, complexity and acuity drove overcrowding, and P3 pathway delays persisted. Learning from the BW UEC Board emphasised earlier planning, more agile ICB financial decision-making, strengthening the Community First model, deeper integration across urgent care pathways (same-day access, UCR, SDEC), Trusted Assessor approaches, better use of insights tools, rapid escalation mechanisms, and clearer mapping of voluntary-sector support.

2026/27 Priorities

UEC discretionary funding was allocated at the start of the financial year to protect the services already developed for admission avoidance: Virtual Wards, Single Point of Access, Same Day Emergency Care, Urgent Community Response, Transfer of Care and the Clinical Assessment Service. RBFT and BHFT received further funding for additional capacity at peak-demand periods. Crucially, the system is explicit that there will not be significant additional capacity across Berkshire West this winter – the focus is on maximising flow through what already exists.

- Bed occupancy no more than 92% across the bed base; delivery of the agreed ED 4-hour trajectory and minimised proportion of patients over 12 hours in ED.
- Zero tolerance of ambulance handover delays over 60 minutes.
- Minimising the number of patients no longer meeting Criteria to Reside, and protecting elective care trajectories throughout winter.
- Continued use of SHREWD as the single portal for system status, performance and escalation level.

Risks flagged locally

Risk	Owner	Mitigating action
Workforce, particularly therapies and social work	Local authorities, BHFT, RBFT	Ensure therapists and social workers are targeted only at tasks only they can perform
Non-CtR patients and length of discharge waits	Local authorities, BHFT	Comprehensive oversight, reporting and escalation arrangements
SCAS handover delays	SCAS; system ownership required	Internal processes to ensure 15-minute handovers
Elective recovery programme impact	RBFT	System ambition to protect elective care
Removal of place-based UEC teams under the new Model ICB	ICB	Discussions under way with NHS England and providers on the ICB's approach to winter oversight and resilience

4.4 East Berkshire

East Berkshire's plan is inherited from the former Frimley system, preserving what worked, while fitting it to the new Thames Valley strategic commissioning model.

- **Protect –** preserve the strengths of the former Frimley system – mature pathways, local ownership and established operational routines.
- **Optimise –** make utilisation, referral quality, occupancy, throughput and response times visible across the whole pathway.
- **Target –** use segmentation, deprivation and risk stratification – recognising Slough's materially greater deprivation and lower healthy life expectancy relative to Windsor and Maidenhead – to focus prevention and communications where winter risk is greatest.

Learning From 2025/26

East Berkshire's 2025/26 review showed that resilience was strongest where pathways were already mature, operational oversight was clear and targeted action was taken early. Established community and discharge pathways – including UCR, Virtual Wards/Hospital@Home and Place-based discharge improvement – supported admission avoidance and flow, while dashboards, micro-audits, escalation routes and targeted communications improved operational visibility. Primary Care navigation, Pharmacy First, vaccination outreach and CYP interventions helped residents reach appropriate services. However, structural constraints persisted: workforce pressure, partner capacity, housing, equipment and care-package delays continued to limit flow; variation in pathway utilisation reduced the impact of services that existed on paper; and data quality, attribution and coding changes weakened assurance and made impact harder to evidence. Discharge and downstream capacity remained a significant constraint, and some interventions could not demonstrate impact due to incomplete baselines and outcome data. These lessons shape the 2026/27 approach: protect and optimise what already works, set explicit utilisation and reliability expectations, treat workforce/social care/housing/equipment/data limitations as planning assumptions, define a smaller coherent metric set with named data owners, and use inequalities and risk stratification to target interventions rather than relying solely on system-wide messaging.

2026/27 Priorities

East Berkshire organises its plan into eight delivery areas, each to be tested for baseline capacity, winter peak, surge trigger, named owner, metric and evidence source: prevention and vaccination; primary care, NHS 111 and pharmacy; community, UCR and Hospital@Home; ambulance alternatives and handover (targeting 15-minute handovers and a 45-minute maximum); acute front door and Same Day Emergency Care (Model ED, corridor care elimination); mental health and children and young people; discharge and intermediate care (non-criteria-to-reside, P0–P3, reablement, pre-Christmas occupancy); and SCC, OPEL, infection prevention and control, and workforce.

Risks flagged locally

- Discharge and social care capacity: risk of high occupancy, prolonged ED waits and corridor care without a quantified capacity plan and pre-Christmas occupancy actions.
- Workforce availability: reduced capacity across the whole pathway without rota resilience, sickness assumptions and cross-cover plans.
- Variation in community pathway utilisation: capacity that exists on paper but does not reduce acute demand without referral standards and a utilisation dashboard.
- Data and analytics capacity: weak assurance and delayed response without named data owners and agreed baselines.
- Respiratory/infectious disease surge, and organisational transition and finance – unclear accountability or slow authorisation during the ICB's own restructuring.

5. Prevention and Vaccination: A Thames Valley-Wide Programme

Prevention and vaccination is a Thames Valley wide programme, and this section draws on the ICB's Flu Vaccination Assurance Statement for AW26/27 (submitted to the regional PMO ahead of the 27 July deadline, for Regional Director sign-off by 31 July).

5.1 Scale and delivery model

Across Thames Valley, 196 GP practices are engaged in the seasonal vaccination programme, of which 194 have signed up for flu and 170 for COVID-19; 249 community pharmacies are signed up for adult flu, 102 for children's flu and 199 for COVID-19; and one hospital hub completes the network, giving a maximum travel time of 20 minutes to a vaccination site across the region. Twenty-six practices have opted out of the COVID-19 programme, two of them also opting out of adult flu – the ICB is working with alternative providers to cover the resulting gaps for housebound and care home residents.

RSV vaccine eligibility expands further from 1 September 2026 to include people aged 65–74 in certain clinical at-risk groups, alongside the existing offer to pregnant women, older adults aged 75 and over, and older adult care home residents.

5.2 Assurance status

The AW26/27 assurance return is summarised below:

- **Fully assured: –** maintaining vaccination activity through the historically quieter month of November; uptake monitoring and reporting; GP sign-up to the 2–3-year-old childhood flu programme (only one Thames Valley practice has not signed up, with three community pharmacies covering the gap in Abingdon); School Age Immunisation Service (SAIS) capacity, contract management and action plans; frontline healthcare worker (FHCW) vaccination plans across all seven Thames Valley trusts (BHFT, BHT, OUHFT, FHFT, SCAS, OHFT and RBHFT); and long-stay inpatient and care-home-discharge vaccination plans; NHS trusts' use of the Record a Vaccination Service (RAVS); Overall uptake ambitions for 2026/27 plans are being progressed to support vaccination uptake in line with NHS England's targets; targeted outreach for low-uptake communities and groups;
- **Partially assured, with plans in train: –** vaccination access for people experiencing homelessness; and older adult care home vaccination, where two GP practices remain unsigned and are being covered by alternative providers.
- **A specific system gap: –** Whilst Buckinghamshire Healthcare NHS Trust, Oxford Health and Buckinghamshire more broadly will not be onboarded to the national Manage Vaccinations in Schools (MAVIS) reporting system for this autumn's campaign. NHSE are assured that all three providers will have transitioned from the National immunisation and Vaccination System (NIVS) bulk upload to the MAVIS national reporting tool from September 2026.

5.3 Vaccine Targeting and Communications

The autumn/winter outreach campaign focuses on six localities with historically low vaccine uptake, spanning all four Thames Valley geographies: Slough, Aylesbury, East Oxford, High Wycombe, Reading and Banbury. This is delivered alongside a year-round Access and Inequalities programme (April 2026–March 2027) running Community Champions engagement in each of the four geographies, and vaccine-hesitancy training for staff and community workers built around ‘Making Every Contact Count’ principles – including a Community Pharmacy Vaccination Education Programme from September 2026 and a four-day ‘Let's Talk About Vaccines’ health coaching course in November 2026.

The wider communications campaign launches in early October using the national ‘Help Us Help You’ and ‘Stay Strong, Get Vaccinated’ assets, supplemented by a dedicated two-week maternity vaccination campaign (1–14 September) across local press in every geography, and a six-day COVID-19 ‘ad van’ tour of the Thames Valley footprint.

The frontline healthcare worker ambition is set nationally at 60–65% uptake over the next three years, monitored through the Federated Data Platform (FDP); Thames Valley's own performance against this ambition in 2025/26 should be reported alongside this plan when the wider BAS is finalised.

6. Comms and Engagement

This winter communications will take on a sharper, funded purpose: reducing avoidable demand on emergency departments by making alternatives visible and easy to use and standing ready to support providers directly once winter pressures build.

6.1 Promoting alternatives to ED, led by Pharmacy First

Regional financial allocations will be used this winter to promote alternatives to ED across Thames Valley, with Pharmacy First as the lead campaign.

The external campaign objectives – reducing pressure on the emergency department, increasing flu and COVID vaccine uptake, and promoting self-care – sit alongside alongside a Pharmacy First push, and its own test for good messaging (informative, distinctive, insightful and measurable) are clear.

This runs as a separate, parallel campaign to the vaccination and prevention communications set out in Section 5.3, using the same regional funding route and, where sensible, the same channels and partners – including the refreshed Stay Well website and community pharmacy network already in place across all four places.

6.2 Supporting providers through winter pressures

Alongside the public-facing campaign, Thames Valley's comms and engagement teams will work directly with provider colleagues to advise and support the management of winter pressures where that is helpful – for example, helping providers communicate clearly with patients and staff during periods of escalation, or supporting local messaging when a service is under particular strain. This is deliberately offered as support rather than mandated activity: providers retain their own communications functions and escalation routes.

7. Local Coordination & Governance

The ICB operates within 4 Health and Care Partnerships each with strong local knowledge of their health economies. During periods of Winter pressure, issues and escalations arising within any of these areas can be supported by bringing in local partners who understand those systems well and can act at pace. Further conversations with partners are continuing in line with the Model ICB Blueprint, particularly around how organisations will undertake more joint convening in the future to strengthen collective system leadership.

Providers will also be engaging in multi-lateral discussions to coordinate surge responses, with an increased emphasis on providers leading these conversations. This approach is intended to ensure that operational decisions are informed by those closest to delivery, while maintaining alignment with the wider system’s Winter resilience arrangements.

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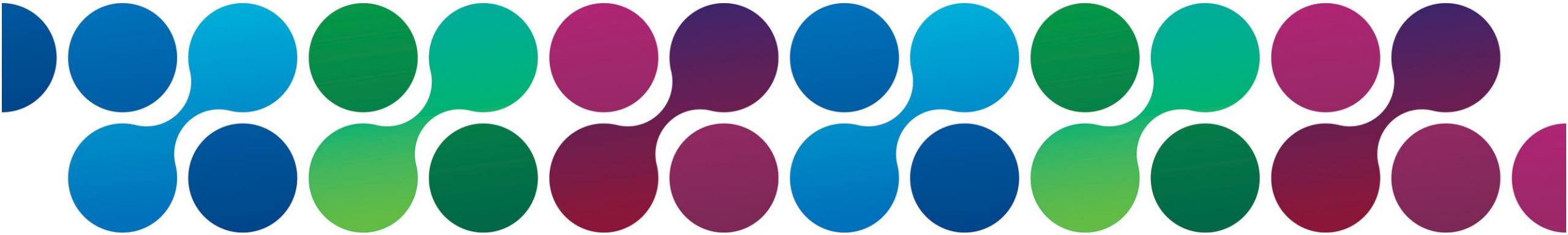
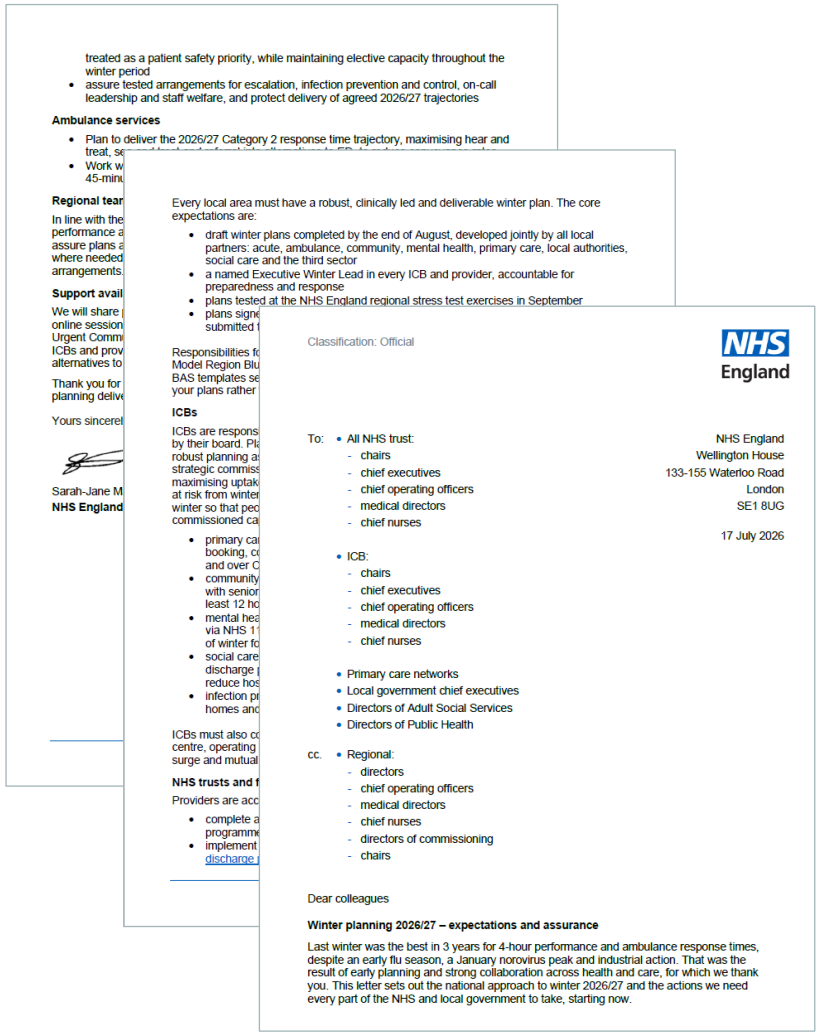
Thames Valley Winter Plan 2026/27

Draft v0.1 – September 2026



The national ask:

Winter Planning in August, Assurance in September



Classification: Official

NHS England

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NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

17 July 2026

Dear colleagues

Winter planning 2026/27 – expectations and assurance

Last winter was the best in 3 years for 4-hour performance and ambulance response times, despite an early flu season, a January norovirus peak and industrial action. That was the result of early planning and strong collaboration across health and care, for which we thank you. This letter sets out the national approach to winter 2026/27 and the actions we need every part of the NHS and local government to take, starting now.

17 July	NHSE Winter Planning letter issued
August	Draft Winter Plans
14 September	Regional ‘Stress-test’ Event
Before 30 Sept	ICB Board BAS sign-off
30 September	BAS submitted to NHSE

Clear roles and accountabilities across the system

Winter delivery depends on explicit ownership across Commissioners, Providers and Partners. The Thames Valley plan brings these responsibilities together through a single assurance framework

ICB commissions & assures

- System capacity
- Prevention & vaccination
- SCC/OPEL coordination
- BAS evidence & risk position

Providers deliver

- Organisational Winter Plans
- Model ED / Internal Flow / Discharge
- Operational grip & trajectories
- Elective protection

Partners enable

- Local authority discharge capacity
- Care Market
- Social care, housing, equipment
- VCSE/Community

‘Strategic Commissioning’ changes the conversation. The ICB can commission, coordinate and assure – but does not directly control all the Provider and Local Authority levers.

One Thames Valley Plan:
Four local geographies, one system oversight

This acknowledges genuine local differences while giving the ICB one Board assurance position.

BAS	**Demand & Capacity**	**SCC**	**Prevention**	**Data / Metrics**
Single Board return	Common whole-system picture	One OPEL / escalation model	TV-wide vaccination & comms	Shared definitions & trajectories

Local delivery plans retain the detailed geography, partner and pathway priorities:

Buckinghamshire
- CAS
- Care Homes
- Home First
- INT neighbourhoods

Oxfordshire
- Integrated Neighbourhoods
- UCR
- Care home conveyance reduction
- MH Crisis Coverage

Berkshire West
- Protected admission avoidance capacity
- SHREWD
- Discharge & Flow

East Berkshire
- FHFT Front Door
- Discharge & Flow
- Slough targeting

Winter 2026/27 will prioritise operational grip over broad ambition

Across the four Places, the plan focuses on optimising established pathways and protecting safety through predictable periods of pressure.

What we will do

- Define the core Winter Operating Model
- Manage risk and use vaccination and targeted comms
- Maximise 111 / Primary Care / UTCs / Pharmacy / Community
- Maintain grip on daily flow, SDECs, MADE events and discharge escalation
- Protect elective capacity while balancing risk

What will be System-wide

- One Thames Valley BAS rather than four independent returns
- SCC/OPEL and escalation framework
- Whole-system demand & capacity visibility
- Consistent Place-level performance trajectories

What will it lead to

- Reduced corridor care and waits in ED
- Improved 4-hour / 12-hour / handover trajectories
- Reliable use of community and admission-avoidance capacity
- Elective trajectories protected where clinically safe

Place trajectories show the performance expected throughout the Winter months

The same core measures will be tracked for each Place, based on existing plan trajectories:

March 2027 Target	Buckinghamshire	Oxfordshire	Berkshire West	East Berkshire
All type 4-hour	83.21%	83.91%	82.00%	80.67%
12-hour A&E breaches	7,905	5,008	4,751	26,630
Average handover time	15:53	17:14	17:42	19:17
% of handovers >45mins	0.00%	0.00%	0.00%	1.54%
ED paediatric performance	85.20%	85.52%	95.01%	91.00%

A common trajectory set allows the Board to see both the Thames Valley ambition and the local contribution from each geography.

Assurance framework from local delivery to ICB Board

Operational delivery remains local; system coordination and Board assurance are brought together at Thames Valley level.

ICB Board	Approves Winter Plan and BAS; reviews QEIA, stress-test learning and the final system assurance position.
Executive Lead	Provides system oversight of preparedness, delivery risk, assurance evidence and escalation.
TV SCC / OPEL	08:00–18:00, 7 days a week; shares intelligence, balances risk, coordinates mutual aid and maintains the regional interface.
Places & Providers	Deliver local and organisational plans, agreed trajectories, discharge and admission-avoidance pathways, workforce and escalation actions.

Evidence supporting Board assurance

- Whole-system Demand & Capacity
- Place Performance trajectories
- Provider BAS / organisational plans
- Prevention and vaccination assurance
- Learning from September Test Event
- IPC, EPRR, workforce and mutual-aid assurance

Key risks to manage throughout Winter 2026/27

The plan is designed to manage these risks actively through Thames Valley SCC/OPEL oversight, local delivery routes and Board-level assurance – recognising that many operational levers sit with Providers and Local Authority partners rather than being under direct ICB control.

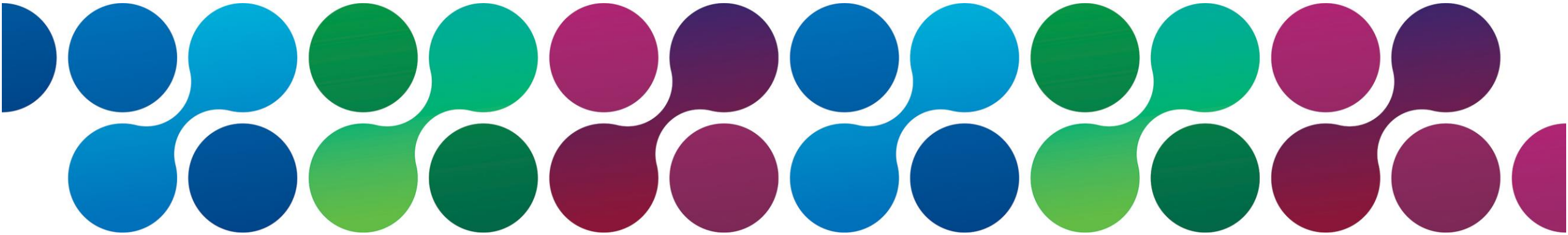
BAU	Core Winter Plans are established across the four places, covering vaccination, 111/Primary Care access, UCR, Virtual Wards / Hospital@Home, Discharge grip and SCC oversight.
Surge	Demand, occupancy and discharge pressure may be sustained by respiratory and infectious disease, high bed occupancy, NCTR, care-market capacity, housing, equipment and transport delays.
In Extremis	If several Providers or Places deteriorate together, mutual aid, workforce, elective protection and capacity flex may be limited, and require rapid executive intervention.

Active controls thoughout Winter:

1. Daily SCC/OPEL view of ambulance, ED, beds, community capacity, discharge and workforce
2. Place and provider trajectories reviewed against agreed baselines and winter peak assumptions
3. Targeted prevention, vaccination and support for high-risk cohorts and low-uptake communities
4. Clear escalation of constraints outside direct ICB control: social care, Provider capacity, workforce, estates, elective cancellations

NHS

Thames Valley



Winter Planning 26/27
Board Assurance Statement (BAS)
Integrated Care Board (ICB)

1. Purpose
The purpose of the Board Assurance Statement is to ensure the ICB's Board has oversight that all key considerations have been met. It should be signed off by both the ICB Accountable Officer and Chair.

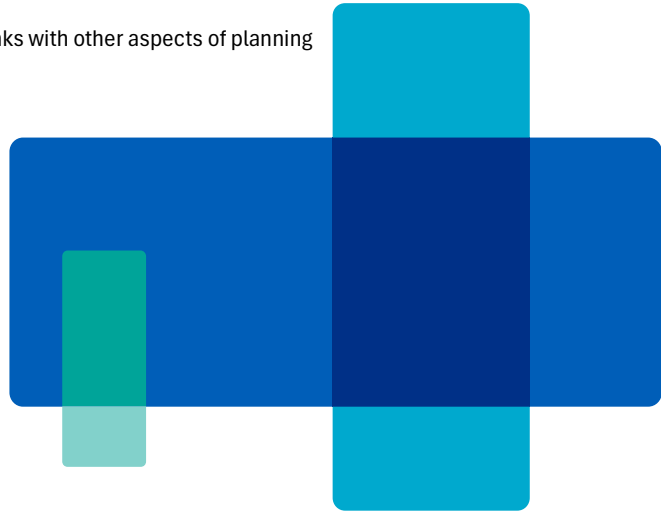
2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement
Please include the Integrated Care Board's (ICB) name at the top of the tab.
This section gives ICBs the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 26/27 Winter Plan checklist
This section provides a checklist of what Boards should ensure is covered in their 2026/27 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2026.**



Winter Planning 26/27
Section A: Board Assurance Statement (BAS)

This section gives ICBs the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Integrated Care Board (ICB):	Thames Valley
If Other, write ICB Name here:	
Contact details (email, phone number):	Sam Burrows
Date:	08/09/2026

Please complete these sections

		Assurance statement	Is this in place? (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Governance					
1	1.1	The Board has assured the ICB Winter Plan for 2026/27.	Yes	16/09/2026	
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the ICB's plan and this has been reviewed by the Board.	No		The ICB is taking advice on whether an EQIA is required for this plan.
	1.3	The Board is assured that the ICB's plan was developed with active engagement and input of all system partners, including primary care, 111 providers, Community Health Service Providers (including NHS and non-NHS providers), acute and specialist trusts, mental health, ambulance services, local authorities and social care provider colleagues.	Yes	There has been engagement with all providers via Place UEC Programme Boards in the development of Place plans that have informed the ICB plan. All hosted acute, community and mental health NHS Trusts, SCAS, Local Authorities, Primary Care and VCSE have been engaged in the process.	
	1.4	The Board has identified a named Executive Winter Sponsor with clear accountability for winter preparedness, delivery, escalation and system oversight.	Yes	Sam Burrows	
	1.5	The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	Took place on 14/09/26	
	1.6	The Board is assured that clear winter governance arrangements, escalation processes and operational leadership arrangements are in place across the system.	Yes	As per section 7 of the winter plan document	
	1.7	The Board is assured that fit testing arrangements, PPE provision and other key infection prevention and control mitigations, as set out in the Health and Social Care Act 2008: code of practice on the prevention and control of infections are in place across the system and are supported by plans to scale rapidly in response to infectious disease surges, ensuring continuity of safe care and workforce protection.	No		Limited assurance in primary care setting, FIT testing arrangements for FFP3 respirator masks to maintain safe working conditions in IPC, are in place. Working with stakeholders and providers to work towards meeting this requirement.
	1.8	The Board has received assurance that health protection governance, escalation processes, and provider response arrangements are effective and support timely management of infectious disease incidents and outbreaks, as set out in the ICB Commissioning Guidance - https://www.england.nhs.uk/long-read/clinical-response-outbreaks-of-infectious-disease-commissioning-guidance-icbs/	Yes		The outbreak/incident response pathways across Thames Valley system are delivered through the following services/contractual agreements: -BOB ICB locally commissioned service,Westcall for Flu outbreak management to respond to localised community outbreaks of seasonal influenza, in both the out of season periods and formally notified flu season and for prophylaxis and treatment and incidents involving exposures to avian influenza, covering prophylaxis of asymptomatic exposed persons (suspected cases of avian influenza)

Winter Planning 26/27

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.

		Section B: 26/27 Winter Plan checklist	Please complete these sections Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Prevention and vulnerable cohorts					
1	1.1	The Board is assured that those eligible have access to priority vaccination programmes, including childhood vaccinations. This includes 1. RSV vaccination for pregnant women, older adults aged 75 years and over, and older adult care home residents; 2. pneumococcal vaccination for all adults aged 65 years and over and children and adults in a clinical risk group; 3. the annual winter flu and COVID-19 vaccination campaigns.	Yes	Plan in place	
	1.2	The Board is assured that a risk-stratified approach is in place to identify individuals at increased risk of winter-related deterioration or admission, including those with co-morbidities that leave them susceptible to hospital admission as a result of winter viruses, younger people with significant co-morbidities, and other vulnerable cohorts. Targeted interventions are in place, including vaccination, pre-winter health checks, personalised care planning, access to antivirals where appropriate, and community-based support to reduce avoidable admissions and support continuing care in the community.	Yes	Targeted interventions will take place as part of both neighbourhood working and targeted approach from primary and community services	
Flow, occupancy and discharge					
2	2.1	The Board is assured there are clear operational plans and daily processes to reduce avoidable bed occupancy and improve patient flow seven days a week, including pre-winter review of bed demand and capacity, delivery of model discharge pathway requirements, and executive oversight of required and actual daily discharges, patients with no criteria to reside by pathway, discharge performance and long discharge delays.	Yes	Each provider has clear processes in place for daily management of patient flow, with escalation processes in place	
	2.2	The Board is assured that system partners have agreed and implemented measures to eliminate corridor care, with defined patient safety thresholds, supported by coordinated patient flow, discharge and escalation arrangements, with system level oversight and mitigation of risk during periods of increased demand.	Yes	Each provider has clear processes in place to manage patient flow. To be noted that elimination of corridor care may not be possible but processes and measures are agreed to minimise volumes and elimination is an ambition of the Thames Valley system	
	2.3	The Board is assured that discharge planning is being undertaken jointly with local authorities and social care partners, with effective system discharge coordination arrangements, clear processes to identify, escalate and resolve discharge delays, and real-time visibility of demand and community capacity.	Yes		
	2.4	The Board is assured that providers have baselined current discharge arrangements against the model discharge pathway, identified gaps, and agreed improvement actions across acute, community and social care partners.	Yes		
	2.5	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans have been agreed and will be implemented.	Yes	It is expected that additional assurance processes will take place ahead of holiday periods also	
Demand, capacity, and surge management					
3	3.1	The board is assured that whole system demand and capacity modelling has informed winter planning and that tested surge and extreme surge response arrangements are in place to support safe operational delivery during periods of increased demand.	Yes		
	3.2	The Board is assured that workforce, NHS 111 and mutual aid arrangements are sufficient to respond safely to sustained periods of increased demand.	Yes	Note - Limited additional capacity has been secured for 2026/27 due to funding limitiations.	
	3.3	The Board is assured that bed escalation capacity arrangements have been agreed and tested across system partners.	Yes		
Primary Care, NHS 111 and admission avoidance					
	4.1	The Board is assured that anticipated general practice demand has been assessed, and that: •sufficient capacity has been commissioned, including for surge periods (e.g. ARI hubs) •robust escalation process are in place •through the IUC Clinical Assessment Service (or equivalent), sufficient capacity will be commissioned for out of hours general practice, including weekends and bank holidays.	Yes	Note - Limited additional capacity has been secured for 2026/27 due to funding limitiations.	

4	4.2	The Board is assured that practices are compliant with contractual requirements, including opening hours, use of online consultation, clinically urgent same day appointments (working towards 90% target) and practices making 1 appointment per 3,000 registered population available to NHS 111 for direct booking.	Yes		
	4.3	The Board is assured that PCN enhanced access appointments are available and that PCNs make available to NHS 111 any unused on the day slots as per DES requirements.	Yes		
	4.4	The Board is assured that unscheduled dental care delivery is monitored as part of the mandated number of urgent dental care appointments.	Yes		
	4.5	The Board is assured that for community pharmacy, demand, activity and capacity has been assessed, including sufficient out of hours provision across the ICB footprint; and delivery of Pharmacy First and the Discharge Medicines service.	Yes		
	4.6	The Board is assured that the NHS 111 Directory of Services profiles are accurate, regularly reviewed, and aligned to available capacity across primary care and community services.	Yes		
	4.7	The Board is assured that for all provision, both in and out of hours, there will be communications activity to ensure the public is aware of what services are available.	Yes	Comms plan with funding available is in place	
Community Health Capacity					
5	5.1	The Board is assured that sufficient urgent community capacity, including UCR, Virtual Wards, Hospital at Home and community diagnostic interventions where applicable, has been commissioned, is monitored and utilised effectively to support admission avoidance and discharge, with appropriate escalation arrangements in place and access to senior clinical decision-making through SPOAs at least 12 hours a day, 7 days a week.	Yes	Note - Limited additional capacity has been secured for 2026/27 due to funding limitiations.	
Whole System Response					
6	6.1	The Board is assured that a system wide approach is in place to optimise the use of out-of-hospital capacity and admission avoidance pathways to reduce avoidable admissions and support timely discharge.	Yes	Each place or geography has this in place, however further work is required to ensure this is a fully Thames Valley wide approach	
Leadership, operational grip and resilience					
7	7.1	The Board is assured that on-call arrangements are in place and have been tested. Staff on-call have access to medical and nursing leaders for urgent advice if needed.	Yes		
	7.2	The Board is assured there will be an appropriately skilled and resourced operating model for system co-ordination over the winter period to enable the sharing of intelligence and risk balance to ensure this is appropriately managed across all partners.	Yes	As per section 7 of the winter plan document	
	7.3	The Board is assured that tested command, control and escalation arrangements are in place, including OPEL reporting, EPRR arrangements and clearly defined leadership responsibilities.	Yes		
	7.4	The Board is assured that mutual aid arrangements, business continuity plans, severe weather preparedness arrangements and industrial action contingencies have been reviewed and tested where appropriate.	Yes		
	7.5	The Board is assured thatplans are in place to support staff welfare through periods of high demand.	Yes		
System Co-ordination Centres					
8	8.1	The Board is assured that SCCs will be proactive in resolving operational pressures in hours, and that ICBs will maintain on-call functions for the oversight and resolution of operational pressures and patient flow and safety out of hours.	Yes		
	8.2	The Board is assured that SCCs will be fully operational 08:00 to 18:00 7 days per week and have the ability to extend hours of operation during periods of extreme pressure.	No	Thames Valley ICB SCC operates Mon-Fri 0900-1700 only with on-call arrangements in place outside of these hours. Additional SCC support can be stood up if required and deemed ne	
	8.3	The Board is assured that ICB SCCs will maintain proactive engagement and communication with NHSE Regional teams.	Yes		

BAS Self-Assessment Dashboard

ICB

Overall Assessment Rating: 5 - Full assurance

		Rating
Section A	Governance	4 - Substantial assurance
Section B	Prevention and vulnerable cohorts	**5 - Full assurance**
	Flow, occupancy and discharge	**5 - Full assurance**
	Demand, capacity, and surge management	**5 - Full assurance**
	Primary Care, NHS 111 and admission avoidance	**5 - Full assurance**
	Community Health Capacity	**5 - Full assurance**
	Whole System Response	**5 - Full assurance**
	Leadership, operational grip and resilience	**5 - Full assurance**

Executive Approval

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the ICB Accountable Officer and Chair.

Integrated Care Board (ICB) name:	Thames Valley ICB
ICB CEO/AO name:	Nick Broughton
Date reviewed:	16/09/2026
ICB Chair name:	Dr Priya Singh
Date reviewed:	16/09/2026

Please update following completion of the BAS template

Please provide name and contact details of designated Senior Responsible Officer (Executive Level)
Sam Burrows, sam.burrows3@nhs.net

Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming they are correct and complete.
Confirmed

Please confirm date reviewed
09/09/2026

NHS
Thames Valley

Thames Valley Integrated Care Board

Title of Paper	Thames Valley Strategic Commissioning Sprint Programme and Commissioning Intentions Development		
Agenda Item	8	**Date of meeting**	16 September 2026
Exec Lead	Hannah Iqbal, Chief Strategy and Commissioning Officer		
Author(s)	Paul Swan, Head of Strategic Commissioning and Planning		

Purpose	To Approve	☒
	To Ratify	☐
	To Discuss	☐
	To Note	☒

Link to Strategic Objective	*Paper relates to all 3 strategic objectives*

Executive Summary

Thames Valley Integrated Care Board was established on 1 April 2026 with the mandate to be a strategic commissioner of services across Buckinghamshire, Oxfordshire and Berkshire. We are tasked with maximising the value that can be created from our £5.8bn healthcare budget to improve outcomes, reduce inequalities and improve access to high-quality care for the 2.5m people we serve.

With this new mandate the newly formed ICB must pivot its focus and ways of working to achieve our purpose. This paper focuses on the work that has been underway to enable this organisational pivot. It provides an update on a sprint-based programme of work through summer and early autumn to move the organisation forwards at pace, setting the foundations for the ICB to be an effective strategic commissioner.

This important and comprehensive work has required a deliberate shift in time, leadership capacity, prioritisation and focus. The sprint programme forms the critical foundation for 2027/28 planning, enabling us to strategically commission and drive change for our population. The mobilisation of the workstreams along with organisational development is bringing strategic commissioning to life for the new organisation as new teams come together through implementation of the transition programme.

This paper sets out:

- **National context**: an update on the Strategic Commissioning Development Programme and the Commissioning Academy.
- **Building organisational ownership of strategic commissioning:** the progress on Thames Valley senior leadership involvement in how the organisation develops its foundations as a strategic commissioner
- **Progress on strategic commissioning sprints:** progress reports against the four strategic commissioning sprints that were outlined in the paper *'Pivoting to Strategic Commissioning and resetting our foundations'* that was reported to the Commissioning and Population Health Committee on 24 June 2026 and to the ICB Board on 15 July 2026. This includes an expanded progress report on the development of Commissioning Intentions since this sprint programme paper was presented to the Commissioning and Population Health Committee on 1 September.

• **Governance of Commissioning Intentions:** key governance steps and the timeline up to the finalisation and sharing of commissioning intentions with NHSE and providers on 30 September.	
Recommendation	The Board is asked to note the report and approve the approach to finalisation and sign off of Commissioning Intentions.

Conflict of interest identified
Yes ☐ No ☒
Detail

Reporting – has this paper been discussed at other meetings		
Committee Name	Date discussed	Outcome
Commissioning and Population Health Committee	1 September 2026	Committee noted the report and agreed the scheduling of an extraordinary meeting to sign off Commissioning Intentions subject to Board approval.

Thames Valley ICB

Thames Valley Strategic Commissioning Sprint Programme

Overview

1. Thames Valley Integrated Care Board was established on 1 April 2026 with the mandate to be a strategic commissioner of services across Buckinghamshire, Oxfordshire and Berkshire. We are tasked with maximising the value that can be created from our £5.8bn healthcare budget to improve outcomes, reduce inequalities and improve access to high-quality care for the 2.5m people we serve.

2. With this new mandate the newly formed ICB must pivot its focus and ways of working to achieve our purpose. This paper focuses on the work that has been underway to enable this organisational pivot. It provides an update on a sprint-based programme of work through summer and early autumn to move the organisation forwards at pace, setting the foundations for the ICB to be an effective strategic commissioner.

3. This important and comprehensive work has required a deliberate shift in time, leadership capacity, prioritisation and focus. The sprint programme forms the critical foundation for 2027/28 planning, enabling us to strategically commission and drive change for our population. The mobilisation of the workstreams along with organisational development is bringing strategic commissioning to life for the new organisation as new teams come together through implementation of the transition programme.

4. This paper sets out:
    a. **National context**: an update on the Strategic Commissioning Development Programme and the Commissioning Academy.
    b. **Building organisational ownership of strategic commissioning:** the progress on Thames Valley senior leadership involvement in how the organisation develops its foundations as a strategic commissioner
    c. **Progress on strategic commissioning sprints:** progress reports against the four strategic commissioning sprints that were outlined in the paper *'Pivoting to Strategic Commissioning and resetting our foundations'* that was reported to the Commissioning and Population Health Committee on 24 June 2026 and to the ICB Board on 15 July 2026. This includes an expanded progress report on the development of Commissioning Intentions since this sprint programme paper was presented to the Commissioning and Population Health Committee on 1 September.
    d. **Governance of Commissioning Intentions:** key governance steps and the timeline up to the finalisation and sharing of commissioning intentions with NHSE and providers on 30 September.

National context

5. This sprint programme is informed by the NHSE Strategic Commissioning Development Programme and Commissioning Academy launched in June 2026. The programme will include training and development for ICBs including Board development, a commissioning in practice action learning programme and a learning networks programme for neighbourhood health leaders. The TV ICB Chief Strategy and Commissioning Officer is part of the national steering group for the development programme, and the ICB is linking in with development opportunities and identifying participants for the training programmes. The Commissioning Academy is the single one-stop shop for commissioning tools, communities of practice, webinars and training. It includes a strategic commissioning maturity diagnostic tool, along with national expectations and resources for the stages of the strategic commissioning cycle and their component functional areas.

Building organisational ownership of strategic commissioning

6. As recognised in the *'Pivoting to Strategic Commissioning and resetting our foundations'* paper, there has been a strong focus over the summer on organisational development within the context of the ongoing organisational change programme. This has included bringing people together across teams to lean into the ICB's role as a strategic commissioner and work on the foundational sprints.

7. The paper and the strategic commissioning sprint programme was presented to the Senior Leaders Forum workshop on 1 July. This launched the programme with senior leaders but also enabled their contribution into the definition of the programme and how it can be mobilised. The workshop also provided an opportunity for senior leaders to input into the framing and development of Commissioning Boards, combined with a dedicated follow up session with organisational development leads and strategic commissioning.

8. Commissioning Boards were launched in the week commencing 27 July as internal non-statutory groups acting under Board delegation. They are established as the engines of strategic commissioning within the organisation, reporting to the Executive. The boards will lead the strategic commissioning cycle for each area, translating population need, evidence and strategy into commissioning priorities, investment decisions and measurable improvements in population health outcomes. They will own their portfolio priorities, interpret analytical insights, direct work within their respective portfolio and make recommendations to Executive.

9. The boards will provide the senior leadership space to organise collectively, develop and assure plans, and prepare for formal commissioning decisions. They act as a critical enabler of the wider commissioning process, ensuring proposals are sufficiently developed, aligned and deliverable before progressing through formal governance and contracting routes. They will coordinate delivery, align priorities and resolve operational issues within their portfolios, whilst escalating risks and issues where appropriate.

10. The four Commissioning Boards cover the following areas:

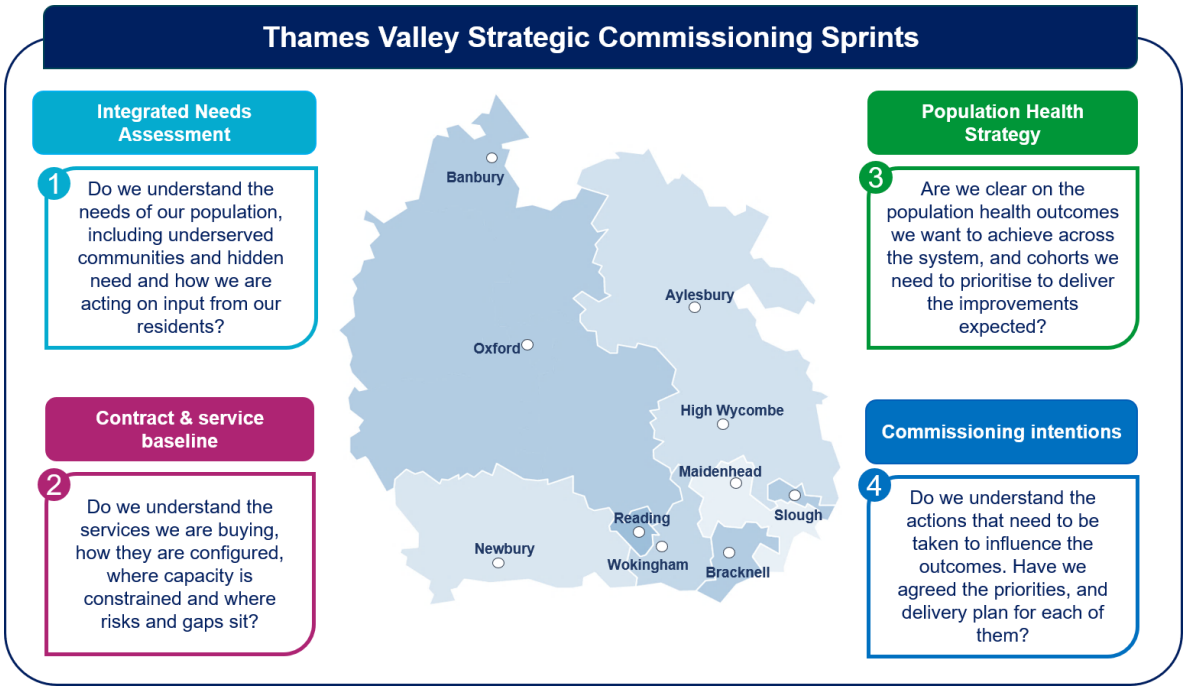
    - Acute and Specialised Care

- Neighbourhood Health (incl. Primary Care, Community services, Long Term Conditions, Neighbourhood Urgent Care, Frailty, End of Life)
- Perinatal, Children and Young People
- Mental Health, Neurodiversity and Learning Disabilities

11. The boards and their respective portfolio commissioning teams were tasked in the first meetings with contributing to the Contract and Service Baseline sprint and Commissioning Intentions Development sprint.

Strategic Commissioning Sprints

12. The strategic commissioning sprint programme is for the ICB to establish solid strategic commissioning foundations from the first two stages of the strategic commissioning cycle and their four component functional areas. These are to be delivered over summer and early autumn culminating in the finalisation of commissioning intentions by 30 September 2026. The sprint programme forms the critical foundations for 2027/28 planning.



Sprint 1: Integrated Needs Assessment

Recap of national ask

Scope – An integrated needs assessment brings together data and qualitative insights to build a comprehensive and dynamic understanding of population need, risk, demand and inequalities. It builds on the Joint Strategic Needs Assessment (JSNA) and brings together person-level linked data, public health intelligence and lived experience (gathered from engaging with people and communities) across health, local government and Voluntary,

Community, and Social Enterprise (VCSE) partners. The integrated needs assessment provides commissioners with a starting point for strategic prioritisation, care model design, investment decisions and long-term planning.

Outputs

- Risk stratification profiles and population segments, highlighting inequalities;
- Thematic insight from engagement with communities, VCSEs and service users, highlighting unmet need, trust, acceptability and cultural factors; and narrative evidence combining lived experience with quantitative analysis to inform prioritisation and care pathway design;
- Analysis of drivers of demand and variation;
- Baseline mapping of performance, quality and productivity.

Outcomes

- ICBs have a clear understanding of who needs what support, and why, combining data with lived experience;
- Improved identification of underserved communities and hidden need, including groups poorly captured in activity data;
- Commissioning priorities shaped by population voice as well as population metrics; and
- Stronger relationships with communities and VCSE partners, supporting trust and sustained engagement.

Integrated Needs Assessment - Progress since June

Overall Status - Green

- The workstream has made strong headway through a collaborative approach involving the ICB, local authority public health teams, Connected Care, NHS providers and academic partners. Working within challenging timescales, partners have established a shared framework, governance arrangements and workstream leadership, enabling coordinated delivery across all areas of the assessment.
- Progress is being made across the key themes of population demographics, risk factors, life-course health needs, wider determinants of health, future demand and access to services. A consistent analytical approach has been agreed, including common methodologies, indicator selection principles, reporting standards and visual presentation, ensuring the final assessment provides a coherent view of population need and inequalities across Thames Valley.
- A key strength has been the willingness of partners to share expertise, data, tools and best practice. Regular Task and Finish Group meetings and analyst workshops have supported joint problem-solving, peer review and alignment of outputs, helping to build a robust and actionable evidence base to inform strategic commissioning, resource allocation and population health improvement.

- Overall, the workstream remains on track for September sign-off, with substantial advances made in both content development and the creation of a strong system-wide partnership approach to population health intelligence.

Sprint 2: Contract and Service Baseline

Recap of national ask

Scope – The contract and service baseline should establish a clear, evidence-based understanding of what is currently commissioned via contracts and grants across the system. This includes commissioned activity, cost, service specifications, quality requirements, contractual risk, and the capacity implications of existing arrangements.

Focus – The focus is on understanding what the system is buying, how services are configured, where capacity is constrained or flexible, and where risks to services currently sit. To be comprehensive – and therefore as useful as possible – the baseline should include services commissioned by the ICB, jointly with local government, across multiple ICBs, and specialised portfolios where applicable. It should also capture dependencies and cross-border flows.

Outputs –

- A system-wide contract, grants and service baseline assessment, covering commissioned scope of each service/contract, activity, cost, quality and key variations, including health inequalities. This baseline will be used in subsequent stages of the commissioning cycle, supporting prioritisation, pathway redesign and future commissioning decisions
- A commissioning risk register including service continuity risks, VCSE sector fragility, dependencies and capacity constraints.
- A clear articulation of capacity implications of current commissioning arrangements

Contract and Service Baseline - Progress since June

Overall Status – Amber/Green

- A multidisciplinary sprint team (Strategic Commissioning Operations, Contracts, Finance, Data Analytics) has established the scope and approach for developing a comprehensive contract and service baseline. The objective is to provide a clear understanding of what the ICB commissions, from whom, at what cost and to what standard, creating the evidence base required for strategic commissioning and future resource allocation.
- Contract records from legacy organisations have been consolidated within the TV ICB Atamis contract management system. The contract record has been reviewed and validated to 786 contracts in the system as of the end of July. While significant progress has been made, further work is required to ensure all contracts, service specifications and associated spend are fully captured and recorded.

- Commissioning Boards and portfolio teams have been tasked with validating contract information and completing service area commissioning overviews outlining the commissioned services in place and providing insight that identifies risks, opportunities and priorities for strategic commissioning that can inform commissioning intentions. The deadline for this is 25 August.
- The sprint team will analyse the returns to produce a foundational contract and service baseline, highlighting areas of opportunity, risk and potential focus for commissioning intentions. Commissioning Boards are to use the information to inform priorities for action, including further in-depth review of contracts/specifications, and commissioning intentions. This represents the first phase of developing a contract and service baseline in the shorter term, informing further analysis and review of contracts and services in greater depth. Ensuring a live and comprehensive contract and service understanding will be an ongoing task for the ICB, linked with optimised management of the Atamis system.

Sprint 3: Population Health Strategy

Recap of national ask

Scope – The Population Health Strategy will provide a comprehensive, evidence-based assessment of current and future population health and wellbeing needs, outcomes, and inequalities across the life course. It will bring together insights from integrated needs assessments, population health management, health and wellbeing strategies, commissioning priorities, and provider, place-based, and system strategies. The Population Health Strategy will include:

- Clear, measurable objectives including those on inequalities (e.g., Core20PLUS5 alignment) based on a case for change
- An outcomes framework with success measures, including for populations experiencing health inequality
- Priority actions and commissioning intent with delivery chain mapping (who does what) and governance & resourcing stated

These then lead to outcomes including:

- A shared strategic direction with explicit line of sight from needs to priority programmes, to delivery arrangements (including resources required for successful delivery).
- ICBs and their partners have a strong, shared foundation for prioritisation and service planning.
- An improved readiness to deliver prevention/LTC shifts through a clear evidence case and aligned planning cycles.

Population Health Strategy - Progress since June

Overall Status – Amber

- The focus of the Population Health Strategy sprint has been on the development of a draft population outcomes framework in readiness for testing with ICB and system partners
- The outcomes framework has been developed through the synthesis of national frameworks and guidance, comparable ICB and place frameworks, our local health & wellbeing strategies, and Thames Valley's own evidence. The framework has been designed as a cascade, where every outcome or metric influences the one above, giving visibility and assurance that activities and progress are meaningful and relevant.
- The draft outcomes framework is structured using a life course approach with ambitions for start well, live well, age well and die well. Each is supported by a suite of metrics driving improvements in overall population health, with corresponding metrics to measure progress.
- The aim is to provide clarity regarding the system's ambition, particularly on the shared goals of improving healthy life expectancy and reducing the gap in life expectancy between the populations living in areas with the least and greatest levels of deprivation. It is planned that each outcome or metric is mapped to the Board, a committee of the Board or commissioning board for regular review and oversight.
- The outcomes framework is currently being shared with commissioning colleagues for initial scrutiny and challenge and will be tested with other system stakeholders in due course. Given the need for iteration and validation, with ICB and external colleagues, and the need to ensure alignment with the INA, it is expected the framework will be published later in the year, after September.

Sprint 4: Developing Commissioning Intentions

Recap of national ask

- This sprint will focus on developing the commissioning intentions, a set of coherent actions that deliver the ambition and outcomes described in the Population Health Strategy. These will be developed through the ICB commissioning boards and will include details on population health outcomes, delivery plans and milestones and provides more detail on the ambition for pathway design and service model improvement.
- The commissioning intentions will include a five-year plan to deliver population health improvements for the Thames Valley population; defined commissioning priorities and rationale (including relevant trade-offs, opportunity costs and choices not progressed); a clear delivery plan for each priority with accountability arrangements, relevant outcomes, metrics, milestones and delivery scale; inequality objectives for each priority, where applicable.

These then lead to outcomes including:

- Co-produced priorities demonstrating evidence-informed decisions that reflect what matters to residents, clinicians, and partners, and aligned to the overall population health strategy; improved alignment between local and national expectations, reducing duplication between local priorities and mandatory planning asks; realistic, achievable commissioning intentions, including clear accountability for progress and delivery.

Developing Commissioning Intentions - Progress since June

Overall Status – Green

The commissioning intentions will set out the ambition for change and improvement across the Thames Valley system. This will include the changes required to improve population health outcomes, reduce inequalities and improve access to services. The document will cover how we will commission differently as a strategic commissioner with a stronger focus on outcomes and integrated pathways to slow the progression of ill health, optimise pathways and address unmet need. It will also include the financial principles that will support the delivery of the ambitions including ringfenced resource for transformation.

The draft commissioning intentions are framed according to:

- **Priority populations** identified from our Integrated Needs Assessment and other service pressures, whilst incorporating the outcomes framework life course structure of *start well, live well, age well* and *die well*.
- **Strategic interventions** to deliver our strategic objectives
- **Service-focused commissioning intentions** to deliver population health improvements
- **Enabling commissioning intentions** to support delivery

The content of the commissioning intentions has been developed by commissioning teams and tested and further refined through the newly formed Commissioning Boards. This is allowing the testing of interdependencies, requirements and understanding across portfolios and to enable a more coherent set of priorities. The intentions will include how local partnerships may be commissioned, using new contractual mechanisms to take responsibility for the delivery of certain services and the associated improvements.

The Commissioning Board development of the intentions has focused on the following three strategic interventions and what is planned to change rather than documenting everything that will be commissioned:

- **Slowing the progression of ill-health** from lower to higher population health need segments through prevention and proactive care
- **Optimising pathways** to improve population offer through improved quality and value (model of care, pathway design, resource utilisation)
- **Addressing unmet need and inequalities** proactively to address under-representation and drive improvements of identified populations

The commissioning intentions will set a longer-term ambition with a particular focus on plans and expectations for 2027/28. They will build on the Thames Valley Commissioning Intentions published last year.

High level themes will be shared with the System Delivery Committee (10 September) and a draft will be shared with the ICB Board. It is proposed that a final draft set of commissioning intentions is approved by an extraordinary meeting of the Commissioning and Population Health Committee with delegated authority from the Board before 30 September. The final draft of commissioning intentions will be shared with system partners and the NHSE regional team on 30 September.

During October feedback will be received from system partners and the commissioning intentions will be iterated where necessary, leading to a final and confirmed set of commissioning intentions. 2027/28 priorities will be developed with commissioning leads and confirmed through Commissioning Boards. A road map for delivery of commissioning intentions will be developed with system partners as we move through the planning process. This work will be progressed in alignment with the developing Outcomes Framework and Population Health Strategy.

Governance

13. NHSE South East Region has confirmed ICB commissioning intentions need to be completed by 30 September 2026.

14. The table below outlines the governance timeline up to the finalisation and sharing of commissioning intentions on 30 September. Whilst the sprint programme is progressing at pace, the timeline for finalisation of commissioning intentions is tight in the context of ongoing organisational change and recent establishment of commissioning boards, who are overseeing content development and prioritisation.

15. As noted above, the ambition is that the draft commissioning intentions will be completed and shared with the Board, with the document then finalised and shared with the system on 30 September. To support this timeline, the Commissioning and Population Health Committee agreed to hold an extraordinary online meeting of the committee Chair, Deputy Chair, Chief Strategy and Commissioning Officer and other members as required to provide review and approval of the final draft of commissioning intentions to be shared with system partners and the NHSE regional team. The Board is asked to delegate final approval of the commissioning intentions to the Commissioning and Population Health Committee.

Meeting	Date	Proposed content
Commissioning and Population Health Committee	1 September 2026	• Strategic Commissioning Sprint Programme update • Framing the Financial strategy, approach to left shift and investment for 2027/28
Discussion with Trust Planning Leads	TBC – prior to System Delivery Committee	• Draft planning approach and principles
System Delivery Committee	10 September 2026	• Planning approach and principles, including:

		○ Finance principles for agreeing Trust envelopes ○ Approach to delivering on left shift / transformation ○ Key themes for commissioning intentions
ICB Board	16 September 2026	• Commissioning approach and principles (public)
Extraordinary Commissioning and Population Health Committee	TBC – prior to 30 September 2026	• Final draft of commissioning intentions for review and approval to share with system partners and NHSE regional team.
NHSE and Providers – sharing commissioning intentions	30 September 2026	• Final draft of commissioning intentions shared with NHSE South East Region and Provider Trusts and partners – including updated ambition and principles for supporting the left shift / transformation

NHS
Thames Valley

Thames Valley Integrated Care Board

Board Meeting

Title of Paper	Thames Valley Maternity and Neonatal Services Review		
Agenda Item	9	**Date of meeting**	16 September 2026
Exec Lead	Lalitha Iyer, Chief Medical Officer Sam Burrows, Chief System Development & Engagement Officer Sarah Bellars, Chief Nursing Officer		
Author(s)	Caroline Tack, Associate Director of Transformation and Improvement Sarah Adair, Associate Director of Communications and Engagement Robert Bowen, Director of Strategy and System Development		

Purpose	To Approve	☒
	To Ratify	☐
	To Discuss	☐
	To Note	☐

Link to Strategic Objective	The paper relates to all strategic objectives

Executive Summary

Maternity and neonatal services continue to be an area of significant national and local focus following a series of reviews, investigations and improvement programmes that have highlighted concerns relating to safety, quality, inequalities in outcomes and experience, workforce sustainability and the need for system-wide improvement. Most recently, the Independent National Maternity and Neonatal Investigation, led by Baroness Amos and published in June 2026, identified persistent challenges and set out recommendations for long-term transformation across maternity and neonatal services. An NHS-wide conversation opens on 21 September Your Voice: shaping the future of maternity and neonatal care, which will give staff the opportunity to share views and help shape improvements to maternity and neonatal services. Feedback will inform the National Maternity and Neonatal Taskforce's action plan.

Locally, concerns raised by women and families regarding maternity services at Oxford University Hospitals NHS Foundation Trust have further reinforced the importance of understanding the quality, safety and sustainability of services across Thames Valley.

At the same time, maternity services across Berkshire, Buckinghamshire and Oxfordshire are operating within a changing environment characterised by increasing clinical complexity, changing birth patterns, workforce pressures, rising demand in some areas, and persistent inequalities in outcomes and access to care.

As the strategic commissioner for health services across Thames Valley, NHS Thames Valley has a responsibility to understand whether current maternity and neonatal services are meeting the needs of women, babies and families, both now and in the future, and whether services are delivering safe, effective and equitable outcomes across the system.

It is therefore proposed that NHS Thames Valley undertake a comprehensive system-wide review of maternity and neonatal services.

The review will establish a robust evidence base across quality, safety, outcomes, health inequalities, workforce, service configuration and commissioning arrangements. It will identify how services are currently operating in the context of national standards, identify unwarranted variation and its underlying causes, consider future population need and demand, and evaluate whether current

service and workforce models are sustainable for the future. It will also seek to recognise areas of strength in our services that can be shared and built upon, while also identifying opportunities for improvement.

Within this it will be important to dovetail with existing work being undertaken by NHS Trusts in the last 12-18 months, the 10-point plan submissions (national review requirements), as well as the national Taskforce action plan to ensure alignment and avoid duplication. Given the volume of work currently being undertaken across Thames Valley Maternity and Neonatal services to respond to the national ask the resources and capacity required to deliver this review effectively and meaningful should be carefully considered.

The attached paper is the proposed Terms of Reference for the Maternity Services Review. In finalising the Terms of Reference an Equality Impact Assessment (EqIA) will be completed to ensure quality and patient safety are considered throughout the review, as well as ensuring a lens of eliminating discrimination, tackling inequality and understanding our communities is maintained throughout.

Recommendation	The Board is asked to: • Agree the commencement of a Thames Valley Maternity and Neonatal Services Review as described in the review terms of reference. • Consider the resource requirements of the proposed review. • Note that there may be minor changes to the terms of reference following the Board discussion, to ensure feedback from wider stakeholders is incorporated.

Conflict of interest identified
Yes ☐ No ☒
Detail

Reporting – has this paper been discussed at other meetings		
Committee Name	Date discussed	Outcome

Terms of Reference: Thames Valley Maternity and Neonatal Services Review

Background and Context

1. Nationally and locally, maternity and neonatal services continue to be the focus of significant scrutiny following a number of national reviews and investigations, including Better Births, the Ockenden Review, the NHS Three-Year Delivery Plan for Maternity and Neonatal Services, and the Independent National Maternity and Neonatal Investigation led by Baroness Amos. These reviews have highlighted the need for continued focus on safety, quality, equity of access, workforce sustainability, service user experience and reducing inequalities.
2. Maternity services across Berkshire, Buckinghamshire and Oxfordshire are operating within a changing environment characterised by increasing clinical complexity, changing patterns of service utilisation, workforce challenges, variation in service models and persistent inequalities in outcomes and experiences for some population groups.
3. Each of these challenges put pressure on our existing service providers. It is essential that they are understood and addressed comprehensively and consistently across the Thames Valley. People accessing maternity and neonatal services should be able to do so with confidence that services are consistently high-quality, safe, and provided equitably to all.
4. The work will reflect the fact that maternity and neonatal services are subject to strong national expectations around safety, equity, personalisation, workforce, quality surveillance, service user voice and the integration of neonatal planning with maternity planning. National policy also increasingly emphasises a whole-system approach, meaning that maternity services cannot be reviewed in isolation from interdependent services and wider pathways of care.
5. The review will need to take account of recent national reviews (referenced above) and recommendations to ensure commissioned services meet the needs of the local populations, address health inequalities, and provide safe and equitable provision and what will be required to ensure safe and sustainable services into the future.

A review will allow evidence-led strategic commissioning

6. As the strategic commissioner for health services across Berkshire, Buckinghamshire and Oxfordshire, NHS Thames Valley has a responsibility to commission the provision of services that meets current and future population needs, improves the population's health, delivers safe and high-quality care, and addresses variation and inequalities.
7. The Thames Valley Commissioning Intentions for 2026/27 to 2029/30 set out objectives that underpin a new approach to commissioning services for the population. Key programmes of work include changes to commissioning services and pathways, underpinned by the principles of value-based healthcare. These focus on maximising economies of scale, improving outcomes, reducing clinical variation, optimising workforce models and ensuring effective use of funding.
8. The commissioning intentions set out the ambition for a Thames Valley Clinical Services Review within which maternity services were identified as a priority area.
9. **A maternity and neonatal services review will establish a comprehensive baseline of maternity and neonatal services across Thames Valley, recognising areas of strength that can be shared and built upon, while also identifying opportunities for improvement.**

Purpose of the Review

10. The purpose of the review is to:

- Develop a system-wide understanding of maternity and neonatal services across Thames Valley
- Understand the extent to which services are delivering safe, effective, equitable and person-centred care
- Understand how current service models meet the needs of women, babies and families now and in the future
- Understand the degree of unwarranted variation in service delivery, outcomes and experience across the system
- Identify opportunities to improve quality, safety, equity and consistency of provision
- Identify areas of strength across the Thames Valley maternity services, where good practice can be shared and adopted more widely to support continuous improvement.
- Provide evidence-based insights to inform any potential future commissioning intentions and service development

11. This programme of work is intended to be a strategic review and is not a performance management exercise of any individual provider. It is intended as an evidence and intelligence gathering exercise to inform future commissioning priorities, to ensure national and local recommendations are fully and consistently implemented.

Core questions the review will answer

12. At a minimum, the review will be designed to address the following questions.

a) To what extent are current services delivering safe, effective, equitable and person-centred care?

b) How well do current maternity and neonatal service models meet the needs of the population today?

c) Does unwarranted variation exist across the system and what are the underlying causes?

d) How will future population need, service demand and clinical requirements change over time?

e) Are current service configurations and care models clinically, operationally and financially sustainable for the future?

f) What opportunities exist to improve outcomes, reduce unwarranted variation and improve the quality, safety, equity and consistency of provision?

13. These questions will collectively aim to address **how services can best be commissioned to ensure national and local recommendations are implemented effectively and consistently in the Thames Valley**.

14. Through the review period it may be necessary to supplement or adapt the scope of the review. This will be agreed through the relevant governance (see below).

Scope of the Review:

15. It is proposed the review will be structured into five domains, each designed to collect and review specific information.

Domains	Initial scope
Population Need, Demand and Health Inequalities	This will consider how the population needs are changing driven by demographic changes in the population, birth trends and activity patterns, changes in the complexity and acuity of deliveries. It will consider any variations in access, experience or outcomes, particularly how this relates to different populations and communities to identify the extent of any inequalities in provision.
Quality, Safety and Experience	This will focus on alignment with national quality and clinical standards, the implementation of national and local recommendations for change from reviews or inspections, learning from patient experience and feedback, risks and mitigations identified, and the outcomes that are achieved in each provider unit.
Service Delivery and Clinical Model	The focus will be on any variation in clinical model across the Thames Valley providers and the dependencies with aligned clinical services. This will include trends in activity, patient pathways including triage, and operational performance and culture of each unit. It will consider demand for services, and the capacity of relevant providers.
Workforce and sustainability	This will review the existing workforce arrangements, and the supporting midwifery, obstetric, neonatal and anaesthetic workforce models, routes for appropriate clinical escalation, the sustainability of staffing models in each provider. This will also consider requirements and trends in recruitment, retention and workforce utilisation.
Strategic Commissioning and future developments	The final domain will consider current commissioning arrangements, opportunities and lessons learnt from other systems. The work will consider opportunities to reduce unwarranted variation and make improvements to current delivery models, to ensure alignment with national policy and best practice.

16. Health inequalities should be embedded throughout the review rather than treated as a separate area of work. An inequalities perspective should be incorporated into population health analysis, demand forecasting, access assessments, workforce deployment, patient experience and clinical outcomes.

17. The review will ensure that it dovetails will existing work that has been undertaken or that is currently in progress to ensure alignment and avoid duplication of effort.

18. The review is intended to provide a shared evidence base for service improvements as well as optimising areas of good practice. The review will not:

- Be undertaken as a cost-reduction programme
- Focus solely on individual organisations
- Make decisions regarding future service reconfiguration

- Replace statutory public consultation processes should future changes be proposed at a later stage
- Duplicate regulatory, inspection or assurance activities already undertaken by NHS England, CQC or national reviews.

Communication and Engagement

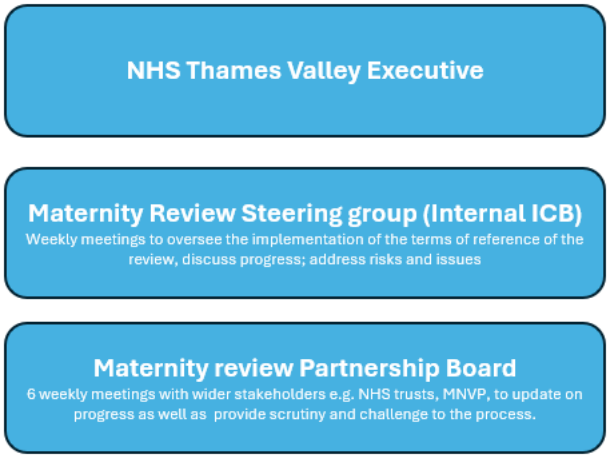
19. The review will be undertaken in collaboration with key partners and stakeholders across the Thames Valley. These include:
    - NHS partner organisations (e.g. NHS Trusts and Foundation Trusts, NHS England, neighbouring ICBs)
    - Professional and staffing groups (e.g. Midwives, obstetricians, ambulance staff)
    - Service users and communities (e.g. Women, birthing people and their families, equality and inclusion networks, community groups, maternity and neonatal voice partnerships, Healthwatch)
    - Other partner organisations (e.g. local authorities, health overview and scrutiny committees, Voluntary and community sector organisations)
20. The review will be supported by a comprehensive engagement approach. The engagement approach will support transparency and inclusion, ensuring the voices of those most affected by inequalities are heard throughout the review process. The full detail of this will be established in the mobilisation phase.

Resources Required

21. To successfully undertake a review of maternity services, an appropriate programme management structure and process must be in place. Detailed resource requirements will be confirmed during the mobilisation phase. The resourcing requirements will likely need to be flexed at different points in the review process and across the different areas of work.
22. The review will require programme support including the following:
    - ICB Executive leadership – Executive sponsor and SRO
    - Programme manager (senior lead)
    - Workstream leads(s) / project manager(s)
    - Administrative support
    - Provider leads – Clinical, Analytical, Operational, Engagement, Finance
    - ICB Clinical leads
    - Subject matter experts as required and identified in the planning stage – estimates include representation from finance, maternity service specialists, estates and procurement, HR.
    - Data analyst/s
    - Communication and engagement manager/s
    - Risk and governance support

Governance

23. The review will be overseen through an agreed programme governance structure, which will ensure the progress of the review remains visible to the Thames Valley Executive team and therefore upwards to the ICB Board.



24. Amongst other groups, additional communication and engagement will be required to individual trust boards, local scrutiny committees, relevant clinical groups senates and advisory groups as well as each maternity and neonatal voice partnerships and community groups. Where appropriate the review team will also connect regularly with NHS South East regional colleagues, and other ICB teams who may be coordinating reviews of similar services. This will allow for shared learning through the review process.

Maternity Review Timeline

25. The Review Programme Board will oversee the delivery of the review and ensure relevant products are developed. In the mobilisation phase this will include a more detailed plan for the whole review process and clarity about the reporting timescales. Each phase will be subject to a gateway review process, undertaken in collaboration with stakeholders, with decisions required before progression to the subsequent phase.

Phase	Activity	Timescale
Phase 1	Mobilisation and detailed design	3 months
Phase 2	Evidence gathering and analysis and stakeholder engagement	6 months
Phase 3	Final report and recommendations	3 months

Audit Committee Assurance Report

Audit Committee Escalation and Assurance Report – Alert, Advise, Assure	
Report From:	Audit Committee
Date of Meeting:	21 July 2026
Committee Chair:	Ilona Blue
Key escalation and discussion points from the meeting	
Alert:	
• The Committee raised urgent concerns about cyber security, noting a partial assurance rating, two high-priority findings, delays in audit organisation, and insufficient assurance over the past year. • Members highlighted the critical risk posed by outdated systems across the GP estate and weaknesses in third-party access controls. • The Committee expressed concern that a high-priority internal audit action remained overdue, reiterating expectations for timely completion and potential escalation to action-owner attendance.	
Advise:	
• The Committee advised that cyber security required a clearer and more effective governance home, noting past gaps in oversight and the need for strengthened executive grip. • The Committee suggested that OPIC required explicit assurance coverage within the Internal Audit Plan, either through a standalone audit or incorporation into existing reviews. • The Committee advised adopting a streamlined, minimum-viable approach for future Annual Reports to reduce unnecessary complexity.	
Assure:	
• The Committee received assurance that the Board Assurance Framework had been reviewed by the Board and was broadly supported, with minor refinements planned. • Members noted improved progress on ISFE2 supplier payments, with additional senior resource accelerating resolution and confidence increasing around returning to business-as-usual invoicing by early September. • The Committee received assurance that counter-fraud controls were effective, including the prevention of a £103,000 attempted supplier-payment fraud.	

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Committee Escalation and Assurance Report – Alert, Advise, Assure	
Report From:	Remuneration & Culture Committee
Date of Meetings:	26 August 2026
Committee Chair:	Tim Nolan, Non-Executive Member

Key escalation and discussion points from the meeting

Alert:

None

Advise:

Executive Team: The Committee approved contractual changes for members of the Executive Team.

Change Programme Update and Voluntary Redundancy Scheme: The Committee received an update on progress with the ongoing Change Programme and the second Voluntary Redundance Scheme which had launched on Wednesday 1 July 2026.

Clinical and Care Professionals Leadership (CCPL) Pay Framework: At its meeting in June the Committee approved the recommendation that Thames Valley ICB adopts a single pay framework for all CCPL roles, replacing the different pay arrangements for the legacy Frimley and Buckinghamshire, Oxfordshire and Berkshire West ICBs. The Committee was provided with a further update on the ongoing discussions with members of the CCPL in this matter, which will be further discussed offline prior to a decision at the next meeting of the Remuneration and Culture Committee in October.

Assure:

Terms of Reference: The Committee was asked to review and agree the inclusion the additional generic wording to ensure alignment with other Committees of the Board.

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Committee Escalation and Assurance Report – Alert, Advise, Assure	
Report From:	Finance and Performance Committee
Date of Meeting:	25 June and 28 July 2026
Committee Chair:	Tim Nolan, Non-Executive Member

Key escalation and discussion points from the meeting

Alert:

Complaints backlog - There are a number of patient complaints with the ombudsman at present. This could result in a reputational risk to the ICB should these complaints be upheld. The backlog of complaints varies in complexity, with Primary Care complaints taking 60+ days on average to investigate. These are largely outside of the ICB's direct control but the Committee feels that the Board needs to be alerted to this issue. Extensive work is in hand to improve this unacceptable position and the trajectory is showing improvement.

Advise:

CIP - The Non-Executive Members present raised a challenge regarding the recent CIP Internal Audit that had resulted in a rating of "partial assurance" by RSM. Clarification is being sought as to whether the identified management actions are in hand. Early signs are appearing that AACCC and S117 CIP delivery is under pressure. However, there is a possibility that primary care prescribing could end up over-achieving and further CIP savings could be delivered from this over-achievement.

Quality update – in addition to the red-rated alert relating to the complaints function, the Board is asked to note that OUH was working to address improvements outlined in the recent Amos report and CQC review.

ISFE2 invoice backlog – Whilst still at unacceptably high levels, the total number of unpaid invoices was now down to 13175. Four WTE agency staff had been deployed to support rapid reduction of the backlog. The CFO confirmed that a notice to small businesses had been circulated asking them to contact the ICB directly if they were experiencing financial issues.

PSR update - The Committee was asked to note the approval of one urgent award and one competitive process contract at the PSCG meeting held on the 2 June 2026.

Performance Metrics (discussed 28/07) – Good progress made, with clarity gained on the 43 NOF metrics and how they would be split across committees. More work needed on the leading metrics beneath the NOF, strong support for the escalation and dependency model and contract oversight meetings feeding into both. The leading indicator is the missing element which will allow the committee to apply clear scrutiny and gain full assurance.

Terms of Reference for QPF (discussed 28/07) – Progress made and clarity gained on committee membership with small amendments made. Further work needed to tighten the drafting to reflect that it is an assurance committee, rather than leading on activity. More

thought needed on how additional areas such as day-to-day operations, cyber, IG, workforce will be reported into the committee and the skill set required on the committee.
Assure:
BAF update – The Committee received a risk and governance update confirming that the Board had approved its Risk Appetite Statement in June. The first full outline BAF would be approved by the Board in July.

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Committee Escalation and Assurance Report – Alert, Advise, Assure	
Report From:	Quality, Performance and Finance Committee (formerly FPC)
Date of Meeting:	27 August 2026
Committee Chair:	Tim Nolan, Non-Executive Member

Key escalation and discussion points from the meeting

Alert:

Quality – Neurology and ADHD
Concerns were raised around neurology performance and impact on patient safety with further work required to reported ED attendance and patient deaths whilst on the waiting lists. It was noted that there is a national problem with a significant shortage of neurologists.

ADHD waiting lists also remained high and whilst this was recognised as a national issue, the Committee would like more detail on improvement actions.

Complaints – Whilst still too high, the complaints backlog has reduced with significant improvements in 3-day response rate now reaching 75%. The team accept that there is still some way to go to deliver consistent improvements and are working with Ben Gattlin to improve reporting.

Both invoice and complaints backlogs are standing items at the weekly Executive meeting and remain areas of focus.

Advise:

Finance – In-year projections are break-even, but concerns remain over growing variance of CIPs for AACCC and s117 in particular.

Performance – performance reporting is maturing with further work to be done in understanding how other committees and their data will feed up to QPF.

Risk – Assurance provided that the risk management framework is in place but further assurance on outputs is needed.

Assure:

Capital – Good in-depth report from the Finance team with particular focus on the Warneford and Frimley Park new hospitals. Comprehensive explanation of DHSC and NHS Capital processes e.g CDEL and clarity around the importance of Neighbourhood capital expenditure.

PSR – Overall positive, potential risk highlighted in relation to BOB contracts which are due for renewal over the next 18 months. Team are confident that this can be managed effectively.

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Committee Escalation and Assurance Report – Alert, Advise, Assure	
Report From:	TVICB Commissioning and Population Health Committee
Date of Meeting:	1st September 2026
Committee Chair:	Sajjad Khan

Key escalation and discussion points from the meeting

Alert:

The Committee noted that while an innovation funding mechanism is now in place, the likely scale of investment required to support prevention, neighbourhood health and wider system transformation is likely to exceed the existing NHS funding source of 1%. Exploratory work is therefore underway to assess the feasibility of attracting additional non-NHS investment to support long-term strategic commissioning ambitions while simultaneously trying to ascertain what floor of investment can be funded by the NHS budget over the medium term

Advise:

The Committee noted that the ICB's first Strategic Commissioning Intentions Paper will be submitted to NHS England by 30 September 2026. This will represent an important milestone in the ICB's transition towards a more mature strategic commissioning model and the Committee will continue to provide oversight of its development. This will be raised at the next ICB Board in September

Assure:

The Committee received updates on the Strategic Commissioning Sprint Programme and was assured that good progress is being made in establishing the foundations required to support the ICB's transition to a strategic commissioning organisation.

Members also received and welcomed the first Integrated Needs Assessment, recognising it as an important evidence base for future commissioning priorities, population health interventions and resource allocation decisions.

The Committee noted that the ICB's Commissioning Boards are now operational and beginning to provide the mechanisms through which strategic commissioning priorities can be translated into delivery and implementation.

The Committee was further assured that a dedicated transformation funding mechanism has been agreed, providing investment equivalent to approximately 1% of system funding to support innovation, transformation and strategic commissioning priorities.

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Committee Escalation and Assurance Report – Alert, Advise, Assure	
Report From:	System Delivery Committee
Date of Meetings:	15 July 2026
Committee Chair:	Priya Singh – ICB Chair

Key escalation and discussion points from the meeting

Alert:

None

Advise:

At the inaugural meeting of the System Delivery Committee – the Chair outlined the purpose of the Committee as a forum for system leaders to discuss transformation priorities, identify shared challenges and opportunities, and support collective decision-making across the Thames Valley system.

The Acute and Mental Health Provider Collaborative representatives provided high-level overviews of their current workplans, transformation programmes and system focussed priorities. GP representatives from across the Thames Valley geography updated on place and neighbourhood programmes of work.

Assure:

Thames Valley Neighbourhood Development Programme - the Committee received a presentation on the Thames Valley Neighbourhood Development Programme which summarised the strategic organisational development work that was taking place to accelerate neighbourhood working to support health and care partnerships across the system.

Terms of Reference: The Committee discussed its role as a forum for shared accountability and ownership of system wide priorities. The feedback provided by members would be incorporated into a further updated version of the draft Terms of Reference which would be approved at its next meeting in September.

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THAMES VALLEY INTEGRATED CARE BOARD

Title of Paper	Board Assurance Framework and Board Governance Update		
Agenda Item	11	**Date of meeting**	16 September 2026
Exec Lead	Caroline Corrigan (Chief People & Corporate Affairs Officer)		
Author(s)	Tom Allinson (Senior Governance Manager)		

Purpose	To Approve	☒
	To Ratify	☐
	To Discuss	☐
	To Note	☐

Link to Strategic Objective	*All*

Executive Summary

The ICB Board is responsible for agreeing the strategic objectives of the organisation and ensuring the delivery of the strategic objectives of the ICB. The Board Assurance Framework (BAF) captures the objectives as agreed by the Board and the key risks to their delivery as identified through discussion with executives and non-executive members and agreed by the Board. The BAF facilitates Board visibility and assurance on elements impacting delivery and the effectiveness of the controls in place to manage the risks.

The BAF itself can be found appended to the paper.

There are currently seven principal risks on the BAF. These have been assigned to the Strategic Objectives for Thames Valley agreed by the Board for 2026/27, and the current position as of September 2026 is shown below:

Strategic Objective 1 - We will improve outcomes by prioritising prevention and proactive care, using data to effectively manage risk and prevent worsening health

REF	Domain	Principle Risk	Risk Owner	System Board/Assurance Committee	Initial Risk rating (before mitigation)			Current Risk rating (after mitigation)			Risk Appetite / Threshold	Status (in/out of appetite)	Move from last quarter
					I	L	Rating (IxL)	I	L	Rating (IxL)			
1A	Transformation	Population Health / Health Inequalities	Hannah Iqbal / Lalitha Iyer	Commissioning and Population Health Committee	4	4	16	4	3	12	SEEK / 16	In	N/A
1B	Financial	Cyber Security	Hannah Iqbal	Commissioning and Population Health Committee	5	4	20	4	3	12	OPEN / 12	In	N/A
1C	Reputational	Complaints Procedure	Sarah bellars	Quality, Performance and Finance Committee	5	4	20	4	3	12	OPEN / 12	In	N/A

Strategic Objective 2 - We will drive equity for communities experiencing the worst outcomes by redistributing resources to drive improvement and improving our understanding of hidden need

REF	Domain	Principle Risk	Risk Owner	System Board/Assurance Committee	Initial Risk rating (before mitigation)			Current Risk rating (after mitigation)			Risk Appetite / Threshold	Status (in/out of appetite)	Move from last quarter
					I	L	Rating (IxL)	I	L	Rating (IxL)			
2A	Financial	Financial Sustainability	Rich Chapman	Quality, Performance and Finance Committee	5	5	25	5	4	20	OPEN / 12	Out	N/A

Strategic Objective 3 - We will reduce unwarranted variation in quality (experience, safety and effectiveness), service provision, cost, productivity, using our collective levers to address risk, drive improvement and maximise value

REF	Domain	Principle Risk	Risk Owner	System Board/Assurance Committee	Initial Risk rating (before mitigation)			Current Risk rating (after mitigation)			Risk Appetite / Threshold	Status (in/out of appetite)	Move from last quarter
					I	L	Rating (IxL)	I	L	Rating (IxL)			
3A	People	Workforce, Leadership and Culture	Caroline Corrigan	Thames Valley Executive Team	4	4	16	4	3	12	OPEN / 12	In	N/A
3B	People	Transition and Integration	Caroline Corrigan	Thames Valley Executive Team	4	4	16	4	3	12	OPEN / 12	In	N/A
3C	Reputational	Office of Pan-ICB Commissioning ("OPIC")	Sam Burrows	OPIC Hosting Committee	4	3	12	4	3	12	OPEN / 12	In	N/A

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There have been no changes to BAF scores in the interim Q3 position. Updates have been made against all outstanding actions, and new revised due dates have been agreed for all outstanding actions where applicable. The Audit Committee reviewed the BAF at its meeting on 21 July, where it was agreed that the BAF would be further revised to include more detail on listed controls as well as tightening risk descriptions where some areas were more sparsely populated than others. The current version of the BAF now shared with the public reflects these changes. The three lines of defence will be updated to better reflect the latest operating model for the next public BAF update in November. The Commissioning Boards have now been established and will regularly review the risks that underly the BAF, escalating anything material up to the Board's principal assurance committee, the Quality Performance and Finance Committee ("QPF"). The QPF will review the BAF alongside the corporate risk register on a regular basis, as will the Audit Committee and Risk Oversight Group, comprising the Chief Executive and all Chief Officers. This ensures robust engagement with and oversight of the BAF in between Board meetings.	
Recommendation	The ICB Board is asked to note the development of the Thames Valley Board Assurance Framework ("BAF") and the interim Q3 position as of September 2026/27, and to approve the publishing of this document to the public website.

Reporting – has this paper been discussed at other meetings		
Committee Name	Date discussed	Outcome
Audit Committee	21 July	Further revisions recommended, now incorporated in this latest version.

NHS Thames Valley ICB

Board Assurance Framework 2026/27

Interim Q3 2026-27 (September 2026)

The Board Assurance Framework (BAF) sets out the principal risks to the achievement of the ICB's strategic objectives and is a practical means through which the Board can assesses progress against delivery of these. In so doing, the BAF also serves as a primary source of evidence in describing how the ICB is discharging its responsibility for internal control.

The BAF further sets out the controls in place to manage these risks and the assurances available to support judgements as to whether the controls are having the desired impact. It additionally describes the actions to further reduce each risk.

Board Strategic Objectives 2026/27

Thames Valley ICB: Mission, strategic objectives and enablers
Our mission – [why we exist]
We are here to improve population health outcomes and reduce unwarranted variation at scale.
Our strategic objectives – [how we will drive change]
1. We will **improve population outcomes** by **prioritising prevention and proactive care**, using data to effectively manage risk and prevent worsening health.
2. **We will drive equity** for communities experiencing the worst outcomes by **redistributing resources** to drive improvement and improving our understanding of hidden need.
3. **We will reduce unwarranted variation** in quality (experience, safety and effectiveness), service provision, cost, productivity, using our collective levers to address risk, drive improvement and maximise value.
Our enablers – [How we will work]
• **Improvement focused** – We will be a dynamic, improvement focused organisation, applying improvement cycles and a clear measurement framework to ensure future-focused commissioning that drives population outcome improvement
• **Insight led, AI & data literate** – We will be insight led, using user experience and population data to drive our strategy and actions. We will grow our collective capability in AI and equip all our teams with analytical tools as part of their everyday work
• **Investing in our people** – We will build commissioning capability and confidence, so that we can commission confidently for outcomes, creating a culture where our teams are empowered to tackle the complex problems facing our population and health system
• **Partnering for innovation** – We will partner across our system and beyond to drive innovation, working together to reshape our system landscape and partnering to generate investment and innovation to drive improvement

Risk Summaries

Strategic Objective 1 - We will improve outcomes by prioritising prevention and proactive care, using data to effectively manage risk and prevent worsening health

REF	Domain	Principle Risk	Risk Owner	System Board/Assurance Committee	Initial Risk rating (before mitigation)			Current Risk rating (after mitigation)			Risk Appetite / Threshold	Status (in/out of appetite)	Move from last quarter
					I	L	Rating (IxL)	I	L	Rating (IxL)			
1A	**Transformation**	**Population Health / Health Inequalities**	Hannah Iqbal / Lalitha Iyer	Commissioning and Population Health Committee	**4**	**4**	**16**	**4**	**3**	**12**	**SEEK / 16**	**In**	=
1B	**Financial**	**Cyber Security**	Hannah Iqbal	Quality, Performance and Finance Committee	**5**	**4**	**20**	**4**	**3**	**12**	**OPEN / 12**	**In**	=
1C	**Reputational**	**Complaints Procedure**	Sarah bellars	Quality, Performance and Finance Committee	**5**	**4**	**20**	**4**	**3**	**12**	**OPEN / 12**	**In**	=

Strategic Objective 2 - We will drive equity for communities experiencing the worst outcomes by redistributing resources to drive improvement and improving our understanding of hidden need

REF	Domain	Principle Risk	Risk Owner	System Board/Assurance Committee	Initial Risk rating (before mitigation)			Current Risk rating (after mitigation)			Risk Appetite / Threshold	Status (in/out of appetite)	Move from last quarter
					I	L	Rating (IxL)	I	L	Rating (IxL)			
2A	**Financial**	**Financial Sustainability**	Rich Chapman	Quality, Performance and Finance Committee	**5**	**5**	**25**	**5**	**4**	**20**	**OPEN / 12**	**Out**	=

Strategic Objective 3 - We will reduce unwarranted variation in quality (experience, safety and effectiveness), service provision, cost, productivity, using our collective levers to address risk, drive improvement and maximise value

REF	Domain	Principle Risk	Risk Owner	System Board/Assurance Committee	Initial Risk rating (before mitigation)			Current Risk rating (after mitigation)			Risk Appetite / Threshold	Status (in/out of appetite)	Move from last quarter
					I	L	Rating (IxL)	I	L	Rating (IxL)			
3A	**People**	**Workforce, Leadership and Culture**	Caroline Corrigan	Thames Valley Executive Team	**4**	**4**	**16**	**4**	**3**	**12**	**OPEN / 12**	**In**	=
3B	**People**	**Transition and Integration**	Caroline Corrigan	Thames Valley Executive Team	**4**	**4**	**16**	**4**	**3**	**12**	**OPEN / 12**	**In**	=
3C	**Reputational**	**Office of Pan-ICB Commissioning ("OPIC")**	Sam Burrows	OPIC Hosting Committee	**4**	**3**	**12**	**4**	**3**	**12**	**OPEN / 12**	**In**	=

Board Risk Appetite Statement 2026/27

Risk appetite is defined as the amount of risk that we are willing to seek or accept in the pursuit of long-term objectives.

It is key to achieving effective risk management and is agreed by the Board so that that the nature and extent of significant risks we are willing to take in achieving our strategic objectives is understood. It represents a balance between the potential benefits of transformation, the challenges we face, and the threats change inevitably brings.

The Board will review its risk appetite annually or more frequently should the environment we operate in change significantly. The risk appetite sets the threshold for risk against key domains and enables the Board, its Committees and Boards and teams to effectively manage risks.

Risk Statement:

Thames Valley ICB recognises that long term sustainability of health and care services depends upon managing risks in relation to the delivery of our strategic objectives. Our approach to our risk appetite is influenced by the context in which we operate including population health data and outcomes and maturity of our system working.

We believe that no risk exists in isolation and that effective risk management is about finding the right balance between risks and opportunities to deliver our ambitions, to act in the best interests of our communities alongside delivering value for money. Our risk appetite approach recognises the need for risk trade-off conversations, creating a flexible framework within which we can drive transformation, make agile decisions and balance boldness and caution, risk and reward and cost and benefit. It also aims to provide a proportionate approach to risk reducing bureaucracy but ensuring appropriate rigour in our risk management.

We recognise that no health and care is risk free and when balancing risk, we will tolerate some more than others. For example: we will have a cautious approach to risks which impact quality (clinical quality, safety and patient experience) which means we prefer safe delivery options and take decisions that aim to mitigate the level of risk. When driving transformation and innovation we will seek options that have bigger rewards but greater risks to get there, using our risk approach to understand and balance the risk with benefits.

Overall Thames Valley ICB has an open appetite to take well-considered balanced risks to pursue innovation and opportunities where positive gains can be expected, whilst being confident that through good risk management the threats can be averted.
References: Good Governance Institute: Board guidance on risk appetite: 2020; NHSE/I Risk Appetite 2021

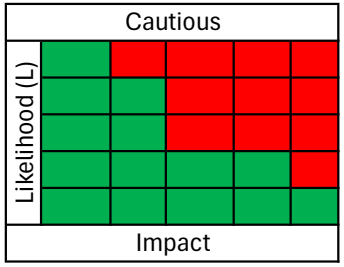
The Board has agreed its risk appetite in the following domains for 2025/26:

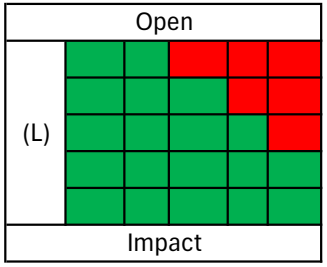
Domains	Risk Appetite	Risk Threshold
FINANCIAL	OPEN	12
PERFORMANCE	OPEN	12
PEOPLE	OPEN	12
REGULATORY	OPEN	12
REPUTATIONAL	OPEN	12
QUALITY	CAUTIOUS	8
TRANSFORMATION	SEEK	16

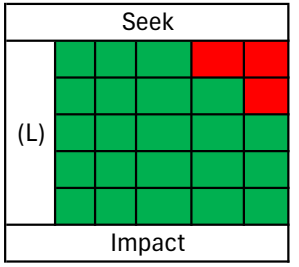
Risk Appetite	Description
None	We have no appetite for decisions or actions that will impact in anyway - avoid risk at all costs and all decisions taken to remove the risk
Minimal	We are only willing to accept the possibility of very limited risk and will avoid any decisions or actions that may result in heightened risk unless absolutely essential
Cautious	We are prepared to accept the possibility of limited risk. Our preference is for safe delivery options but we are able to tolerate low level risk and uncertainty. Every decision will be with the aim of mitigating the level of risk.
Open	We are willing to consider all potential delivery options and choose while providing an acceptable level of reward. Take a greater degree of risk and tolerate higher uncertainty to achieve a bigger reward.
Seek	We are eager to be innovative and to choose options offering greater rewards but have greater inherent risk. Eager to take on risk to achieve strategic objectives
Significant	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust. Will chose the option with greater reward and will accept any loss as the price for the reward.

Heat Map

Domains	Risk Appetite	Risk Threshold
FINANCIAL	OPEN	12
PERFORMANCE	OPEN	12
PEOPLE	OPEN	12
REGULATORY	OPEN	12
REPUTATIONAL	OPEN	12
QUALITY	CAUTIOUS	8
TRANSFORMATION	SEEK	16







BAF REF: 1A	Strategic Objective 1	Principal Risk: Population Health / Health Inequalities There is a risk that the ICB is unable to deliver a whole-system approach to prevention, population health improvement and reducing health inequalities at scale due to inconsistent embedding of prevention-focused, proactive, data-driven and outcomes-based care. This may result from limited integration of population health insight, lived experience and community intelligence into decision-making and service transformation, alongside inconsistent use of system levers, organisational complexity and variable capability. Consequently, the system may struggle to improve outcomes, reduce unwarranted variation, optimise use of resources and services, deliver commissioning intentions and achieve financial sustainability, leading to widening inequalities and increased avoidable demand.	Risk Domain: TRANSFORMATION	Current Risk Score: 12

Assurance Committee: Commissioning and Population Health Committee						Delegated Risk Owners: CMO / CSCO			Date Added to BAF: Q2 2026/27				
Initial Risk Rating (before mitigation)			Current Risk Rating (after mitigation)			Risk Appetite / Threshold	Status (in/out appetite)	Last updated	Q2 26/27	Q3 26/27	Q3 26/27	Q4 26/27	Q1 27/8
I	L	Rating (IxL)	I	L	Rating (IxL)								
4	4	16	4	3	12	SEEK / 16	In	Sep-26	12	TBC	TBC	TBC	TBC

Key Controls in Place	Key Assurance					
	First Line of Defence: Management control and reporting		Second line of Defence: Functional Oversight / Governance		Third line of Defence: Independent review / Assurance / Regulatory oversight	
Population Health Unit - Provides population health intelligence and insight to identify need, inequalities and unwarranted variation, informing strategic planning, commissioning and prevention activity across the system.	CMO / CSCO SLT meetings	Monthly	Commissioning and Population Health Committee	Bi-monthly	Annual NHSE Oversight Framework	TBC
Value Lab - Identifies opportunities to improve outcomes, reduce unwarranted variation and optimise use of resources, supporting partners to translate evidence and insight into service and commissioning improvements.	4Risk Reviews	Ad hoc	Risk Oversight Group	Quarterly	Annual Internal Audit Programme	"Substantial Assurance" 25/26
The Population Health Dashboard provides Board and system oversight of key population health, inequalities and NHS outcomes measures, including variation between geographies and population groups.	Commissioning Board risk reviews	Quarterly	Board, QPF, Audit Committee, Exec Team meetings	Bi-monthy	Annual External Audit Programme	"No Control issues Raised" 25/26
Community engagement and insight - Established approaches to engaging communities and incorporating lived experience and community intelligence into strategic planning, commissioning and service transformation, with particular focus on underserved and seldom-heard communities.						

Gaps in Control and/or Assurance	Mitigating Action	Target Date	Action Lead	Update
Translation of insight from population health data analytics and neighbourhood plans into action and mechanisms to consistently convert insight, lived experience and community intelligence into commissioning, service redesign and delivery decisions are not yet fully embedded	**The population health committee core purpose ; neighbourhood heath board being sighted on data and the plans**	**31-Sept-26**	Lalitha Iyer / Hannah Iqbal	**September 2026 update:** Work is underway to strengthen the connection between population health intelligence, neighbourhood plans and commissioning and service transformation. The Population Health Committee and Neighbourhood Health Boards have now met and are being used to improve oversight and ensure insight is translated into priorities and delivery. Further work is required to establish consistent mechanisms and demonstrate impact.
Need robust data on migrant health and other inclusion groups, hidden need to inform commissioning	**Consistent mechanism across the organisation on sense checking any commissioning decisions on impact on population health outcomes by reducing unwarranted varation.**	**31-Sept-26**	Lalitha Iyer / Hannah Iqbal	**September 2026 update:** Work is underway to strengthen the availability and use of data relating to migrant health and other inclusion groups. This will support a better understanding of hidden need and inform future commissioning and service planning. Further development is required to ensure this intelligence is consistently available and embedded in decision-making.
Community partnership and co-production - community voice and lived experience are not yet systematically embedded into planning, prioritisation and redesign.	**Linking with the other partners such as health and well being board for intelligence from on going pieces of work.**	**31-Sept-26**	Lalitha Iyer / Hannah Iqbal	**September 2026 update:** Opportunities are being developed to strengthen the systematic use of community intelligence and lived experience in planning and service redesign, including through closer working with Health and Wellbeing Boards, local authority and VCSE partners. Further work is required to ensure this is consistently embedded across the ICB.

BAF REF: 1B	Strategic Objective 1	Principal Risk: Cyber Security A cyber-attack on a Thames Valley ICS provider (or provider supplier) could impact the ability of the provider to deliver care to patients, which will affect the ICB achieving/meetings its strategic objectives	Risk Domain: FINANCIAL	Current Risk Score: 12

Assurance Committee: Quality, Performance and Finance Committee						Delegated Risk Owner: CSCO			Date Added to BAF: July 2026				
Initial Risk Rating (before mitigation)			Current Risk Rating (after mitigation)			Risk Appetite / Threshold	Status (in/out appetite)	Last updated	Q2 26/27	Q3 26/27	Q3 26/27	Q4 26/27	Q1 27/8
I	L	Rating (IxL)	I	L	Rating (IxL)								
5	4	20	4	3	12	OPEN / 12	In	Sep-26	12	TBC	TBC	TBC	TBC

Key Controls in Place	Key Assurance					
	First Line of Defence: Management control and reporting		Second line of Defence: Functional Oversight / Governance		Third line of Defence: Independent review / Assurance / Regulatory oversight	
1) Thames Valley cyber strategy and the consolidated 2026/27 Cyber Risk Management Framework and Assurance Improvement Plan bring together legacy BOB/Frimley controls, both 2026 RSM audits, named owners, target dates and closure evidence; delivery is tracked to 30 May 2027.	Monthly IG Team Risk Reviews	Monthly	Exec Team	Monthly	Annual NHSE Oversight Framework	TBC
2) Cyber risk has SIRO/executive accountability and is reported through Digital leadership, Executive, Board and Audit Committee routes. The single Thames Valley governance map, RACI, policy approval route and BAF/corporate-risk escalation are being formalised during 2026/27.	4Risk Reviews	Ad hoc	Risk Oversight Group	Quarterly	Annual Internal Audit Programme	"Substantial Assurance" 25/26
3) Quarterly operational assurance covers corporate and primary-care estates: CareCERT and Microsoft Defender alert investigation, vulnerability/patching oversight, MFA/RBAC and privileged access, dormant-account management, secure-score monitoring, backups and recovery testing.	Commissioning Board risk reviews	Quarterly	Board, QPF, Audit Committee, Commissioning and Population Health Committee	Bi-monthy	Annual External Audit Programme	"No Control issues Raised" 25/26
4) Mandatory IG/cyber training and phishing-awareness activity are being established, with the improvement plan extending suspicious-email and cyber-awareness campaigns across ICB staff and GP practices.						
5) More than £2m of national cyber investment has been secured over the last 24 months to strengthen monitoring, resilience and protection of patient data accross the Thames Valley ICS including the provider organisations; investment is prioritised against risk and maturity needs.						
6) Annual DSPT/CAF assurance is supported by independent RSM audit and follow-up. The CAF-aligned DSPT audit reported Low cyber risk with High confidence, with one medium supplier-assurance action; recommendations are managed through a consolidated tracker and evidence repository.						
7) Thames Valley leads the South East third-party risk management (SE TPRM) workstream. The phased ICB model covers critical-supplier registers, risk tiering, due diligence, subcontractors/processing locations, connection and access reviews, contract minimum standards, evidence packs, exceptions and ongoing monitoring.						
8) Provider and supplier cyber resilience is overseen through commissioning, procurement, contract, IG and annual DSPT/CAF evidence routes, alongside incident/DR arrangements. Supply-chain tabletop testing, supplier incident playbooks and annual cyber assurance reporting are included in the 2026/27 improvement plan.						

Gaps in Control and/or	Mitigating Action	Target	Action Lead	Update
Limited cyber requirements in IT service specification for ICB and GP practices IT Supplier	**Review and develop existing IT service specifications, to ensure cyber resilience is clearly documented in ICB IT Service specification, and resources are available to monitor ICB IT Service specification**	**01-Sep-26**	Mark Sellman	**September 2026 update:** The 2026/27 improvement plan includes review of ICB and GP IT service specifications and alignment of cyber-resilience requirements with service monitoring. Delivery remains dependent on Digital, Procurement and Contract Management input; approved minimum standards and monitoring evidence are still required.
Lack of ICB staff awareness on how to prevent a cyber incidents	**Fund resources to rollout suspicious email and cyber awareness campaigns across the ICB and GP practices**	**01-Dec-26**	Mark Sellman	**September 2026 update:** Mandatory IG/cyber training and phishing-awareness controls are inherited and operating. The Thames Valley plan extends suspicious-email simulations and awareness campaigns across ICB staff and GP practices; rollout resources, schedule and completion evidence are being confirmed.
No assurance on ICB suppliers and their cyber assurance	**Contracting team to assess all ICB suppliers for cyber assurance and resilience**	**01-Apr-27**	Rich Chapman / Ian Murdock	**September 2026 update:** The supplier-assurance gap is confirmed by the RSM CAF-aligned DSPT audit, which raised one medium-priority A4.a action. Thames Valley is leading the SE TPRM workstream and developing a phased model covering a critical-supplier register, risk tiering, due diligence, evidence packs, exceptions and ongoing monitoring; delivery is phased through January-April 2027.
No contractual requirements on ICS providers to implement safe and secure services	**Contracting team to review and update providers contracts to require providers to provide cyber assured and resilient services**	**01-Sep-26**	Rich Chapman / Ian Murdock	**September 2026 update:** Cyber and IG Minimum Standards are to be embedded in new, renewed and varied contracts, supported by approved wording, legal review and procurement governance. The consolidated improvement plan sets a 31 March 2027 delivery date, so the current September milestone requires re-baselining.
Limited engagement of ICS providers to work together to increase cyber assurance across the ICS	**Allocate/fund resources to support and work with providers to increase cyber assurance**	**01-Dec-26**	Mark Sellman	**September 2026 update:** The Thames Valley ICS cyber strategy and workplan have been drafted and shared, and the South East Regional Cyber Lead has been supportive. Engagement through the parent ICS/CIO forum has been limited and some meetings have been cancelled; formal approval, ownership and a sustainable provider-engagement route remain outstanding.
Lack of oversight of ICS providers resilience testing	**Allocate/fund resources to support and work with providers to undertake resilience testing**	**01-Dec-26**	Mark Sellman	**September 2026 update:** Backup and recovery testing is operating for the managed corporate estate. Wider provider and supplier resilience oversight will be strengthened through refreshed DR evidence, a supply-chain incident tabletop exercise by 28 February 2027, and supplier off-boarding/emergency-revocation testing by 31 May 2027.
Lack of funding to implement more cyber secure networks	**Utilise NHS England cyber funding to support ICS providers to purchase cyber monitoring tools to proactively monitor their networks**	**01-Dec-26**	Mark Sellman	**September 2026 update:** More than £2m of national cyber investment has been secured by TV ICB and the previous BOB ICB over the last 24 months to strengthen resilience and protect patient data across Thames Valley, including provider organisations. The remaining issue is prioritisation, specialist capacity and evidence of benefits rather than an absence of funding; this gap should be reviewed and reworded or closed.
Single Thames Valley cyber governance, reporting and assurance-evidence arrangements are not yet fully embedded	**Approve the Cyber Risk Management Framework and governance RACI; align cyber risks to the BAF/corporate risk register; establish the consolidated audit tracker, MI/KRI reporting and cyber assurance evidence repository**	**30-May-27**	SIRO / Cyber / Risk / Governance	**September 2026 update:** The consolidated 2026/27 framework and 30-action improvement plan are drafted. Phase 1 covers governance and foundations, with framework/RACI approval targeted for October 2026 and full evidence, annual assurance and risk refresh activity completing by 30 May 2027. Assurance remains developing until these arrangements are embedded.
Specialist cyber knowledge and delivery capacity are concentrated in a single ICB role	**Prioritise audit-critical actions, confirm cross-functional ownership and consider additional specialist capacity to support cyber assurance, infrastructure transition, supplier assurance and delivery of the improvement plan**	**30-May-27**	Executive Lead / SIRO / Digital Leadership	**September 2026 update:** The Executive assurance report identifies a material key-person and capacity dependency, with no established access to dedicated specialist cyber support. Active executive prioritisation and additional capacity remain necessary to protect delivery of the 2026/27 plan.
Thames Valley supplier cyber-incident and supply-chain response arrangements have not yet been fully tested	**Update the cyber incident procedure and supplier incident playbook, then conduct a supply-chain tabletop exercise covering notification, escalation, communications, recovery and lessons learned**	**28-Feb-27**	Cyber / IG / Procurement	**September 2026 update:** This is a defined action in the consolidated improvement plan. The exercise is due by 28 February 2027 and should produce an exercise report, decision log, lessons learned and tracked remediation actions.

BAF REF: 1C	Strategic Objective 1	Principal Risk: Complaints Process There is a risk that delays in progressing the organisation's complaints processes, including legacy and complex complaints, may result in the organisation failing to meet its statutory responsibilities and associated regulatory requirements.	Risk Domain: REPUTATIONAL	Current Risk Score: 12

Assurance Committee: Quality, Performance and Finance Committee						Delegated Risk Owner:			Date Added to BAF:				
Initial Risk Rating (before mitigation)			Current Risk Rating (after mitigation)			Risk Appetite / Threshold	Status (in/out appetite)	Last updated	Q2 26/27	Q3 26/27	Q3 26/27	Q4 26/27	Q1 27/8
I	L	Rating (IxL	I	L	Rating (IxL								
5	4	20	4	3	12	OPEN / 12	In	Sep-26	12	TBC	TBC	TBC	TBC

Key Controls in Place	Key Assurance					
	First Line of Defence: Management control and reporting		Second line of Defence: Functional Oversight / Governance		Third line of Defence: Independent review / Assurance / Regulatory oversight	
1) Complaints Management and Monitoring All complaints are recorded and monitored through the Blueteq system, with cases logged in real time to support timely progression and reduce avoidable delays. **2) Executive Oversight of Aged Cases** The five oldest open complaints are reported to the Chief Nursing Officer (CNO) on a weekly basis. This provides enhanced oversight, supports escalation where required, and helps identify and resolve barriers to progression. **3) Board Assurance and Governance** Complaints performance, including timeliness and outstanding cases, is reported to the Board through routine performance reports, providing oversight, assurance, and governance of the complaints process.	CNO SLT meetings	Monthly	Exec Team	Monthly	Annual NHSE Oversight Framework	TBC
	4Risk Reviews	Ad hoc	Risk Oversight Group	Quarterly	Annual Internal Audit Programme	"Substantial Assurance" 25/26
	Commissioning Board risk reviews	Quarterly	Board, QPF, Audit Committee	Bi-monthy	Annual External Audit Programme	"No Control issues Raised" 25/26

Gaps in Control and/or Assurance	Mitigating Action	Target Date	Action Lead	Update
Backlog of inquiries and complaints present in system and delays to responses as a result	Work through backlog and introduce new measures to address delays to compaints responses Consideration of removing additional resource	**01-Nov-26**	Sarah Bellars	**September 2026 update:** The backlog of complaints has reduced demonstarting that our recovery actions has had a positive impact.
Complaints handling software in need of review of its functionality and fitness for purpose	Review to be undertaken	**01-Nov-26**	Sarah Bellars	**September 2026 update:** Awaiting the review.
Unclear escalation routes as a result of prolongued organisational change	Implement new structures	**30-Sep-26**	Sarah Bellars	**September 2026 update:** Implemetation of new ways of working continues, with new inox srtuctures and work flow management. A new web page development is underway which includes a complaints submission form. This will support improved quality and completeness of information received at first contact.

BAF REF: 2A	Strategic Objective 2	Principal Risk: Financial Sustainability The risk is that the system fails to deliver the greatest possible value for the health and wellbeing of the population with the resource with which it is entrusted. If the ICB fails to deliver in-year financial balance and recurrent financial sustainability then it is likely that external intervention will ensue. That intervention is likely to adopt a short-termist approach to financial balance which places at risk the ICB's strategic objectives. If key suppliers such as NHS providers within the geography fail to deliver financial balance then that will disrupt system working to deliver strategic objectives through the same mechanism. If the system fails to secure sufficient capital and revenue resource to achieve strategic and operational aims, including delivery of the new hospital and associated transformation then that will threaten the objective to the minimise health inequalities and maximise healthy life years.	Risk Domain: FINANCIAL	Current Risk Score: 20

Assurance Committee: Quality, Performance and Finance Committee	Delegated Risk Owner: CFO	Date Added to BAF: July 2026

Initial Risk Rating (before mitigation)			Current Risk Rating (after mitigation)			Risk Appetite / Threshold	Status (in/out appetite)	Last updated	Q2 26/27	Q3 26/27	Q3 26/27	Q4 26/27	Q1 27/8
I	L	Rating (lxL	I	L	Rating (lxL)								
5	5	25	5	4	20	OPEN / 12	OUT	Sep-26	20	TBC	TBC	TBC	TBC

Key Controls in Place	Key Assurance					
	First Line of Defence: Management control and reporting		Second line of Defence: Functional Oversight / Governance		Third line of Defence: Independent review / Assurance / Regulatory oversight	
1) Active oversight of the Quality, Finance & Performance report ensures there is a mechanism to undertake deep dives and seek assurance where the ICB is off track with delivery, with clear escalation routes to both the Executive Committee and the Board.	CFO SLT meetings	Monthly	Exec Team	Monthly	Annual NHSE Oversight Framework	TBC
2) Additional scrutiny is applied by regional and national teams through tiering and ICB assurance meetings, alongside internal contract management meetings providing assurance that all reasonable actions are being taken and creating a route for intervention or the deployment of improvement support where this is deemed necessary.	4Risk Reviews	Ad hoc	Risk Oversight Group	Quarterly	Annual Internal Audit Programme	"Substantial Assurance" 25/26
3) Monthly contract management meetings in place to monitor delivery of agreed plans. Risks and issues are escalated through the Contract review monitoring process including details of where contract performance notices have been issued.	Commissioning Board risk reviews	Quarterly	Board, QPF, Audit Committee	Bi-monthy	Annual External Audit Programme	"No Control issues Raised" 25/26
4) The QPF report incorporates all the key metrics associated with the operating plan and the national oversight framework. Areas for escalation are clearly set out in the report						

Gaps in Control and/or Assurance	Mitigating Action	Target Date	Action Lead	Update
There is variable use of contractual levers and recovery action plans and improvement in contract enforcement and improvement processes required.	**Develop and train teams in contract enforcement and improvement processes.**	**30-Sep-26**	Rich Chapman	**September 2026 update:** The organisational change process has delayed the full population of the new structure but in key areas, people and process are in place to ensure appropriate contractual levers are utilised. However, capacity is limited and the ICB is forced through circumstance to prioritise the most material risks (e.g. ADHD RTC) or finds itself in a position whereby operational process is under such pressure (AACC) that it may not have the ability to impement appropriate controls until remedial actions are completed. In other areas, such as planned care, contractual levers are being fully utilised but there is th epotential for regulatory operational pressure to require ICBs to commission more activity than was planned for (and afforded within plans) in order to mitigate the impact on waiting list and waiting time performance of demand which exceeds planning assumptions. the ICB is rigorously assessing its aggregated plan to demonstrate that the original plans commissioned sufficient activity under the mandated demand assumptions.
The ICB is developing the report to reflect the changes to ICBs focus and will continue to develop this to a fully functioning suite.	**Continue to develop QPF report to support and enhance monitoring of oversight metrics**	**30-Sep-26**	Rich Chapman	**September 2026 update:** The ICB is focused on the 43 national metrics, and has broken these down into H1 and H2 metrics in order to assign responsibility for monitoring within its governance framework. Work is underway on prioritisation and lead metrics on which the ICB should focus in order to impact the national metrics, which are often lag indicators.
The QF&P Committee has been established with a revised terms of reference in place to focus assurance across quality, operational and finance performance.	**Revised terms of reference to support changing role of the new QP&F Committee reviewed and agreed by TV ICB Board.**	**31-Jul-26**	Rich Chapman	**September 2026 update:** Revised terms of reference have been agreed - **propose for closure.**
Unless the delegation agreement for specified functions is implemented in full and consistent with the agreement itself, the ICB will be in breach of the agreement. The agreement transfers the employment of staff in the following functions: - Medicines Optimisation - All Age Complex and Continuing Care - Thames Valley Workforce Training and Education Hub - Berkshire Community Equipment Services - Associated Finance Support Staff The transfer of these functions allows the ICB to fulfil its role as a strategic commissioner whilst living within the revised financial envelope provided by NHSE as the regulator of ICBs.	**The approval of the delegated functions agreement is subject to the completion of the pre-transfer conditions precedent as described in para 24 which requires both parties to agree operational baselines in all functions. Secondarily, the agreement requires both FHFT and the ICB to establish a Joint Board Committee to lead on the oversight of the agreement. This Joint Committee needs to be in place before 1 February 2026. Both of these act as safeguards to ensure that the risk to the ICB is actively mitigated, and to act as an early alert system to the executive of areas of non-compliance. Gateway reviews of effectiveness of the agreement to be undertaken at the 6 and 12 month points.**	**01-Sep-26**	Sam Burrows	**September 2026 update:** The delegation agreement has been signed. There remain some operational model risks around areas such as the governance associated with non-ICB employees carrying authorisation rights to commit ICB expenditure, but this is being addressed through the Audit Committee, to whose next meeting a paper will be brought.

BAF REF: 3A	Strategic Objective 3	Principal Risk: Workforce, Leadership and Culture There is a risk that organisational change, including CSU close down and integration of legacy teams does not sufficiently support workforce stability, leadership alignment, staff engagement and cultural integration. This may impact organisational effectiveness, delivery of strategic objectives, staff productivity, wellbeing, retention, and the ICB's ability to operate as a coherent strategic commissioner.	Risk Domain: People	Current Risk Score: 12

Assurance Committee: Executive Team						Delegated Risk Owner: CPCO			Date Added to BAF: July 2026				
Initial Risk Rating (before mitigation)			Current Risk Rating (after mitigation)			Risk Appetite / Threshold	Status (in/out appetite)	Last updated	Q2 26/27	Q3 26/27	Q3 26/27	Q4 26/27	Q1 27/8
I	L	Rating (IxL)	I	L	Rating (IxL)								
4	4	16	4	3	12	Open / 12	In	Sep-26	12	TBC	TBC	TBC	TBC

Key Controls in Place	Key Assurance					
	First Line of Defence: Management control and reporting		Second line of Defence: Functional Oversight / Governance		Third line of Defence: Independent review / Assurance / Regulatory oversight	
1) Workforce Transition Management (TUPE/COSOP) - Structured approach to staff transfer, role mapping, and compliance. 2) Operating Model Implementation - Delivery of a clear organisational structure with defined roles and accountabilities. Capability building assessment and programme of work to address. 3) Workforce Planning and Critical Role Oversight - Identification and monitoring of key roles, vacancies and succession needs. 4) Engagement, OD and EDI Support - Delivery of engagement activity, EDI impact assessments and cultural integration support. 5) Strengthened Leadership Development Framework - Defined expectations, behaviours and development for leaders across the ICB. 6) Leadership Oversight and Governance - Executive-led oversight of organisational change and workforce risks.	CPCO SLT meetings	Monthly	Exec Team	Quarterly	Annual NHSE Oversight Framework	TBC
	4Risk Reviews	Monthly	Risk Oversight Group	Quarterly	Annual Internal Audit Programme	"Substantial Assurance" 25/26
	Commissioning Board risk reviews	Quarterly	Board, QPF, Audit Committee	Bi-monthy	Annual External Audit Programme	"No Control issues Raised" 25/26

Assurance gaps	Mitigating Action	Target Date	Action Lead	Update
Workforce turnover and critical capacity gaps	**Finalise change programme, confirm roles and recruit to priority posts.**	**31-Oct-26**	Director of People	**September 2026 update:** Delivery remains on track. The change programme and Filling of Posts process continue to progress, with appointments being confirmed and recruitment to priority vacancies underway. These actions are helping to reduce critical capacity gaps and support workforce stability.
Risk to staff engagement, wellbeing and inclusion	**Deliver structured engagement plan, strengthen wellbeing support, and complete EDI impact assessments.**	**31-Oct-26**	Director of Organisational Development	**September 2026 update:** Mitigating controls remain effective. Staff engagement has been strengthened through monthly engagement forums, wellbeing and EAP promotion, embedded OD support, and completion of EDI impact assessments throughout the change programme. EDI representatives have been involved in recruitment and alignment processes, with tailored guidance and support available for staff across all protected characteristics.
Inconsistent culture and leadership behaviours across legacy organisations	**Strengthened leadership framework, behavioural expectations, and cultural integration plan.**	**31-Dec-26**	Director of Organisational Development	**September 2026 update:** The risk is being mitigated through the establishment of a Senior Managers Network, providing regular HR, OD and EDI updates and promoting leadership alignment. The Leadership and Management Framework is being embedded into development and appraisal processes, while completion of the Strategic Commissioning Academy self-assessment is informing future leadership and team development priorities to support cultural integration and consistent leadership behaviours.
Limited workforce intelligence and assurance	**Develop People/OD dashboard covering workforce, engagement, EDI, turnover and vacancies with regular Executive review.**	**31-Mar-27**	Director of People	**September 2026 update:** Development of the People and OD dashboard is underway with metrics being defined and aligned to reporting requirements. Once implemented, the dashboard will strengthen workforce intelligence, assurance and Executive oversight.

BAF REF: 3B	Strategic Objective 3	Principal Risk: Organisational Transition and integration There is a risk the concurrent absorption of legacy South-West and Central CSU services and the complex operational merger forming the new NHS Thames Valley ICB results in critical capacity gaps, inconsistent processes, service delivery failure, and unbudgeted legacy liabilities.	Risk Domain: PEOPLE	Current Risk Score: 12

Assurance Committee: Executive Team						Delegated Risk Owner: CPCO			Date Added to BAF: July 2026				
Initial Risk Rating (before mitigation)			Current Risk Rating (after mitigation)			Risk Appetite / Threshold	Status (in/out appetite)	Last updated	Q2 26/27	Q3 26/27	Q3 26/27	Q4 26/27	Q1 27/8
I	L	Rating (IxL)	I	L	Rating (IxL)								
4	4	16	4	3	12	OPEN / 12	In	Sep-26	12	TBC	TBC	TBC	TBC

Key Controls in Place	Key Assurance					
	First Line of Defence: Management control and reporting		Second line of Defence: Functional Oversight / Governance		Third line of Defence: Independent review / Assurance / Regulatory oversight	
1) Oversee Transition Finances - CFO team monitors legacy South-West and Central CSU Service Level Agreements (SLAs), separating current contractual costs from historic baseline spend. 2) Manage Workforce Transition and TUPE - CPO oversees a structured approach to track staff transfers, match incoming CSU employees to roles in the new ICB structure, and comply with TUPE requirements. 3) Manage Information Governance and Data Migration - Teams carry out onboarding activities, including Data Protection Impact Assessments (DPIAs) and migration plans, to transfer business-critical data securely and in full (including patient-level data and contracting history). 4) Maintain Contract Management During Transition - Teams continue to use established CSU contract monitoring processes and templates to oversee provider performance and maintain service continuity during transition.	CPCO SLT meetings	Monthly	Exec Team	Quarterly	Annual NHSE Oversight Framework	TBC
	4Risk Reviews	Monthly	Risk Oversight Group	Quarterly	Annual Internal Audit Programme	"Substantial Assurance" 25/26
	Commissioning Board risk reviews	Quarterly	Board, QPF, Audit Committee	Bi-monthy	Annual External Audit Programme	"No Control issues Raised" 25/26

Gaps in Control and/or Assurance	Mitigating Action	Target Date	Action Lead	Update
Limited visibility of residual ("stranded") costs and liabilities - The ICB has not yet fully reconciled legacy CSU costs, including shared services, infrastructure, and potential exit or redundancy liabilities.	**Review all legacy CSU SLAs to identify, test, and agree how to handle residual costs. Build the agreed position into the 2026/27 financial plan.**	**31-Sept-26**	Caroline Corrigan	**September 2026 update:** CSU provided their schedule of stranded costs to be agreed with the ICB before submission to NHSE on 31 August as part of their bid against an NHSE Funding Pot. RREquest has gone back to the CSU on 21 August for analysis of the BI data they have used to ensure that the ICB can validate and hopefully agree the submission.
Risk to business intelligence and analytical capacity - The transition could reduce analytical capacity, particularly for performance tracking, population health insight, and commissioning decisions.	**Set up and resource an internal analytics function to replace CSU capability and provide locally-based analytical support.**	**31-Oct-26**	Caroline Corrigan	**September 2026 update:** 14 CSU analytic staff TUPE'd into the ICB
Service continuity risks from workforce attrition and role gaps - Uncertainty during transition has led to staff leaving and gaps in key areas, including procurement, CHC, and contracting.	**Finalise and publish the operating model, finalise the change programme, confirm roles, and recruit into critical posts to stabilise services.**	**31-Oct-26**	Director of People and Director of Organisational Development	**September 2026 update:** The operating model has been published. The Filling of Posts process continue to progress, with appointments being confirmed and recruitment to priority vacancies underway. These actions are helping to reduce critical capacity gaps and support workforce stability. Work is underway to develop the next iteration of the OD Plan. This will support implementation of the operating model and help strengthen organisational capability, culture and ways of working.
Inconsistent procurement and commissioning approaches - Differences in legacy processes across the footprint lead to variation in procurement, contract management, and provider oversight.	**Introduce a single ICB-wide "Procurement and Market Management Strategy" to standardise commissioning and reduce variation.**	**31-Dec-26**	Rich Chapman	**September 2026 update:** Ongoing.

BAF REF: 3C	Strategic Objective 3	Principal Risk: Office of Pan-ICB Commissioning ("OPIC") Poor delivery of the OPIC Programme with implications for financial due diligence, people and culture, governance (statutory, legal and regularity duties), transfer of functions and processes (digital & IT, contracts, policies, HR, stakeholder management and coms etc) and ultimately reputation.	Risk Domain: REPUTATIONAL	Current Risk Score: 12

Assurance Committee: OPIC Hosting Committee						Delegated Risk Owner: CSD&PO		Date Added to BAF: July 2026				
Initial Risk Rating (before mitigation)			Current Risk Rating (after			Risk Appetite / Threshold	Status (in/out appetite)	Last Updated	Q2 26/27	Q3 26/27	Q3 26/27	Q4 26/27	Q1 27/8
I	L	Rating (IxL)	I	L	Rating (IxL)								
4	3	12	4	3	12	OPEN / 12	In	Sep-26	12	TBC	TBC	TBC	TBC

Key Controls in Place	Key Assurance					
	First Line of Defence: Management control and reporting		Second line of Defence: Functional Oversight / Governance		Third line of Defence: Independent review / Assurance / Regulatory oversight	
Thames Valley ICB has agreed to host the OPIC on behalf of the SE Region and this has been endorsed by the NHS England national team. The OPIC Programme is a joint venture between NHS England and Thames Valley ICB, with engagement from all 4 ICBs across the SE Region established to manage the transition of staff and services in-scope from NHS England to the OPIC directorate within Thames Valley ICB. The Programme is being led by joint SROs: the NHS England SE Regional Director of Commissioning and the Chief System Development and Partnerships Officer (NHS Thames Valley). Programme governance is well defined and established including project boards and workstream groups overseen by an OPIC Leader's Group that reports to an OPIC Programme Board. The Programme Board has the mandate for making decisisons in accordance with its terms of reference and for providing assurance to the SE system regarding OPIC activities. It reports to the SE Region Leadership Team (SERLT) which is chaired by the NHS England SE Regional Director and which brings together membership from the ICB CEOs and NHS England SE Regional executive. There is a Programme Strategy and Plan which have been approved by the OPIC Programme Board and aganist which delivery will be monitored and risks/issues identified and mitigated. The Programme is supported by a Programme Management Office (PMO) led by an experienced Programme Director and the approach to programme management has adopted standard industry tools and techniques including a comprehensive RAID Log. The Programme produces regular reports including a monthly programme highlight report and a OPIC Programme Director's report which is submitted to the Programme Board, Thames Valley ICB (executive and board sessions) , the Joint Committee of the SE ICBs and to SERLT.	OPIC Leadership Group	Fortnightly	Exec Team	Quarterly	Annual NHSE Oversight Framework	TBC
	OPIC Programme Board	Monthly	Risk Oversight Group	Quarterly	Annual Internal Audit Programme	"Substantial Assurance" 25/26
	OPIC Hosting Committee	Quarterly	Board, QPF, Audit Committee	Bi-monthy	Annual External Audit Programme	"No Control issues Raised" 25/26

Gaps in Control and/or Assurance	Mitigating Action	Target Date	Action Lead	Update
Stakeholder Communications, Engagement and OD	A Stakeholder Communications, Engagement and OD Strategy to be approved by Programme Board. A comprehensive plan of communication and engagement activities involving all staff affected by change and staff networks/trade unions; ICBs; NHS providers, local government, local communities and patients.	01-Oct-26	Alison Edgington	**September 2026 update:** The Programme Board approved the Stakeholder Communications, Engagement and OD Strategy on the 07 July 2026. Since then 400 members of ICB and NHS England joined an online 'Introduction to OPIC' which took place on the 20 July. The next event is scheduled for 05 October. In addition the Shadow OPIC Sub-committee reporting to the Joint Committee of SE ICBs has met for an inaugural meeting on the 02 July 2026, and the OPIC Design Project Board has been strengthed with membership from all 4 SE ICBs. An OPIC Design Collective Leadership Event designed to bring c. 60 leaders together from NHS England and the SE ICBs is scheduled for 24 September. A OD/culture approach to staff engagement has been implemented through an Horizon 1 Plan. This has been launched with a pulse survey to assess the impact of the proposed transition to OPIC on the staff implicated. Earlier in August Engagement and communications leads from the 4 ICBs met with the Programme to develop an external stakeholder plan. **02/07 AE:** A Stakeholder Communications, Engagement and OD Strategy has been compiled and submitted to the OPIC Programme Board for approval. This follows a successful Joint OPIC Design Event which included senior leader representation from all SE ICBs and NHS England. The OPIC Leader's Group has agreed a stakeholder plan for July and August which includes theinformal engagement of staff in non-contractual changes to their roles; and an ICB event : 'Open-to-All' which is scheduled for the 20 July 2026.
People and Culture: The staff in scope include the Direct Commissioning Teams and Healthcare, Public Health Teams in NHS England; staff displaced by the dissolution of the Commissioning Support Units (CSUs); and Pharmacy and Optometry Teams in Thames Valley ICB. Engagement of staff affected by change in OPIC design and OD activities. Formal consultation regarding NHS England staff transfer to Thames Valley ICB.	A process and plan for engaging all staff affected by change in OD and OPIC Design activities. The formal consultation with staff transferring from NHS England to Thames Valley.	01-Oct-26	Alison Edgington	**September 2026 update:** The engagement of NHS England staff affected by change, in non-contractual change is complete. The next step is the implementation of the Horizon 1 Plan which has commenced with a pulse survey to assess how people feel. The next step will be the scheduling of focus groups. **02/07 AE:** A People and Culture Project Board has been convened with membership from NHS England SE region and Thames Valley ICB. This group will oversee all staff support and engagement activities through the transition period. The NHS England staff group are currently working with their line managers to develop a core team structure on the basis of non-contractual change. Informal engagement activities are continuing through July to support this approach. The broader engagement of the wider group of staff is under development.
Safe transfer of all functions	Due diligence process to manage the transfer of functions. •Governance and Leadership •IT and data •People •Estates •Records management •Information Governance •Legal •Finance •Contracts and providers (assurance) •Communication and Stakeholders •Quality and Equality	01-Oct-26	Alison Edgington	**September 2026 update:** The OPIC Programme Board has noted the Safe Transfer Plan which is being implemented by the Safe Transfer Project Board. The Project Board has completed the first phase which is to compile a comprehensive checklist of all transfer arrangements and identify any dependencies. **02/07 AE:** A Safe Transfer Project Board has been convened with membership from NHS England and Thames Valley ICB. The Project Board is responsible for managing the transfer of all functions associated with the new responsibilities that will be transitioned to OPIC.
Thames Valley ICB Governance and Assurance	Robust internal governance and assurance including: - establishing an OPIC Hosting Committee. - Updating of the Governance Handbook (SORD/SFIs) - Forming an OPIC Collaboration Agreement between the ICBs. - SLA setting out the role and functions of the OPIC teams hosted by ThamesValley ICB..	01-Oct-26	Alison Edgington	**September 2026 update:** Draft terms of reference have been formated for the OPIC Hosting Committee and these will be recieved by the OPIC Programme Board for comment in September. It is proposed that the inaugural meeting be scheduled for October 2026 so that the Committee can provide assurance to the Thames Valley ICB on the Target Operating Model (which includes the commissioning model i.e how OPIC allocations will be managed across the 4 ICBs). **02/07 AE:** An OPIC Hosting Committee is proposed as a formal sub-committee reporting to the Thames Valley Board. This would ensure the hosting arrangement is well governed and that risks to the ICB are well managed on behalf of the ICB Board
Finance	Clear financial arrangements including: - Ring-fenced running costs for the OPIC teams. - The allocation of commissioning revenue by ICB. - A risk share agreement.	01-Mar-27	Alison Edgington	**September 2026 update:** A commissioning model options paper is being compiled for discussion at the OPIC Programme Board and the OPIC Hosting Committee in October. The 3 options are: **1.Individual commissioner model –** This model retains local control through individual ICB governance and financial policies while utilising the Joint Committee for overarching decisions. While ensuring local autonomy, this approach risks creating operational fragmentation, slower decision-making, and inconsistent patient accessor **2.Update ICB SFIs and Scheme of Reservation and Delegations (SORDs) and Standard Financial Instructions (SFIs) to reflect the decision-making authority of the Joint Committee –** This model aligns operational rules and commissioning processes under the joint committee while maintaining local financial allocations for individual ICBs. While improving consistency, the structure may lack a designated statutory body for large-scale procurement, leading to potential delays and confusion. **3.Principal Commissioner Model –** This model would allow the OPIC host ICB to act as the principal commissioner for four ICBs, as has been the model for delegated arrangements in the South-West Region. Decision-making would operate through a Collaboation Agreement. This option may provide the clearest single route for commissioning, financial authorisation and risk management, but requires explicit agreement from all parties. **02/07 AE:** The Finance Workstream is overseeing the allocation of commissioning funds to SEICBs for the specialised and complex services being transferred toICBs.
OPIC Design	Development and implementation of the hosting model.	01-Dec-26	Alison Edgington	**September 2026 update:** Thames Valley ICB's proposals for hosting OPIC are to be shared with the OPIC Programme Board in September for noting. The terms of reference for an OPIC Hosting Committee reporting to the Thames Valley ICB Board have been drafted and it is expected that the inaugural meeting will take place in October 2026. **02/07 AE:** The Thames Valley executive team have endorsed a proposal to develop the hosting arragement as a "hosted ring-fenced unit" model acting as an administrative anchor and legal wrapper, rather than absorbing the OPIC into its local day-to-day operations. In essence this means that the SE OPIC would become a regional directorate contained within the Thames Valley structure with its own Managing Director reporting to the Chief Executive.

Risk Score Matrix

Likelihood					
5	5	10	15	20	25
4	4	8	12	16	20
3	3	6	9	12	15
2	2	4	6	8	10
1	1	2	3	4	5
			Impact		

Low risk	Medium risk	High risk	Significant risk
*1-3	*4-8	*9-12	15+

Likelihood Score

Likelihood score		(L)			
Descriptor	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
Frequency How often does it/might it happen	This will probably never happen/recur	Do not expect it to happen / recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen / recur but it is not persistent issue	Will undoubtedly happen / recur, possibly frequently
Probability Will it happen or not? % chance of not	<0.1 per cent	0.1-1 per cent	1-10 per cent	10-50 per cent	>50 per cent

Impact (Consequence) Score

Consequence score (impact levels) and examples of descriptors

	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Serious	Catastrophic
Impact on the safety of patients, staff or public (physical /psychological harm)	• Minimal injury requiring no/minimal intervention or treatment. • No time off work	• Minor injury or illness, requiring minor intervention • Requiring time off work for >3 days • Increase in length of hospital stay by 1-3 days	• Moderate injury requiring professional intervention • Requiring time off work for 4-14 days • Increase in length of hospital stay by 4-15 days • RIDDOR/agency reportable incident • An event which impacts on a small number of patients	• Major injury leading to long-term incapacity/disability • Requiring time off work for >14 days • Increase in length of hospital stay by >15 days • Mismanagement of patient care with long-term effects	• Incident leading to death • Multiple permanent injuries or irreversible health effects • An event which impacts on a large number of patients
Quality/ complaints/ audit	• Peripheral element of treatment or service • suboptimal • Informal complaint /inquiry	• Overall treatment or service suboptimal • Formal complaint / • Local resolution • Single failure to meet internal standards • Minor implications for patient safety if unresolved • Reduced performance rating if unresolved	• Treatment or service has significantly reduced effectiveness • Formal complaint/ • Local resolution (with potential to go to independent review) • Repeated failure to meet internal standards • Major patient safety implications if findings are not acted on	• Non-compliance with national standards with significant risk to patients if unresolved • Multiple complaints/ independent review • Low performance rating • Critical report	• Totally unacceptable level or quality of treatment/ service • Gross failure of patient safety if findings not acted on • Inquest/ombudsman inquiry • Gross failure to meet national standards
Human resources/ Organisational development/ staffing/ competence	• Short-term low • staffing level that temporarily reduces service quality (< 1 day)	• Low staffing level that reduces the service quality	• Late delivery of key objective/ service due to lack of staff • Unsafe staffing level or competence (>1 day) • Low staff morale • Poor staff attendance for mandatory/key training	• Uncertain delivery of key objective/service due to lack of staff • Unsafe staffing level or competence (>5 days) • Loss of key staff • Significant numbers of staff not attending mandatory / key training	• Non-delivery of key objective /service due to lack of staff • Ongoing unsafe staffing levels or competence • Loss of several key staff • No staff attending mandatory training key training on an ongoing basis
Statutory duty/ inspections	• No or minimal • impact or breech of guidance/ statutory duty	• Breech of statutory legislation • Reduced performance rating if unresolved	• Single breech in statutory duty • Challenging external recommendations/ improvement notice	• Enforcement action • Multiple breeches in statutory duty • Improvement notices • Low performance rating • Critical reports	• Multiple breeches in statutory duty • Prosecution • Complete systems change required • Zero

Adverse publicity / reputation	Rumors Potential for public concern / media interest Damage to an individual's reputation.	• Local media coverage – short-term reduction in public confidence • Elements of public expectation not being met • Damage to a team's reputation	• Local media coverage – long-term reduction in public confidence • Damage to a services reputation	• National media coverage with <3 days service well below reasonable public expectation • Damage to an organisation's reputation	• National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) • Total loss of public confidence (NHS reputation)
Business objectives/ projects	Insignificant cost increase/ schedule slippage	• <5 per cent over project budget • Schedule slippage	• 5–10 per cent over project budget • Schedule slippage	• Non-compliance with national 10–25 per cent over project budget • Schedule slippage • Key objectives not met	• Incident leading >25 per cent over project budget • Schedule slippage • Key objectives not met
Finance including claims	Small loss Risk of claim remote	• Loss of 0.1–0.25 per cent of budget • Claim less than £10,000	• Loss of 0.25–0.5 per cent of budget • Claim(s) between £10,000 and £100,000	• Uncertain delivery of key objective/ Loss of 0.5–1.0 per cent of budget • Claim(s) between £100,000 and £1 million • Purchasers failing to pay on time	• Non-delivery of key objective/ Loss of >1 per cent of budget • Failure to meet specification / slippage • Loss of contract / payment by results • Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	• Loss/ interruption of >8 hours • Minor impact on environment	• Loss/interruption of >1 day • Moderate impact on environment	• Loss/interruption of >1 week • Major impact on environment	• Permanent loss of service or facility • Catastrophic impact on environment
Data Loss / Breach of Confidentiality	Potentially serious breach. Less than 5 people affected or risk assessed as low eg files	• Serious potential breach and risk assessed high eg unencrypted clinical records. Up to 20 people affected	• Serious breach of confidentiality eg up to 100 people affected	• Serious breach with either particular sensitivity eg sexual health details or up to 1000 people affected	• Serious breach with potential for ID theft or over 1000 people affected

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Thames Valley Integrated Care Board

Title of Paper	Fit and Proper Person Test – Annual Assurance Submission		
Agenda Item	12	**Date of meeting**	16 September 2026
Exec Lead	Priya Singh, Chair		
Author(s)			

Purpose	To Approve	☐
	To Ratify	☐
	To Discuss	☐
	To Note	☒

Link to Strategic Objective	*All Strategic Objectives*

Executive Summary

Purpose:

The purpose of this paper is to provide assurance to the Board that the ICB has discharged its duties in respect of implementing the Fit and Proper Person Test (FPPT) Framework and submitted its 2025-26 Annual FPPT Submission to NHS England in June 2026. **See Appendix 5 below.**

Summary:

The requirements of the FPPT are set out in Regulation 5 of the Health and Social Care Act 2028 (Regulated Activities) Regulations 2014 ("the Regulations"). The FPPT Framework applies to all new board level appointments or promotions and for annual assessment and is comprised of three core elements (i) good character (ii) qualifications, competence, skills required and experience (iii) financial soundness.

Regulation 5 recognises that individuals who have authority in NHS organisations that deliver care are responsible for the overall quality and safety of that care. The regulation requirements are that:

a. the individual is of good character
b. the individual has the qualifications, competence, skills and experience that are necessary for the relevant office or position or the work for which they are employed.
c. the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks that are intrinsic to the office or position for which they are appointed or to the work for which they are employed.
d. the individual has not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) while carrying out a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.
e. none of the grounds of unfitness specified in part 1 of Schedule 4 apply to the individual.

The grounds of unfitness specified in Part 1 of Schedule 4 to the Regulated Activities Regulations are:

a. the person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged
b. the person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland

c. the person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986
d. the person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it
e. the person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland
f. the person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

The good character requirements referred to above in Regulation 5 are specified in Part 2 of Schedule 4 to the Regulated Activities Regulations, and relate to:

a. whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence
b. whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

Every Board member is required to complete an annual self-attestation, to confirm that they are in adherence with the FPPT requirements.

The ICB commissioned the SCW CSU to conduct independent FPPT checks – the CSU provide assurance to the Chair of the ICB on the completeness of these checks.

The Chair of the ICB is responsible for signing off all FPPT checks for members of the Board and submitting the Annual FPPT Submission to NHS England.

All ICB Board Members have been confirmed as Fit and Proper Persons, in accordance with the Framework.

Recommendation	**The Board is asked to *note* that all ICB Board Members have been confirmed as Fit and Proper Persons, in accordance with the Framework.**

Conflict of interest identified
Yes ☐ No ☒
Detail

Reporting – has this paper been discussed at other meetings		
Committee Name	Date discussed	Outcome

Appendix 5: NHS FPPT submission reporting template

This is a submission form. If anything changes during the year, submit a new form and notify an RD immediately. Do not alter the form.

NAME OF ORGANISATION	TYPE OF ORGANISATION *Select organisation*		NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:
NHS Thames Valley ICB		Trust	Dr Priya Singh	2025-26
		Foundation Trust		
	√	ICB		

Part 1: FPPT outcome for board members including starters and leavers in period

Role**	Total Number Count	Confirmed as fit and proper?			Leavers only	
		Yes	No	How many Boad Members in the 'Yes' column have mitigations in place relating to identified breaches? *	Number of leavers	Number of Board Member References completed and retained
Chair/NED board members	5	5		0	4	4
Executive board members	9	9		0	2	2
Partner members (ICBs)	5	5		0	8	8
Total	19	19		0	14	14

**** See 3.8 'Breaches to core elements of the FPPT (Regulation 5)' in the Framework.***

***** Do not enter names of board members.***

Have you used the Leadership Competency Framework as part of your FPPT assessments for individual board members?	Yes √	No

Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
NHS Frimley ICB Board	16.09.2025	The Frimley Board noted an assurance report on completion of the annual FPPT annual assurance process.	N/A	N/A
Remuneration Committee	17.06.2026	The Remuneration Committee noted the assurance provided by the Chair that all FPPT checks have been completed, and all individuals are confirmed as fit and proper persons.	Submit annual assurance return to NHS England.	June 2026

Add additional lines as needed

Part 3: Declarations

DECLARATION FOR NHS Thames Valley ICB					
For the SID/deputy chair to complete:					
FPPT for the chair (as board member)	Completed by (role)	Name	Date	Fit and proper? Yes/No	
	NHSE Regional Director South East	Anne Eden	22.06.26	Yes	
For the chair to complete:					
Have all board members been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:			
	Yes	N/A			
Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?	Yes/No	If 'yes', provide detail:			
	No	N/A			
As Chair of [organisation], I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.					
Chair signature:	Priya Singh				
Date signed:	25 June 2026				
For the regional director to complete:					
Name:					
Signature:					
Date:					

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Thames Valley Integrated Care Board
Public Board

Title of Paper	**Responsible Officer Annual Report & Statement of Compliance**		
Agenda Item	13	Date of meeting	16 September 2026
Exec Lead	Dr Lalitha Iyer, CMO		
Author(s)	Dr Ben Riley, DCMO & Responsible Officer for Medical Revalidation		

Purpose	To Approve	☒
	To Ratify	☐
	To Discuss	☐
	To Note	☐

Link to Strategic Objective	ICB Statutory Requirement

Executive Summary	
This report is provided for Board assurance regarding the discharge of statutory Responsible Officer and medical revalidation functions previously undertaken by Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB), a General Medical Council designated body during 2025/26. Following establishment of Thames Valley Integrated Care Board on 1 April 2026, responsibility transferred to the successor organisation. BOB ICB complied with statutory requirements during the reporting period. Two out of two connected doctors completed annual appraisal during this period (100%); no doctors were due a revalidation recommendation, and no fitness to practise concerns were escalated to the Responsible Officer.	
Recommendation	The Board is asked to: • Note the contents of the Responsible Officer Annual Report. • Take assurance that appropriate arrangements were in place to meet the statutory requirements for medical appraisal and revalidation during 2025/26. • Approve the attached Statement of Compliance. • Authorise submission of the Statement of Compliance to NHS England.

Conflict of interest identified
Yes ☐ No ☒
Detail

Reporting – has this paper been discussed at other meetings		
Committee Name	Date discussed	Outcome
Executive Committee	7 September 2026	Recommended to Board

Responsible Officer's Report 2025-26

Purpose
To provide assurance, demonstrate compliance with statutory requirements and seek Board approval of the Statement of Compliance.

Governance and Statutory Context
Medical revalidation supports assurance that licensed doctors remain up to date and fit to practise. Designated bodies must support their Responsible Officer in accordance with the Medical Profession (Responsible Officers) Regulations 2010 and NHS England Framework of Quality Assurance. Thames Valley ICB is the successor organisation to BOB ICB and is submitting this report on its behalf.

Responsible Officer Arrangements
Dr Ben Riley acted as Responsible Officer (RO) for BOB ICB throughout the reporting period and continues in the role under delegated arrangements within Thames Valley ICB. Dr Riley completed the recommended Responsible Officer Training at the General Medical Council (GMC) London Office on 16 Sep 2025 and has met regularly with the SE Region Higher Level Responsible Officer Team's Associate Medical Director for expert advice and support on the RO role.

Connected Doctors and Appraisal
There were two doctors with a prescribed connection to BOB ICB during this reporting period. Both completed a satisfactory annual appraisal, representing 100% appraisal compliance. No doctors were reported as non-engaged with the revalidation process. In line with NHSE and GMC guidance, and to prevent any potential conflicts of interest given the senior positions of the connected doctors within the ICB, the appraisals for these doctors were carried out by senior appraisers outside of the organisation, as recommended by the SE Region Higher Level Responsible Officer.

Revalidation Activity
No revalidation recommendations fell due during the reporting period.

Medical Governance and Concerns
No concerns relating to conduct, capability or fitness to practise of the connected doctors were raised with the Responsible Officer during the reporting period. Appropriate escalation routes are available through employer processes, the General Medical Council Employer Liaison Service and NHS Resolution Practitioner Performance Advice.

Employment Checks
Onboarding processes operated by SCW CSU were in place for BOB ICB employed doctors (and doctors employed by Thames Valley ICB going forwards) to verify identity, registration, qualifications, references, Disclosure and Barring Service checks and other pre-employment requirements.

Internal checks and audit arrangements will be refreshed following the organisational change and population of medically qualified roles in the new ICB structure.

Priority Improvement and Compliance Actions 2026/27
The following actions are recommended for 2026/27:

- Finalise and ratify the Medical Appraisal and Revalidation Policy for the new TV ICB;
- Review prescribed connection and appraisal/revalidation processes for employed and off-payroll doctors with a prescribed connection to the new ICB;
- Confirm audit processes for medical recruitment checks;

Summary of Board Responsibilities relating to Medical Revalidation
As the governing body of a GMC Designated Body, the ICB Board is responsible for ensuring that effective systems are in place to support medical appraisal and revalidation and that the Responsible Officer is adequately supported to discharge their statutory duties. Specifically, the Board is responsible for:

- Ensuring a suitably trained and appointed Responsible Officer is in place and has sufficient time, authority and resources to undertake the role.
- Receiving assurance that all doctors with a prescribed connection participate in annual medical appraisal and medical revalidation processes.
- Ensuring robust systems are in place to identify, monitor and respond to concerns about doctors' performance, conduct, capability or health.
- Ensuring appropriate recruitment, employment and professional registration checks are undertaken for doctors working within the organisation.
- Reviewing annual compliance with the Responsible Officer Regulations and supporting continuous improvement in appraisal and revalidation arrangements.

What the Board is Being Asked to Take Assurance On
The Board is asked to take assurance that during 2025/26:

- BOB Integrated Care Board, as a Designated Body, complied with its statutory responsibilities for medical appraisal and revalidation.
- An appropriately trained Responsible Officer was in post and supported to fulfil their duties.
- All doctors connected to the organisation completed annual appraisal, with no cases of non-engagement.
- No significant concerns regarding doctors' fitness to practise required Responsible Officer intervention or regulatory referral.
- Appropriate governance, employment and professional oversight systems were in place to support safe medical practice.
- The Statement of Compliance accurately reflects the organisation's compliance with the Responsible Officer Regulations and national requirements.

Requested Board Actions
The Board is requested to:

- Note the contents of the Responsible Officer Annual Report.
- Take assurance that appropriate arrangements were in place to meet the statutory requirements for medical appraisal and revalidation during 2025/26.
- Approve the attached Statement of Compliance.
- Authorise submission of the Statement of Compliance to NHS England.

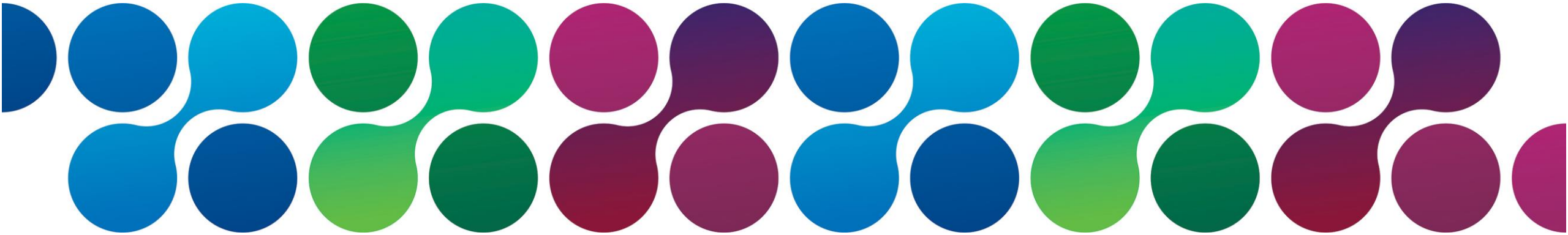
Statement of Compliance for Board Approval and CEO signature:
The Board of Thames Valley Integrated Care Board, acting as successor organisation to Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board, confirms compliance for the reporting year 1 April 2025 to 31 March 2026 with the Medical Profession (Responsible Officers) Regulations 2010 and the General Medical Council revalidation framework. An appropriately trained Responsible Officer was in place, appropriate systems supported appraisal, revalidation, management of concerns and employment checks, and the Board has reviewed compliance and improvement actions.

NHS
Thames Valley

Annual Report and Accounts 2025-2026

NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

NHS Frimley Integrated Care Board



Reflecting on the year gone by

Across NHS Buckinghamshire, Oxfordshire, Berkshire West (BOB) and NHS Frimley ICBs, improving outcomes, efficiency and value for money remained a key focus. Together we:

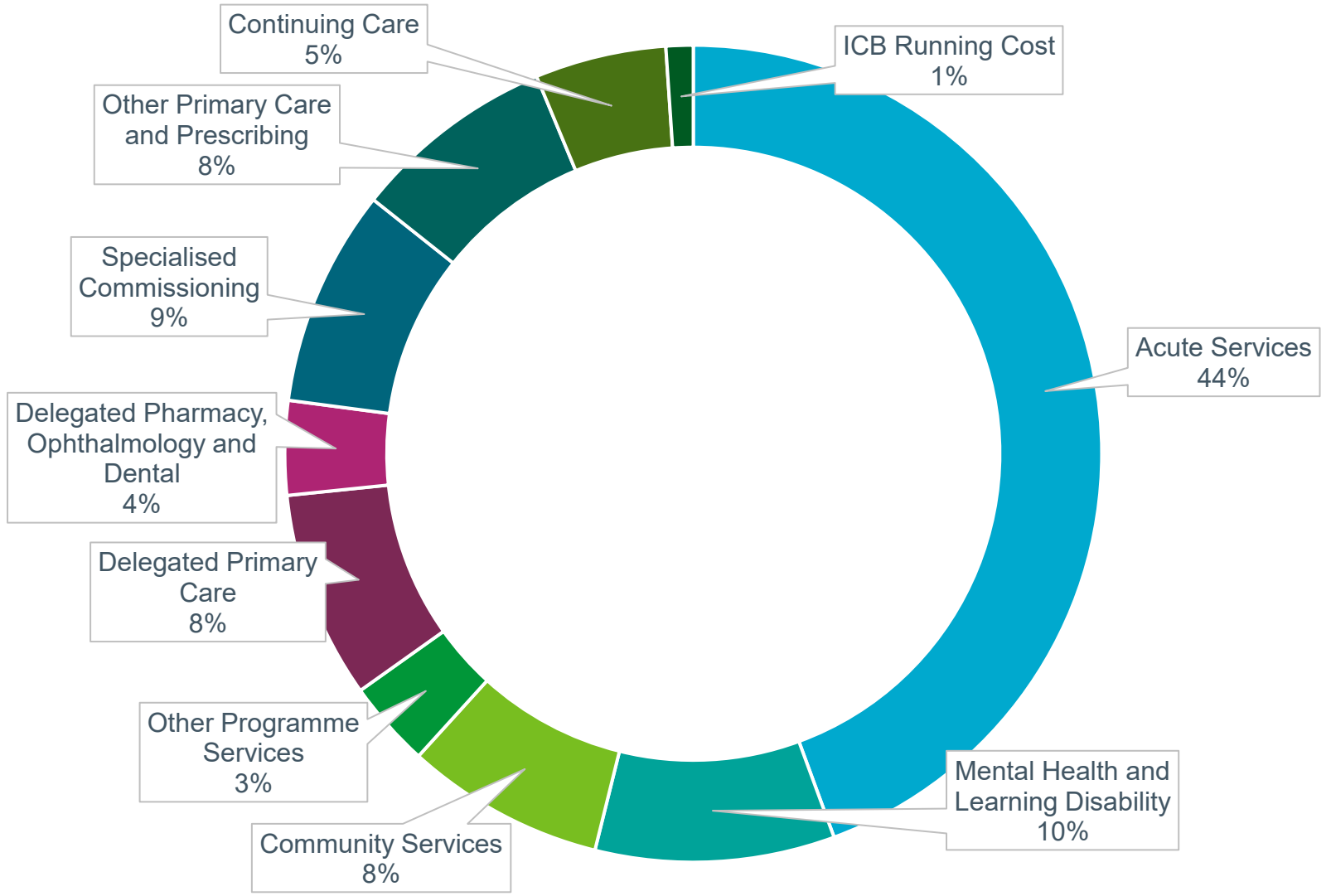
- ✓ Improved care, access and outcomes while maintaining strong financial control in an environment of rising demand and efficiency targets.
- ✓ Reduced treatment waits, expanded diagnostics and improved access to care.
- ✓ Strengthened community and preventative services, supporting more people closer to home.
- ✓ Tackled health inequalities through targeted prevention, outreach and partnerships.
- ✓ Established joint leadership, governance and collaborative working across both ICBs. Created the foundations for NHS Thames Valley ICB and its future strategic commissioning role.

Annual Report and Accounts - Frimley

Total expenditure:
£1,974.7m

Spend per person:
£2,318

Financial surplus:
£44,000
(2024-25 surplus = £27,000)

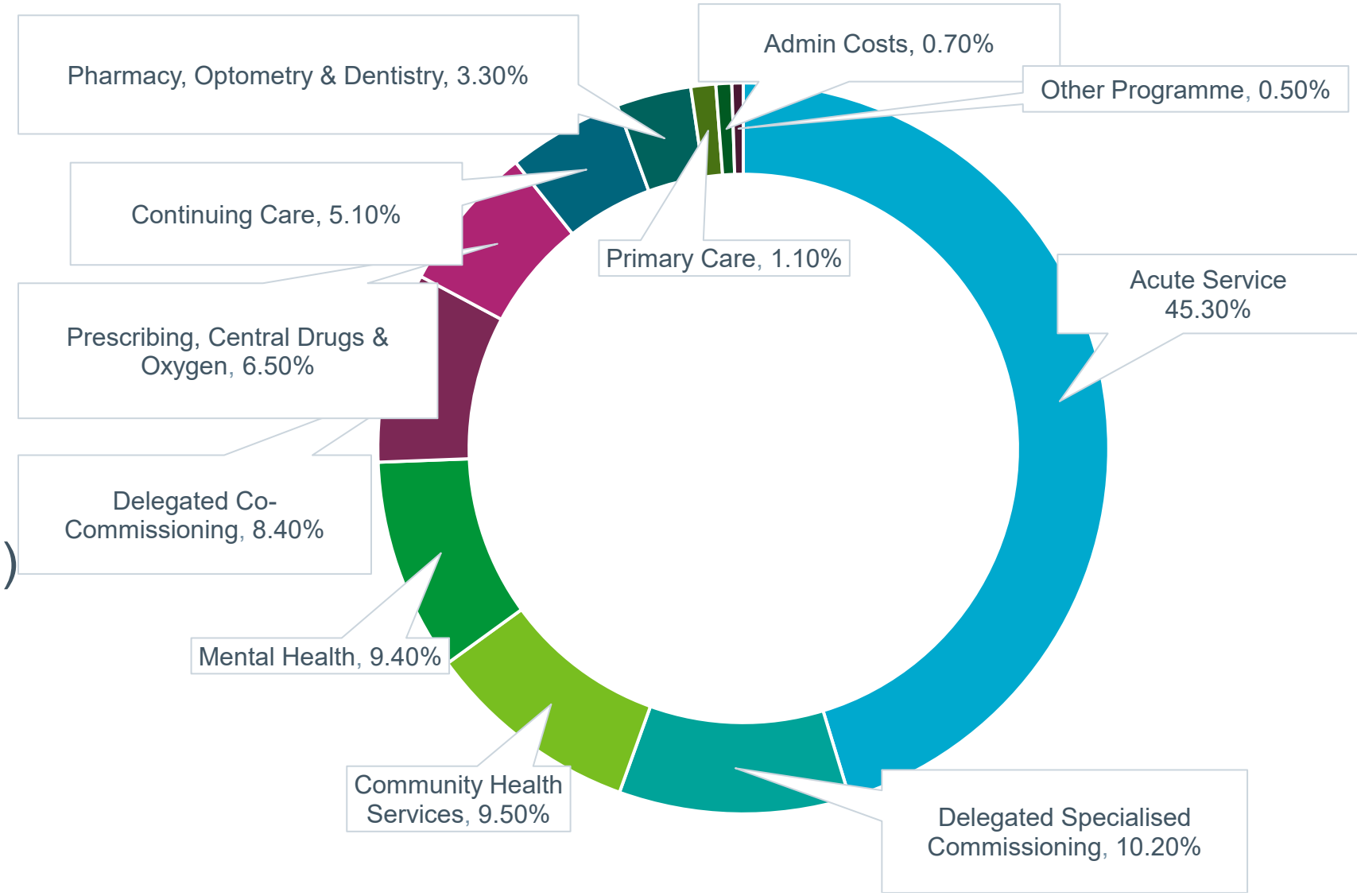


Annual Report and Accounts - BOB

Total expenditure:
£4.6bn

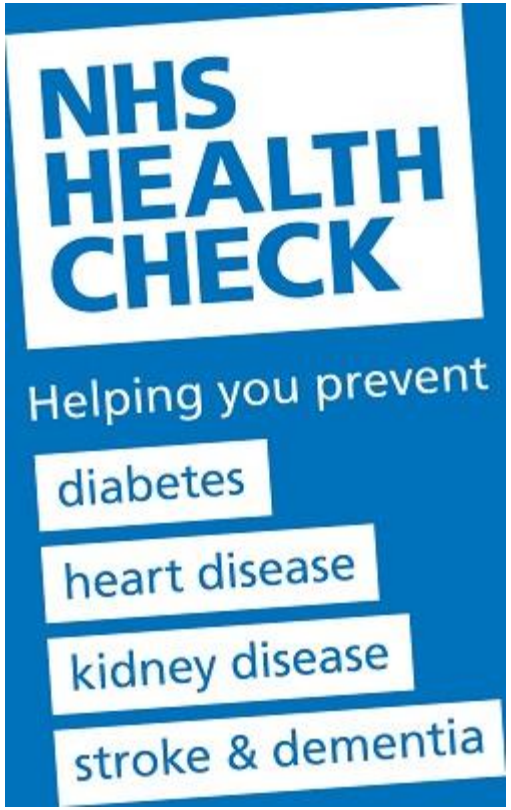
Spend per person:
£2,581

Financial surplus:
£0.2m
(2024-25 surplus = £9,000)



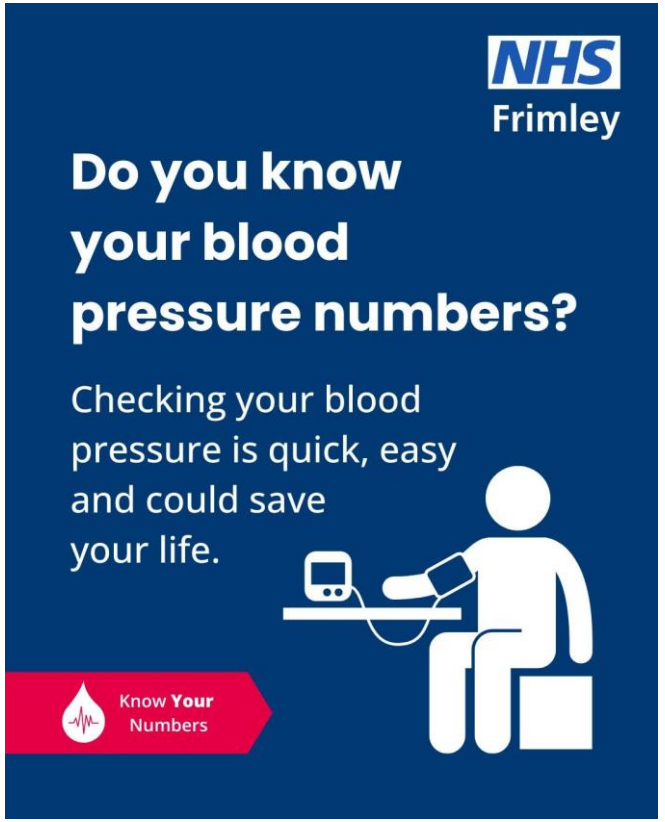
BOB ICB – community wellness and prevention

- Delivered around 10,000 Community Wellness Outreach health checks across Berkshire West.
- Focused on people least likely to access traditional healthcare services.
- Identified significant unmet need:
  - 70% with high BMI
  - Nearly 50% with high cholesterol
  - 20-25% with raised blood pressure or blood glucose.
- Over 3,000 referrals made to lifestyle and support services.
- 85% of participants reported improved awareness of cardiovascular health risks.
- 75% reported making positive lifestyle changes following intervention.



NHS Frimley – cardiovascular prevention

- Achieved significant improvement in cardiovascular disease (CVD) prevention, becoming the highest-performing system in the South East and ranked second nationally for hypertension control.
- HYP007 performance improved year-on-year, with Frimley recognised as the most improved system in England in March 2026.
- Reduced inequalities in hypertension outcomes, achieving the highest proportion of patients from the most deprived communities treated to target in the South East.
- Achieved the smallest gap between the most and least deprived populations for hypertension control, demonstrating improved equity alongside improved performance.
- Reached 92% on HYP004 (blood pressure recording) and 77% on HYP007 (blood pressure controlled to target).
- Estimated to prevent 43 heart attacks, 64 strokes and 34 deaths over three years, generating approximately £2 million in combined NHS and social care savings.



NHS Frimley – mental health and learning disabilities

- Reduced average length of stay in adult acute mental health beds by 10 days (63 to 53 days).
- Increased access to mental health services for children and young people, exceeding national ambitions.
- More than 14,000 children and young people accessing mental health services by March 2026.
- Reduced reliance on inpatient care for people with learning disabilities and autistic people.
- Achieved national targets for reducing adult learning disability inpatient admissions.
- Improved outcomes through earlier intervention, community support and personalised care.
- Focused mental health communication campaigns run across social media platforms throughout the year.

Looking ahead – NHS Thames Valley ICB

Since being established on 1 April 2026, NHS Thames Valley ICB aims to:

- strengthen partnerships to deliver more joined-up care across Thames Valley;
- reduce health inequalities through prevention, population health and targeted support;
- expand neighbourhood health services and deliver more care closer to home; and
- drive innovation, digital transformation and sustainable system improvement.

Thames Valley ICB will meet the national expectations for ICB running cost reductions in 26/27. We continue to support our staff as we complete the final stages of organisational restructure.

www.thamesvalley.icb.nhs.uk

NHS

Thames Valley