NHS
Thames Valley

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

Agenda
Wednesday 18 November 2026 – between 11.00am and 1.30pm

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
11.00am	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 16 September 2026	Approve	Paper	Chair
		Operating Context			
11.05am	4	Chief Executive Officer's report	Note	Paper	Nick Broughton, Chief Executive Officer
11.15am	5	Quality, Performance and Finance Reports	Note	Paper	Sarah Bellars, Chief Nursing Officer, Stephen Dunn, Chief Strategy and Commissioning Officer (interim) and Rich Chapman, Chief Finance Officer
11.25am	6	Thirlwall Inquiry Report and Recommendations	Note	Paper	Sarah Bellars, Chief Nursing Officer
11.35am	7	National Quality Strategy	Approve	Paper	Sarah Bellars, Chief Nursing Officer
		Strategic Commissioning			
11.45am	8	Planning Update	Note	Paper	Sam Burrows, Deputy Chief Executive

Timing	No.	Item	Action	Delivery	Lead
12.00pm	9	Winter Update	Note	Paper	Stephen Dunn, Chief Strategy and Commissioning Officer (interim)
		Building Conditions for Success			
12.10pm	10	Neighbourhood Health Update	Note	Paper	Rob Bowen, Chief System Development and Engagement Officer (interim)
		Annual Reports and Governance			
12.40pm	11	Annual Sexual Safety Report	Approve	Paper	Sarah Bellars, Chief Nursing Officer
12.45pm	12	Freedom to Speak Up Report – Q1 & Q2	Approve	Paper	Sarah Bellars, Chief Nursing Officer
12.55pm	13	Annual Emergency Preparedness, Resilience and Response (EPRR) Report	Approve	Paper	Sam Burrows, Deputy Chief Executive
1.00pm	14	Advise, Alert, Assure (AAA) Board Committee Reports • Audit & Risk • Remuneration & Culture • Quality, Performance & Finance • Commissioning & Population Health • System Delivery Committee	Note	Paper	Committee Chairs
1.10pm	15	Board Assurance Framework	Note	Paper	Caroline Corrigan, Chief People & Corporate Affairs Officer
1.15pm	16	International Fraud Awareness Week	Note	Verbal	Rich Chapman, Chief Finance Officer
		Other items of Business			
1.20pm	17	Public Questions		Verbal	Chair
	18	Any other Business	-	Verbal	Chair
1.30pm	19	Close	-	Verbal	Chair
		Date of next meeting: 20th January 2027			

ICB Board Declarations of Interest Register v 9 Nov								
Surname	First Name	Job Title	Interest	Description of Interest	Type of Interest	Type of Interest	Type of Interest	Actions agreed with Line Manager to mitigate risk
Bellars	Sarah	Chief Nursing Officer	Son works for FHFT	Son works for FHFT as a Community 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
Bowen	Rob	Chief System Development and Engagement Officer (interim)			Nil Declaration			

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	Non-Financial Professional	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	Deputy Chief Executive	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			
Dunn	Stephen	Interim Chief Strategy and Commissioning 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

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	Executive Advisor	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	Executive Advisor	States Consulting Ltd	Director and Shareholder	Declarations of Interest – Other	Financial	Direct	No work currently being done within healthcare or public sector
Khan	Sajjad	Executive Advisor	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
Nolan	Tim	Non-Executive Member	Westminster and City of London criminal bench	Magistrate and Presiding Justice on the Westminster and City of London criminal bench	Declarations of Interest – Other	Non-Financial Professional	Indirect	The potential conflict can be managed in accordance with the COI Policy.
Nolan	Tim	Non-Executive Member	Board of Citizens Advice, Westminster	Trustee on the Board of Citizens Advice, Westminster, The Stowe Centre, 258 Harrow Road, London W2 5ES.	Declarations of Interest – Other	Non-Financial Professional	Indirect	The potential conflict can be managed in accordance with the COI Policy.
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 16th September 2026 – 11am-1.15pm
MS Teams

Name	Role	Attendance
Members		
Priya Singh	Chair	Present
Nick Broughton	Chief Executive Officer	Present
Rich Chapman	Chief Finance Officer	Present
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	Apologies
Sajjad Khan	Vice-Chair and NEM for Commissioning & Population Health	Present
Tim Nolan	NEM for Remuneration, Culture, Quality & Safety	Apologies
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	Present
Martin Reeves	Local Authority Partner Member	Present
Lance McCarthy	NHS Trust or Foundation Trust Partner Member	Apologies
Julian Emms	NHS Trust or Foundation Trust Partner Member	Present
Attendees		
Caroline Reid	Regional Director of Commissioning for Southeast Region	Present for item 5
Rob Bowen	Director of Strategy and Innovation	Present
Safina Nadeem	EDI Advisor	Apologies
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 Ilona Blue, Tim Nolan, Lance McCarthy and Safina Nadeem.	
2.	**Declarations of Interest** The Declarations of Interest register was noted.	
3.	**Minutes of the meeting held on 15th July 2026** The minutes of the Board meeting held in public on 15th July 2026 were agreed as a correct record.	
	Operating Context	
4.	**Chief Executive Officer's Report** Nick Broughton, Chief Executive Officer introduced his report and highlighted some recent senior appointments in the wider Thames Valley system – Simon Ashton had been appointed as Group Chief Executive for the two Ambulance Trusts across the Southeast. This was a new arrangement bringing together SECam and SCAS. In addition, Michael Holland had recently started as Chief Executive of Oxford Health NHS Foundation Trust, succeeding Grant Macdonald. Finally, Nick Broughton reported that Hannah Iqbal, Chief Commissioning and Strategy Officer would be leaving Thames Valley ICB in early November and thanked her for all her hard work in this role and her previous role within BOB ICB. The Executive Team were particularly grateful for her leadership on strategic commissioning and wished her luck in her new role.	

	In response to Board members' questions, it was noted that the feedback from a recent Neighbourhood Health visit had been included as an appendix to the Chief Executive's report and Sam Burrows advised that a further update would be included on the November Board agenda. **ACTION: Sam Burrows** The update on the WorkWell programme was also noted. Caroline Corrigan advised that the Frimley pilot had been a valuable experience and learning from the pilot had informed the recent Thames Valley ICB plan submitted to the Department of Work and Pensions (DWP). The team were working closely with partners across the Thames Valley to provide focussed support to just over 6,000 young people looking to get into work. It was agreed that a more detailed report on WorkWell would come to a future Board meeting. **ACTION: Caroline Corrigan** *The Board noted the Chief Executive Officer's report.*	
5.	**Office of Pan-ICB Commissioning (OPIC)** Caroline Reid, Regional Director of Commissioning for the Southeast and joint Senior Responsible Officer for the OPIC programme alongside Sam Burrows, was welcomed to the meeting. Sam Burrows and Caroline Reid provided an update on the Office of Pan-ICB Commissioning (OPIC), and the following main points were noted: • From April 2027, it was anticipated that many commissioning duties currently held by NHS England would be transferred to ICBs. This would include specialist commissioning, community pharmacy, optometry and dentistry, much of which had previously been delegated. • There were clear benefits to undertaking these commissioning activities at scale, therefore an OPIC would be established and Thames Valley would host the OPIC on behalf of the four ICB's across the Southeast. In total, seven OPICs were being set up across the country. • Over the last year, Thames Valley ICB had been working closely with colleagues in NHS England's regional team and the other three ICBS in the Southeast to design an operating model and agree the approach to developing the OPIC to ensure safe transfer for 1st April. • Whilst this was a complex task, strong programme management was in place ensuring regular Board and Chief Executive oversight across the region between the ICBs and within NHS England and everything was on track for transfer on 1st April 2027, subject to the required legislative change. • For governance oversight of Thames Valley ICB's role in hosting the OPIC, an OPIC Hosting Committee would be established – this would be a committee of the Board, with strong non-executive leadership to provide assurance that any OPIC-related risks were understood and mitigated. • The main purpose of the OPIC was to provide high-quality care to the Southeast region, including the population of Thames Valley. It was envisaged that transferring commissioning duties to the ICBs and the OPIC would enable commissioning to be more focussed on population need, reducing inequalities and unwarranted variation and improve outcomes, whilst delivering best value. • Caroline Reid thanked Thames Valley for hosting the OPIC on behalf of the Southeast and providing a collaborative approach and programme management rigour via Alison Edgington and her team. • OPIC intended to make the most of the expertise that existed across the region whilst recognising that accountability would sit with each individual ICB. • Caroline Reid outlined three key elements of the OPIC delivery programme – i) Operating Model – how will good decisions be made in a timely way? ii) People and Culture – Organisational design of the OPIC and creating a culture whilst also overseeing a 25% reduction in headcount within the regional commissioning team and iii) Safe Transfer – ensuring the safe transfer of people and functions on 1st April 2027. • Alongside these three key elements, the four ICBs were also agreeing priority services such as cardiac surgery or cancer, where commissioning at scale could drive improvements. There would also be more opportunity to consider whole pathways of care, so that OPIC commissioning could link in more with ICB prevention initiatives to support left shift. The Chair thanked Caroline Reid and Sam Burrows for the comprehensive overview of the OPIC programme. *The Board noted the OPIC update.*	
6.	**Quality, Performance and Finance Reports**	

	The Chair invited Rich Chapman, Chief Finance Officer to introduce the Finance report. The following main points were noted: • The ICB was reporting a breakeven position at the end of month 4. There were a number of cost pressures emerging, particularly in continuing healthcare, mental health and prescribing, which totalled around £13million. These cost pressures were being offset by existing mitigations and management actions. • Efficiency savings would be key to the ICB's financial position – year to date £51.5million had been delivered against a target of £162 million, which was approximately £2million behind plan. • With regards to Capital the ICB was on track to utilise fully its £14.2million capital allocation during the financial year. • Overall, the ICB finances were relatively stable but with risks associated with cost pressures and delivery of efficiencies. The Chair invited Sarah Bellars, Chief Nursing Officer to present the Quality report. Two elements were highlighted – the complaints trajectory was improving with a significant reduction in the number of older complaints awaiting resolution and an improvement in the timeliness of acknowledgements. Work was continuing to establish a sustainable operating model with consistent performance standards. In addition, the Learning Disabilities Mortality Review (LeDer) programme continued to address a backlog of cases inherited from the legacy ICBs. Additional reviewers had now been recruited and whilst challenges remained due to the volume of cases, the quality of reviews was strong and continued to provide valuable learning to support service improvement. *The Board noted the Quality and Finance reports.*	
7.	**Winter Readiness** Sam Burrows, Chief System Development and Engagement Officer introduced the Winter Plan for 2026-27 which subject to Board approval, would be submitted to NHSE by 30th September. This was a consensus plan developed across the Thames Valley's four places and the plan had been tested during a regional exercise earlier in the week, which resulted in positive feedback. Sam Burrows highlighted that the self-assessment element of the plan was not 100% green. This was due to two elements – firstly the ICB had decided not to include an Equality Impact Assessment, as this was not felt to be a proportionate ask for this planning exercise which would be delivered by providers and secondly the proposal to operate a system co-ordination centre between 9am and 5pm falls slightly short of the suggested 8am-6pm, but partners had agreed to be flexible with timings where necessary. It was also noted that this was a year of transition for winter readiness – as the ICB moved more into a strategic commissioning role, there was more of an onus on providers in each of the four places to hold a convening role to deliver the plan. Julian Emms, Chief Executive for Berkshire Healthcare NHS Foundation Trust welcomed this approach, commenting that previously winter planning had involved too many people - it was better for the ICB to set clear strategic expectations and empower local providers to organise themselves appropriately to deliver for their residents. Nick Broughton raised one concern about the coverage for the seasonal vaccination programme and asked if more work was needed in this area. Sarah Bellars explained that this was discussed at every winter planning meeting and where some GPs had declined to participate, alternative providers would be identified. Sara Blackmore, Director of Public Health for Royal Borough of Windsor and Maidenhead, also confirmed that Health Protection Forums were in place to oversee vaccinations from a public health perspective and would provide assurance across the wider system. *The Board approved the Winter Plan for 2026-27 and the associated Board Assurance Statement.*	
	Strategic Commissioning	
8.	**Strategic Commissioning Sprint Programme and Commissioning Intentions Development** Hannah Iqbal, Chief Commissioning and Strategy Officer and Rob Bowen, Director of Strategy and Innovation updated the Board on the progress of the Strategic Commissioning Sprint Programme and	

	the development of the Thames Valley Commissioning Intentions. During the presentation and in response to subsequent questions, the following main points were noted: • Strategic Commissioning was now the central purpose of all ICBs. Over the summer Thames Valley ICB had run a sprint programme to focus on building capacity and expertise in strategic commissioning. As a result, a clearer picture had been established of the health needs of the Thames Valley population, with an Integrated Needs Assessment being co-produced with Public Health colleagues. • In addition, a Contract baseline had also been established and an Outcomes Framework to sit alongside the Commissioning Intentions document was being developed in partnership with the Thames Valley Value Lab. • The Commissioning Intentions built on the Integrated Needs Assessment and to address inequalities and service variations and to provide a strong foundation for commissioning decisions. • The Commissioning Intentions had three key themes – i) slowing the progression of ill-health, ii) Optimising pathways to improve experience and outcomes and iii) addressing unmet need, unwarranted variation and health inequalities. • Priority population groups and pathways had been identified with a deliberate move towards earlier support and intervention. • The Commissioning Intentions also set out to provide further clarity on funding transition to a more preventative approach with a commitment to 1% of total ICB funding to support innovation and left shift. • In terms of next steps, the final Commissioning Intentions would be published on 30th September and during October and November, the ICB would invite and respond to feedback from stakeholders and members of the public. • The Board were pleased to see the collaborative work that had produced the Commissioning Intentions and welcomed the clear explanation of the ICB's priorities, as well as the focus on inequalities. It was important to communicate to the public what this would mean in practice for them over the next three years and it was key that the Board could receive feedback in future which would demonstrate the success. It was recognised that some of the ambitions in the document would need time to come to fruition therefore transition milestones would be needed to demonstrate to the Board that progress was being made. The Chair thanked everyone across the system who had contributed to the development of the Commissioning Intentions and reiterated that it was important to align meaningful metrics to enable the Board to track progress and be accountable for delivery. Difficult decisions may be necessary to support the left shift but alignment on the Commissioning Intentions was a good starting point. *The Board agreed to delegate sign-off of the final version of the Commissioning Intentions to the Commissioning and Population Health Committee which was meeting on 28th September to scrutinise a further updated version. Members of the Board could attend that meeting if they wished – the Governance team would share an invitation.*	
	Building Conditions for Success	
9.	**Maternity Services in the Thames Valley** Sam Burrows, Chief System Development and Engagement Officer introduced a proposal to commission a systemwide review of Maternity and Neonatal services in Thames Valley. Sam Burrows took the Board through some slides which outlined the national and local context and the purpose of this review. A draft Terms of Reference was also shared with the Board for feedback. Board members supported the review but were mindful that it should be proportional and add value, in light of it following on from numerous national reviews and local CQC inspections. Sam Burrows reported that he, Sarah Bellars, Chief Nursing Officer (CNO) and Lalitha Iyer, Chief Medical Officer (CMO) had met with CNOs and CMOs at the relevant Trusts last week and made it clear that the review was not intended to be an added burden on maternity staff. The importance of public engagement to ensure that a breadth of voices could be captured in order to strengthen the review was also discussed. Nick Broughton, Chief Executive Officer asked if perinatal mental health services would be included in the scope of the review and Sam Burrows agreed that this should be added to the Terms of Reference.	

	The Board: • *agreed the commencement of a Thames Valley Maternity and Neonatal Services Review as described in the review terms of reference, with the specific addition of perinatal mental health services.* • *Considered the resource requirements of the proposed review.* • *Noted that there may be minor changes to the terms of reference following the Board discussion, to ensure feedback from wider stakeholders is incorporated.*	
10.	**Advise, Alert, Assure (AAA) Board Committee Reports** *The Board noted the AAA Board Committee reports.*	
11.	**Board Assurance Framework** Caroline Corrigan, Chief People and Corporate Affairs Officer introduced the latest Board Assurance Framework (BAF), explaining that the BAF continued to iterate and improve as the new organisation refined its risks in relation to the overarching strategic objectives. The Executives were regularly reviewing the risks, as well as the Board Committees. Audit Committee had reviewed the BAF at its July meeting and further revisions had been made to the Cyber risks as a result of their discussions. A Non-Executive Member commented that the BAF Cyber Security score and wording were not an accurate reflection of the Audit Committee discussions. It was agreed that this would be reviewed after the meeting and the wording would be further revised. **ACTION: Caroline Corrigan/ Governance team** *The Board noted the development of the Thames Valley Board Assurance Framework ("BAF") and the interim Q3 position as of September 2026/27, and approved the publishing of this document to the public website, subject to further amendment of the Cyber Security risk wording.*	
12.	**Fit and Proper Person Test Annual Board Return** *The Board noted that all Board members have been confirmed as Fit and Proper Persons, in accordance with the framework.*	
13.	**Designated Body Annual Report and Statement of Compliance** *The Board noted:* • *the contents of the Responsible Officer Annual Report.* • *And were assured that appropriate arrangements were in place to meet the statutory requirements for medical appraisal and revalidation during 2025/26.* • *And approved the attached Statement of Compliance.* • *And authorised submission of the Statement of Compliance to NHS England.*	
	Annual General Meeting	
14.	**2025-26 Annual Reports and Accounts for BOB ICB and Frimley ICB** Having taken items 15, 16 and 17 ahead of item 14, the Chair closed the Public Board meeting and opened the Annual General meeting at 12.27pm, which would consider the 2025-26 Annual Reports and Accounts for BOB ICB and Frimley ICB. It was noted that both organisations closed on 31st March 2026 and had been replaced by Thames Valley ICB on 1st April 2026, which had a new geographical footprint. Sam Burrows, Rich Chapman, Lalitha Iyer and Sarah Bellars gave a presentation highlighting some of the achievements of both BOB and Frimley ICBs. The following main points were noted: • 2025-26 was a year of major change for both BOB and Frimley ICB with additional demand for NHS services, financial constraints, workforce challenges, industrial action, and the requirement for the ICBs to significantly reduce running costs. • Despite this, improvements were delivered for residents – for example, the size of the elective waiting list across all of our providers reduced, cancer access performance improved, and access to diagnostics was also expanded. • Progress was made in delivering care closer to people's home through the introduction of neighbourhood teams, virtual wards and other community-based support and both organisations, through working with partners, were running initiatives to reduce health inequalities. • Across the year new leadership and governance arrangements were established, alongside more collaborative working, not just across Thames Valley, but also across the Southeast region with neighbouring ICBs. All that work was invaluable in setting the foundations for Thames Valley ICB and its new strategic commissioning role.	

- In terms of finance, the two ICBs collectively managed £6.6billion on NHS funding to deliver services for residents of Buckinghamshire, Oxfordshire, Berkshire West and the Frimley geography which equated to approximately £2300 per head of population.
- 44% of Frimley funding and 45% of BOB funding was spent on Acute services, with significant investment also in mental health, primary care, prescribing, community specialist services and continuing healthcare, with the overwhelming majority of ICB expenditure being on frontline patient care and service.
- Both ICBs demonstrated financial discipline and maintained a financial balance throughout the year with Frimley reporting a surplus of £44,000 and BOB around £200,000 at year end.
- Two slides demonstrated proactive prevention programmes which had been operated by both BOB and Frimley ICBs. In Berkshire West an outreach programme delivered 10,000 community health checks and 85% of participants reported improved awareness of cardiovascular risks and 75% made positive lifestyle changes as a direct result of the health check.
- In Frimley, through a Know your Numbers campaign, the ICB had improved results year on year to become the top performing system for hypertension management and cardiovascular disease prevention in the Southeast and also ranks second nationally.
- In 2025-26, Frimley ICB reduced the average length of stay in mental health acute beds from 63 days to 53 days meaning that patients could return home sooner with support in the community.
- Frimley ICB also increased access to mental health services for children and young people.
- Looking forward to 2026-27, Thames Valley ICB aimed to: strengthen partnership working to deliver more joined-up care to best meet the needs of residents; reduce health inequalities with more focussed support; expand neighbourhood health services to deliver care closer to home and utilise digital technology and innovation to maximise opportunities to support our residents whilst delivering value for money.
- Thames Valley ICB would meet the national requirements to reduce running costs and would continue to support staff whilst organisational change continued. Sam Burrows thanked staff of both BOB ICB and Frimley ICB and those working in Thames Valley for their dedication.

The Chair thanked all the Executives for the presentation.

The Board noted the Annual reports and accounts for both BOB and Frimley ICBs.

Other Items of Business

15. **Public Questions**

The Chair advised that there were two public questions which would receive a written response after the meeting – one was an HR related question on pay and banding of community-based workers and the other related to the results of GP satisfaction surveys in Reading.

Rich Chapman, Chief Finance Officer provided an answer to a question which had been raised by a Care Providers Association in connection with outstanding invoices. The answer is included here in full:

First of all, I would like to apologise to those providers who have been impacted by the issues which have affected our payment of invoices. We absolutely recognise the impact that the issues had on providers. We take it seriously. We're continuing to work to ensure that the issues are resolved at pace and that they do not recur. Since our last supplier update, the backlog has reduced by more than 30%. We would normally expect to have 7 to 8000 invoices outstanding at any point in time as part of regular business. And as of the 14th of September, 11,800 invoices remained outstanding.

Before adjusting for invoices on hold or in dispute, our current payment performance for invoices paid within 30 days of receipt is 71% by volume but 95% by value. We have a dedicated recovery programme in place which is supported by NHS England and NHS Shared Business Services and the resources are split between maintaining business as usual processing and resolving historic queries directly with providers. We're also running additional payment cycles, strengthening invoice validation and addressing common causes of delay, including duplicated invoices, missing non-identifiable patient references, or periods of care, and build rates that don't match agreed packages of care.

Where an invoice can be released for payment on account while an outstanding query is resolved, we're using that approach to accelerate payment and to reduce financial pressure on providers and providers facing an urgent risk to payroll or service continuity should continue to use the supplier query form which

	is available on the website. Those cases are prioritised by the programme team. Finally, to reduce the risk of recurrence, the ICB has commissioned an end-to-end review of all age continuing care and section 117 services. This will inform improvements to service process, the future operating model, data quality, automation, and the replacement of the existing digital patient management system and progress on that is being overseen through the ICB executive.	
16.	**Any Other Business** There was none.	
17.	**Close** The meeting closed at 1.15pm.	
	Date of Next Meeting 18th November 2026	
END 1.15pm		

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Thames Valley Integrated Care Board

Public Board

Title of Paper	Quality Exception Report – November 2026		
Agenda Item	5	**Date of meeting**	18 November 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

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Quality Exception Report – Thames Valley ICB Public Board (November 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

Three Never Events was reported by a provider organisation during the reporting period. The provider is completing the Patient Safety Incident Investigations (PSII) with the learning to be shared once completed. 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 one provider 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:

GPs: Across the Thames Valley geography, 14 GP practices have recently undergone Care Quality Commission (CQC) return-to-good inspections and have successfully retained their 'Good' rating. In addition, Thatcham Health Centre underwent a

comprehensive CQC inspection in September 2026 and also retained its 'Good' rating. These outcomes provide continued assurance regarding the quality and safety of primary care services across the system.

BHFT have been inspected within the reporting period in a number of areas including a “Well Led” Inspection. The Trust and ICB are awaiting the outcome.

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 Group 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.

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Thames Valley Integrated Care Board

Thames Valley Board

Title of Paper	Performance Overview		
Agenda Item	5	**Date of meeting**	18 November 2026
Exec Lead	Stephen Dunn, Interim Chief Strategy and Commissioning Officer		
Author(s)	Ben Gattlin, Associate Director Planning and Performance		

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

Link to Strategic Objective	*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.*

Executive Summary

Thames Valley ICB Performance reporting is in development, with four Commissioning Boards[1] taking responsibility for performance across their designated portfolios. Commissioning Boards will ultimately escalate to appropriate sub-committees of the Board, and this Board will receive the amalgamated Commissioning Board reports. This report is a subset of performance focused primarily on Planned Care. The scorecard within the report is Commissioner data.

The pack brings together three pieces of analysis from the Thames Valley data workbook: an executive briefing on waiting times, a four-provider review of the acute trusts, and an RTT deep dive into demand, delivery and reconciliation. All actuals run from April 2026; the latest month for the core waiting measures is August 2026, A&E runs to September. Prior-year figures are used as context only.

Recovery since April is uneven. The RTT waiting list has not improved - it is up 1,045 (0.5%) to 226,010 and now 21,328 above the August plan. The pressure is demand: clock starts ran 5.6% above the same Apr-Aug period YoY. Resulting in 10.9% above plan, against completed pathways only 1.9% above plan. Cancer 62-day and 31-day rates are below plan, diagnostics under-delivered on activity, and in Community the 52+ week list has fallen by more than half although children and young people's access is the weak spot.

Recovery actions are underway across RTT, Cancer and Diagnostics with providers undertaking waiting list validation, along with additional activity within their challenged specialties. The ICB is contributing with demand management initiatives centred on advice and guidance, eTriage and ‘Single Point of Access’.

Recommendation	Note the content of report

[1] Acute & Specialised Commissioning Board; Neighbourhood Health Commissioning Board; Children, Young People and Perinatal Commissioning Board; Mental Health, Learning Disability and Neurodiversity Commissioning Board

Conflict of interest identified
Yes ☒ No ☐
Members of the Board are directly accountable for performance portfolios contained within the report.

Reporting – has this paper been discussed at other meetings		
Committee Name	Date discussed	Outcome
Thames Valley Executive Meeting	9 November 2026	Approved for ICB Board

Thames Valley Performance Overview

Scorecard

1. The one-page view. Latest actual is August 2026, compared with the April baseline and the August plan. For the RTT list, 52+ week waits and the diagnostic 6+ week rate, lower is better, so a positive gap against plan is adverse. Only 28-day cancer diagnosis, RTT 52+ waits (marginally) and Community 52+ waits are ahead of plan. Cancer rows are single-month rates, April against August. They differ from slide 7, which shows the April to August YTD rates: in August the 28-day rate was 81.0% against an 80.5% plan, 62-day 71.4% against 76.7%, and 31-day 87.2% against 94.7%. Diagnostic activity is 14,064 tests below the August plan.

Referral to Treatment (RTT)

2. The RTT list opened at 224,965 in April and closed at 226,010 in August. The plan assumed it would fall to 204,682, the gap to plan has doubled from 10,528 in M1 to 21,328 in M5. The list dipped in July to 220,398 but rebounded by 5,612 in August. In August 2025 Thames Valley had 6,082 patients waiting 52+ weeks, at the end of August 2026 the number of patients waiting over 52 weeks has dropped to 2,363; a 61% reduction in the number of patients waiting over a year for elective treatment.

3. Access within 18 weeks has stayed close to 66% every month. In April Thames Valley was marginally ahead of the plan rate; by August the plan climbed to 68.8% while actual performance has not moved, producing a gap of 2.9%.

4. Buckinghamshire Healthcare Trust (BHT) has the largest relative overshoot at 11.2% above plan, and its list has grown by 1,590 since April. Oxford University Hospitals Foundation Trust (OUH) has the biggest list and the biggest absolute gap, 8,005, but it is the only large provider to have reduced its list, by 262. Frimley Hospitals Foundation Trust (FHFT) 52+ waits rose by 416 to 1,078. Royal Berkshire Foundation Trust (RBFT) is ahead of plan on 18-week access at 80.7% against 76.0%. All figures are end-August 2026 positions.

5. BHT recovery actions cover waiting-list validation, access and capacity. A single PTL is in place, TOCA[2] is live in 13 services and phase 2 is underway, with patient texts, closure and validation continuing. Patients waiting 18 weeks are to be seen or booked by 30 November, alongside weekly reviews of patients waiting 48+ weeks. Extra clinics are live, while cataract and glaucoma capacity is under review. Respiratory recruitment and a focus on Cardiology also identified.

6. OUH is adding four extra Pain clinics each week alongside specialty activity and insourcing. The Ophthalmology extension is pending, and Urology has been delayed to November. Productivity actions include Advice & Guidance in 19 specialties, with SPA targeting 10 by December. PIFU[3] and e-Outcome rollouts continue.

[2] TOCA is a digital low-code platform and automated e-referral/triage system used by clinicians and administrative staff to process patient referrals

[3] Patient Initiated Follow Up

7. Neurology outsourcing has commenced at FHFT to address recruitment-related capacity gaps. The ICB and FHFT have jointly planned MSK and Dermatology demand-management initiatives. Referral growth and specialty capacity gaps threaten recovery, with RTT fluctuations and challenging year-end delivery still expected.

Cancer

8. Cancer performance is a mixed picture. The August YTD faster diagnosis standard (28-day) rate was 82.0% against a plan of 79.7%. 62-day performance was 71.0% against 75.6%, and the 31-day performance at 88.2% against 94.2%, which is the largest cancer standard shortfall vs plan.

9. Cancer recovery actions at BHT include continued pathology recruitment, support and utilisation, alongside clearing Breast, Gynae and Skin backlogs. Skin and Plastics pathways are aligned, while Gynae changes require nursing backfill. Treatment actions include extra Lower GI and Urology lists and Urology redesign.

10. Additional Urology lists and ad hoc longer days live at OUH. Prostate clinics, split MDTs and same-day Gynae pre-assessment are live, while radiotherapy watermarking and auto-contouring are in progress. Oncology actions include continued recruitment, pathology reporting, chair utilisation and homecare transfers. Colorectal pathway review at FHFT identifies delays and improvement actions, with 28-Day recovery plans covering haematology, lung and the prostate pathway. Skin Analytics implementation is planned for urgent suspected cancer referrals.

Diagnostics

12. Diagnostics tells two stories. Reported activity is low vs plan: 427,231 tests were done April to August, 46,580 (9.8%) below plan, with a shortfall in every one of the five months. The waiting list has shrunk from 67,108 to 52,049. But the share waiting 6+ weeks, while down from 20.3% in April, rose again in August to 19.0% from 16.6% in July, against a plan of 14.5%. Last year's August share was 20.4%. August long waits were 9,865 against 6,000 planned.

13. Diagnostic recovery actions include weekend MRI[4] and NOUS[5] activity, with additional MRI staffing due to start in November. In Buckinghamshire extra capacity for Urogynaecology cystoscopy and urodynamics is due to come online in December. A second mobile MRI unit will be available in Oxfordshire and extended CDC days, with ultrasound adding 60 slots each week and two Medicare sessions. Endoscopy actions include new scopes, extra lists and recruitment, with booking changes and validation prioritising the longest waits. Audiology insourcing provides 500 units per month, alongside Horton and weekend CDC activity. Oversight includes a delivery group and weekly modality and PTL reviews;

Community

15. Community services show the clearest recovery in the pack. The 52+ week list fell from 1,270 to 561, a 55.8% reduction, and is 625 below plan. Children and young people drove

[4] Magnetic Resonance Imaging
[5] Non-Obstetric Ultrasound

75.0% of that reduction: their 52+ waits fell from 739 to 207. Adult 52+ waits fell more slowly, from 531 to 354. But the wider picture is less positive: the total list grew by 1,914 (6.0%) to 34,075, and the number waiting over 18 weeks rose 637 (9.4%) to 7,433, with adults accounting for the increase.

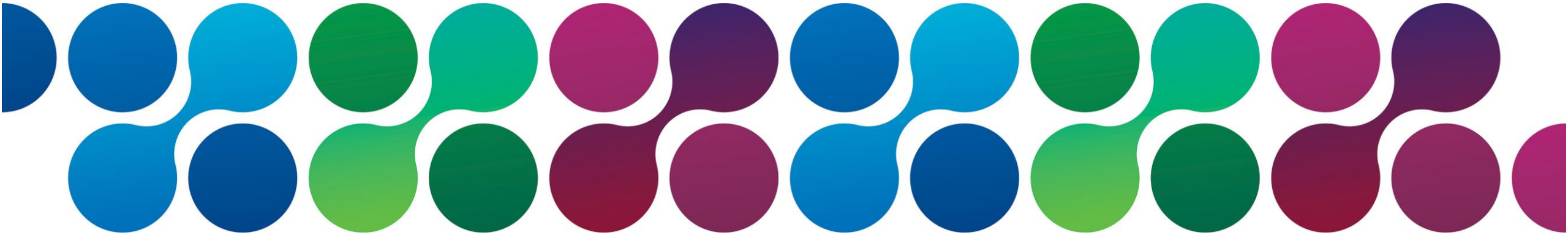
16. Looking at access within 18 weeks, adults sit at 82.4% in August, while children and young people are at 54.1%, down 3.5 points since April and 3.1 below plan. The CYP list itself fell from 6,080 to 5,068, so the rate fell even though the list got smaller. Over-18-week waits for adults rose 890 (21.1%), whereas CYP over-18-week waits fell 253 (9.8%). The recommendation in the workbook is to prioritise CYP Community access alongside recovery against current-year plans.

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Thames Valley ICB performance review

Planned care and access: executive briefing, four-provider review and RTT deep dive

Data April to August 2026 | November 2026



RTT, Cancer & Diagnostics Scorecard

Measure	Aug 2026	Apr 2026	Change since April	Aug plan	Actual vs plan	Status
RTT total list	226,010	224,965	+1,045	204,682	+21,328	Behind
RTT within 18 weeks	65.9%	66.0%	-0.1 pp	68.8%	-2.9 pp	Behind
RTT 52+ weeks	2,363	2,200	+163	2,374	-11	Ahead
Cancer 28-day diagnosis	81.0%	79.7%	+1.4 pp	80.5%	+0.6 pp	Ahead
Cancer 62-day	71.4%	70.0%	+1.4 pp	76.7%	-5.3 pp	Behind
Cancer 31-day	87.2%	85.7%	+1.5 pp	94.7%	-7.5 pp	Behind
Diagnostic activity (tests)	79,479	89,574	-10,095	93,543	-14,064	Behind
Diagnostics 6+ week rate	19.0%	20.3%	-1.3 pp	14.5%	+4.4 pp	Behind
Community CYP within 18 weeks	54.1%	57.6%	-3.5 pp	57.3%	-3.1 pp	Behind
Community 52+ weeks	561	1,270	-709	1,186	-625	Ahead

Source: ICB Insights. Cancer rows are single-month rates; slide 7 shows Apr-Aug YTD

Recovery is uneven: RTT has stalled while Community long waits fall

- **RTT has stalled:** list up 1,045 since April, now 21,328 above plan
- **Demand is the pressure:** starts 10.9% above plan, completions 1.9% above
- **Cancer:** 62-day (71.0%) and 31-day (88.2%) rates below plan
- **Diagnostics:** tests 9.8% below plan; 19.0% waiting 6+ weeks vs 14.5% plan
- **Community:** 52+ waits down 55.8%, but children and young people lag

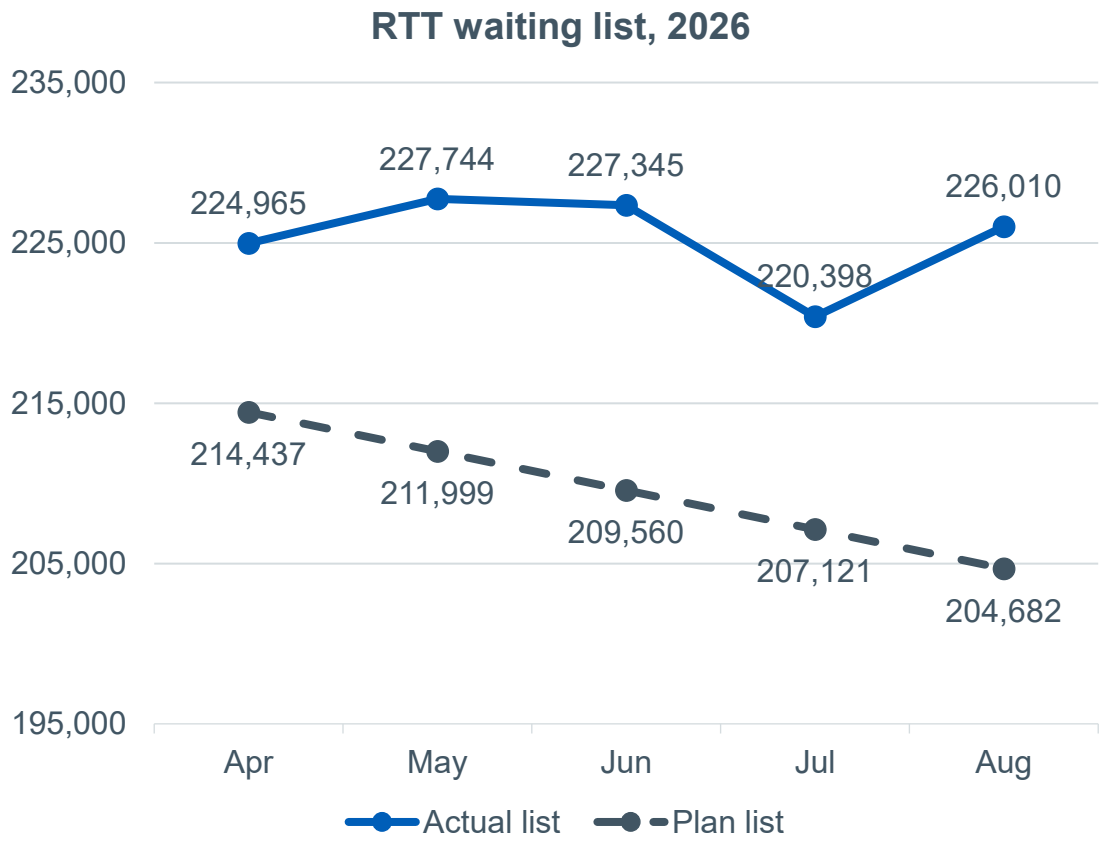
226,010
RTT waiting list, 21,328 above plan

65.9%
within 18 weeks vs 68.8% plan

2,363
waiting 52+ weeks, up 163 since April

71.0%
cancer 62-day rate, Apr-Aug, vs 75.6% plan

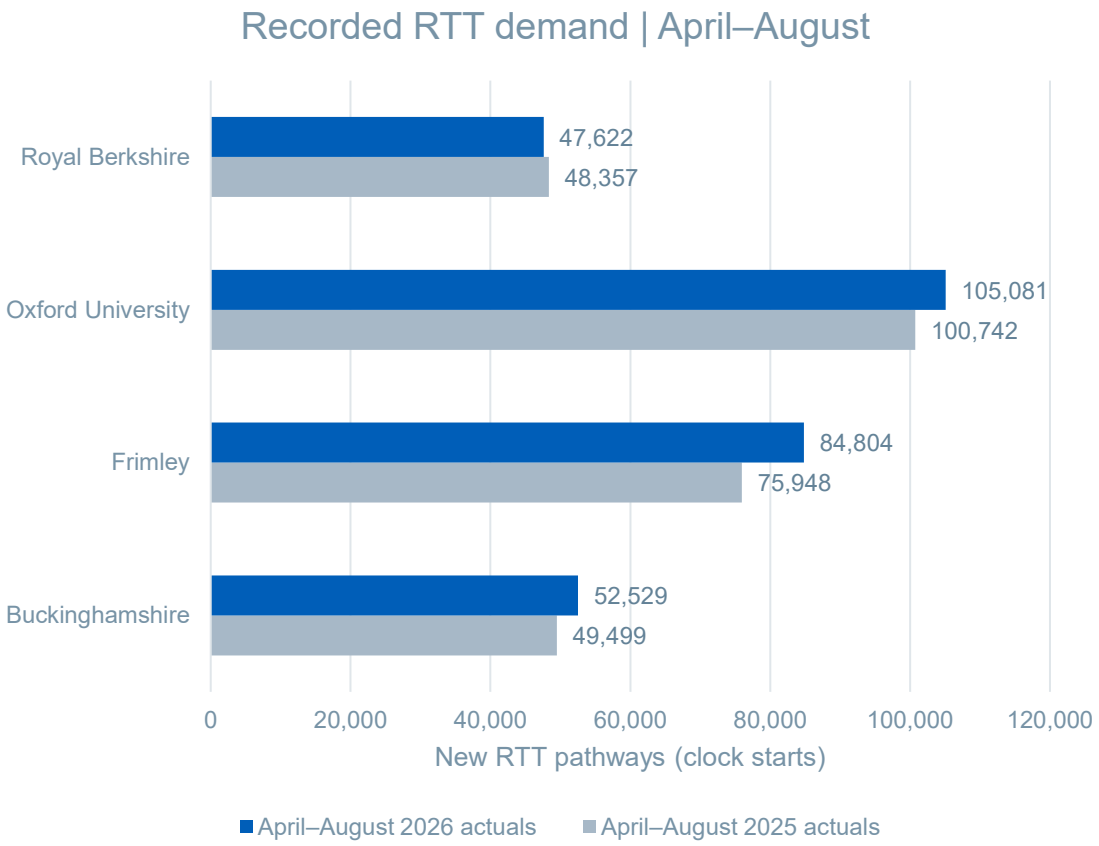
RTT list is flat while the plan assumes a 9,755 fall



- **Little recovery:** list up 1,045 (+0.5%) since April
- **Gap widening:** over plan by 21,328 in August, up from 10,528
- **Long waits:** 52+ weeks up 163 (+7.4%) to 2,363, just under the 2,374 plan

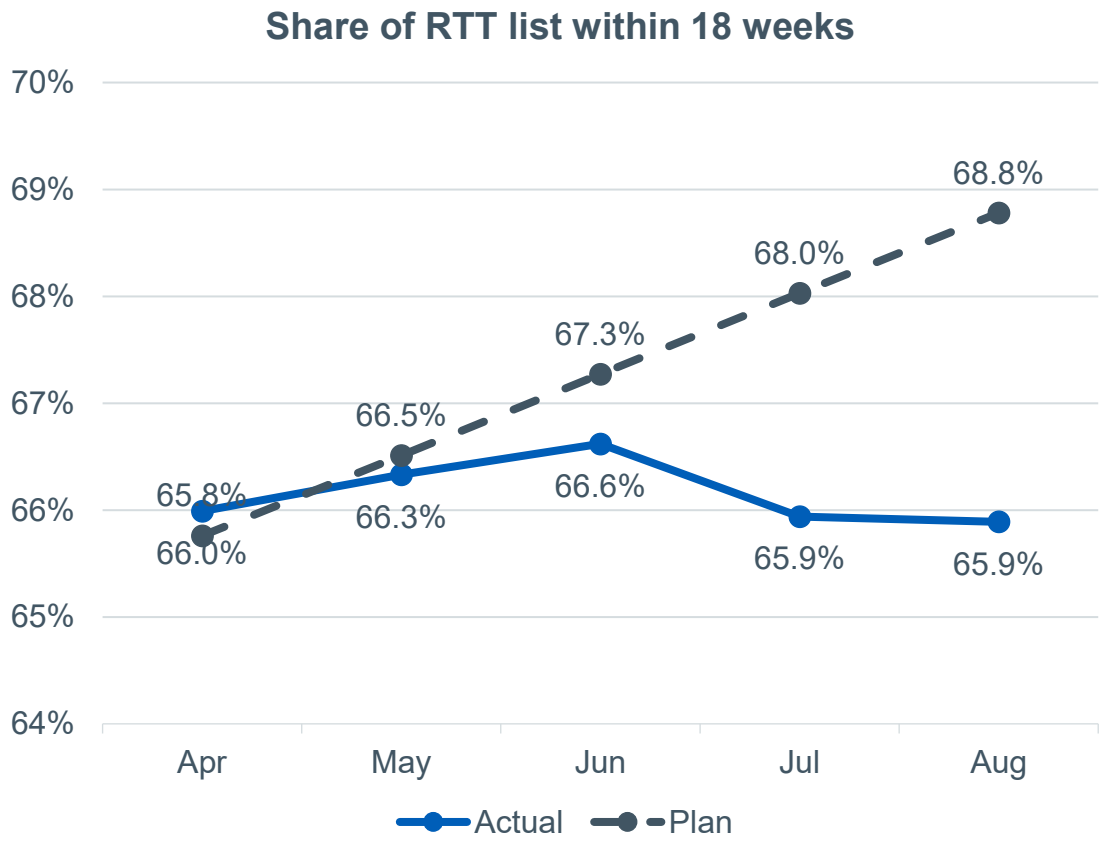
Source: RTT Trends. Axis starts at 195,000.

RTT Demand growth YoY



- **Demand growth is real in the recorded actuals—not just a variance against plan.**
- Recorded demand increased by 15,490 starts (5.6%).
- Frimley has the strongest growth and contributes **57.2% of the net increase**.
- Royal Berkshire's starts fell slightly
- Increasing demand is not a common explanation across all providers.

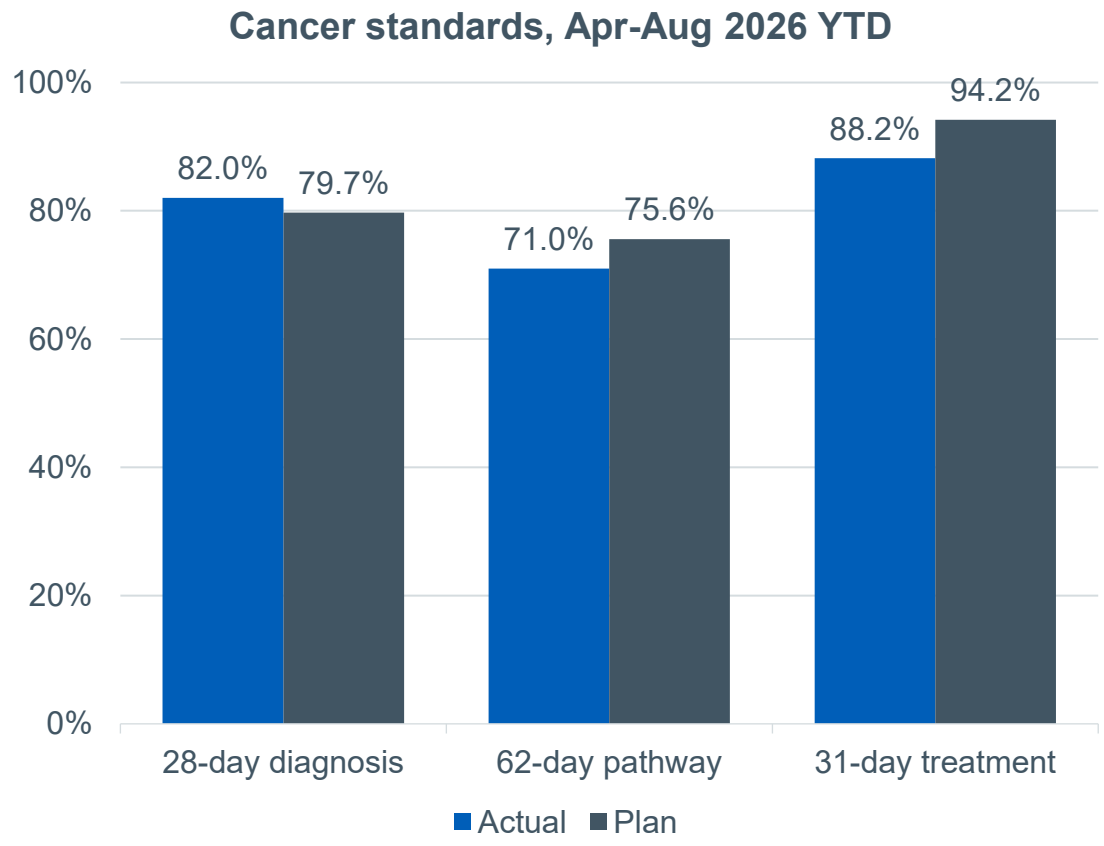
Broad access sits near 66% as the plan rate climbs away



- **April:** actual 66.0%, 0.2 pp ahead of plan
- **August:** actual 65.9% vs 68.8% plan, 2.9 pp behind
- **Over 18 weeks:** 77,101 patients, almost unchanged from 76,519

Source: RTT Trends. Axis starts at 64%.

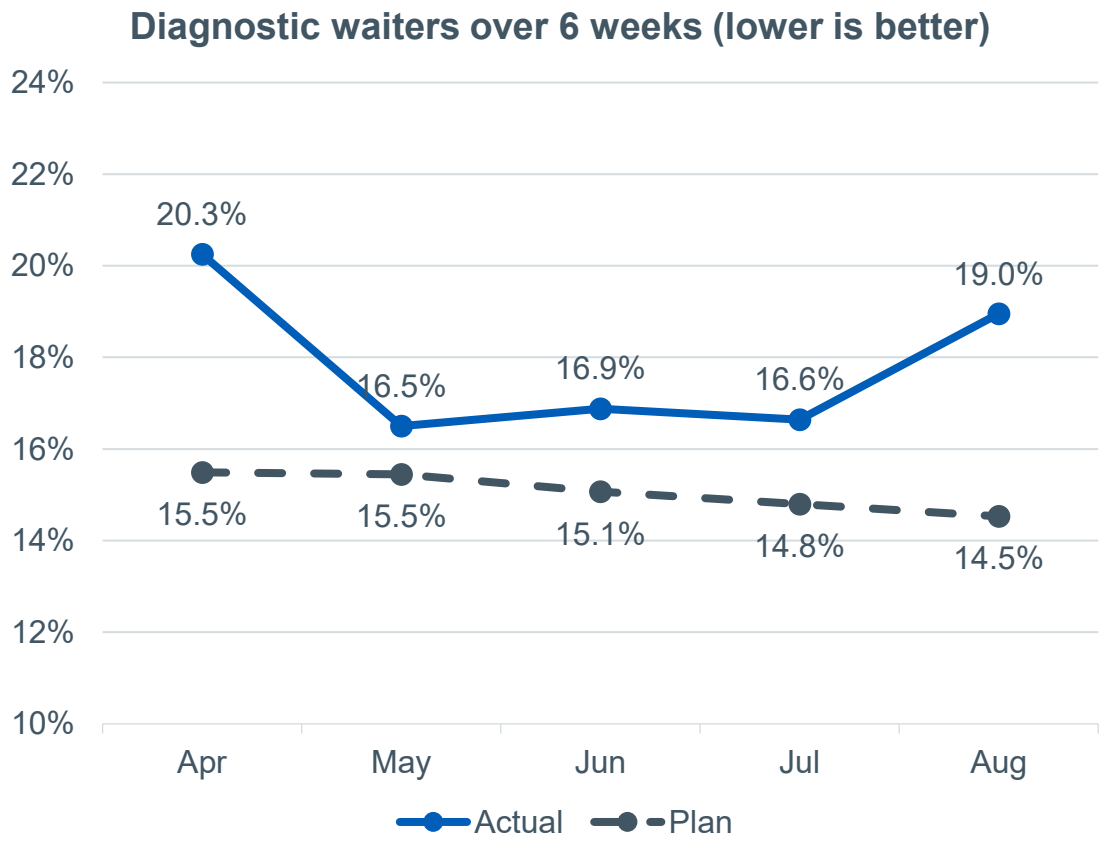
Cancer: diagnosis ahead of plan, treatment-stage rates behind



- **28-day:** +2.3 pp vs plan
- **62-day:** -4.6 pp vs plan; 1,521 breaches
- **31-day:** -6.1 pp vs plan, the largest gap; 1,282 breaches

Source: Cancer Trends. Plan = count-derived rate.

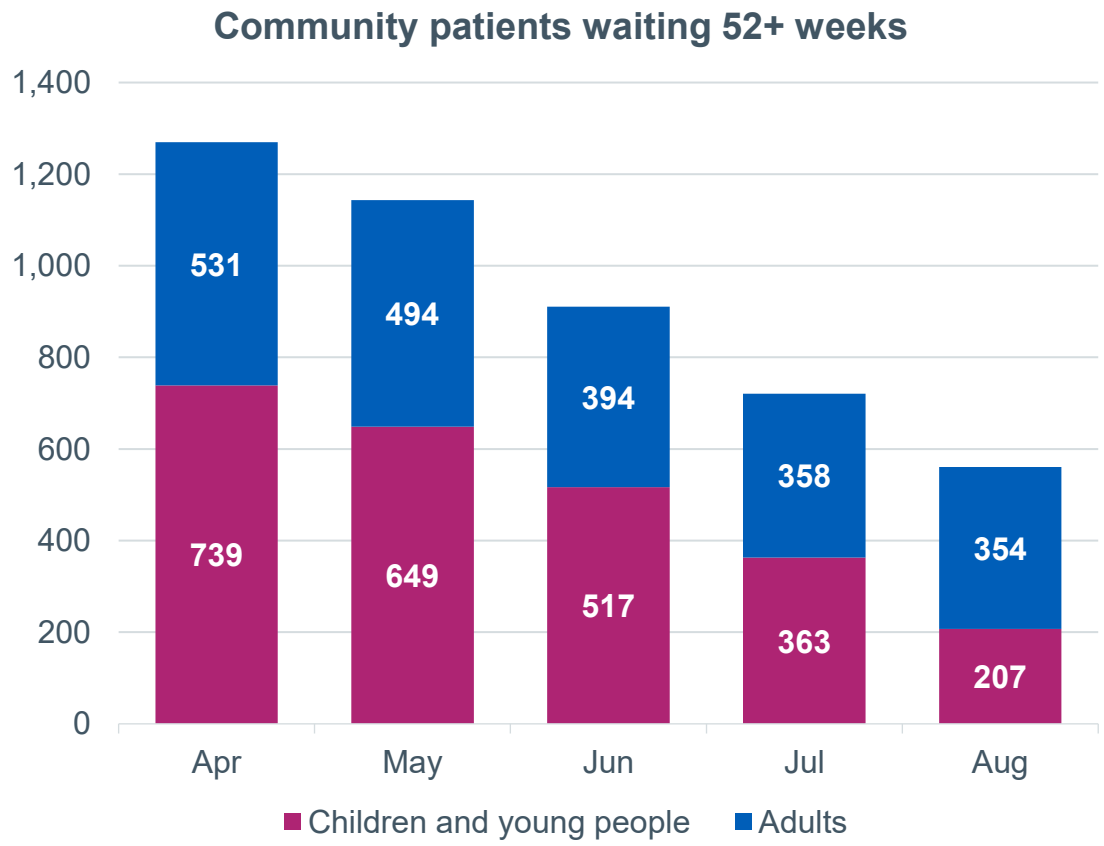
Diagnostics: a shrinking list but the delay share is rising again



- **Activity:** 427,231 tests, 46,580 (9.8%) below plan in all five months
- **Long waits:** 9,865 over 6 weeks in August vs 6,000 planned
- **List:** down 15,059 since April to 52,049

Source: Diagnostics Trends. Axis starts at 10%.

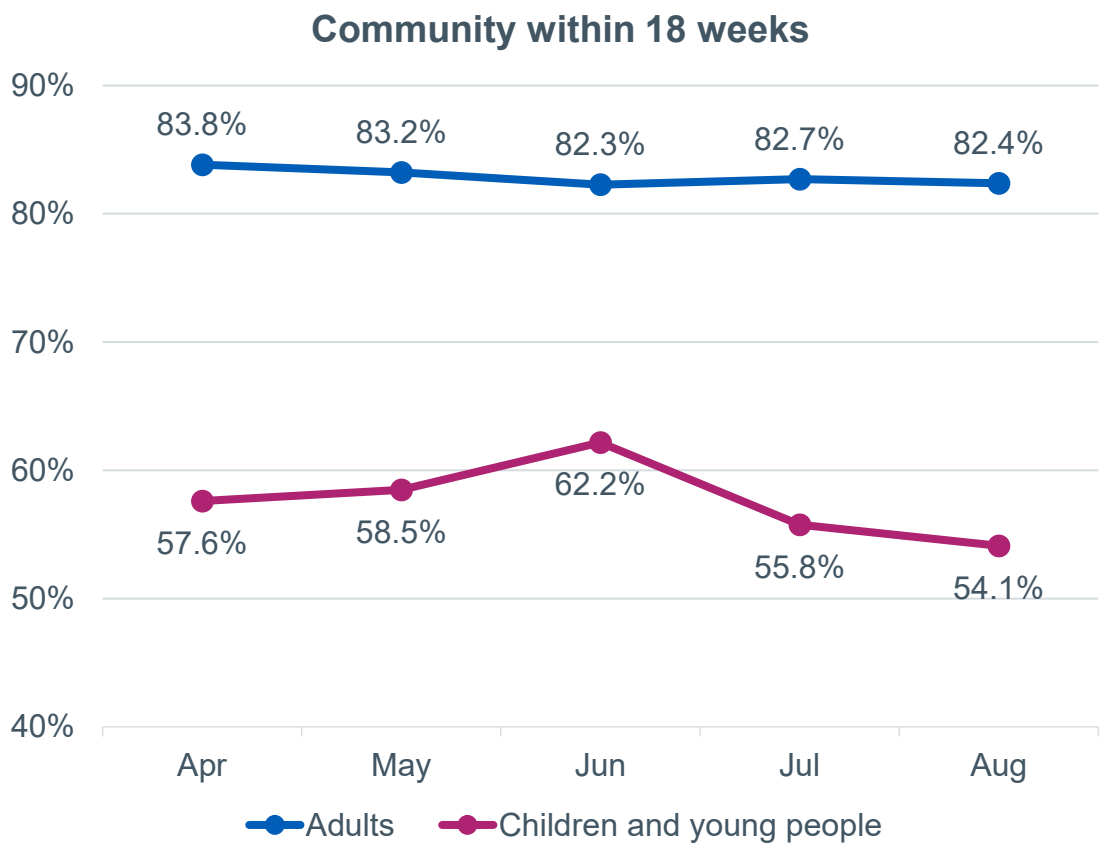
Community: 52+ week waits have more than halved since April



- **52+ list:** down 709 (-55.8%) to 561, 625 below plan
- **CYP drove it:** 75.0% of the reduction (739 to 207)
- **But:** total list up 1,914 (+6.0%); over-18-week waits up 637 (+9.4%)

Source: Community Trends.

Community: children and young people trail adults by 28 points



Source: Community Trends. Axis starts at 40%.

- **Adults:** 82.4% within 18 weeks, down 1.4 pp since April
- **CYP:** 54.1%, down 3.5 pp and 3.1 pp below plan
- **Adults over 18 weeks:** up 890 (+21.1%) since April

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Four-provider review

Buckinghamshire, Frimley, Oxford University and Royal Berkshire: RTT position, delivery and acute flow

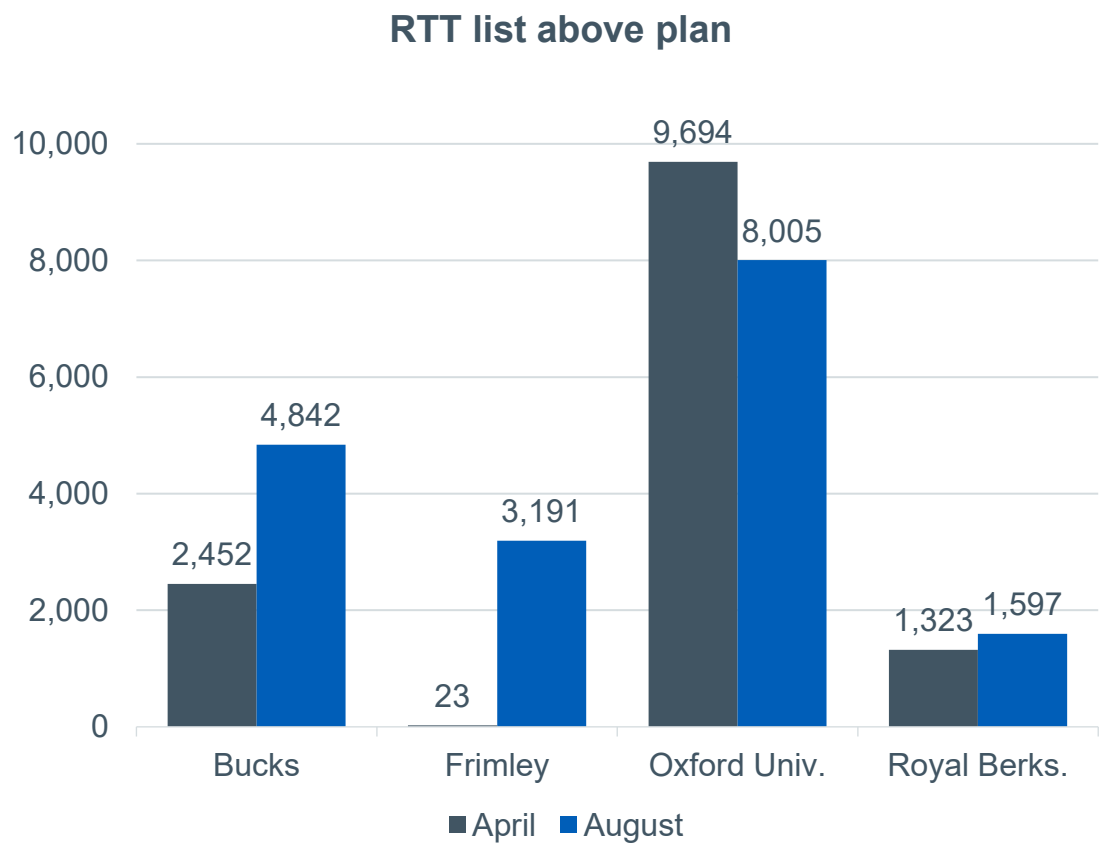
Provider position: Buckinghamshire furthest over plan, Frimley long waits rising

Provider	Aug RTT list	Over plan	Over plan %	Change since Apr	Within 18 wks	Plan	Gap (pp)	52+ waits	52+ change
Buckinghamshire	47,942	4,842	11.2%	**+1,590**	63.5%	67.6%	**-4.2**	55	**-14**
Frimley	66,684	3,191	5.0%	**+562**	61.1%	63.0%	**-1.9**	1,078	**+416**
Oxford University	89,879	8,005	9.8%	**-262**	62.2%	62.0%	**+0.2**	1,516	**-81**
Royal Berkshire	34,597	1,597	4.8%	**-726**	80.7%	76.0%	**+4.7**	35	**-3**

Every trust is above its list plan, yet Oxford University and Royal Berkshire have shrunk their lists since April while Buckinghamshire and Frimley have grown theirs.

Source: Provider Comparisons. Red = adverse, green = favourable.

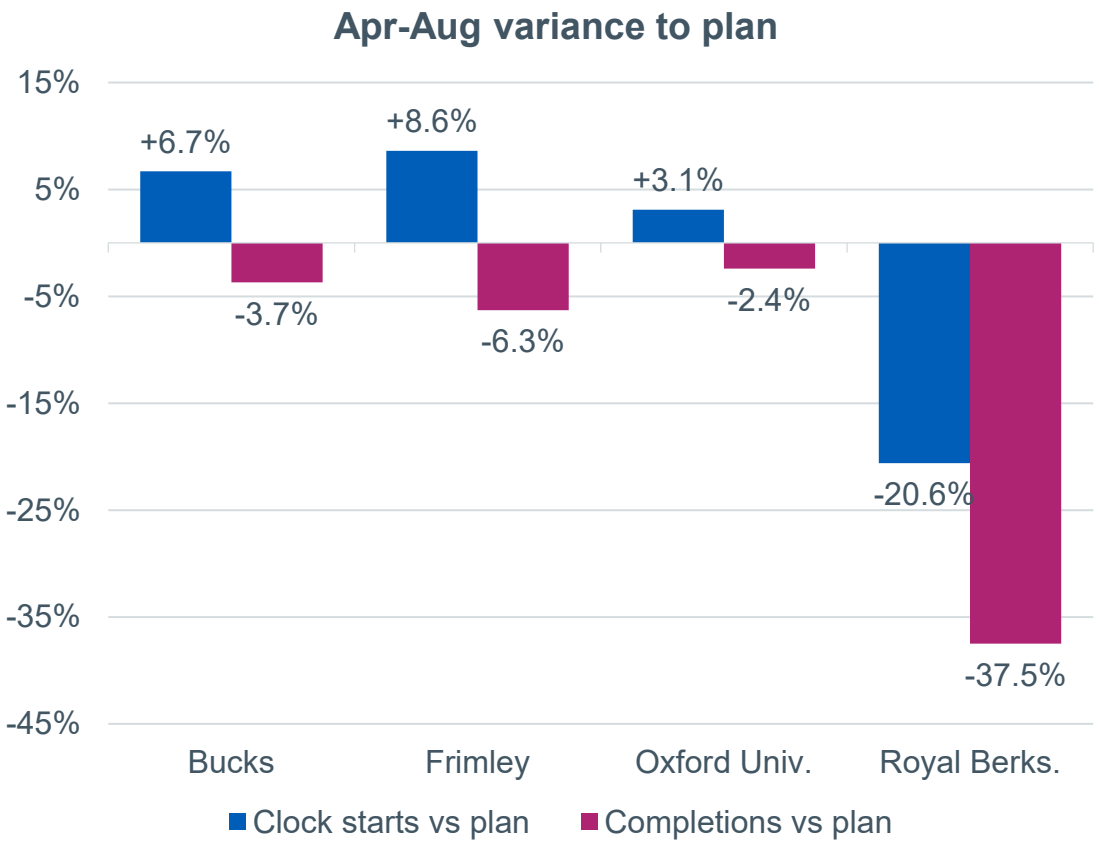
The gap to plan widened at Frimley and Buckinghamshire, narrowed at Oxford



- **Frimley:** gap up 3,168 since April, from 23 to 3,191
- **Buckinghamshire:** up 2,390 to 4,842
- **Oxford University:** down 1,689, still the largest gap at 8,005
- **Royal Berkshire:** up 274 to 1,597

Source: Provider Comparisons; provider RTT tabs.

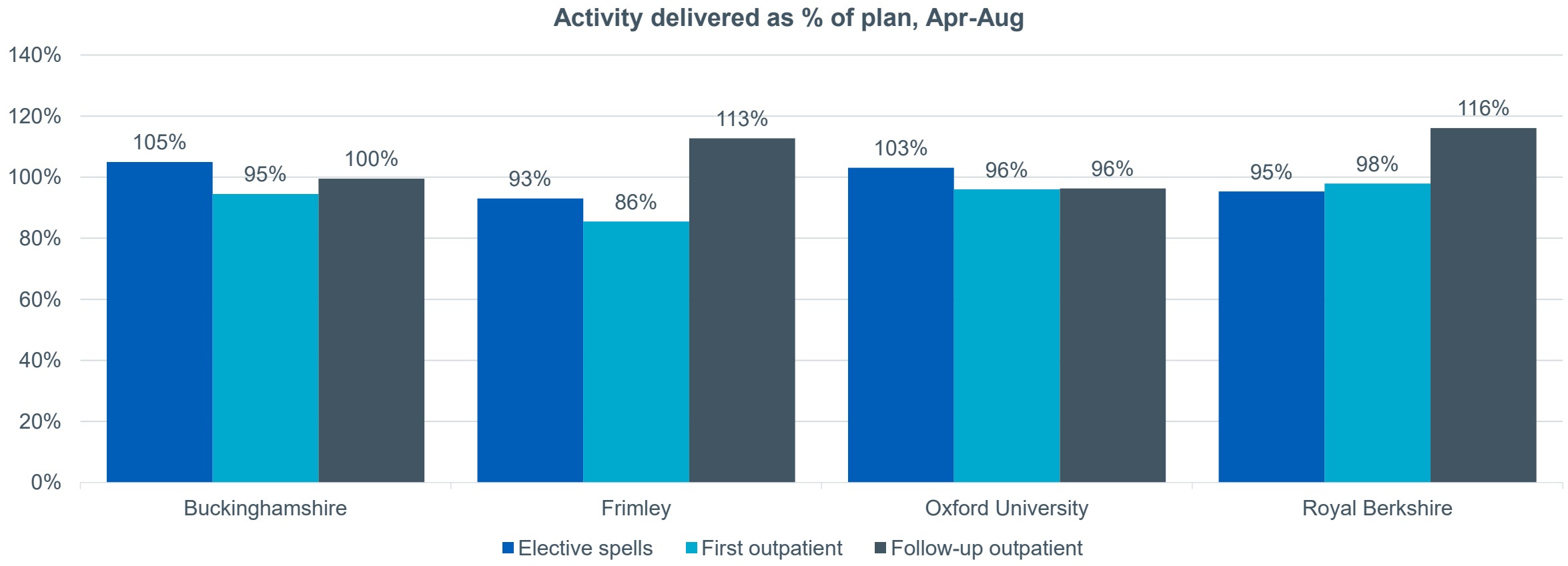
Starts above plan, completions below: three trusts follow the same pattern



- **Frimley:** starts +8.6%, completions -6.3%, the widest split
- **Buckinghamshire, Oxford:** starts up 6.7% and 3.1%, completions down 3.7% and 2.4%
- **Royal Berkshire:** starts -20.6%, completions -37.5%: validate definitions first

Source: Provider Comparisons. Completions = treatment-stop proxy.

Frimley is below plan on elective and first outpatient work; follow-ups mask the gap



Source: Provider Comparisons. 100% = on plan.

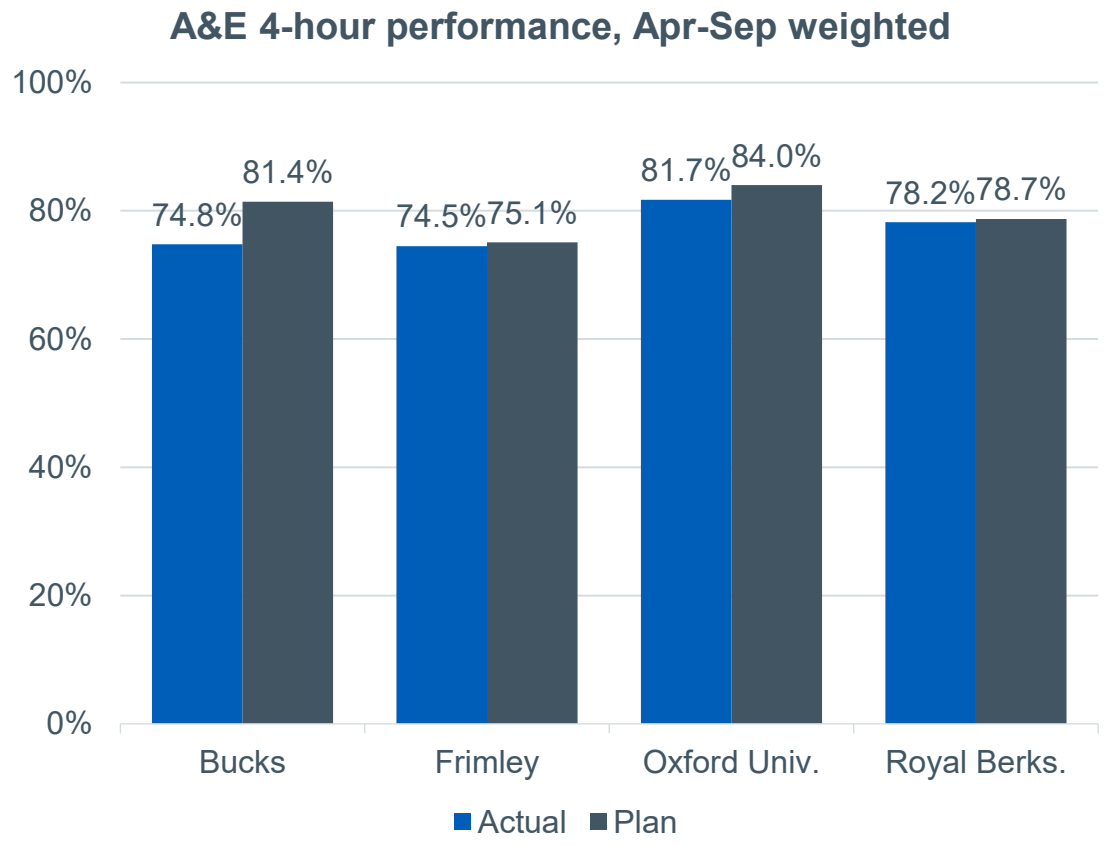
Pathway flow: large unexplained residuals need validating before conclusions

Provider	Starts vs plan	Completions vs plan	Excess net inflow	Gap to plan change since Apr	Residual May-Aug	Completed / starts
Buckinghamshire	+6.7%	-3.7%	**4,997**	**+2,390**	-4,409	84.7%
Frimley	+8.6%	-6.3%	**12,051**	**+3,168**	-4,102	93.4%
Oxford University	+3.1%	-2.4%	**5,373**	**-1,689**	-13,479	84.3%
Royal Berkshire	-20.6%	-37.5%	**-104**	**+274**	-22,446	43.0%

Residuals are unexplained differences, not identified removals. Royal Berkshire in particular needs a definitions check.

Source: Provider Comparisons. Excess net inflow = starts minus completions, above plan.

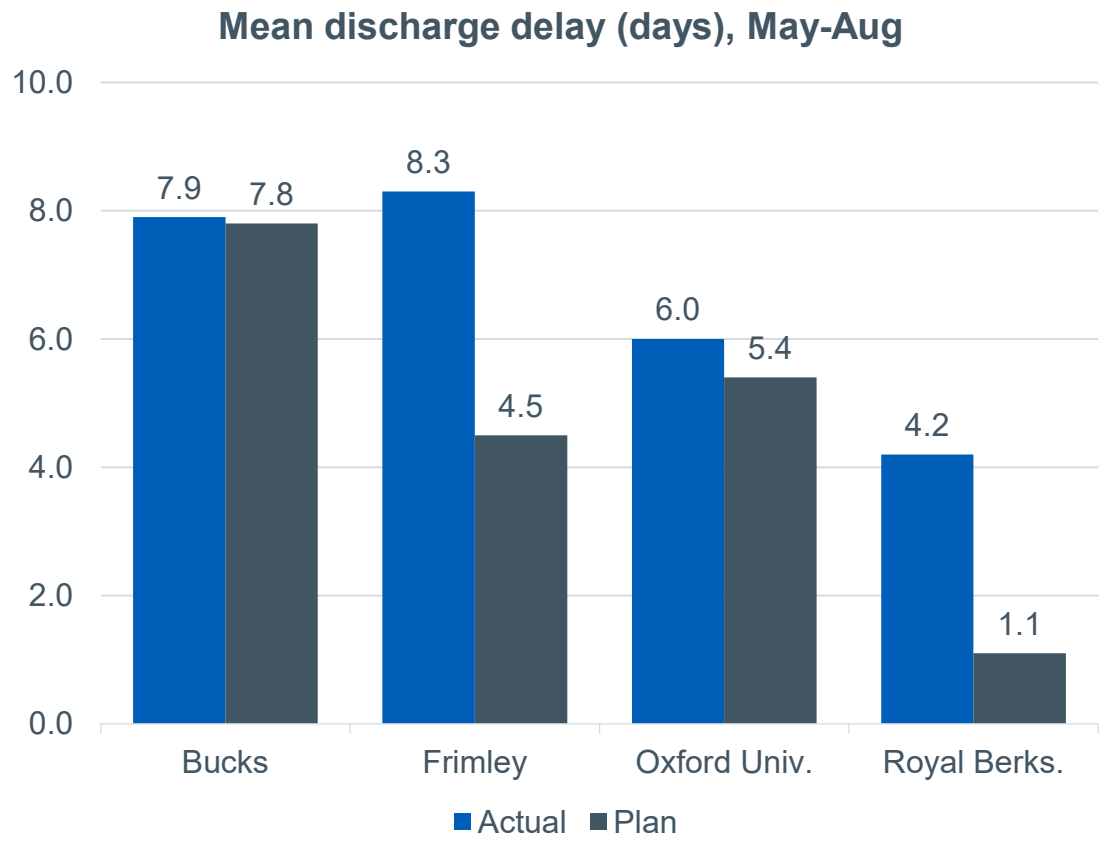
A&E: Buckinghamshire is 6.6 points short of its four-hour plan



- **Buckinghamshire:** -6.6 pp; 12h+ waits 6,045 vs 3,950 plan
- **Oxford University:** -2.3 pp, with the lowest 12h+ share (1.3%)
- **Royal Berkshire:** attendances +19.4% vs plan; 12h+ 3,960 vs 1,687

Source: Acute Flow & Discharges. Apr-Sep, four acute providers.

Discharge: Frimley and Royal Berkshire have delays well above plan



- **Frimley:** 8.3 days vs 4.5 plan, +3.8 days
- **Royal Berkshire:** +3.1 days vs plan; ready-date rate 74.2% vs 84.0%
- **Buckinghamshire, Oxford:** within 0.6 days of plan

Source: Acute Flow & Discharges. May-Aug common window.

Four providers, four different constraints

Buckinghamshire

Starts +6.7%, completions -3.7% vs plan

Elective spells 105% of plan

List gap nearly doubled to 4,842

A&E 4-hour gap -6.6 pp

Focus: why above-plan activity is not converting into completed pathways

Frimley

Starts +8.6%, completions -6.3% vs plan

First outpatients 85.5% of plan

52+ waits up 416 to 1,078

Discharge delay 8.3 days vs 4.5

Focus: first-appointment capacity and discharge delays

Oxford University

List gap down 1,689, still 8,005

Elective spells 103% of plan

1,516 waiting 52+, on plan

A&E 4-hour gap -2.3 pp

Focus: sustain gap reduction and protect the 52+ position

Royal Berkshire

18-week access 80.7% vs 76.0% plan

Starts -20.6%, completions -37.5%

A&E attendances +19.4% vs plan

Ready-date discharge 74.2% vs 84.0%

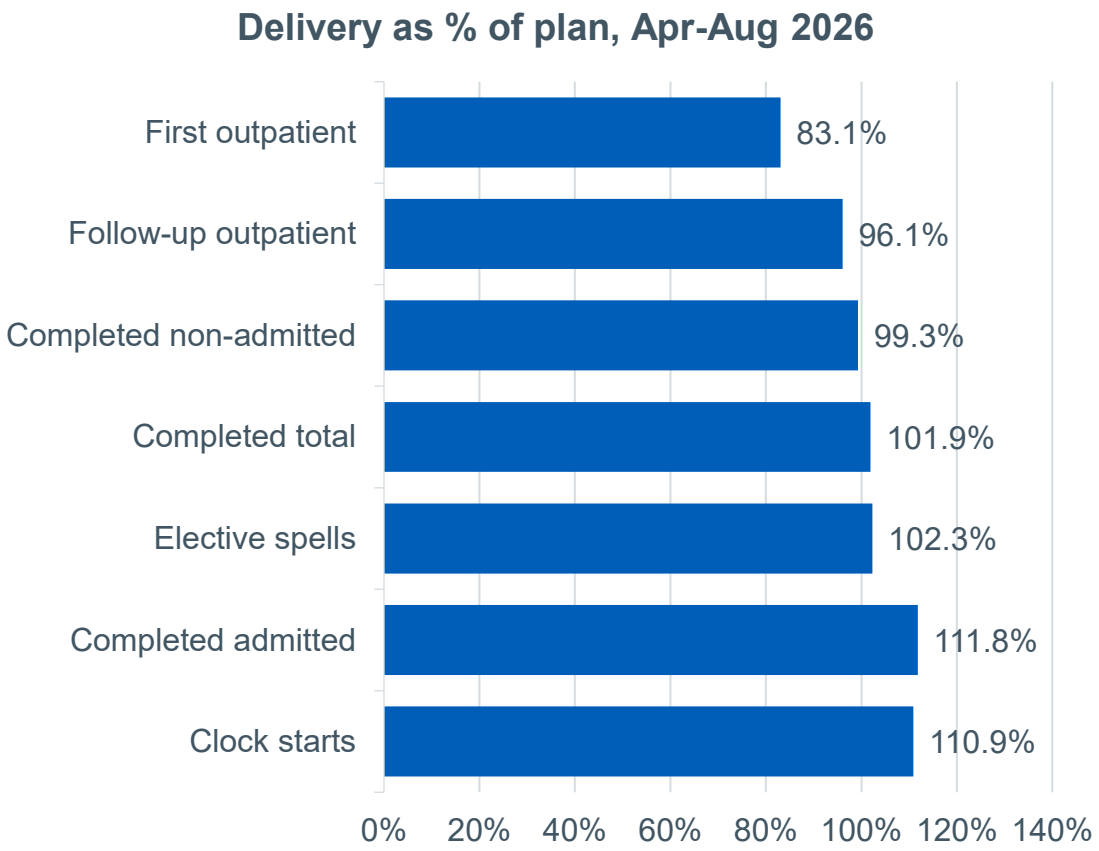
Focus: validate pathway definitions before inferring capacity failure

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RTT deep dive

Demand, delivery and reconciliation: what is driving list pressure?

Demand is the pressure: starts are 10.9% above plan, elective activity is not short



- **Demand:** starts 278,982 vs 251,459 plan (+27,523)
- **Delivery:** completed pathways +3,998 (+1.9%); elective spells +2.3%
- **Access:** first outpatients 16.9% below plan; follow-ups 3.9% below

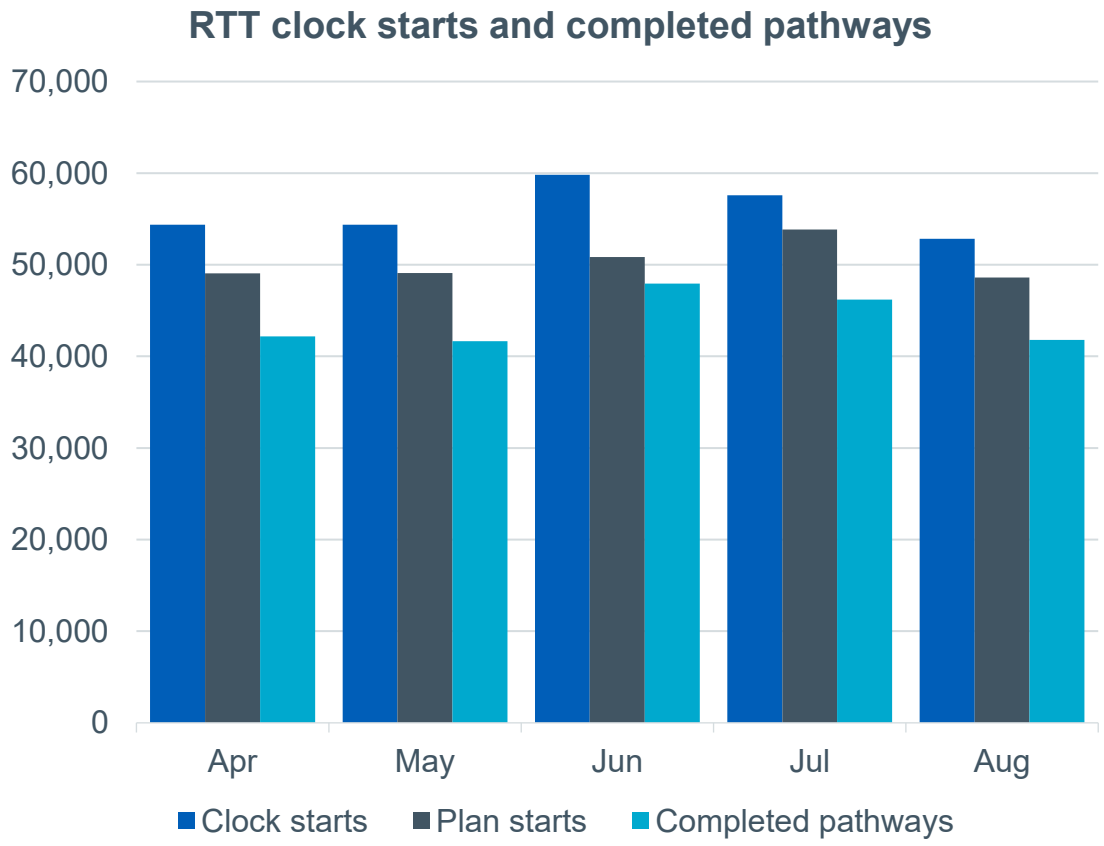
Source: RTT Demand & Delivery. Completions = treatment-stop proxy.

Demand and delivery against plan, April to August 2026

Measure	Actual	Plan	Variance	Delivery vs plan
Clock starts	278,982	251,459	+27,523	110.9%
Completed admitted	49,405	44,179	+5,226	111.8%
Completed non-admitted	170,357	171,585	-1,228	99.3%
Completed total	219,762	215,764	+3,998	101.9%
Elective day cases	99,676	97,596	+2,080	102.1%
Elective ordinary spells	16,048	15,508	+540	103.5%
Elective spells total	115,724	113,104	+2,620	102.3%
First outpatient attendances	396,158	476,617	-80,459	83.1%
Follow-up outpatient attendances	680,197	707,550	-27,353	96.1%
Outpatient attendances total	1,076,355	1,184,167	-107,812	90.9%

Source: RTT Demand & Delivery. Red for starts = demand pressure.

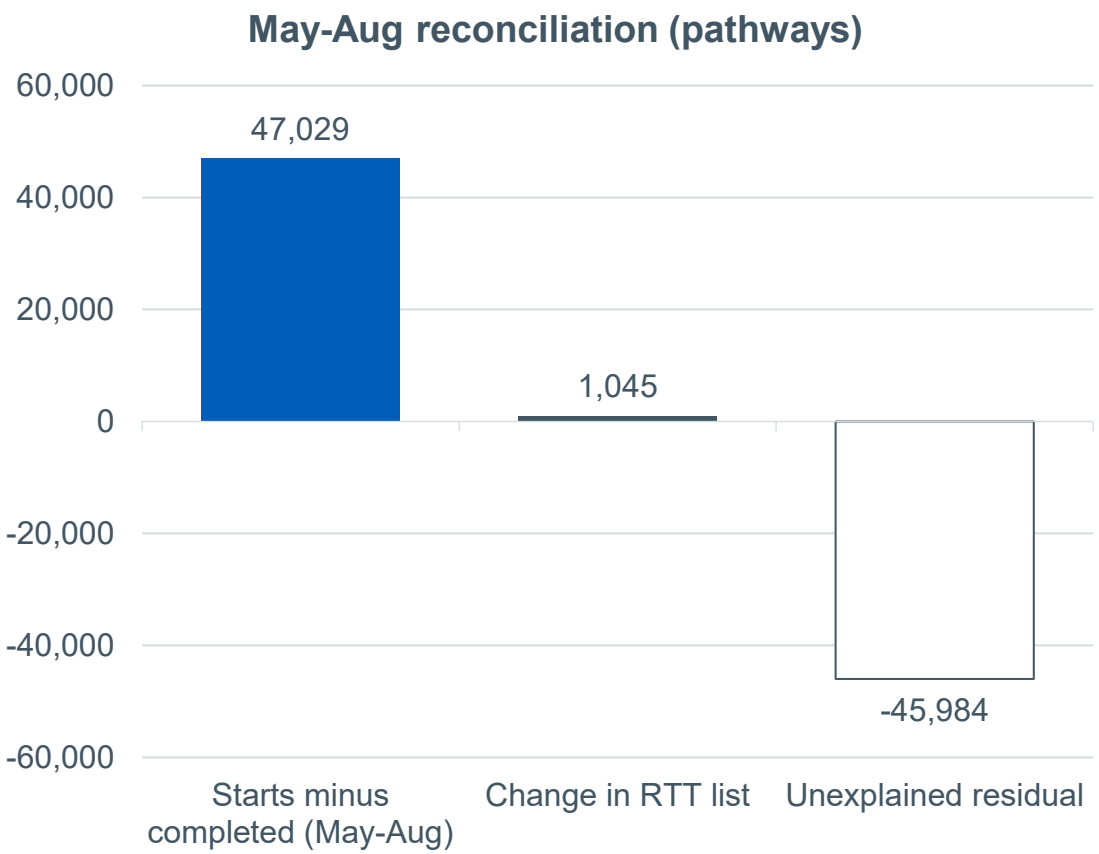
Starts have outrun completions in every month since April



- **Net inflow:** starts minus completions was 59,220 over Apr-Aug vs 35,695 plan
- **Excess:** 23,525 above plan, above plan in every month
- **June peak:** starts 59,811 vs 50,840 planned

Source: RTT Demand & Delivery.

Reconciliation: a 45,984 residual must be explained before causes are claimed



Source: RTT Demand & Delivery. Completions = proxy.

- **Net inflow:** +47,029 starts minus completed pathways, May-Aug
- **List movement:** only +1,045 over the same period
- **Residual:** -45,984 - unexplained, not identified removals
- **Next:** reconcile clock stops, validation and transfers

Priorities: target the constraint, not the average

- **RTT long waits:** 52+ list up 7.4% since April; Frimley up 416
- **Diagnostics:** tests 9.8% below plan; 6+ week share 4.4 pp over plan
- **Cancer:** 62-day and 31-day rates 4.6 pp and 6.1 pp below plan, Apr-Aug
- **Community CYP access:** 54.1% within 18 weeks vs 57.3% plan

- Reconcile clock stops, removals and validation to explain the residual
- Identify provider and specialty contributions to plan gaps
- Test first-attendance conversion and admitted / non-admitted completion capacity
- Investigate diagnostic and RTT bottlenecks and CYP Community access
- Validate data definitions before attributing causes



Coverage, definitions and how to read the numbers

- **Period:** April-August 2026 actuals; A&E to September; discharge May-August
- **Providers:** four acute trusts only; Berkshire Healthcare and Oxford Health excluded
- **Plans:** rates derived from planned counts, not national standards
- **Prior year:** context only; comparability uncertain

- **Completed pathways:** a treatment-stop proxy, not all RTT removals
- **Residuals:** unexplained differences, not identified removals
- **Units:** spells, attendances and pathways must not be added together
- **Causation:** none established; acute flow measures are context

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Recovery Actions

What are we doing to recover our position

Elective recovery: targeted specialty interventions

Focused pathway changes are reducing avoidable demand, creating alternatives to acute care and releasing specialist capacity.

SPECIALTY	CHALLENGE / OPPORTUNITY	TARGETED INTERVENTION	DELIVERY MILESTONE / IMPACT
Dermatology	Demand and completion imbalance; high-referring practices offer a targeted opportunity.	Skin analytics and associated imaging across three trusts; GP-led minor surgery; independent-sector consultant capacity available subject to funding.	Implementation being progressed. Expected impact to be quantified.
ENT	OUH ENT waiting list increased by 916 from March to July; USC and sino-nasal demand are key pressures.	DORA risk stratification; OUH weekend clinics; community ENT expansion; TV-wide SPoA starting with adult and paediatric tonsils; HVLC pathway work.	DORA by end November. Around 125 patients seen per OUH weekend. Grommets completed; tonsil pathway being established. c.-30% taken out of USC pathway and c.-20% referral to ENT for nasal issues.
Audiology	Audiology pressure constrains ENT pathways and remains relevant to DM01 recovery.	Frimley Park audiology service; Heatherwood tinnitus pilot; move age-related hearing loss patients aged 40+ to community AQP audiology.	Frimley service operational; FHFT DM01 reported as 65% in June and 17% in September. Tinnitus rollout depends on NHSE funding release.
Gynaecology	Need to direct patients to the right setting and reduce avoidable secondary-care referrals.	Berkshire West community service; FedBucks triage; Oxfordshire pathway redesign and community triage; Medinet; e-Triage / SPoA.	Bucks mobilisation stated for 1 October; Berkshire West targeted for mid-to-late November. Full-system e-Triage / SPoA could reduce referral conversion by around 10%.

Specialty actions are specific and time-bound; final assurance requires quantified PTL, referral and completed-pathway impact.

Referral optimisation readiness across the four acute trusts

Advice & Guidance, e-Triage and Single Point of Access: current stated position and next milestones

LIVE / READY | IN PROGRESS | TO CONFIRM

TRUST	ADVICE & GUIDANCE	E-TRIAGE	SINGLE POINT OF ACCESS
OUH	LIVE A&G operating in all 12 agreed priority specialties across the four trusts.	IN PROGRESS Implementation underway. Go-live stated by end November 2026.	IN PROGRESS Largely ready. 100% service mapping reported. Data clean-up, services in transition and some clinical sign-off remain; A&G/email referrals affect initial timelines.
RBFT	LIVE A&G operating in all 12 agreed priority specialties across the four trusts.	LIVE Fully live.	IN PROGRESS Advanced / operational. 100% DOS mapping; established trust-wide middleware processes e-RS/A&G. Around 10% referral return rate reported, with evidence of benefits.
BHT	LIVE A&G operating in all 12 agreed priority specialties across the four trusts.	IN PROGRESS Live in 15 specialties. Completion of rollout stated by end October 2026.	IN PROGRESS Partially live / progressing. Around half of specialties live; wider rollout approach and DOS mapping queries remain.
FHFT	LIVE A&G operating in all 12 agreed priority specialties across the four trusts.	TO CONFIRM	IN PROGRESS Preparing to start. Implementation expected to take around 4–8 weeks, subject to governance and e-RS requirements.

A&G is operating across the agreed top 12 specialties in all trusts. SPoA readiness varies by trust, rollout controlled by NHSE.

RTT and elective recovery actions

Pathway accuracy	BHT single PTL in place. TOCA live in 13 services, with phase 2 underway. Patient texts, pathway closure and validation continue. e-Outcome supports outcome capture.
Access and productivity	Advice & Guidance covers 19 specialties at OUH. SPoA targets 10 specialties by December. PIFU, clinic-template and space reviews, and patient engagement continue.
Extra capacity	Four extra Pain clinics weekly and specialty activity/insourcing. Neurology outsourcing has started at FHFT. Extra clinics are live. Cataract/glaucoma capacity remains under review. Hernia clinic booked 300 patients.
Long waits and specialties	18-week patients seen or booked by 30 November. Weekly 48+ week reviews and oversight of 40-week first-outpatient cohorts. Plans target no waits over a year by March 2027. Diabetes, Rheumatology and Endocrinology target 92%. Respiratory recruitment and Cardiology focus continue.
Dependencies and risks	Ophthalmology extension pending. Urology delivery delayed to November. Urogynaecology tender with Contracts. MSK/dermatology demand plan needs timescales, with dermatology pathway/funding agreement outstanding. T&O, booking, referral growth and capacity gaps threaten year-end recovery.

Cancer recovery actions

Faster diagnosis

Pathology recruitment/support and utilisation continue. Breast, Gynae and Skin backlogs are clearing. Recovery plans cover haematology, lung and prostate Faster Diagnosis. Skin Analytics for urgent suspected cancer referrals remains planned.

Pathway redesign

Skin and Plastics aligned. Gynae changes depend on nursing backfill. Urology redesign continues, with the prostate review unconfirmed.

Prostate clinics, split MDTs and same-day Gynae pre-assessment are live. Radiotherapy watermarking and autocontouring remain in progress. Colorectal review targets delays.

Treatment capacity

Extra Lower GI/Urology lists and ad hoc longer Urology days are live. Extra Gynae lists remain in progress.

Oncology recruitment continues plus extra pathology reporting, chemotherapy chair utilisation and homecare transfers continue.

Tracking and escalation

Weekly COO/CMO 40–55-day reviews at OUH track avoidable breaches. Daily cohort plans, tumour-site/MDT reviews and admin Infoflex access support long-wait tracking.

Diagnostic recovery actions

60
additional ultrasound slots weekly

500
audiology insourcing units per month

4
additional DEXA slots weekly

Imaging and endoscopy

Weekend MRI/NOUS capacity continues. MRI staffing due November. CT-2 adds capacity. Second mobile MRI and extended CDC days add capacity. Ultrasound also adds two external sessions.

Biopsy capacity review and DEXA booking/insourcing continue. Endoscopy work covers capacity and maintenance, new scopes, IT, extra lists and recruitment. Booking changes and validation prioritise longest waits.

Other diagnostics and oversight

Audiology capacity includes hospital clinics and weekend CDC sessions. Neurophysiology and sleep outsourcing continue. Extra CNS capacity for cystoscopy/urodynamics moved to December.

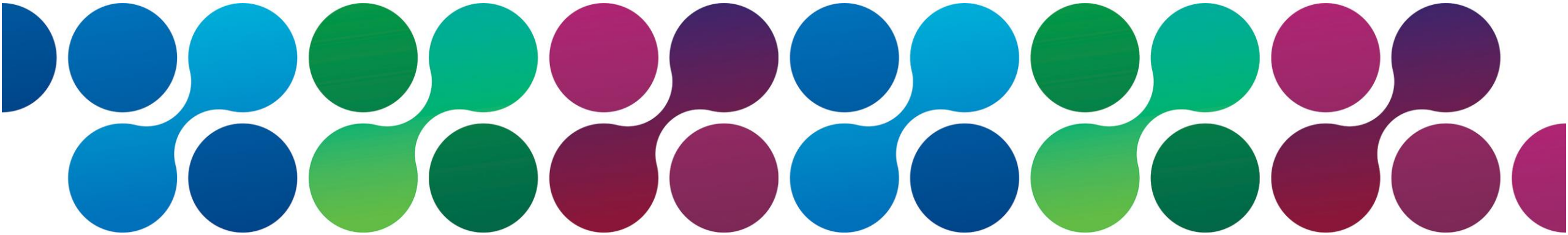
Paediatric list sign-off due mid-November. Recall clinics and lead target December. ABRs, harm reviews, mutual aid and SME support continue. Protect recall capacity.

Delivery group and weekly modality/PTL reviews track recovery. DM01 validation is complete.

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Thames Valley Integrated Care Board

Public Board

Title of Paper	Finance Report		
Agenda Item	5	**Date of meeting**	18 November 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 6 finance position for Thames Valley ICB.

Finance

At month 6 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 **£3.7m YTD** and **£3.6m FOT**. The budget is experiencing cost pressures in community equipment, mitigations plans are in place to ensure controls and reviews are implemented therefore the expectation is this expenditure will reduce as we progress through the 2nd half of the year but will not be fully recovered. There are continued pressures in the termination of pregnancy contract, the forecast has moved to £0.9m at M6 this pressure is because of an increase in activity rather than price. The physiotherapy service is seeing a YTD pressure of £0.3m at M6 which is an improvement since M5 (£0.5m YTD), these providers have IAPs in place therefore the expectation is that the activity will be on plan by year end.
  Complex care has seen a slight improvement in month, £0.7m overspend YTD (£0.5m at M5), the forecast remains at £1.2m adverse given the increase in Length of Stay for both short- and long-term placements.
- **Elective, Cancer and Diagnostics £1.3m adverse YTD** and **£0.6m FOT**. The in system acute providers and the independent sector providers are show a YTD adverse, this is being largely mitigated by a reduction in the NCA expenditure where cost is now included in the acute contracts. Activity query notices have been issued to all overperforming IS providers.
- **Mental Health, LD, CYP and Maternity YTD adverse £5.6m** and **£8.4m FOT**. Predominately driven by the ADHD RtC and the S117 budgets, although IAPs are in place with the providers the ICB cannot fully recover this overspend. There is a cost pressure in the other Adult MH budgets due to a shortfall in the S3 budget and an overspend in S12 due to increased activity.
- **All Age Complex and Continuing Care YTD adverse £8.6m** and **FOT £14.5m adverse**. This reflects the continued adverse movement, particularly within the Berks West and Oxford geographies, and the ongoing operational issues. The forecast has been calculated at £14.5m adverse, this includes some risk that was being held outside of the position in M5.

Additional capacity has been brought into the operational team to help with the workload associated with the backlog of invoices and data accuracy issues.

- **Primary Care Prescribing YTD adverse £3.7m** and **FOT £7.2m adverse** there is continued underlying pressure due to ongoing NCSO and concessionary pricing, growth in Endocrine System drugs, Cardiovascular medicines and appliances.
- **Primary Care and POD budget favourable YTD £4.1m** and **FOT £8.4m favourable** this is largely due to YTD underspends in POD and the release of uncommitted dental reserves. The forecast underspend is due to uncommitted dental and other POD reserves and a forecast underspend within the GP delegated budget.

The cost pressures at Month 6 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 **£57.1m** (83.5%) of this target, with **£2.5m** against plans developed but not started and **£8.2m** with plans in progress. The remaining **£0.6m** remains opportunities without fully developed plans.

At Month 6, the programme has delivered £29.7m of savings against a planned £32.5m, resulting in a £2.9m adverse variance to plan, representing a improvement of £1.1m from the £0.5m adverse variance reported at Month 5. 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 £31.2m, savings delivery is £1.5m behind plan. The remaining £1.3m 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 £2.7m delivered against a plan of £3.5m, an adverse variance of £0.8m.
- All-age Continuing Care, delivering £3.4m against a plan of £7.4m, an adverse variance of £4m.
- Community Healthcare, where no savings have been delivered against a planned £0.9m.

These adverse variances are partially offset by Primary Care Prescribing, which has delivered £10.2m against a plan of £7.1m, exceeding plan by £3.1m.

Capital

The ICB capital allocation for 26/27 is **£14.2m** and remains on track to be fully utilised by year end. At M6 the capital expenditure is £6.9m behind plan, primarily due to the profiling assumptions made at the planning stage. £6.9m of the Operational capital schemes are currently progress through the PID process.

Recommendation	N/A

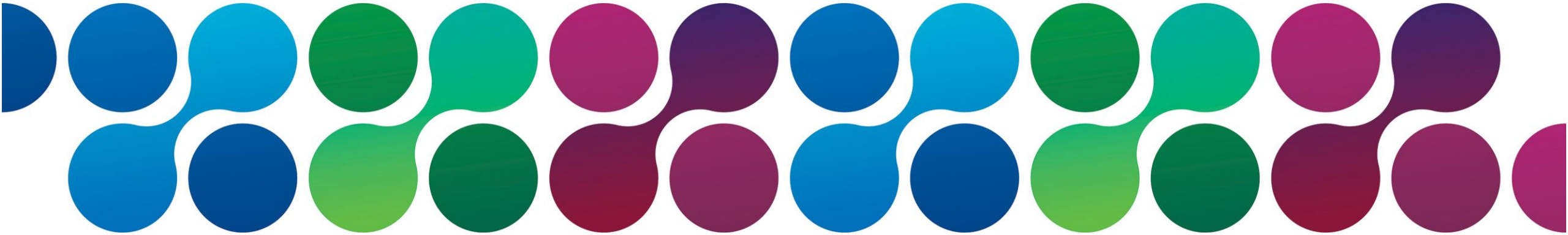
Conflict of interest identified
Yes ☒ No ☐
Members of the Committee have responsibility and/or accountability for performance portfolio included within the report

Reporting – has this paper been discussed at other meetings		
Committee Name	Date discussed	Outcome
Quality, Performance and Finance	22nd October 2026	Noted

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Financial Performance Report

Month 06



Thames Valley ICB Position at M06

Year To Date & Forecast Outturn - break-even

Thames Valley ICB Month 06	YTD Budget	YTD Actual £m	YTD Variance	Annual Budget	Forecast Outturn £m	Forecast Variance
Allocation	(2,909.5)	(2,909.5)	0.0	(5,899.3)	(5,899.3)	0.0
Expenditure	2,909.5	2,909.5	0.0	5,899.3	5,899.3	0.0
Month 06 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 6 (YTD and FOT)

Portfolio Summary YTD & FOT

Thames Valley ICB Month 06	YTD Budget	YTD Actual £m	YTD Variance	Annual Budget	Forecast Outturn £m	Forecast Variance
Total Allocation	**(2,909.5)**	**(2,909.5)**	**0.0**	**(5,899.3)**	**(5,899.3)**	**0.0**
Portfolio						
UEC, Community and Long Term Conditions	364.7	368.3	(3.7)	729.3	732.9	(3.6)
Elective Cancer and Diagnostics	1,522.9	1,524.2	(1.3)	3,071.8	3,072.4	(0.6)
Mental Health, LDA, CYP and Maternity	301.7	307.3	(5.6)	604.9	613.3	(8.4)
All Age Complex and Continuing Care	140.0	148.6	(8.6)	280.0	294.5	(14.5)
Primary Care Prescribing	187.6	191.3	(3.7)	375.3	382.5	(7.2)
Primary Care and POD	387.8	383.7	4.1	789.7	781.3	8.4
Estates	2.1	2.2	(0.1)	4.3	4.3	0.0
Corporate	31.4	31.6	(0.2)	62.8	63.9	(1.1)
Other	0.6	0.5	0.1	0.9	0.9	0.0
Reserves	(29.4)	(48.3)	18.8	(19.6)	(46.6)	27.0
Total Expenditure	**2,909.5**	**2,909.5**	**0.0**	**5,899.3**	**5,899.3**	**0.0**
Month 06 Financial Position (break even)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

UEC, Community & Long-Term Conditions

Cost pressures in the community equipment budget of £1.9m YTD and £1.7m FOT, joint work ongoing with the local authority and mitigation plans are in place to ensure some controls and reviews are implemented . The level of risk has reduced compared to last month.
The Termination of Pregnancy (TOPs) contract continues to experience cost pressures (£0.5m YTD and £0.9m FOT). The cost pressure appears to be a year-on-year increase in activity rather than price. The Physiotherapy contracts are showing a £0.3m YTD adverse variance, a slight reduction from M5 (£0.5m) these providers have IAPs in place and AQPs have been issued. The expectation is that the activity will be in line with plan by year end.
The Complex Care budget is £0.7m YTD adverse and £1.2m FOT adverse due to increase in average Length of Stay in both short and long term. This has improved slightly (£0.4m) from M5. Complex Care will be reported as part of AACCC from M7 onwards.

Elective Cancer and Diagnostic

The in system Acute providers and the independent sector providers are showing a YTD adverse variance of £3.6m and £1.7m, this is being partly mitigated by reductions in NCAs where activity is now included in the contracts. The forecast for this budget is an adverse variance of £0.6m, as AQNs/AMPs are expected to reduce the overspends during the second half of the year.

Mental Health, LDA, CYP & Maternity

Overall **YTD pressure of £5.6m** across the portfolio, ADHD RTC (£3.1m) and S117 (£1.7m remain the primary driven of pressure. There are pressures in the other Adult Mental health budgets mainly the Section 3 and S12 budgets.
A large number of the ADHD RTC providers have IAPs in place but the number of providers continues to grow month on month. The **FOT** for this portfolio is showing a **£8.4m** cost pressure.

All Age Complex and Continuing Care

YTD £8.6m adverse and **FOT £14.5m** adverse. The budget is experiencing significant adverse movements compared to 25/26 outturn. The team have operational capacity issues and issues with the database, additional capacity has been brought into the operational team to help with the workload associated with the backlog of invoices and data accuracy issues.

Prescribing

YTD shows a **£3.7m adverse** variance and **£7.2m FOT adverse,** the YTD has improved slightly from M5 largely as a result of higher than forecast rebate income. The underlying cost pressures continue to be driven by growth in Endocrine System drugs, cardiovascular medicines, appliances, and ongoing NCSO and concessionary pricing pressures. The forecast remains subject to uncertainty as it is based on four months of actual expenditure data, this will be continually reviewed and monitored as more data becomes available

Primary Care and POD

YTD £4.1m favourable and FOT £8.4m favourable, the delegated POD budgets have underspends of £1.9m YTD, the dental reserve is not being fully utilised, £2.2m of this is reflected in the YTD position. The forecast reflects the underspends in the dental and POD reserves and some underspend in the GP delegated budgets.

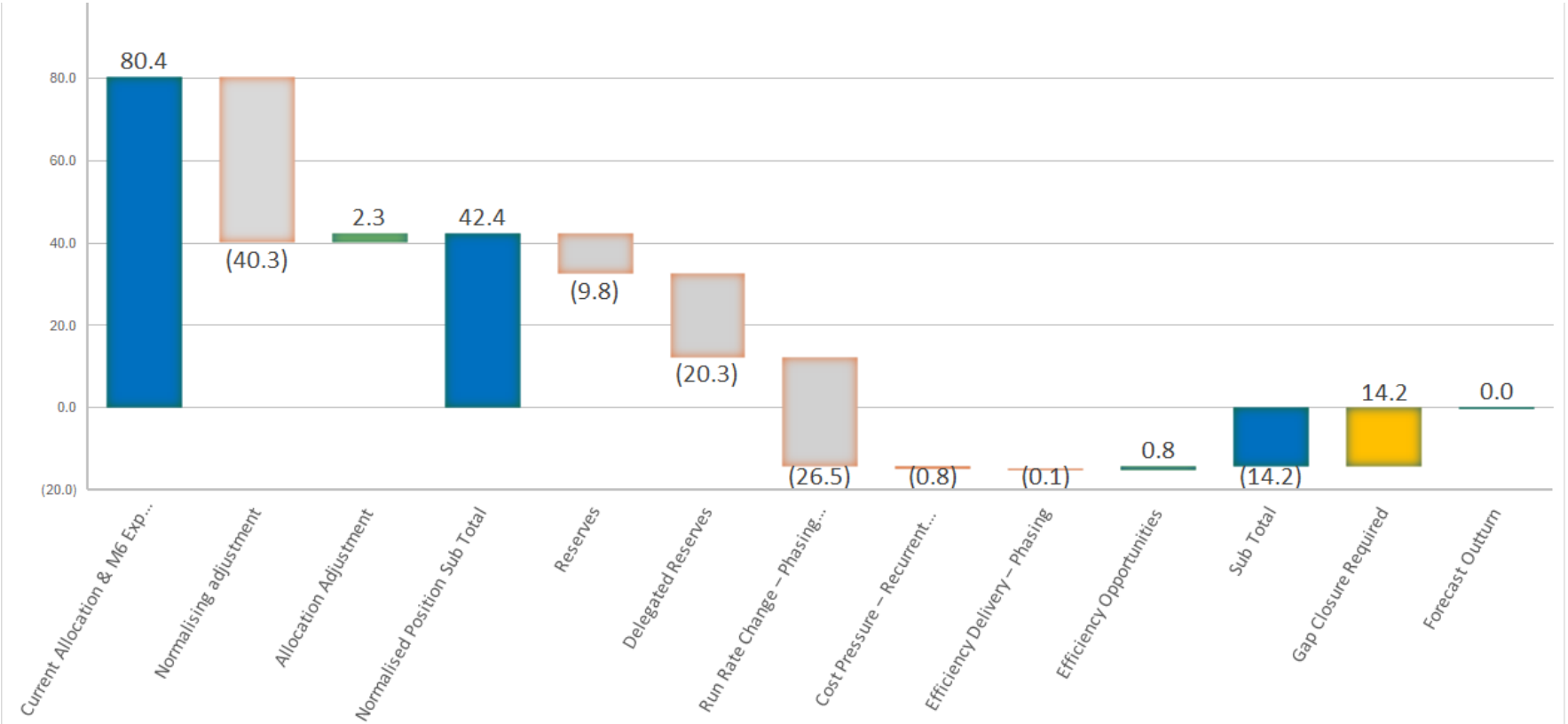
Corporate

The cost pressure YTD and FOT is driven by the overhead charge for the TV Delegated Functions.

The **YTD adverse** variances are fully mitigated by non recurrent benefits at Month 6 and the ICB remains **on plan overall** YTD and FOT.

Run Rate Analysis

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.



ICB Run Rate Bridge	Current Allocation & M6 Exp Run Rate	Normalising adjustment	Allocation Adjustment	Normalised Position Sub Total	Reserves	Delegated Reserves	Run Rate Change – Phasing (Non-Recurrent)	Cost Pressure – Recurrent (Run Rate Impact)	Efficiency Delivery – Phasing	Efficiency Opportunities	Sub Total	Gap Closure Required	Forecast Outturn
£m													
Allocation	**5,899.3**	0.0	0.0	5,899.3	0.0	0.0	0.0	0.0	0.0	0.0	**5,899.3**	0.0	**5,899.3**
Expenditure	**(5,818.9)**	(40.3)	2.3	**(5,857.0)**	(9.8)	(20.3)	(26.5)	(0.8)	(0.1)	0.8	**(5,913.5)**	14.2	**(5,899.3)**
Net	**80.4**	**(40.3)**	**2.3**	**42.4**	**(9.8)**	**(20.3)**	**(26.5)**	**(0.8)**	**(0.1)**	**0.8**	**(14.2)**	**14.2**	**0.0**

The ICB has a **starting surplus of £80.4m** based on a straight-line expenditure run rate and current allocation.

Following normalisation and allocation adjustments, this reduces to a **normalised surplus of £42.4m.**

After reflecting delegated reserves, phasing adjustments, undelivered efficiencies and cost pressures, the position moves to a £14.2m 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.

Month 6 Efficiency Plan Delivery Summary

Budget Area	Executive Lead	YTD M6 Plan £m	YTD M6 Actual £m	YTD M6 Variance £m	Financial Plan £m
Acute	Hannah Iqbal	0.2	0.0	0.2	0.3
Acute IS	Hannah Iqbal	5.5	5.4	0.1	11.0
All-Age Continuing Care	Sarah Bellars	7.4	3.4	4.0	14.8
Community Healthcare	Hannah Iqbal	0.9	0.0	0.9	1.7
Mental Health	Sarah Bellars	3.5	2.7	0.8	7.0
Primary Care (inc. Primary Co-Commissioning)	Hannah Iqbal	0.0	0.0	-0.0	0.0
Primary Care Prescribing	Lalitha Iyer	7.1	10.2	-3.1	14.2
Running Cost	Richard Chapman	8.0	8.0	-0.0	15.9
Other Programme	Richard Chapman	0.0	0.0	0.0	0.0
Total		32.5	29.7	2.9	65.0
Acute - Avoidance of anticipated demand growth - left shift, contract levers		14.0	14.0	0.0	28.0
2% Contract Efficiency		34.5	34.5	0.0	69.0
Total Delivery against Financial Plan Submission		81.0	78.2	2.9	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.
Schemes totalling £68.4m have been identified against the £65.0m CIP target, providing £3.4m of headroom and demonstrating that sufficient opportunities have been identified to achieve the target.
At Month 6, CIP delivery is £29.7m against a planned £32.5m, representing an adverse variance of £2.9m (9%).
Current forecasts indicate a realistic year-end delivery of £60.0m, reducing to £48.7m under the current risk assessed worst case forecast.
Forecast under-delivery is primarily driven by challenges within All-Age Continuing Care and Mental Health (ADHD Right to Choose) schemes, which continue to present significant delivery risks.
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.
In response, the ICB is strengthening financial control arrangements and programme governance to increase the pace of CIP identification and delivery, prevent further deterioration in performance, and mitigate the forecast shortfall against plan.

Capital

Month 6 TVICB gross capital expenditure was £6.9m below plan, primarily due to the profiling assumptions made during the planning stage.

Operational Capital Schemes: £6.9m 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)	563	0	563	1,125	1,125	0
Operational Capital Digital	1,640	0	1,640	3,279	3,279	0
System Strategic Projects	3,600	0	3,600	7,199	7,199	0
Digital ARRS	0	0	0	513	513	0
IFRS 16 Impact	50	0	50	100	100	0
National Programmes - UMF	1,000	0	1,000	2,000	2,000	0
Total CDEL	**6,852**	**0**	**6,852**	**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 6 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 50% of PIDs have now been submitted to NHS England for approval.

NHS
Thames Valley

Thames Valley Integrated Care Board

Public Board November 2026

Title of Paper	ICB response to Thirlwall Inquiry		
Agenda Item	6	**Date of meeting**	18th November 2026
Exec Lead	Sarah Bellars, CNO		
Author(s)	Sarah Bellars, CNO		

Purpose	To Approve	☐
	To Ratify	☐
	To Discuss	☐
	To Note	X

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

Executive Summary

The publication of the Thirlwall Inquiry represents a significant and sobering moment for the NHS. At the heart of the report are the babies who died or were harmed and the devastating impact on their families.

The Board acknowledges the profound suffering experienced by those families and recognises the courage of parents and staff who raised concerns in pursuit of answers and accountability.

The Inquiry reinforces the importance of patient safety, transparency, compassionate leadership and organisational culture across all NHS organisations. [gov.uk], [england.nhs.uk]

Whilst the Inquiry focused on events within a provider organisation, the findings have implications across the wider health system, including commissioners, regulators and system leaders. NHSE required all ICB and Trust Boards to review the report and consider the findings of the Thirlwall Inquiry at its next Board meeting, following publication of the report in September 2026.

This paper considers the relevance of the Inquiry to NHS Thames Valley ICB, outlines existing governance and assurance arrangements and highlights work already underway that aligns with several of the themes emerging from the Inquiry.

These include strengthening:

- Freedom to Speak Up arrangements
- Maintaining perinatal safety oversight
- Undertaking a system-wide maternity and neonatal commissioning review
- developing a closer working relationship with the Thames Valley and Wessex Neonatal Network through attendance at their programme board meetings and their team attendance at PSCG and PQO
- Working jointly with NHS England on provider insight visits.

This paper represents an initial reflection on the implications for the ICB. Further work will be undertaken following publication of the Government and NHS England implementation response.	
Recommendation	The Board is asked to: 1. Note the findings of the Thirlwall Inquiry 2. Acknowledge the devastating impact on affected babies and families. 3. Note the actions already underway across NHS Thames Valley ICB. 4. Support further review of local arrangements once the Government and NHS England implementation response is published. 5. Receive a further update through the appropriate Board committee structure.

Conflict of interest identified
Yes ☐ No X
Detail

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

Thames Valley ICB response to Thirlwall Inquiry

1. Purpose

To:

- Acknowledge the findings and significance of the Thirlwall Inquiry.
- Consider the implications for NHS Thames Valley ICB as a commissioner and system leader.
- Review current governance and assurance arrangements.
- Highlight work underway that aligns with themes emerging from the Inquiry.
- Agree a programme of further review once the national response is confirmed.

2. Background

The Thirlwall Inquiry was established to examine the circumstances surrounding events at the Countess of Chester Hospital and the organisational, professional and systemic factors that contributed to failures in recognising, escalating and responding to concerns.

The Inquiry identified recurring themes relating to:

- Patient safety.
- Organisational culture.
- Freedom to Speak Up.
- Safeguarding.
- Clinical governance.
- Leadership and accountability.
- Duty of candour.
- Learning from incidents and deaths.
- Escalation of concerns.
- Listening to families and frontline staff. Although the events occurred within a provider organisation, the Inquiry emphasises that the lessons are relevant across the NHS and should be considered by Integrated Care Boards as well as provider organisations.

3. Why This Matters to NHS Thames Valley ICB

As a commissioning organisation, the ICB does not directly provide maternity, neonatal or acute clinical services. However, the ICB has statutory responsibilities in relation to:

- Improving the quality of commissioned services.
- Safeguarding.
- Population health.
- Strategic commissioning.
- System leadership.
- Patient safety improvement.
- Oversight of commissioned services

The Inquiry therefore provides an important opportunity for reflection on whether current arrangements effectively support the identification, escalation and response to emerging concerns and whether the voices of women, families, staff and communities are sufficiently reflected in decision-making.

The findings reinforce the importance of considering intelligence from multiple sources and avoiding reliance on a single mechanism of assurance.

4. Key Themes Relevant to Commissioners

Culture and Speaking Up

The Inquiry highlights the importance of cultures in which concerns can be raised safely, heard openly and acted upon appropriately. Effective Freedom to Speak Up arrangements are essential but, in themselves, are not sufficient unless supported by a culture of openness, curiosity and learning.

Listening to Patients and Families

The experiences of patients and families must be heard, valued and incorporated into decision-making. The Inquiry highlights the risks that can arise where concerns raised by families are not fully recognised or understood.

Patient Safety and Escalation

The Inquiry demonstrates the importance of identifying weak signals, triangulating information from multiple sources and escalating concerns promptly where emerging risks are identified. https://thirlwall.public-inquiry.uk/the-report/

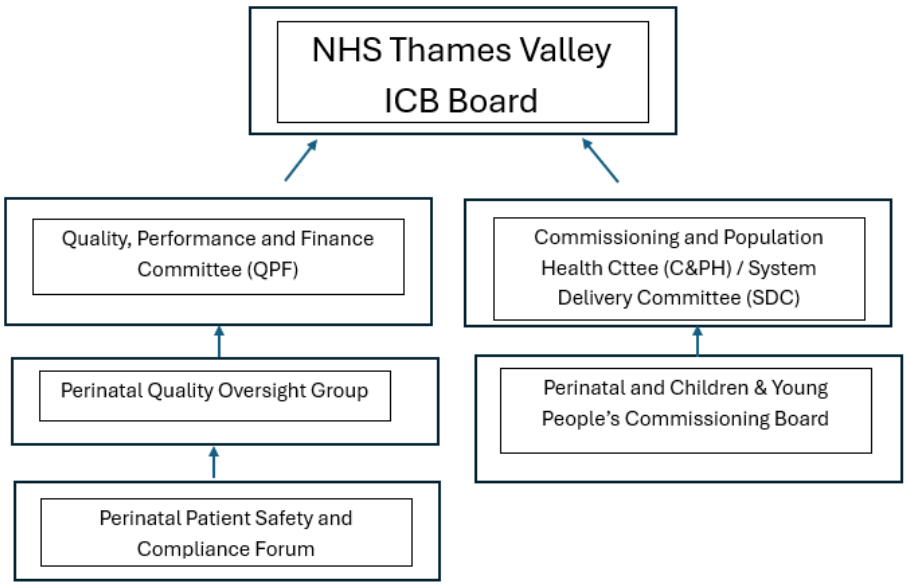
Governance and Accountability

The report reinforces that governance structures alone do not guarantee safe care. Assurance must be supported by professional curiosity, constructive challenge, transparency and effective organisational leadership.

5. Current Governance and Oversight Arrangements

The ICB has established governance arrangements through both quality and commissioning routes, recognising the importance of triangulating intelligence from multiple sources and ensuring that quality, safety, experience, commissioning and population health intelligence are considered through complementary governance pathways.

Governance Structure



The Board should note that NHS Thames Valley has deliberately established complementary quality and commissioning oversight routes. This reflects the importance of considering intelligence from multiple sources and avoiding reliance on a single mechanism of assurance, a theme strongly reflected throughout the Inquiry.

Quality and Safety Route

The Thames Valley Perinatal Patient Safety and Compliance Forum provides a psychologically safe environment in which organisations can:

- Share learning from patient safety incidents.
- Review national guidance and recommendations.
- Discuss emerging risks and safety concerns.
- Consider compliance with national requirements.
- Identify opportunities for improvement.
- Escalate concerns where appropriate.

The Forum reports through the Perinatal Quality Oversight Group (PQOG) and onwards through the quality governance route to the Quality, Performance and Finance Committee (QPF Committee).

The ICB also receives intelligence from:

- Patient safety reporting.
- Complaints and patient experience.
- Safeguarding processes.
- Freedom to Speak Up.
- Maternity Outcomes Surveillance System (MOSS) alerts.

- Joint NHS England and ICB insight visits.
- The Thames Valley and Wessex Neonatal Network Programme Board

Commissioning and Population Health Route

Strategic oversight is provided through the Perinatal and Children and Young People's Commissioning Board, which reports through the Population Health and Commissioning Committee (PHCC).

Together these governance arrangements support consideration of intelligence relating to quality, safety, patient experience, commissioning, inequalities and population need from different perspectives and provide routes for escalation through formal Board committees where appropriate.

6. Freedom to Speak Up

Following publication of the Inquiry, NHS Thames Valley ICB has revised its Freedom to Speak Up Policy to reflect emerging learning, including themes identified within Chapter 40.

The ICB has additionally appointed a dedicated Non-Executive Director to provide independent oversight and assurance in relation to Freedom to Speak Up arrangements.

The ICB will continue to review speaking up intelligence alongside workforce, safeguarding, patient safety, complaints and patient experience information to identify themes requiring further attention.

7. Strategic Commissioning and Service Planning

The ICB is currently undertaking a system-wide review of maternity and neonatal services across Thames Valley. The review has been commissioned to establish a comprehensive commissioning baseline and assess whether commissioning arrangements remain aligned to population need, service-user expectations, national policy and contemporary models of care.

The purpose of the review is not to performance manage providers. Rather, it is intended to help the ICB understand whether current commissioned services remain aligned with population need and whether future commissioning intentions support the best possible outcomes for women, babies and families across Thames Valley.

The review includes engagement with:

- Women and families.
- Maternity and Neonatal Voices Partnerships.
- Clinicians and provider organisations.
- Local authorities.
- Healthwatch.
- Health Overview and Scrutiny Committees.

- Members of Parliament.
- NHS England and wider system partners.
- The Thames Valley and Wessex Neonatal Network

Although commissioned independently of the Inquiry, the review aligns with several of its broader themes, including listening to the experiences of women and families, understanding changing patterns of need and risk, drawing intelligence from multiple sources and ensuring services evolve in response to evidence, learning and population need.

8. Quality Intelligence and Provider Engagement

The ICB works closely with NHS England regional colleagues to support quality oversight and system learning.

As part of this approach, the ICB and NHS England are undertaking joint maternity insight visits with provider organisations. These visits provide opportunities to understand culture, governance arrangements, patient safety processes and the experiences of frontline teams and service users.

Visits have been completed at:

- Royal Berkshire NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust

A visit to Buckinghamshire Healthcare NHS Trust is scheduled for 4 November 2026, with a visit to Frimley Health NHS Foundation Trust planned for 9th and 14th December

These visits complement information received through formal governance arrangements and provide an additional source of intelligence and triangulation.

9. Areas for Further Development

Pending publication of further national guidance, the ICB will:

1. Undertake a detailed review of relevant recommendations and implementation requirements.
2. Review how intelligence from patients, families, staff and partners is triangulated across governance structures.
3. Review existing escalation pathways across patient safety, quality and safeguarding functions.
4. Continue development of Freedom to Speak Up arrangements.
5. Review learning arising from joint provider insight visits.
6. Report progress through both the Quality, Performance and Finance Committee and the Population Health and Commissioning Committee.

10. Risks and Considerations

Failure to appropriately consider and respond to the learning arising from the Inquiry may increase the risk of:

- Missed opportunities to identify emerging concerns.
- Reduced confidence in governance and oversight arrangements.
- Failure to fully incorporate the voices of patients, families and staff in decision-making.
- Reputational impact for the NHS.

The actions outlined within this report are intended to support continual improvement in commissioning, quality oversight and patient safety arrangements of commissioned services.

11. Conclusion

The Board acknowledges the profound suffering experienced by the babies and families at the centre of the Thirlwall Inquiry and recognises the courage of those who repeatedly raised concerns.

The Inquiry demonstrates that effective assurance depends not solely upon governance structures but upon organisational culture, professional curiosity, transparency, challenge and a willingness to act when concerns are raised.

NHS Thames Valley ICB has established complementary governance arrangements through both quality and commissioning routes, reporting through the Quality, Performance and Finance Committee and the Population Health and Commissioning Committee. These arrangements are intended to bring together intelligence relating to quality, safety, experience, population need and strategic commissioning to support learning, oversight and improvement across the system.

The Board is invited to view the Inquiry as an opportunity for continued reflection and learning and to support ongoing work to ensure that commissioning, quality and patient safety arrangements remain responsive to the needs of women, babies, families and staff across Thames Valley.

NHS
Thames Valley

Thames Valley Integrated Care Board

ICB Board

Title of Paper	**NHS England Quality Strategy for NHS-Funded Care in England (Published 14 July 2026)**		
Agenda Item	7	**Date of meeting**	18 November 2026
Exec Lead	Sarah Bellars CNO		
Author(s)	Sarah Bellars		

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

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

Executive Summary

Executive Summary

The new National Quality Board strategy represents the most significant national reframing of quality oversight since *High Quality Care for All* (Darzi, 2008). It establishes **quality as the organising principle of NHS-funded care** and provides a single framework for improving outcomes over the next decade.

The strategy moves beyond a predominantly safety-focused approach and introduces a more balanced emphasis on three equally important domains of quality:

1. **Safety**
2. **Effectiveness**
3. **Experience**

For ICBs, the strategy signals a shift from assurance-focused quality oversight towards **strategic leadership of quality improvement, reduction of variation, improvement in outcomes and experience, and tackling inequalities through commissioning and system leadership.**

This is particularly relevant in the context of the NHS Model ICB Blueprint and the transfer of some provider oversight responsibilities away from ICBs. The strategy reinforces that although operational oversight models may change, ICBs retain a statutory duty to secure continuous improvement in quality across NHS-funded services.

Recommendation	The Board are asked to: 1. Note the publication of the National Quality Board's Quality Strategy for NHS-funded Care in England. 2. Agree that a gap analysis is undertaken against the strategy. 3. Acknowledge that a review of existing quality governance arrangements to ensure alignment with the new framework

	and the emerging Thames Valley ICB operating model will be undertaken.

Conflict of interest identified
Yes ☐ No ☒
Detail

Reporting – has this paper been discussed at other meetings		
Committee Name	Date discussed	Outcome
Thames Valley Executive Committee	Monday 3rd August	Recommendations Approved

NHS
Thames Valley

Overview of NHS England Quality Strategy for NHS-Funded Care in England (Published 14 July 2026) and implications for ICB's

Purpose

To provide the Thames Valley Board with a summary of the newly published Quality Strategy for NHS-funded Care in England, highlight the implications for Integrated Care Boards (ICBs), and identify the key actions required to ensure compliance and readiness.

Executive Summary

The new National Quality Board strategy represents the most significant national reframing of quality oversight since *High Quality Care for All* (Darzi, 2008). It establishes **quality as the organising principle of NHS-funded care** and provides a single framework for improving outcomes over the next decade.

The strategy moves beyond a predominantly safety-focused approach and introduces a more balanced emphasis on three equally important domains of quality:

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2. **Effectiveness**
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For ICBs, the strategy signals a shift from assurance-focused quality oversight towards **strategic leadership of quality improvement, reduction of variation, improvement in outcomes and experience, and tackling inequalities through commissioning and system leadership.**

This is particularly relevant in the context of the NHS Model ICB Blueprint and the transfer of some provider oversight responsibilities away from ICBs. The strategy reinforces that although operational oversight models may change, ICBs retain a statutory duty to secure continuous improvement in quality across NHS-funded services.

Background

The strategy was published by NHS England on behalf of the National Quality Board on 14 July 2026. It supports delivery of the NHS 10-Year Health Plan and establishes a common framework for quality improvement across all NHS-funded care.

The stated aims are to:

- Improve health outcomes.
- Improve patient satisfaction and experience.
- Reduce health inequalities.
- Ensure high-quality care is delivered consistently regardless of geography or population group.

Key Policy Messages

1. Quality becomes the organising principle of the NHS

The strategy explicitly states that quality should once again be the primary organising principle of NHS care and decision-making. Quality is expected to drive priorities, investment decisions, improvement activity and performance management.

Implication for ICBs

Commissioning decisions, transformation programmes and resource allocation should be demonstrably linked to improvements in safety, effectiveness and experience rather than activity alone.

2. Equal emphasis on the three domains of quality

Historically, quality governance has often focused most heavily on safety metrics. The new strategy places equal weight on:

- Patient safety
- Clinical effectiveness
- Patient experience

Implication for ICBs

Executive reporting frameworks and quality dashboards will need to demonstrate balanced oversight of all three domains.

Potential review areas include:

- Board Assurance Framework metrics
- Quality and Performance Committee reporting
- Commissioning outcomes frameworks
- Provider quality review mechanisms

3. Greater focus on outcomes and reducing unwarranted variation

The strategy emphasises improving outcomes that matter to patients and reducing variation in quality between organisations, services and populations.

Implication for ICBs

ICBs will increasingly be expected to:

- Use disaggregated data intelligence
- Benchmark providers and place
- Address unwarranted variation.
- Target improvement support where outcomes are poorest.

4. Quality and inequalities are inseparable

A key shift is the expectation that quality improvement activity must actively reduce inequalities rather than treat them as a separate workstream.

Implication for ICBs

Quality governance arrangements should routinely consider:

- Core20PLUS5 outcomes
- Access inequalities
- Experience inequalities
- Protected characteristics
- Inclusion health groups

This aligns well with existing Thames Valley approaches to quality and health inequalities.

5. Increased emphasis on patient experience and trust

The strategy identifies restoring public confidence and improving people's experience of care as a national priority. Experience is defined as compassionate, coordinated and responsive care delivered by supported staff.

Implication for ICBs

There is likely to be increasing scrutiny of:

- Complaints intelligence
- PALS feedback
- Patient experience measures
- Co-production and involvement
- Learning from lived experience

6. Stronger accountability for quality

The strategy identifies a need for clarity regarding who is responsible and accountable for quality at every level of the system.

Implication for ICBs

Boards will need confidence that:

- Executive quality leadership roles are clear.
- Accountability arrangements are documented.
- Quality governance arrangements remain effective during ICB transition and restructuring.

This is particularly important during the move towards the new Thames Valley ICB arrangements.

National Priority Areas

The strategy identifies several areas requiring immediate focus:

- Improving outcomes and reducing variation
- Maintaining patient safety across all settings
- Improving patient experience and restoring trust
- Reducing inequalities
- Improving maternity and neonatal care
- Monitoring clinical and population health outcomes

Many of these areas already feature within existing ICB quality strategies and board assurance frameworks.

What Are the Key Changes for ICBs?

The most significant changes are:

Previous emphasis	New emphasis
Assurance and escalation	Improvement and outcomes
Provider-focused oversight	System-wide quality leadership
Safety as the dominant quality measure	Equal focus on safety, effectiveness and experience
Organisational performance	Population outcomes and equity
Reactive quality monitoring	Continuous improvement culture
Separate quality and inequalities workstreams	Integrated quality and inequalities approach

This represents a maturation of the ICB role from quality assurance towards strategic quality stewardship across the system.

Must-Dos for the ICB

Immediate (next 3 months)

1. **Undertake a gap analysis** against the Quality Strategy and accompanying system letter.
2. **Review Board and committee reporting** to ensure balanced reporting across safety, effectiveness and experience.
3. **Refresh the Quality Strategy and Quality Governance Framework** to align with the national framework.
4. **Map accountability for quality** across the ICB, neighbourhood and provider collaborative arrangements.
5. **Ensure inequalities are embedded in all quality reporting** rather than reported separately.

Medium-Term (2026/27)

1. Develop an integrated quality dashboard that imbeds inequalities and is structured around:
    - Safety
    - Effectiveness
    - Experience

1. Strengthen use of complaints, patient feedback and lived-experience data within quality governance.

2. Align transformation programmes and commissioning priorities with measurable quality outcomes.

3. Ensure quality leadership arrangements remain robust throughout implementation of the Model ICB Blueprint and wider organisational transition.

Risks

Failure to align with the strategy may result in:

- Reduced assurance regarding statutory quality duties.
- Fragmented quality governance arrangements.
- Inability to demonstrate delivery of the NHS 10-Year Health Plan quality objectives.
- Increased national scrutiny of quality leadership and governance arrangements.

Recommendation

The Board is asked to:

- Note the publication of the National Quality Board's Quality Strategy for NHS-funded Care in England.
- Agree that a gap analysis is undertaken against the strategy.
- Acknowledge that a review of existing quality governance arrangements to ensure alignment with the new framework and the emerging Thames Valley ICB operating model will be undertaken.

Overall assessment:

The strategy aligns closely with the direction of travel already underway within the emerging Thames Valley ICB. The principal challenge is not the introduction of wholly new requirements but ensuring that quality, inequalities, patient experience and outcomes are embedded consistently across commissioning, transformation and governance arrangements.

NHS
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Thames Valley Integrated Care Board

Title of Paper	Planning Update		
Agenda Item	8	**Date of meeting**	18 November 2026
Exec Lead	Sam Burrows, Deputy Chief Executive Officer		
Author(s)	Kate Holmes, Director of Strategic Finance & Planning Paul Swan, Head of Strategic Commissioning Operations		

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

Link to Strategic Objective	*Relates to all strategic objectives*

Executive Summary

This paper provides an update on progress with the 2027/28 planning process since the System Delivery Committee considered the Thames Valley planning approach on 22 October 2026, which covered the planning framework, workstreams or system governance. This paper focuses on the developing planning position, the work completed during the intervening period, the emerging high-level financial position, and the remaining actions and governance required ahead of the first planning submission, currently assumed to be 17 December 2026.

Since 22 October, planning has moved from mobilisation and architecture into active development and challenge of the underlying financial, activity, performance, workforce and commissioning assumptions. Weekly Executive-level oversight is integrating the workstreams; Commissioning Boards and portfolio teams are prioritising a smaller number of material interventions; demand and scenario modelling is being linked to finance and contracts; and the first gateway for identifying potential 1% Transformation Fund priorities was reached on 6 November.

The emerging financial assessment identifies a substantial challenge. Work is focused on validating the recurrent baseline, quantifying operational and commissioning requirements, aligning assumptions with providers and developing credible mitigations sufficient to support submission of a balanced plan.

The next critical gateway is 23 November, when priority commissioning and transformation proposals are expected to be quantified across finance, demand, activity and performance for Years 1 to 3, with particular focus on 2027/28. The plan will then be triangulated and tested through Executive, committee, system and Board assurance ahead of the projected submission date of 17 December.

Recommendation	The Board is asked to: • **Note** progress with development of the 2027/28 ICB plan since the System Delivery Committee update on 22 October 2026. • **Note** the emerging high-level financial planning position and the actions underway to validate assumptions and develop a balanced and deliverable plan.

	• **Endorse** the approach to prioritising and quantifying Commissioning Intentions and transformation opportunities as part of an integrated planning process. • **Support** the proposed assurance and governance route to the first planning submission, currently assumed to be 17 December 2026. • **Note** that material strategic choices, unresolved risks and any areas of planned non-compliance will be escalated through Executive and Board governance as the plan develops.

Conflict of interest identified
Yes ☐ No ☒
Detail

Reporting – has this paper been discussed at other meetings		
Committee Name	Date discussed	Outcome
Executive meeting	9/11/2026	Noted

Thames Valley ICB

Planning Update

Purpose and current position

1. The System Delivery Committee paper of 22 October established the planning architecture for Thames Valley, including the expected organisational outputs, the use of a shared evidence base, the relationship between ICB and provider plans, the financial and transformation approach, the principal planning workstreams and the system governance arrangements. Those principles remain unchanged.
2. National planning guidance for 2027/28 has not yet been issued. Pending confirmation, the ICB continues to use the existing national framework, the year-two assumptions within the multi-year planning period, and advice received from the NHS England regional team. The working assumption remains a first submission on 17 December 2026 and a second submission in early February 2027. These dates and requirements will be updated when national guidance is confirmed.
3. The focus of the current phase is therefore not further design of the planning architecture. It is to convert the agreed approach into a coherent, evidence-based and affordable plan, make material choices visible, reconcile the ICB and provider assumptions, and secure the necessary organisational and system assurance within a compressed timetable.

Progress

4. The following table summarises the progress made by 10 November (time of writing) since System Delivery Committee on 22 October.

Area	Progress and emerging position
Planning leadership and control	Executive planning roles and the governance framework have been established. Weekly Planning Executive meetings are being used to integrate workstreams, challenge assumptions, assign actions and escalate key issues.
Commissioning Boards and portfolios	The four Commissioning Boards and portfolio teams have been briefed and mobilised around the planning process and requirements. They are identifying a smaller number of high-impact priorities, assigning senior ownership and developing evidence on need, intervention, phasing and expected impact.
Demand, activity and performance	Work has commenced to develop a do-nothing demand trajectory and priority scenarios. Portfolio sessions are considering current trajectories, operational requirements and the implications of interventions, including

	areas where commissioner and provider assumptions require reconciliation.
Finance and contracts	The initial 2027/28 financial position has been established, with work now focused on validating the recurrent baseline, aligning assumptions with providers and quantifying operational requirements. Activity-led contract baselines, commissioning and transformation impacts, and a deliverable efficiency programme are being developed to address the emerging financial challenge.
Workforce, quality and equality	The three-year workforce plan and assurance of quality, safety, equality and inequalities implications are being developed alongside the substantive proposals, rather than as separate end-stage products.
Transformation Fund	The first-stage gateway was reached on 6 November for Commissioning Boards and Health and Care Partnerships to identify potential priorities. These are initial propositions, not approved investments. The next stage includes the quantification of proposals, particularly with respect to forecast costs, and expected impact.
System alignment	The next phase requires increasingly detailed provider engagement to validate the activity and expenditure baseline, align financial and operational assumptions, identify dependencies and maintain plan-to-contract coherence.

Executive planning oversight

5. The Weekly Planning Executive has moved into active oversight of the integrated position. The work now brings together finance, analytics, operational performance, commissioning and contracting to enable coherent plan development. The Executive discussions have focused on the structure of the financial bridge, the underlying 2026/27 position, demand and scenario modelling, provider data and baselines, prioritisation of Commissioning Intentions, and areas requiring targeted analysis or Executive choice.
6. This is supporting clearer planning discipline: establish the reality baseline; apply agreed demand, performance and business-rule assumptions; identify a focused set of interventions; quantify the financial, activity and performance effects; avoid double counting; and surface residual gaps and risks for decision.

Commissioning Board and portfolio planning

7. The *Thames Valley Commissioning Intentions 2027/28–2030/31* remain the strategic framework for the 2027/28 operational plan and the longer-term five-year Strategic Commissioning Plan. Since 22 October, the emphasis has shifted from describing the intentions to translating them into a prioritised and deliverable portfolio.
8. Commissioning Boards and portfolio teams have been asked to identify the highest-impact opportunities and ensure that each priority is sufficiently developed to answer the following questions:

- What population, pathway or performance problem is being addressed?
- What specific commissioning or service intervention is proposed?
- What impact is expected on outcomes, inequalities, demand, activity, performance, workforce and finance?
- What investment, productivity, redesign, recommissioning or disinvestment is required?
- Which providers, Health and Care Partnerships, primary care partners or collaboratives need to shape and test the proposal?
- What can be delivered in 2027/28, and what benefits are expected over Years 1 to 3?

9. Focused portfolio planning sessions are beginning to test these priorities against current activity and performance, existing trajectories, financial and contractual baselines and the analytical evidence. The discussions are identifying where assumptions need further validation, where commissioner and provider positions need to be reconciled, and where choices between priorities or performance ambitions may need to be made explicit through Executive and Board assurance.

Transformation Fund

10. The Transformation Fund is focused on addressing priority pathways and progressing delivery of proactive and preventative care models. The first-stage deadline for Commissioning Boards and Health and Care Partnerships to identify potential transformation priorities was 6 November. The initial returns are intended to provide a view of the opportunity pipeline and enable related proposals to be aligned, duplication reduced and opportunities for Thames Valley-wide development identified. They do not constitute approval of individual investments.
11. The next gateway is 23 November. The proposals are expected to be quantified, including the population or pathway affected, intended outcomes, implementation requirements, activity and demand effects, financial impact, and quality implications, dependencies, risks and potential sources of resource. The process remains a collaborative strategic planning exercise, not a competitive bidding round.

Emerging financial planning position

12. The financial plan is being developed as an integral part of the wider planning process. It brings together expected demand for services, operational performance requirements, workforce implications, commissioning priorities, transformation proposals and the resources available to the ICB. The first assessment identifies a substantial financial challenge. The current planning position is not balanced and further action is required before a balanced and deliverable plan can be submitted.

Context

13. As outlined above, no further national guidance or updated financial allocations for 2027/28 have been issued beyond those published in autumn 2025 to support the multi-year planning process, of which 2027/28 is year two.

14. The ICB is therefore using the previously notified allocations and planning assumptions as the initial basis for developing its 2027/28 financial plan. These will be updated as further national guidance, allocations or requirements are confirmed.

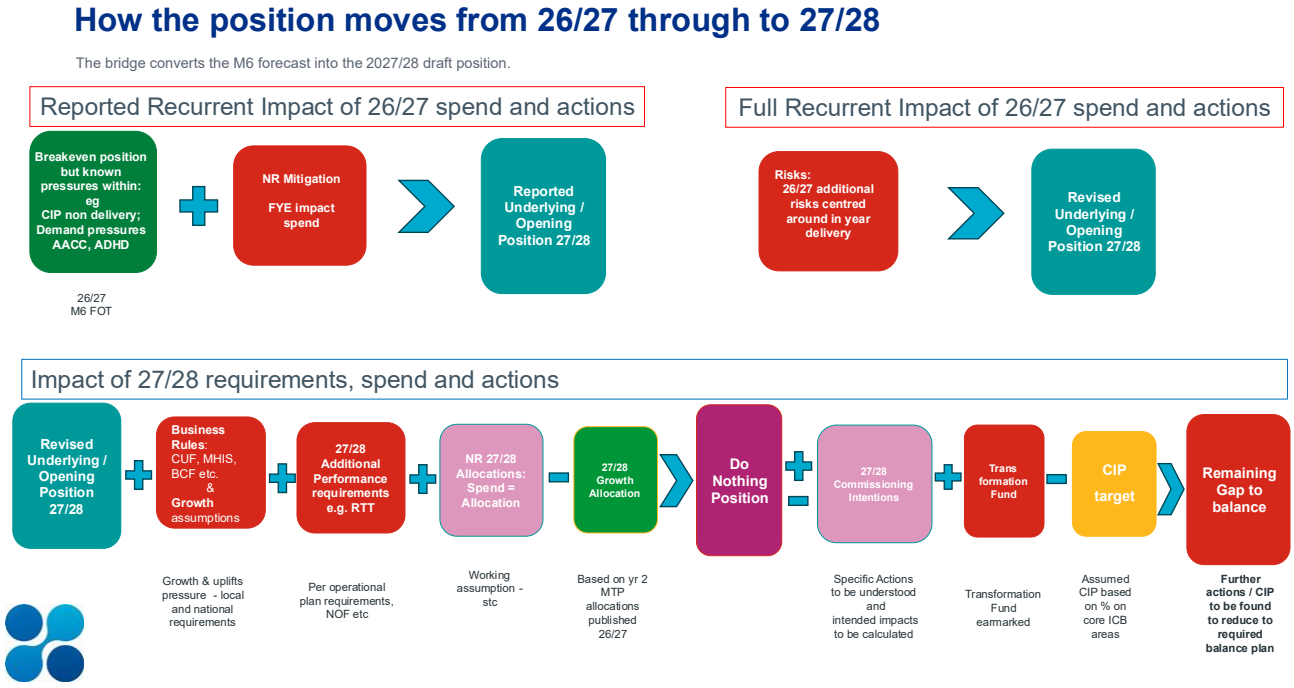
Financial planning approach

15. The ICB is developing an evidence-based financial plan aligned with planned activity, operational performance, workforce and commissioning priorities.

16. The approach is intended to ensure that:

    - the underlying causes of expenditure and income movements are transparent;
    - assumptions are clearly stated, evidenced and consistently applied;
    - the recurrent consequences of the 2026/27 position are fully understood;
    - financial, activity and performance assumptions are aligned across the ICB and its providers;
    - savings and other mitigating actions are realistic, quantified and assigned to accountable owners; and
    - the final plan supports operational delivery and longer-term financial sustainability.

17. The financial plan build starts with the 2026/27 forecast outturn and adjusts this to identify the recurrent opening position for 2027/28. It then reflects known national and local planning assumptions, demand and performance requirements, transformation and commissioning priorities, efficiencies and other mitigating actions to establish the remaining gap to balance. This is outlined in the diagram below.



18. This approach recognises that the pattern of expenditure, activity and performance in 2026/27, together with the recurrent or non-recurrent nature of actions taken during the year, will affect both the opening position and the cost of delivering services in 2027/28.

Progress in developing the plan

19. Accountability for ICB budgets has been confirmed, supported by routine financial reporting and regular executive review of expenditure, forecast out-turn, savings delivery and recovery actions.

20. Finance teams are working with budget holders and executive leads to assess the recurrent implications of the 2026/27 position, including the relationship between expenditure, commissioned activity and operational performance.

21. The ICB financial recovery plan is intended to accelerate in-year action, reduce in-year pressures and minimise the level of recurrent risk carried into 2027/28.

22. Work is under way to align activity, performance, expenditure and income assumptions between the ICB and system providers, reducing the risk of unrecognised pressures or inconsistent planning assumptions. Multidisciplinary Executive Meetings (MDEMs), led jointly by the Chief Finance Officer and Interim Chief Strategy and Commissioning Officer, have been established to reconcile any material differences and assess the implications for 2027/28 plans.

23. The **Thames Valley Demand and Scenario Model** is being used to establish activity-led contract baselines and test the financial and operational effects of demand growth, performance requirements and potential interventions. This allows the do-nothing scenario and alternative interventions to be tested at contract, specialty and ICB level.

24. The model will form the analytical basis for the activity-led contract baselines commissioned for 2027/28, supporting explicit alignment between activity, finance and performance. It will also enable the impact of transformation opportunities to be modelled over future years, providing a consistent evidence base for the ICB's strategic commissioning approach.
25. The Demand and Scenario Model covers a significant proportion of ICB expenditure linked to activity-based contracts. Other material areas including All Age Continuing Care (AACC), prescribing, primary care and running costs are being planned through complementary processes.
26. Initial **national business- rule assumptions** have been applied in line with the NHS England year-two multi-year planning assumptions. These include, for example, a cost uplift factor offset by a general efficiency requirement, together with minimum investment requirements for the Mental Health Investment Standard (MHIS) and Better Care Fund (BCF). These remain subject to confirmation and detailed application within individual budgets and contracts.
27. The additional cost of delivering **2027/28 operational requirements**, including further improvement in Referral to Treatments (RTT) is being modelled so that high level assumptions can be replaced by a more detailed evidence base.
28. TVICB published its **Commissioning Intentions** on 30 September. Work is continuing with commissioning leads to translate these into defined actions, delivery measures and financial effects. These will be included in the plan once they have been sufficiently developed, assessed and approved.
29. The ICB has committed to establishing a **Transformation Fund**, and the full value is included within the high-level financial plan. The source of funding remains under review because the Fund cannot be supported from growth alone. This approach will require the ICB and partners to consider how existing resources can be redirected towards higher-value, preventative and more sustainable models of care. The governance and investment process is as described elsewhere in this paper. As individual schemes and their impacts are confirmed and agreed, specific investments will be incorporated into contracts and budget plans.
30. The high-level plan includes a provisional **Cost Improvement Programme (CIP)** requirement in addition to the general efficiency assumption. The final requirement may change as the recurrent impact of 2026/27 expenditure and recovery actions are confirmed. Work is underway to develop this into a credible programme with clear ownership, milestones, delivery profiles and risk assessment.

Current ICB High Level Plan Position

31. The initial assessment indicates that the cost of maintaining current commitments and meeting expected operational requirements is greater than the resources currently assumed to be available. After allowing for a provisional savings requirement, a gap to financial balance remains.
32. The detailed values underlying this assessment continue to change as the recurrent opening position is validated, national information is confirmed, operational requirements are quantified, and mitigating actions are developed.

33. The current position should be understood as an initial planning assessment rather than an approved budget, a final funding requirement or a forecast of the eventual 2027/28 outturn. The scale and direction of movement will be reported as the plan develops, together with the evidence supporting material changes.

Assurance and route to balance

34. The ICB is required to develop a balanced and deliverable plan. Closing the current gap will require a combination of stronger evidence, deliberate prioritisation, productivity improvement, service transformation, recovery action and, where appropriate, the redirection of existing resources. It will not be achieved through a single measure. The immediate priorities are to:

    - validate the recurrent 2026/27 opening position and distinguish recurrent pressures from non-recurrent items;
    - complete the detailed modelling of demand, activity, performance and financial requirements for 2027/28;
    - reconcile material planning assumptions with providers while retaining appropriate control of live contractual and commercial discussions;
    - quantify and assess the financial and operational effects of Commissioning Intentions and transformation proposals;
    - confirm the funding approach, prioritisation criteria and governance for the Transformation Fund;
    - develop the provisional savings requirement into a sufficiently evidenced and deliverable programme;
    - assess the quality, equality, workforce and service implications of proposed actions before decisions are taken and
    - maintain clear executive, committee and Board oversight of changes in the financial position, delivery risks and any material choices or trade-offs.

35. Further iterations of the financial plan will be considered through the agreed governance route as assumptions are validated, actions are quantified, and national guidance is confirmed.

Implications for the next planning phase

36. The scale of the emerging financial challenge reinforces the need for the November planning phase to focus on a manageable number of material actions rather than a broad collection of initiatives. Commissioning priorities, performance requirements, transformation proposals, productivity opportunities and provider assumptions must now be translated into quantified effects and reconciled against a common baseline.

37. Where a proposal depends upon investment, the corresponding source of resource or financial mitigation will need to be identified. Where operational or performance requirements generate additional cost, this must be visible within the planning position. Equally, where the ICB proposes to prioritise some outcomes over others, the impact on trajectories and any planned non-compliance must be explicit, supported by rationale and brought through the appropriate governance route.

38. The principal areas of focus through the next phase are:

- validating what the current expenditure and contractual baseline purchases;
- reconciling commissioner and provider activity, performance and financial assumptions;
- quantifying the impact and timing of priority commissioning and transformation interventions;
- identifying credible productivity, redesign, recommissioning and disinvestment opportunities;
- ensuring workforce, quality, equality and enabling implications are embedded in each proposition; and
- maintaining a controlled assumptions, risks, decisions and exceptions process through to submission.

Path to the first submission

39. The programme is working to a first national submission on 17 December 2026. This remains a working assumption pending formal national confirmation.

Date / period	Gateway or forum	Required output / purpose
18 November	ICB Board and System Delivery Committee	Review progress, emerging financial position, planning risks and remaining route to submission. Support organisational and system actions.
23 November	Commissioning and transformation gateway	Quantified commissioning and decommissioning priorities developed with commissioner and provider engagement. Includes impacts in Years 1-3 on finance, demand, activity, performance and workforce.
23-30 November	Executive, Commissioning Board and technical review	Challenge and refine portfolio propositions; identify material choices, gaps, dependencies and issues requiring escalation.
End November – Early December	Multidisciplinary Executive Meetings (MDEMs)	Review 2026/27 positions, escalate and resolve material differences, agree a shared forecast outturn and assess the implications for 2027/28 plans.
By end of November	Finance, analytics, contracting and provider reconciliation	Revised envelopes and initial IAPs tested; contract treatments, affordability, CIP and model-to-contract reconciliation progressed.
1 December	Commissioning and Population Health Committee	Strategic assurance of the developing Strategic Commissioning Plan, priorities and alignment with population need.
2 December	Executive Development Session	Consider integrated strategic choices, affordability, priorities, trade-offs and unresolved risks.

7 December	Executive review of draft submission	Review draft integrated planning submission and provide direction for finalisation.
By 14 December	Completion of numerical planning returns	Complete 3-year finance (4-year capital), activity/performance and workforce returns and associated assurance material.
14 December	Executive meeting	Review final integrated position and recommend for Board approval.
16 December	ICB Board	Completion of Board Assurance statements for integrated planning return. Final organisational approval/sign-off, subject to the confirmed national process and any delegated arrangements.
17 December	First national submission	Submit the initial 2027/28 ICB plan returns.
18 December-5 February	Refinement phase	Consider NHS England feedback on initial submission. Complete 5-year Strategic Commissioning Plan. Refine plans with providers and prepare the second submission, currently represented as 5 February deadline for programme purposes.

Governance and assurance

40. The internal ICB assurance route remains distinct from, but connected to, the system alignment route. Organisational accountability for approval of the ICB plan remains with the ICB Board; provider trust boards retain accountability for their own organisational plans. System governance is intended to identify and resolve interdependencies, align assumptions and make unresolved differences and risks transparent.

Forum	Role in planning	Output / assurance
Commissioning Boards	Own portfolio priorities, pathways, interventions, trade-offs and outcomes; develop and test quantified propositions with relevant partners.	Prioritised and quantified recommendations.
Planning workstreams / Matrix Planning Team	Integrate finance, activity, performance, workforce, quality, equality, capital, contracts and transformation; maintain assumptions, gaps and risks.	Integrated plan, controlled assumptions and escalations.
Weekly Planning Executive / Executive Committee	Challenge the combined position, resolve cross-portfolio choices and affordability issues, and recommend material commitments.	Executive direction, decisions and recommendation.

ICB and Provider Multidisciplinary Executive Meetings (MDEMs)	Review 2026/27 positions, escalate and resolve material differences, agree a shared forecast outturn and assess plan implications.	Agreed assumptions, forecasts and operational plan alignment.
System CFO and technical groups	Align financial baselines, envelopes, indicative activity plans, contract treatments and affordability assumptions.	Agreed positions or controlled exceptions.
System Delivery Committee	Provide senior system consultation and assurance on alignment, dependencies, risks and deliverability. Supported by system working groups or priority focus meetings as required.	System alignment and escalation of unresolved issues.
ICB Board	Retain final accountability for the ICB plan and assurance statements. Delegated assurance provided by Commissioning and Population Health Committee and Quality, Performance and Finance Committee as required.	Approval/sign-off before submission.
NHS England	Receive and review the formal planning return.	External review, feedback and plan acceptance.

Risks and issues

Risk / issue	Current response
National requirements and dates remain unconfirmed	Continue planning against existing guidance and working dates; update the programme promptly when national guidance is issued.
A gap to financial balance remains	Validate the opening position, quantify requirements and interventions, develop credible CIP and recovery actions, and maintain Executive oversight.
Commissioner and provider assumptions may not reconcile	Use portfolio commissioner-provider multidisciplinary meetings and existing engagement routes, MDEMs, CFO and technical routes, revised envelopes/IAPs and model-to-contract exception logs.
Too many priorities could dilute analytical and delivery capacity	Concentrate on a smaller number of high-impact interventions and make trade-offs explicit.
Benefits or costs may be double counted across	Use a single integrated modelling structure, assumptions log and benefits framework.

intentions, transformation and performance programmes	
Compressed governance timetable	Use gateway-based assurance, escalate material choices early and avoid deferring unresolved issues to final sign-off.
Workforce, quality and equality implications may lag behind financial planning	Complete these assessments alongside each substantive proposal and incorporate material dependencies in the integrated plan.

Conclusion

41. Since 22 October, the planning process has moved into a more substantive phase of integrated modelling, prioritisation and challenge. The key task before the first submission is to convert the strategic intentions and emerging operational requirements into a focused, quantified and affordable plan, supported by aligned commissioner and provider assumptions and a clear account of residual risks and choices.
42. The milestones to 17 December are demanding but provide a defined route through portfolio development, technical reconciliation, Executive challenge, committee assurance and final Board approval. Maintaining pace, analytical discipline and timely system engagement will be essential if the first submission is to be coherent, credible and capable of further refinement ahead of the second submission in early February.

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Thames Valley Integrated Care Board

Acute & Specialised Commissioning Board

Title of Paper	Winter 2026/27 Update		
Agenda Item	9	**Date of meeting**	18 November 2026
Exec Lead	Dr Stephen Dunn, Interim CSCO		
Author(s)	Debbie New, Philip Kelley (Acute Commissioning), with contributions from Sarah Adair (Communications), Louise Smith and Sanjay Desai (Primary Care)		

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

Link to Strategic Objective	***Strategic Objective 2:*** *Optimise how healthcare is delivered when it is needed.*

Executive Summary

The ICB Winter Plan was presented to the Board in September 2026, and the ICB Board Assurance Statement was signed off as assured. This November 2026 paper provides an update on progress as Winter begins.

The September Plan is now being delivered through the four local health and care partnerships, supported by the ICB's seven-day situational awareness and escalation arrangements. Early indicators suggest rising respiratory demand, alongside continuing pressure on emergency services and hospital flow. Providers are using existing urgent, community and discharge pathways and the ICB is considering targeted additional ED capacity where this would offer measurable benefit.

The focus through the coming months will be on safe patient flow, vaccination and prevention, workforce readiness and coordinated action when pressures affect several organisations. The arrangements are designed to support a timely and proportionate response throughout Winter.

Recommendation	The Board is asked to note: (1) that the September Winter Plan remains in place; (2) the action being taken across local partnerships to deliver it; (3) the emerging Winter demand and infection picture; and (4) the ICB's arrangements to monitor pressure, coordinate support and consider any additional capacity through the established approval routes.

Conflict of interest identified
Yes ☐ No ☒
Detail

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

WINTER 2026/27 UPDATE

Context

1. The Board approved the Thames Valley Winter Plan and its Board Assurance Statement in September 2026. Both remain the basis for delivery. This update describes the preparations now in place across Buckinghamshire, Oxfordshire, Berkshire West and East Berkshire, and how the ICB will support partners as Winter pressures develop.

2. The Plan makes full use of existing urgent and community care services. Buckinghamshire's offer includes a 24-hour care-home Clinical Assessment Service, 23 step-down beds and Home First. Oxfordshire is strengthening urgent community response, neighbourhood frailty support and ambulance-avoidance pathways. Berkshire West is protecting its Single Point of Access, virtual wards and transfer-of-care services, while East Berkshire is concentrating on urgent care at the hospital front door, discharge and targeted work in Slough. Local Health and Care Partnerships are taking these plans forward, with the ICB overseeing delivery across the four areas.

Demand, Capacity and Patient Flow

3. Emergency Department (ED) demand has continued to grow at several sites. January–September Type 1 attendances were around 3–5% higher year-on-year at Royal Berkshire, Oxford University Hospitals and Frimley Health. The March 2027 improvement trajectories remain the focus for Providers, alongside reducing long waits, ambulance handover delays and corridor care while protecting planned treatment as far as safely possible.

4. Royal Berkshire has experienced the most significant increase in Type 1 attendance. To help manage this demand, the ICB is considering further, time-limited urgent care capacity at Reading. Arrangements at other UCCs are being considered as anecdotally EDs are reporting an increase in walk in demand, particularly amongst men aged 40+.

5. In terms of patient flow, the Winter Plan includes daily discharge coordination, Home First and intermediate-care services to help people leave hospital when they no longer need an acute bed. Frimley Health's longer-stay and discharge indicators show why this remains a particular area of attention. The ICB is working with the trust, community providers and local authorities to maintain timely, safe transfers of care.

6. For people with complex needs, partners are reviewing how short-term health-funded care is arranged and how individual decisions are escalated. This work is intended to provide a clear route to timely discharge throughout Winter, with longer-term responsibilities addressed through the wider commissioning programme.

7. Acute, primary care and community teams will continue to use clinical assessment, urgent treatment centres, same-day emergency care, urgent community response and virtual wards to direct people to the right service and avoid admissions where safe. Local discharge meetings will identify delays early and bring together the appropriate health and social care services. The ICB will support resolution where a decision or action spans several organisations.

8. Each local partnership will review the use of its commissioned capacity and make adjustments to patient pathways as demand changes. The aim is to maintain access to urgent care, support discharge and preserve planned activity wherever safely possible.

Additional investment in proactive primary care

9. General practice, Out of Hours, NHS 111 incl directory of services and community pharmacy are central to delivery of the Winter Plan. Practices will continue to improve access and care navigation, while Pharmacy First will provide assessment and treatment for eligible common conditions. Community pharmacies also support urgent repeat medicines, vaccinations and medicines support following discharge.

10. As we approach winter the ICB are working with primary care providers to make these existing routes easier for people to access and strengthen referrals between services. Building on this, additional support is being developed to further strengthen primary care resilience over Winter, informed by engagement with the Primary Care Provider Collaborative and ICB GP Clinical Leads. This is expected to provide additional capacity and support for primary care during periods of increased winter pressure, with further details to be confirmed as proposals are finalised.

11. On 9 November the Department of Health also announced an additional £40m for GPs to keep vulnerable patients out of hospital this winter. The national programme is intended to enable general practice to proactively identify and support vulnerable patients, particularly people with frailty, heart disease and COPD, through interventions including medication reviews, health checks and home assessments. Nationally, Primary Care Networks will be able to receive £126 for each eligible patient supported, with up to 300,000 patients expected to benefit.

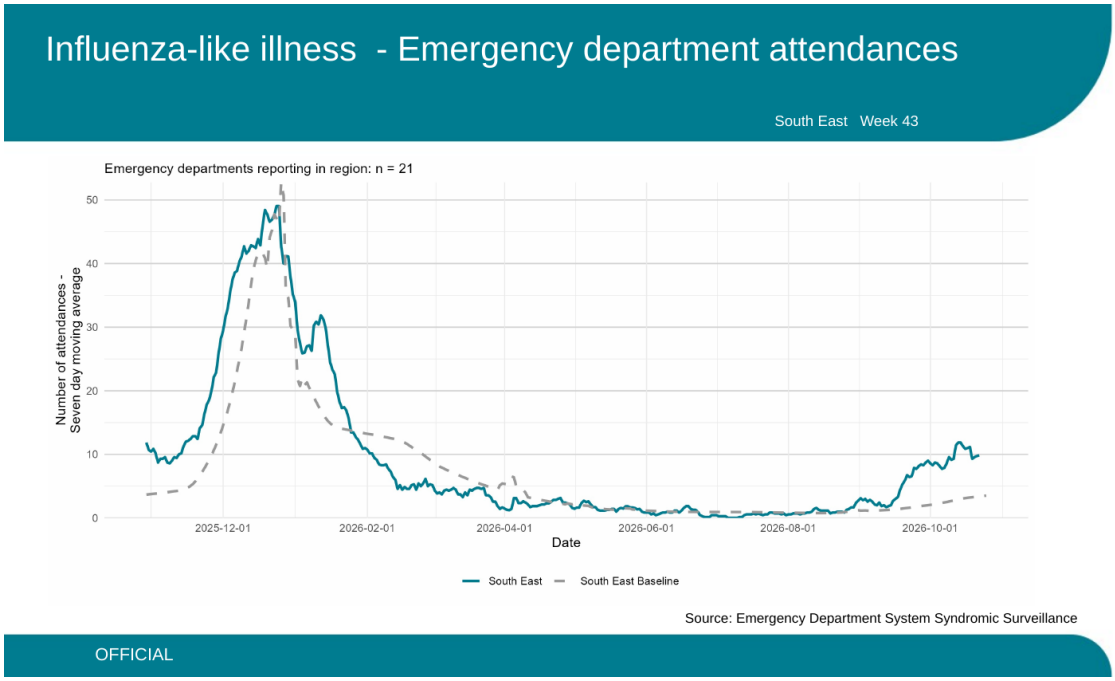
12. Thames Valley has been allocated £1.4m. We will work with primary care and system partners to deploy the funding rapidly, targeting people at greatest risk of deterioration and avoidable hospital admission over the winter period. Importantly, the funding will not be considered in isolation. The ICB will seek to align it with the existing 2026/27 Transformation Fund programme, where proposals are already being developed around prevention, proactive care, pathway redesign and reducing avoidable demand. The current Transformation Fund initiatives are explicitly focused on priority pathways and proactive and preventative models of care, with investments expected to demonstrate measurable impacts on demand, activity, outcomes and resource use.

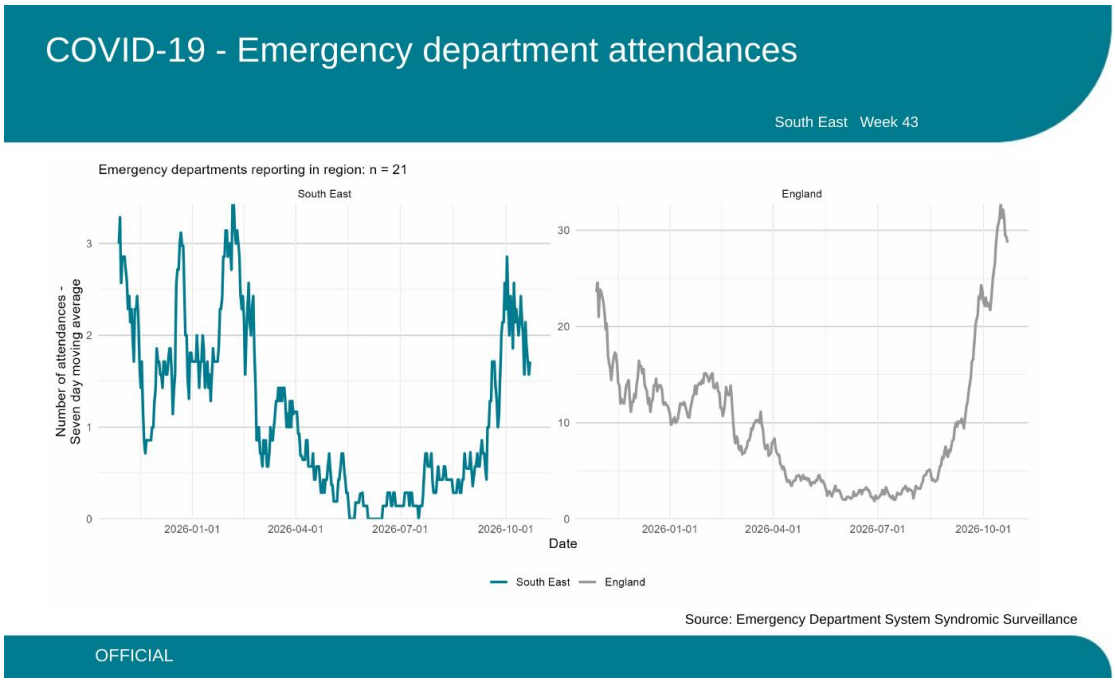
13. This creates an opportunity to combine the new winter funding with existing transformation initiatives to accelerate proactive case-finding and intervention, strengthen neighbourhood models of care and reduce avoidable pressure on urgent and emergency care over winter, while ensuring that short-term investment contributes to sustainable changes in pathways and models of care. This is consistent with the emerging Thames Valley approach that transformation investment should prevent future demand, redesign pathways and reduce or avoid existing activity rather than simply provide additional short-term capacity.

Infection Prevention, Influenza and Immunisation

14. Prevention remains a core part of the Winter Plan. Flu, COVID-19 and RSV immunisation programmes are being delivered through eligible NHS services, with work to reach children, older people, care-home residents and communities where uptake is lower. This is supported by infection prevention and outbreak arrangements across Providers.

15. The latest UKHSA South East surveillance (week 43, 19-25 October) reported influenza and RSV at baseline levels and COVID-19 at low levels. This is not a reason for complacency. Influenza A and RSV detections were increasing, and ED attendances for influenza-like illness are above their seasonal baseline. COVID-like ED attendances have also increased from summer lows, although both flu-like and COVID-like attendance measures fell in the latest reported week. The charts below illustrate the increase in ED attendances above the seasonal baseline. These are regional indicators, not forecasts for Thames Valley, but support preparations for further respiratory demand.





Figures: South East influenza-like illness and COVID-19-related ED attendances, UKHSA week 43. Permission granted for public publication.

16. Regional influenza vaccine uptake at week 43 was 35% for two and three year olds and 55% for people aged 65 and over. These figures reinforce the importance of continued engagement with eligible groups. Local vaccination teams, general practice and community pharmacies will continue to offer and promote vaccination, including targeted communication where coverage is lower.

17. Provider infection prevention arrangements will be important as the season develops, especially for respiratory illness and norovirus. The ICB's oversight will consider infection trends together with usable bed capacity and workforce availability.

Public Information and Communications

18. A coordinated winter communications programme is being delivered across the Thames Valley area to support the wider NHS Thames Valley Winter Plan. The programme aims to help residents stay well, make informed decisions about their healthcare and access the right service, at the right time, whilst supporting system resilience and reducing avoidable pressure on urgent and emergency care services.

19. The overarching public campaign, Make the Right Choice, focuses on increasing awareness and appropriate use of services including community pharmacy, Pharmacy First, NHS 111, general practice, urgent treatment centres and the NHS App. The campaign promotes self-care, encourages residents to seek advice from the most appropriate service and reinforces the use of emergency departments only for serious or life-threatening conditions.

20. Alongside service navigation messaging, communications activity is supporting uptake of flu, COVID-19 and RSV vaccinations amongst eligible and at-risk groups. Activity combines mass-reach communications with targeted outreach in communities where vaccine uptake is lower, helping to protect vulnerable residents and reduce seasonal pressures on NHS services.

21. A significant focus this winter is the promotion of Pharmacy First, delivered through a regional campaign in partnership with NHS England South East and neighbouring ICBs. The campaign seeks to increase use of community pharmacies for common conditions, reducing avoidable demand on GP practices and emergency departments. A region-wide advertising campaign is being supplemented by ICB led targeted communication activity in areas with lower utilisation and greater health inequalities.

22. Communications activity is being coordinated across NHS organisations, local authorities, voluntary and community sector partners to ensure consistent messaging and maximum reach. Delivery includes digital channels, social media, websites, local media, community networks and targeted engagement with underserved communities. Communications arrangements are also aligned to system escalation processes to support timely and coordinated public information should periods of significant operational pressure arise.

Workforce and Wider System Resilience

23. Providers have Winter staffing, redeployment and continuity arrangements and will review sickness levels and staff vaccine uptake as pressures change. The ICB will draw on this intelligence in its wider assessment of system capacity.

24. Providers remain responsible for safe staffing, clinical prioritisation and business continuity over the Christmas and New Year period, including any industrial action. Existing Provider and local

partnership arrangements will manage routine pressures, with the ICB coordinating support where a problem affects more than one organisation.

25. The ICB's emergency preparedness arrangements cover seven-day regional reporting, trained on-call teams, major incidents, adverse weather, cyber disruption and the Christmas bank holidays. Core Standards assurance and Winter escalation exercises are progressing. These arrangements sit alongside Providers' own business continuity plans.

Winter Operating Model, Assurance and Escalation

26. The ICB and its Providers completed their Winter Board Assurance Statements in September and October. Seven-day reporting to NHS England is now operating through the System Coordination Centre (SCC). The ICB is developing a common view of capacity, ambulance handovers, discharge, staffing and significant incidents using established Provider information, enabling emerging pressures to be assessed across Thames Valley.

27. The Winter operating model is designed around clear responsibilities. Providers and local health and care partnerships will manage everyday operational pressures and discharge. Where pressure persists or crosses organisational boundaries, the ICB will review the position and can help arrange mutual aid, commissioning action or regional support. For a critical incident, the ICB will coordinate the wider system response while the Provider retains command of its own services. The recent Stoke Mandeville theatre incident illustrated this approach well: Buckinghamshire Healthcare led the response, while the ICB brought together neighbouring hospitals and ambulance partners to arrange temporary trauma pathways and repatriation.

28. A supporting escalation procedure has been shared with Providers and is being finalised with operational colleagues. It clarifies who should be contacted, when local action should be escalated and how the ICB can assist. These arrangements will be reviewed throughout Winter as experience develops.

Next Steps

29. The main risks for the next few months are well understood: respiratory illness, workforce absence, reduced discharge capacity, and disruption caused by industrial action, severe weather and business continuity incidents. The September Plan addresses these through prevention, expanded use of community pathways, close attention to hospital flow and clear routes for mutual support. The ICB will keep the position under review and act with partners when additional coordination or capacity is required.

30. During November the ICB will continue to review local delivery against the agreed Winter Plan, complete the Provider escalation procedure, monitor respiratory and vaccination trends, and consider targeted urgent care capacity proposals through the established approvals process. Any material changes in performance or risk will be reflected in routine Board assurance reporting.

31. The UEC Value Lab workshop on 2nd November also began work on the strategic improvement of the urgent and emergency care pathways across Thames Valley. Separately, a GIRFT paediatric urgent care peer review is planned for Wexham Park on 26th November. These longer-term improvement activities will complement the immediate delivery of the Winter Plan.

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Thames Valley Integrated Care Board

ICB Board meeting in Public

Title of Paper	Thames Valley Neighbourhood Development Programme: Progress Update		
Agenda Item	10	**Date of meeting**	18 November 2026
Exec Lead	Rob Bowen, Chief System Development and Engagement Officer (interim)		
Author(s)	Daniel Leveson, Director for Partnerships and Neighbourhoods		

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

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

Executive Summary	
This paper provides an update on progress in developing integrated neighbourhood health and care across Thames Valley. The programme is building on existing partnerships and local strengths, establishing a common framework for neighbourhood planning, population health intelligence and more coordinated, proactive care. The next phase, through to March 2027, will focus on completing neighbourhood health plans, strengthening partnership arrangements, developing proactive care management and connecting local priorities more directly to commissioning, investment and service delivery. This is an important opportunity for the ICB to work differently with partners, enabling decisions and resources to be shaped closer to communities, while making better use of collective resources and improving outcomes for local populations.	
Recommendation	The Board is asked to note the progress made in developing neighbourhood health and care across Thames Valley and discuss the proposed priorities and next steps through to March 2027.

Conflict of interest identified
Yes ☐ No ☒
Detail

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

1. Purpose

This paper provides the Board with an update on progress in developing integrated neighbourhood health and care across Thames Valley, including the work underway to strengthen local partnerships, develop neighbourhood health plans and establish the foundations for more coordinated, proactive and preventative care.

2. Strategic context and ambition

The development of neighbourhood health and care is central to the ambitions of NHS Thames Valley ICB and our transition towards a more strategic approach to commissioning. Our published Commissioning Intentions for 2027/28–2030/31 set out three overarching objectives:

- Slowing the progression of ill health.
- Optimising how healthcare is delivered.
- Addressing unmet need and reducing inequalities.

Neighbourhoods are a key part of delivering these ambitions, bringing health, social care, local government, voluntary and community organisations and other partners together around the needs of local populations. This requires the ICB to work differently too: as an active partner in local decision-making, supporting greater devolution of responsibility and resources closer to communities, while working collectively with partners to address the challenges and trade-offs involved in commissioning, allocating and using resources.

While neighbourhood working should benefit all communities, it has potential to improve outcomes for:

- Children, young people and their families, through earlier intervention and more coordinated support.
- People living with or at risk of long-term conditions, including cardiovascular disease, diabetes and mental health conditions.
- Older people living with frailty and people with complex health and care needs.
- People approaching the end of life, through more personalised and coordinated care closer to home.
- Communities experiencing deprivation, health inequalities or poorer access to services.

By providing more proactive, preventative and coordinated support, neighbourhood models can help people remain healthier and independent for longer, reduce avoidable hospital admissions and improve people's experience of care. This is important not only for improving outcomes but also for the long-term sustainability of the health and care system, ensuring we make better use of our collective resources and achieve better value.

Following the visit by Professor Claire Fuller and the national team in June 2026, feedback from national and regional colleagues and local partners was positive. The visit recognised the progress and strong examples of partnership working already taking place across Thames Valley, while providing an opportunity to consider how this work could be developed further and more consistently across the system.

The Neighbourhood Development Programme, supported by Moorhouse and the National Association of Primary Care (NAPC), was established to build on these strengths and support the development of integrated neighbourhood working across Thames Valley.

3. Our approach: different scales, a shared purpose
Our approach recognises that effective neighbourhood working requires strong relationships and coordination at different geographical levels. These are complementary scales, not competing tiers, with decisions taken at the most appropriate level and a shared commitment to improving the health and wellbeing of our communities. The emerging model connects:

- **Thames Valley:** The ICB's role as strategic commissioner and system steward, setting direction, aligning resources and providing oversight.
- **Four Health and Care Partnerships (HCPs):** Bringing together NHS, local government and other partners across wider health economies to coordinate priorities, support neighbourhood development and provide a forum for collective decisions about the use and allocation of resources, including opportunities to share risks, responsibilities and benefits, and agree how services can best be organised across their populations.
- **Eight Health and Wellbeing Boards (HWBs):** Providing democratic and population-based leadership, connecting health and care with wider determinants of health and local authority priorities.
- **15 multi-neighbourhood delivery groups:** Supporting planning and coordination across several neighbourhoods where workforce, services or population needs are best considered at a wider scale.
- **49 neighbourhoods:** Providing the local focus for proactive, integrated and personalised health and care, largely aligned with Primary Care Network (PCN) geographies.
- **Primary care providers:** Including GP practices, pharmacies, opticians and dentists, providing accessible and continuous care and maintaining close relationships with local communities.

The model is underpinned by four principles: subsidiarity, joined-up working, shared responsibility and better outcomes.

Importantly, this is not about creating additional organisational structures or simply transferring responsibilities down the system. It is about strengthening relationships, enabling greater devolution of decision-making and local ownership, and using formal delegation of specific responsibilities where appropriate. This will ensure decisions and resources are aligned at the most appropriate level, with clear accountability and assurance.

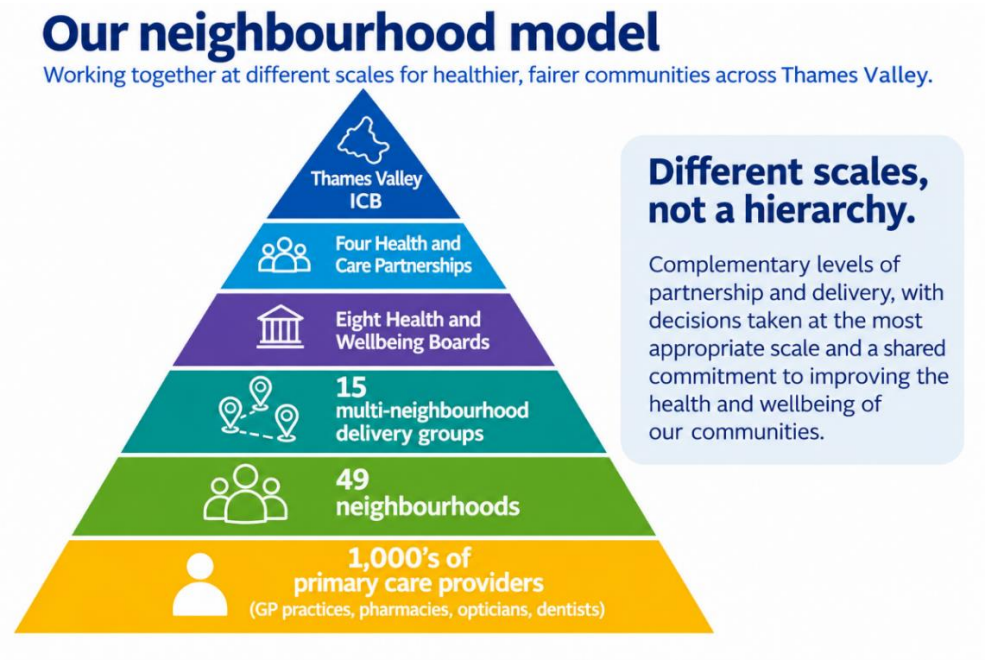


Figure 1: Complementary scales of partnership, planning and delivery

4. Progress to date

The programme has completed its initial mobilisation and baseline phase and is now progressing the development of local partnerships, neighbourhood plans and the arrangements needed to support implementation.

Understanding our neighbourhood geographies

A significant piece of work has been undertaken to map neighbourhood arrangements across Thames Valley and develop a common understanding of the geographical footprint for local planning and delivery.

This includes mapping the four HCPs, eight HWB areas, multi-neighbourhood delivery groups, neighbourhoods and their relationship with PCNs and GP practices. The work provides a consistent geographical framework while recognising the importance of local relationships and circumstances in validating arrangements.

This will support more effective planning, population health analysis and coordination of services across different geographical levels.

These geographical arrangements provide a working framework for neighbourhood development across Thames Valley, rather than a fixed or permanent structure. We recognise that local geographies and partnership arrangements will continue to evolve, influenced by factors including local government reorganisation, existing service and contractual arrangements, and the development of local partnerships. The model will therefore be kept under review and adapted over time to ensure it continues to reflect local circumstances and supports effective integrated working.

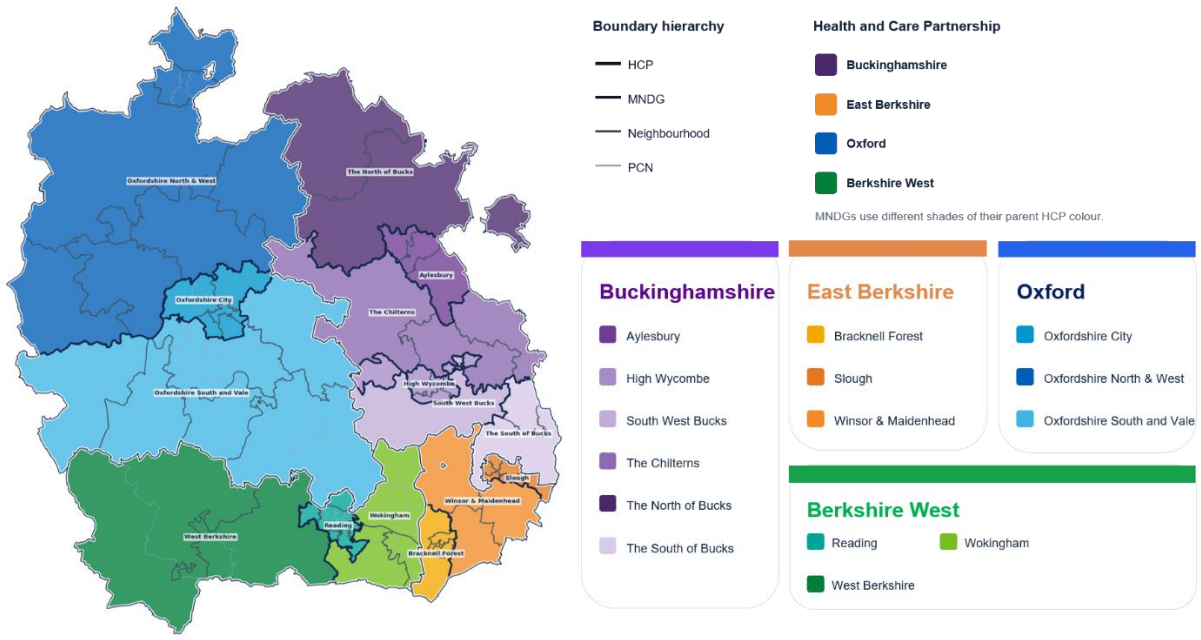


Figure 2: Summary of initial neighbourhood and partnership boundary mapping

Reading provides an example of the practical choices involved in developing neighbourhood footprints. Partners have agreed to use council ward boundaries rather than PCN footprints, reflecting the view that these better represent local population flows and patterns of community connection. GP practice and Family Hub locations have also been considered in developing the map. This illustrates the need to balance locally meaningful geographies with the benefits of alignment around existing primary care and service arrangements.

As highlighted in national discussions on neighbourhood health, footprints matter. Over time, services need to be able to organise around a sufficiently consistent geography to support integrated working. It is a compromise that we are working through together as a system, recognising that no single geographical approach will necessarily meet every requirement.

Developing population health intelligence

Work is underway to develop neighbourhood population health data packs, bringing together information to help local partnerships understand the needs of their populations, identify inequalities and determine where intervention could make the greatest difference.

The packs are intended to provide a consistent view of population characteristics, health needs, priority cohorts, service utilisation and outcomes. Work is also progressing to establish baseline measures and a common approach to understanding and monitoring progress.

This will provide an important evidence base for neighbourhood planning, helping partnerships move from understanding population need to identifying priorities, targeting interventions and evaluating their impact.

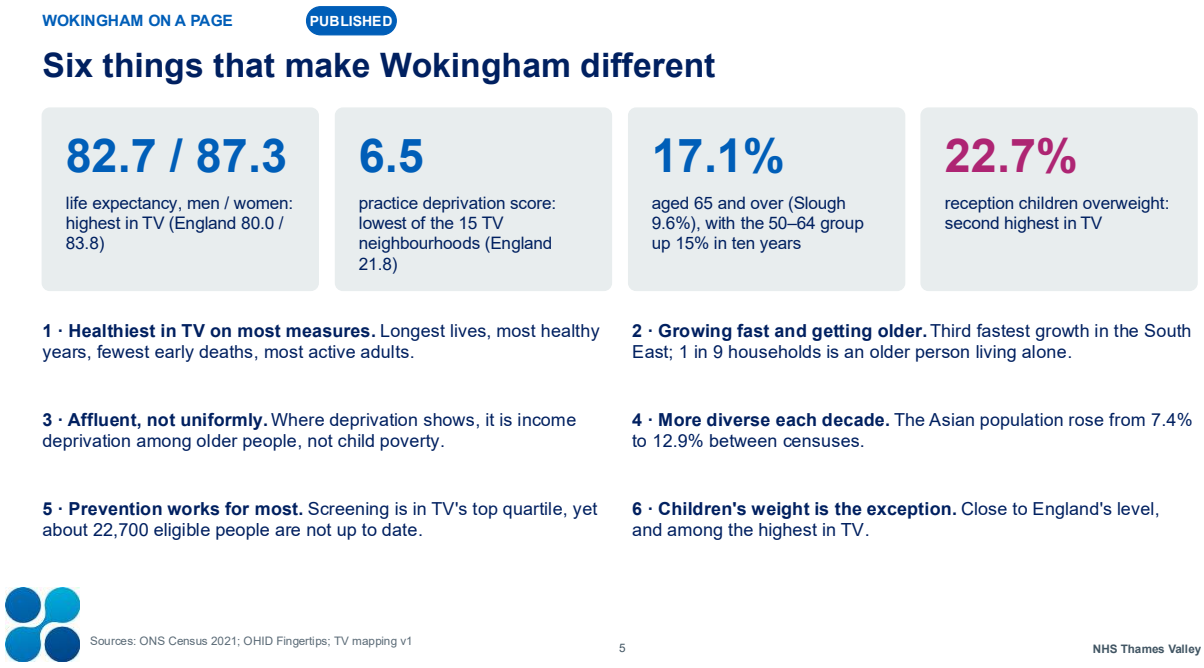


Figure 3: Illustration of data pack being developed for neighbourhood teams

Developing proactive care management

An important part of the national neighbourhood health ambition is to move towards more proactive and coordinated care for people with the greatest health and care needs. It is proposed that ICBs commission a Care Management Service, initially covering at least 1% of the local population and increasing over time. The proposed initial focus is on people living with frailty, with population health analysis informing the identification and expansion of priority cohorts.

This is closely aligned with the development of neighbourhood working across Thames Valley, including the rollout of more proactive approaches to supporting people living with frailty. The intention is to build on existing services and relationships, bringing professionals together around individuals and their needs through holistic assessment, personalised care planning, care coordination and proactive follow-up.

Our approach will be to establish a common core specification, setting out the expected standards, outcomes and requirements for care coordination, while enabling local partnerships and providers to determine how care management is organised and delivered in their areas. The ICB will retain responsibility for commissioning and assurance, with delivery accountability remaining with the organisations and providers undertaking the work. This will support consistency in the quality of care while retaining local ownership, flexibility and the involvement of people in decisions about their own care.

Measuring Success

Alongside this, we are developing a shared approach to measuring the impact of neighbourhood working. This will align the five goals of the Neighbourhood Health Framework with the NHS's national measures and the broader population outcomes set out in the Local Outcomes Framework.

The intention is to provide a clear line of sight between national priorities, the contribution expected from Thames Valley commissioning and the improvements that local partnerships are seeking to achieve for their populations.

Our approach brings together three connected areas of measurement:

Reform agenda	**National goals and measures**	**Longer-term outcomes for local populations**
Improve routine healthcare. Improving access, continuity and care closer to home.	**Goal 2:** Improved access to general practice. **Goal 3:** Improved experience of planned care. Measures include GP access, patient experience, referral and waiting times, outpatient activity and advice and guidance.	Better access and experience. Reduced inequalities in access. More care delivered closer to home.
Improve proactive care. Identifying risk earlier and coordinating support around priority cohorts.	**Goal 1:** Improved health outcomes for priority groups. **Goal 5:** Improved patient and staff experience. Measures include care plan coverage, long-term condition outcomes, frailty and end-of-life outcomes, and patient and staff experience.	Improved health and wellbeing. Greater independence. Reduced inequalities.
Better alternatives to hospital. Developing integrated community services that prevent avoidable hospital use and support recovery at home.	**Goal 4:** Better urgent and emergency care performance. Measures include non-elective admissions, emergency department attendance, ambulance conveyance and discharge performance.	More people supported at home. Reduced reliance on hospital care. More sustainable services.

Figure 4: Summary table of NHS Reform Agenda and Neighbourhood Health Framework goals

Success will be measured and demonstrated across all levels of the neighbourhood model, from individual neighbourhoods and multi-neighbourhood groups through to Health and Wellbeing Boards, Health and Care Partnerships and the ICB. This will allow us to understand the impact of neighbourhood working at the level where change is happening, recognise local improvements and shared achievements, and build a connected picture of progress across Thames Valley. The intention is not simply to aggregate local performance into a single system-wide measure, but to understand and demonstrate how collective action at each level is contributing to better outcomes.

This approach recognises that national NHS measures are an important part of understanding progress, but do not provide the whole picture of success. We will also need to understand whether

neighbourhood working is improving healthy life expectancy, independence, community wellbeing, people's experience of care and reducing inequalities.

Our emphasis will be on learning and improvement rather than performance ranking. The common framework will provide consistency across Thames Valley while allowing local partnerships to focus on the outcomes that matter most to their populations.

Strengthening partnerships and local leadership

Engagement has taken place with leaders and partners across all four HCPs to understand existing arrangements, local priorities and development needs.

This has included facilitating the Thames Valley ICB Senior Leaders Forum on 30 September, completing NHS 10-year plan self-assessment sessions across all HCPs and agreeing an approach to assessing partnership maturity with HCP leadership.

Initial governance mapping has also identified where greater clarity may be needed around the purpose of existing forums, membership, responsibilities and decision-making arrangements.

A key part of the next phase is developing a partnership framework to support effective collaboration and decision-making across neighbourhoods, HWBs, HCPs and the ICB, while respecting the responsibilities and democratic accountability of individual organisations.

Developing neighbourhood health plans

Existing local plans and strategies have been reviewed to understand where plans already exist, what they cover and where further development is needed. A common structure for neighbourhood health plans has also been tested with HCP leads.

The intention is not to impose a single model, but to establish common principles and expectations while allowing plans to reflect local population needs, priorities and opportunities.

Plans will bring together two interconnected dimensions of neighbourhood development:

- **Neighbourhood Health Service:** Focused on improving how health and care services are organised and delivered around local populations, with an emphasis on proactive, preventative and integrated care, particularly for those with the greatest needs. This will include translating national neighbourhood health ambitions into practical improvements in local service delivery.
- **Healthy Neighbourhoods:** Focused on the wider factors that influence health and wellbeing, including tackling inequalities, supporting community assets and strengthening the role of voluntary and community organisations. This recognises the importance of housing, employment, education, the local environment and community connections in shaping people's health.

Together, these provide a framework for neighbourhoods to improve health and care services while also addressing the wider determinants of health and building healthier, more resilient communities. Plans will provide a practical basis for partners to agree priorities, identify the changes needed to services and interventions, and connect these with commissioning, investment and delivery arrangements.

Progress varies across Thames Valley, reflecting different starting points, local arrangements and levels of partnership maturity. Some areas are already developing plans, while others are beginning the drafting process.

5. Connecting neighbourhood development to commissioning and planning

An important next step is to ensure neighbourhood development is connected directly to the ICB's strategic commissioning intentions, investment decisions and wider planning arrangements.

There are several important opportunities to achieve this:

- **Commissioning intentions:** Translating the ICB's strategic priorities into local population-based commissioning, pathway development and service improvement.
- **Transformation Fund:** Supporting investment in new models of proactive and preventative care, including integrated neighbourhood teams and new approaches to service delivery.
- **Better Care Fund (BCF):** Aligning NHS and local authority resources around shared priorities, including prevention, intermediate care, independence and reducing avoidable hospital activity.
- **Mental Health Investment Standard (MHIS):** Ensuring mental health investment and service development are reflected in integrated local planning and neighbourhood models of care.
- **ICB portfolio leadership:** Bringing together commissioning, finance, clinical leadership, transformation and analytical expertise to support local partnerships and ensure neighbourhood priorities are reflected across the ICB's work.

More fundamentally, this is an opportunity to consider how commissioning can better support integrated care around populations and individuals, rather than being organised primarily around individual services and organisational boundaries. This includes developing shared outcomes, improving continuity across pathways and exploring more innovative commissioning and contracting arrangements that support collaboration and collective responsibility for delivery.

This could include approaches that reward the achievement of population health outcomes rather than simply paying for activity. For example, exploring payment models linked to reductions in hospital admissions against an expected baseline, or improvements in the health and care needs of local populations, including movement between Population Need Groups (PNGs) identified through risk stratification. These approaches would require robust baselines, agreed measures and shared accountability, but offer an opportunity to create stronger incentives for prevention, proactive care and improving outcomes.

The Strategic Commissioning Development Programme will be an important enabler of this ambition, building the ICB's capability to plan, commission, contract and evaluate services differently. It will support the development of commissioning approaches at a multi-neighbourhood scale, with a greater focus on population outcomes, prevention and the effective use of collective resources.

The programme will support greater alignment between these different planning and investment cycles, recognising their respective requirements and governance arrangements.

The immediate focus is to connect neighbourhood planning with the ICB's 2027/28 commissioning intentions and associated funding arrangements, while beginning to explore new commissioning and contracting approaches that can support more integrated, outcome-focused models of care. This will provide a stronger foundation for implementation and the longer-term transformation of services.

6. Next steps and priorities

The main priorities through to March 2027 are:

1. **Complete neighbourhood health plans.** Support local partnerships to develop plans reflecting population needs, agreed priorities and opportunities for more integrated care, with plans in place across all HWB areas and brought together in an overarching Thames Valley Neighbourhood Health Plan.
2. **Develop a Thames Valley approach to proactive care management.** Build on the rollout of proactive care for people living with frailty and the emerging national Care Management Service proposals. Establish a common core specification, including expected standards, outcomes and accountability, while working with local partnerships to determine how services are organised and delivered. This will support more consistent, personalised and coordinated care for people with complex needs, while enabling local ownership and delivery.
3. **Strengthen partnership arrangements.** Develop a shared framework setting out recommended approaches to governance, roles and responsibilities, decision-making and ways of working across the different levels of the system.
4. **Develop a common outcomes framework.** Align neighbourhood, HWB, HCP and ICB outcomes, supported by population health intelligence, data packs and baseline measures to help identify priorities, understand variation and monitor improvement.
5. **Align commissioning and resources.** Connect local neighbourhood priorities with commissioning intentions, transformation investment, BCF, MHIS and wider ICB portfolio responsibilities.
6. **6. Explore new commissioning and contracting approaches.** Consider how commissioning and contracting can better support integrated neighbourhood working, including opportunities for pooled budgets, outcomes-based contracts, alliance and lead-provider models, and more integrated provider arrangements. This will include exploring innovative approaches to rewarding improvements in population health and reductions in avoidable hospital activity, supported by the Strategic Commissioning Development Programme.
7. **Support early adoption and spread.** Identify opportunities to translate plans into practical delivery, build on existing good practice and support the development and spread of effective neighbourhood models across Thames Valley.

By March 2027, these outputs will provide the foundations for implementation, with an increasing focus on early adoption, learning, spread and scale.

7. Conclusion

The Neighbourhood Development Programme represents an important part of the ICB's wider ambition to transform how health and care is planned and delivered across Thames Valley. We are building on significant existing strengths and relationships, while establishing greater consistency in how we work with partners, understand population needs and plan services around local communities.

The next phase is about translating these foundations into practical changes: supporting more proactive and coordinated care for people with the greatest needs, strengthening local partnerships, and aligning commissioning, investment and service delivery around shared priorities. Success will depend on making better use of our collective resources and enabling decisions and delivery to take place at the most appropriate level.

This is a shared endeavour across the NHS, local government, voluntary and community organisations and wider partners, with the needs of residents and communities at its centre.

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Title of Paper	Sexual Safety Report		
Agenda Item	11	**Date of meeting**	18 November 2026
Exec Lead	Caroline Corrigan (Chief People & Corporate Affairs Officer), supported by Sarah Bellars (Chief Nursing Officer)		
Author(s)	Anne Lankester (Safeguarding Team) and Nicola Walton (People Team)		

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

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

Executive Summary

In September 2023, NHS England published the Sexual Safety in Healthcare Organisational Charter in collaboration with healthcare partners. The Charter was developed by NHS England, lived experience organisations, professional bodies, employers and partners across healthcare. All NHS Trusts and integrated care boards (ICBs) have signed the Charter, committing to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace.

The Charter's assurance framework sets out the outcomes from each of the 10 core principles and actions to help achieve this. The actions are recommended best practice.

On 20 August 2025, the Sexual safety charter assurance framework was revised to incorporate the latest system-wide guidance outlining new measures to protect patients and staff from sexual misconduct. NHS organisations were asked to review these new actions and evaluate their compliance.

Championing sexual safety remains an NHS priority, as seen by the recently published NHS Staff Standards.

Since the formation of Thames Valley ICB, significant progress has been made in implementing the NHS Sexual Safety Charter's associated assurance framework. Key policies, reporting mechanisms, staff communications and mandatory training arrangements are now in place. The principal areas requiring further development are improving staff training compliance, strengthening evidence of staff confidence to report concerns, implementing updated NHS England escalation requirements and obtaining assurance from provider organisations regarding monitoring and escalation of inappropriate access to patient records.

This paper provides an update to Board members on the ICB's ongoing work around sexual safety. It outlines actions already taken, underway and further actions required, to identify and act against potential perpetrators of sexual misconduct in the NHS.

Recommendation	The Board members are asked to note progress and support the continued prioritisation of this work.

Conflict of interest identified

Yes ☐ No ☒
Detail

Reporting – has this paper been discussed at other meetings		
Committee Name	Date discussed	Outcome
Executive Meeting	02/11/2026	Noted

Sexual Safety Charter Update Report

1. Context

The Sexual safety charter assurance framework was updated on 20 August 2025 to reflect the latest letter to the system on new actions to safeguard patients and staff against sexual misconduct. NHS organisations were asked to review these new actions and assess themselves against them.

This paper provides a further update on implementation of the Sexual Safety Charter and associated assurance framework across Thames Valley ICB. It also considers how this work is being embedded across the newly formed ICB and its principal provider organisations.

2. Progress to Date

An internal working (task and finish) group was established with representatives from safeguarding, communications, trade unions and the people team to ensure the ICB is meeting the charter commitments and that people feel safe and confident to come forward if they have experienced or witnessed incidents of sexual harassment or abuse.

Progress on key aspects of the sexual safety assurance framework are set out below.

People Policy

The Sexual Misconduct policy has now been approved for Thames Valley ICB. Upon receiving an allegation of sexual misconduct, the policy will be followed to ensure that complaints are addressed objectively, promptly, sensitively, and proportionately.

The NHSE template policy has been updated to reflect the new organisation and more recent guidance, including a process for escalation as set out in further NHS England South-East correspondence from June 2026 on “Reporting mechanisms for high profile cases of serious sexual misconduct”.

Communications

A new Safety at Work page has been created on the Thames Valley ICB intranet (Hub) which includes a dedicated page on Sexual Safety. Here, staff members can access the Charter, Sexual Misconduct policy and online reporting form.

The online form has been significantly updated (from what predecessor organisations had in place). It allows staff to report a sexual safety concern which includes the option of anonymous reporting. Reports will be received by the People Team.

Further updates and resources will be added to the page accordingly.

Progress in implementing the Charter was showcased at the All Staff Event on 14th October 2026 in Ascot. A copy of the poster can be found in Appendix 1.

Incident Reporting

The Sexual Misconduct policy sets out the various routes available to report a sexual safety incident (“disclosure”). This includes anonymous reporting via the online form.

Whilst no sexual safety concerns have been formally reported through organisational reporting routes, previous staff survey findings (from the predecessor organisations) identified

experiences and concerns relating to sexual safety. The ICB recognises that under-reporting of sexual misconduct is a known risk across healthcare settings and therefore the absence of reports should not be interpreted as evidence that incidents do not occur. Continued emphasis is being placed on awareness, reporting confidence and psychological safety.

Internal sources of advice, guidance and support is also available from the People team, FTSU, trade union representatives and safeguarding leads. Internal and external contacts and resources can be found in the policy.

Staff Training
Compliance with the mandatory "Understanding Sexual Misconduct in the Workplace" training module was 74.18% at the end of September 2026, compared with 79.97% in August 2026. The reduction in staff numbers reflects the ongoing organisational change programme, including colleagues leaving through voluntary redundancy. While this may have affected overall compliance rates, the training remains a mandatory requirement for all colleagues.

A targeted communications campaign will be undertaken to reinforce the importance of sexual safety and encourage completion of the training. This will be supported by engagement with line managers, targeted reminders, protected learning time and monthly monitoring of compliance across directorates.

These actions aim to improve compliance while reinforcing the organisation's commitment to creating a safe, respectful and inclusive working environment.

System Working
At a system level, a regular set of meetings, 'Safer Workplaces Forum' takes place, bringing together representatives from each of the health providers to share learning, resources and plans to meet their own commitments to the charter. The group has been able to share policies and resources where organisations are further ahead and discuss challenges.

The Forum supports consistency of approach across the system, enables sharing of emerging risks and mitigations, and provides assurance that provider organisations are progressing implementation of the Charter.

Information received through the Safer Workplaces Forum indicates that the ICB's five principal provider organisations have established programmes of work to implement the Sexual Safety Charter and associated assurance framework requirements. Regular reporting enables the sharing of learning and identification of emerging risks or challenges.

Assurance Summary
The table below summarises progress on actions identified in the NHSE letter to the system on 20th August 2025, and additional guidance from NHSE South-East received in June and September 2026. Further detail can be found in Appendix 2.

Action Area	RAG
Self-assessment	Green
Policy audit	Green
Primary care support	Green

ESR/IAT requirements	Green
Chaperoning review	Green
Reporting arrangements	Green
Training compliance	Amber
Information sharing	Amber
Electronic Patient Record (EPR) assurance	Amber
Escalation requirements	Amber

3. Areas Requiring Further Action

Area of Risk	Mitigation
Training compliance below target of 90%.	Quarterly compliance monitoring and targeted follow-up.
Information sharing and escalation process of concerns requires further review.	Further work is required to ensure escalation routes and local information sharing processes regarding sexual misconduct concerns, align with NHS England expectations and NHS Employers guidance.
Provider assurance on inappropriate access to patient records incomplete.	Ongoing scrutiny through Safer Workplaces Forum.
Limited evidence of staff confidence to report concerns.	Continued communications campaign and monitoring through staff survey data (upon publication in 2027).

4. Conclusion

Overall, the ICB is substantially compliant with the expectations of the Sexual Safety Charter and associated assurance framework. The remaining actions relate primarily to strengthening assurance, improving compliance levels and embedding recently issued NHS England requirements.

5. Next Steps

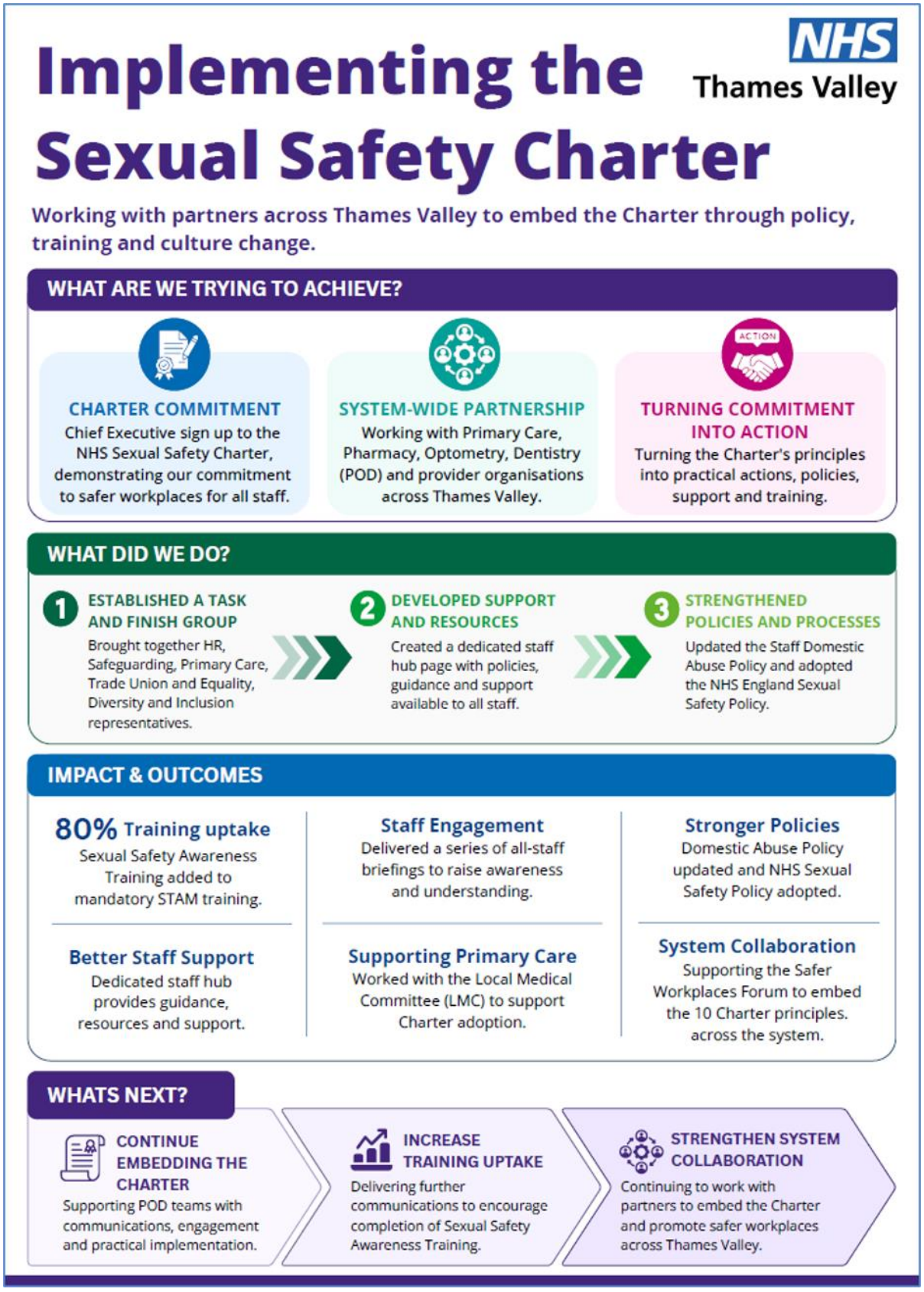
The workstream continues under the oversight of the Chief Nursing Officer and Chief People & Corporate Affairs Officer, supported through the Sexual Safety Task and Finish Group.

Asks of the Board or of members present

The Board is asked to:

- Note progress made in implementing the Sexual Safety Charter
- Note the four remaining amber areas requiring further assurance and development
- Support the continued prioritisation of actions.

Appendix 1: Sexual Safety Poster for All Staff Event (October 2026)



Appendix 2: Action Plan (Detail)

Action areas identified within letter	Progress update	RAG rating
To begin self-assessment against the (updated) assurance framework	Action: Whilst all actions are complete or underway in relation to the original sexual safety assurance framework, the task and finish group will review the updated framework and actions set out in the letter. Complete.	**Green**
To complete the sexual misconduct policy audit (sent to Chief People Officers in Spring 2025) by Monday 1 September 2025.	Both BOB ICB and Frimley ICB had sexual misconduct policies in place. This has now been reviewed and adopted by TV ICB. Complete.	**Green**
To ensure primary care providers receive the support needed to focus on the sexual safety of their staff and patients (to support NHSE guidance to primary care providers on how sexual safety frameworks such as the Charter and sexual misconduct policy framework may be adapted for their structures).	Action: Adult Safeguarding Lead to prepare messaging for distribution via the LMC, GP leadership channels, and the GP bulletin. Complete.	**Green**
To ensure that ESR (where an organisation uses this to record employee relations issues) is up to date with ongoing and complete investigations into staff - inter-authority transfers (IATs) may reveal where there are ongoing investigations and should be built into onboarding processes.	The ICB does not use this ESR function and therefore not applicable. Communication issued to our 5 main health providers.	**Green**
To review chaperoning policies to ensure they empower chaperones and lead to the creation of auditable records	• Not considered necessary for the ICB as there is a multi-disciplinary team approach within All Age Continuing Healthcare (AACHC) i.e. AACHC staff do not visit clients alone. • Lone working information within the ICB's H&S policy. • Primary Care and LMC working through the updated Chaperone requirements	**Green**
To ensure primary care providers notify their commissioner of any allegations of sexual misconduct made against a member of their team. If the subject of the allegation is on the Performers List (medical, dental and ophthalmic), this should be via the Regional Medical Director Systems	Process in place.	**Green**

Improvement and Professional Standards (MDSIPS).		
To encourage staff to complete the e-learning on sexual misconduct, and consider specialist training	The sexual misconduct e-learning module is now part of the ICB's Statutory and Mandatory training. Proposed target compliance 90%. • 'Lunch and learn' sessions undertaken in BOB ICB September and November 2025. • Poster presentation at All Staff Event (October 2026 • End Sept 26: Training compliance c.75%, to be reviewed quarterly with actions to improve compliance. • Awaiting specialist training from NHS England for key colleagues including People team and FTSU colleagues.	**Amber**
To review staff policies and processes to ensure appropriate sharing of concerns about healthcare professionals with future employers and host organisations. This should include investigation findings, relevant DBS information, and reflect cumulative patterns of behaviour, and sexual misconduct should be considered through a patient safety lens as well as through HR processes.	Action: Further work is required to ensure local processes support appropriate information sharing regarding sexual misconduct concerns, in line with NHS England expectations and NHS Employers guidance. NHS England has previously indicated that further clarification on information-sharing responsibilities may be provided. In the meantime, organisations should continue to follow existing NHS Employers guidance, which advises that DBS disclosures should not be relied upon in isolation and that a lack of information should not be interpreted as assurance that no concerns exist.	**Amber**
To engage with your Electronic Patient Record (EPR) suppliers (including prospective providers) to monitor unusual access to patient records and ensure safeguarding oversight	Action: Task and finish group to gain assurance that providers have audit processes and escalation policy in place. This work continues via the Safer Workplaces group. Task & finish group awaits assurance from the 5 main providers in this space. POD: a number of these providers are signed up to the Charter and are working towards the 10 principles. This is relevant in the recent access of records in the case of child death and the resulting letter from Mr Mackey regarding systems and processes for health providers to work through if this is an issue.	**Amber**
Correspondence from NHSE South-East 20th June and 17th September 2026 in respect of additional requirements in	Following June 2026 correspondence, the Sexual Misconduct policy was updated to reflect escalation and reporting requirements to NHSE SE for allegations of sexual misconduct involving staff where allegations are severe	**Amber**

relation to escalation (allegations against staff).	and have potential for regional or national learning. Further review is now required following the September 2026 correspondence “Sexual Safety Senior Responsible Officer Nominations and Escalation Log”. Actions: • Completion of the Sexual Safety Leadership Details - Nomination Form, to nominate a Senior Responsible Officer for Sexual Safety for the ICB. • Incorporate new Escalation Log template to reporting procedure to provide a structure for reporting.	

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Thames Valley Integrated Care Board

Public Board

Title of Paper	Freedom to Speak up Q1 and Q2 Report		
Agenda Item	12	**Date of meeting**	18 November 2026
Exec Lead	Sarah Bellars, Chief Nursing Officer		
Author(s)	Sarah Bellars, Chief Nursing Officer		

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

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

Executive Summary	
This is the first six-month Freedom to Speak Up (FTSU) report for NHS Thames Valley Integrated Care Board (TVICB), covering Q1 and Q2 2026/27 and the period since the new ICB was established on 1 April 2026. It brings together activity, themes, organisational learning, governance development and the implications of the changing national FTSU framework. Fourteen concerns are recorded in the Q1/Q2 activity tables: six in Q1 and eight in Q2, all shown as closed at the reporting point. The principal theme is workforce experience during organisational change. Nine concerns were categorised as worker safety or wellbeing, two as bullying or harassment, one as patient safety or quality and two as other. The presentation describes 80% of concerns as relating to workforce experience during organisational change and highlights psychological safety, communication and transparency, and governance and assurance as the principal learning themes.	
Recommendation	The Board is invited to note this report and endorse the proposed next steps, particularly the strengthened Guardian resource, formal NED oversight, dedicated public-facing access route, Guardian support arrangements and the incorporation of Thirlwall learning into policy and assurance.

Conflict of interest identified
Yes ☐ No ☒
Detail

Reporting – has this paper been discussed at other meetings		
Committee Name	Date discussed	Outcome
QPF	22nd October	Noted

Freedom to Speak Up Q1 and Q2 Report

1. Executive summary

This is the first six-month Freedom to Speak Up (FTSU) report for NHS Thames Valley Integrated Care Board (TVICB), covering Q1 and Q2 2026/27 and the period since the new ICB was established on 1 April 2026. It brings together activity, themes, organisational learning, governance development and the implications of the changing national FTSU framework.

The two predecessor ICBs, Frimley ICB and Buckinghamshire, Oxfordshire and Berkshire West (BOB) ICB, operated different FTSU models. A single TVICB arrangement was therefore required from day one. During the transition, responsibility for the Guardian function has been held by the Chief Nursing Officer (CNO), providing a clear route for staff while the wider organisational structure has been implemented. The CNO completed the required Guardian training and is registered with NHS England.

There was an understandable concern that the seniority of the CNO might discourage colleagues from approaching the Guardian. Experience during the first six months has not borne this out: staff have continued to use the route. The operating model will nevertheless broaden access and resilience as the new structure is established, with FTSU capacity built into the multiprofessional clinical leadership role and the Head of Complaints role and administrative support. This is important both to offer staff choice and to ensure sufficient protected capacity.

Fourteen concerns are recorded in the Q1/Q2 activity tables: six in Q1 and eight in Q2, all shown as closed at the reporting point. The principal theme is workforce experience during organisational change. Nine concerns were categorised as worker safety or wellbeing, two as bullying or harassment, one as patient safety or quality and two as other. The presentation describes 80% of concerns as relating to workforce experience during organisational change and highlights psychological safety, communication and transparency, and governance and assurance as the principal learning themes.

2. Purpose and assurance sought

The Board is asked to:

- Note FTSU activity, themes and learning for Q1 and Q2 2026/27.
- Note the transitional governance arrangements established since 1 April 2026 and the planned increase in Guardian capacity and access routes.
- Note the updated national context following closure of the National Guardian's Office (NGO) and transfer of specified national functions to NHS England.
- Note the findings of Chapter 40 of the Thirlwall Inquiry and the actions proposed to strengthen local assurance.
- Endorse the proposed strengthening of Board-level independence through a named Non-Executive Director FTSU lead and the further development of accessible, adequately resourced Guardian arrangements.

3. Governance arrangements since the establishment of TVICB

3.1 Transition from the legacy organisations

At establishment, TVICB inherited two different approaches to FTSU from Frimley ICB and BOB ICB. Rather than continue parallel legacy arrangements, the ICB established a single organisational approach. The TVICB FTSU policy was approved on day one, providing a common framework for staff across the new organisation.

The Chief Nursing Officer has held the Guardian function since April 2026 while the new operating structure has been implemented. The CNO has completed Guardian training and joined the NHS England arrangements for Guardians. Although the CNO initially considered whether the seniority of the role could create a perceived barrier to speaking up, there is no evidence from the first six months that this has prevented workers from raising concerns through the route. During this time the CNO has been supported by one of the BOB legacy guardians, however this individual has now been successful in securing a substantive position they will cease guardian activity.

3.2 Strengthening capacity and independence

The current model is transitional rather than the intended steady state. Capacity for FTSU is being built into the multiprofessional clinical leadership role and the Head of Complaints role and some administrative support. This will create additional access points, reduce reliance on a single senior office holder and provide practical capacity for case administration, data quality, reporting and follow-up.

The Guardian role is to listen, support, advise on options, ensure concerns reach the appropriate route and identify themes. It is not ordinarily the Guardian's role to investigate or resolve the substantive concern. This distinction is reinforced in current NHS England guidance and is particularly important where matters need to transfer into patient safety, HR, governance or other formal routes.

3.3 Policy, access and public information

The ratified TVICB day 1 policy has been reviewed prior to this submission and amended to reflect the changing organisation and the changed national framework. Updates include the FTSU email address, an additional form-based route, the new Guardian arrangements, replacement of obsolete references to the National Guardian's Office with NHS England arrangements, and updated routes and links. The staff facing website has been reviewed, with outdated NGO material removed and links refreshed. References to Freedom to Speak Up on the public facing website have been removed as the public route for concerns is through the concerns and complaints process.

Ioana Blue has been appointed as the interim Non-Executive Director FTSU lead until the substantive NED appointment is made. This has been recorded in the reviewed policy.

4. Q1 and Q2 activity

Quarter	Ongoing	Closed	Total
Q1 2026/27	0	6	6
Q2 2026/27	0	8	8
Six-month total	**0**	**14**	**14**

A review of the concerns identified most were resolved through early intervention, management discussion and HR support. It also showed that FTSU intelligence has informed communication with staff during organisational change.

5. Themes and organisational learning

Quarter	Worker safety / wellbeing	Bullying / harassment	Patient safety / quality	Other
Q1	4	0	1	1
Q2	5	2	0	1
Total	**9**	**2**	**1**	**2**

- Psychological safety: concerns included feeling unable to speak openly to line managers, fear of disadvantage after speaking up and perceived inequity in competition for roles.
- Communication and transparency: staff sought clear, consistent and accessible communication, including the ability to revisit engagement sessions and greater confidence in senior leadership communication during organisational change.
- Early intervention: listening, management conversations, HR support, mediation and organisational development interventions were frequently sufficient to prevent escalation.
- Learning into practice: FTSU feedback has influenced the recording of organisational briefings so colleagues can listen back, demonstrating a visible link between speaking up and improvement.

6. National context and implications for TVICB

6.1 New NHS England arrangements

From 1 July 2026 NHS England took on specified activities previously undertaken by the NGO, while healthcare organisations, including ICBs, assumed greater local responsibility and accountability for embedding effective FTSU arrangements. NHS England states that organisations must keep Guardian contact arrangements accurate, accessible and publicly available; submit quarterly data; ensure new Guardians complete foundation training and receive continuing professional development; and ensure appropriate psychological support for Guardians once the nationally sourced independent Employee Assistance Programme ends on 31 December 2026.

NHS England also confirms that quarterly quantitative FTSU collection applies to ICBs in 2026/27 and that wider access to submitted data is through Model Health System

For TVICB, these changes support the work already undertaken to update the policy and website, and they add two explicit assurance requirements for the next period: a documented continuing professional development/support offer for all Guardians, and confirmation of independent psychological support for Guardians beyond December 2026. They also strengthen the case for a clear public-facing FTSU page and robust quarterly data governance.

6.2 Thirlwall Inquiry: implications for local assurance

Chapter 40 of the Thirlwall Inquiry identifies significant variation in how Guardian roles are implemented, including concerns that Guardians may lack protected or ring-fenced time. It stresses the importance of proper support and training and concludes that Guardians should remain in place, with their work and organisational responses properly monitored and reported. The Inquiry also emphasises the value of external escalation where serious concerns are not addressed locally.

The Inquiry is particularly relevant to TVICB's developing model. It supports the planned move away from reliance on a single senior Guardian by creating additional capacity and access routes; reinforces the need to define protected capacity for the roles carrying FTSU responsibilities; and underlines the importance of Board assurance not merely that a process exists, but that concerns are listened to, acted upon, followed up and escalated appropriately. Chapter 40 also notes the importance of a senior NED role in supporting independence.

The Inquiry further highlights the risks of poorly chosen investigators and investigations undertaken without sufficient competence or independence. TVICB should therefore make explicit in its policy and case governance how conflicts of interest are identified, how an appropriately independent investigator is selected where investigation is required, and how the Guardian maintains oversight of whether the concern has been responded to without becoming the investigator.

6.3 Wider learning from NHS England

NHS England's October 2026 Board report describes FTSU intelligence as strategic organisational intelligence and warns against assuming that lower case numbers indicate improved culture. It advocates triangulation with staff survey and other organisational data, qualitative insight alongside metrics, adequate resourcing, leadership engagement and proactive feedback from workers who speak up.

The Benchmarking data looks at Trust rates, typically there is a range between 13 to 19 cases per 1,000 staff per year. This indicates that TVICB during Q1 and Q2 had a high rate of reporting.

This is directly relevant to TVICB during organisational change. The six-month report should therefore be viewed as both case reporting and an early cultural indicator, with regular thematic review by the Executive and Board and a stronger feedback loop demonstrating what changed as a result of speaking up.

7. Progress during Q1 and Q2

- Single TVICB FTSU arrangement established from 1 April 2026, replacing two different legacy models.
- Day-one TVICB FTSU policy established and subsequently reviewed to reflect current contact routes, the form process, Guardian arrangements and the transfer of national functions from the NGO to NHS England.
- CNO trained and registered and providing the Guardian function throughout the transition.
- Additional FTSU capacity designed into the developing organisational structure through multiprofessional clinical leadership, Head of Complaints and administrative roles.
- FTSU matters shared promptly with relevant leaders for awareness and action, with immediate escalation where appropriate.
- Attendance at South East ICB Guardian forums to support peer learning.
- Continued guidance for providers on FTSU pathways for primary care and dialogue with NHS England where concerns relate to system partners.
- Public-facing website refreshed, obsolete NGO links removed and current links updated; further work proposed to create a standalone FTSU webpage.
- Work progressing on a form-based route, including the option to raise a concern anonymously, together with information governance consideration of data retention.
- Use of a formal record of conversation to document the concern, agreed next steps and follow-up, supporting continuity and auditability.

8. Priorities and actions for Q3 and Q4

Priority	Action	Assurance sought
Governance	Confirm executive and Non-Executive FTSU leads, including the interim NED arrangement, and ensure NHS England records are current.	Named Board-level leadership and independent route.
Capacity	Implement additional Guardian/support capacity and define protected time within relevant roles.	Resilience, accessibility and compliance with Thirlwall learning.
Policy	Publish the revised TVICB FTSU policy with current routes, roles, escalation options and national references.	Single current policy across the ICB.
Access	Launch a standalone staff facing FTSU webpage and update intranet information.	FTSU is visible and easy to find.
Guardian support	Document CPD, peer/network participation and independent psychological support arrangements for Guardians.	Guardian wellbeing and ongoing competence.
Culture	Use Speak Up Month and ongoing communications to promote “speak up, listen up, follow up”, shaped by local staff feedback.	Visible leadership commitment and awareness.
Learning	Triangulate themes with Staff Survey/pulse, HR/OD, complaints and relevant quality/safety intelligence.	FTSU used as an early-warning and cultural indicator.
Thirlwall	Review investigation/conflict-of-interest arrangements and any further national response to the Inquiry recommendations.	Independent, competent escalation and learning.

9. Overall assurance and recommendation

The first six months provide reasonable assurance that a functioning FTSU route was maintained throughout the transition to TVICB, that colleagues have used the route despite in the interim the named Guardian being the CNO with support from legacy BOB guardian, and that concerns have generated tangible organisational learning. The Board should, however, view this as a developing arrangement rather than a completed model. The priority now is to embed greater capacity, choice and independence; strengthen data quality and follow-up; and demonstrate that speaking-up intelligence is routinely triangulated and acted upon.

The Board is invited to note this report and endorse the proposed next steps, particularly the strengthened Guardian resource, formal NED oversight, dedicated public-facing access route, Guardian support arrangements and the incorporation of Thirlwall learning into policy and assurance.

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Thames Valley Integrated Care Board

Title of Paper	Emergency Preparedness, Resilience and Response (EPRR) end of year update, including the annual Core Standards for EPRR assurance outcomes.		
Agenda Item	13	**Date of meeting**	18 November 2026
Exec Lead	Sam Burrows, Deputy Chief Executive		
Author(s)	Lyndsay Cladingboel, Head of EPRR and SCC		

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

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

Executive Summary

This is the Emergency Planning Resilience and Response (EPRR) Core Assurance Report which provides assurance that the Integrated Care Board complies with relevant legislation and guidance (as summarised by the NHS England's core standards for EPRR) as a category one responder.

The Board is asked to:

1. Note our compliance for EPRR 2026/27 is SUBSTANTIALLY COMPLIANT
2. Note the EPRR action plan for the Thames Valley ICB

Recommendation	The Board is asked to note/approve the following: The Thames Valley ICB's Overall Assessment as Substantially Compliant to the NHS Core Standards for EPRR. TVICB has achieved full compliance in **44/47** of the core standards with the remaining 3 reaching partial compliance.

Conflict of interest identified
Yes ☐ No ☒
Detail

Reporting – has this paper been discussed at other meetings		
Committee Name	Date discussed	Outcome
Audit & Risk Committee	10/11/2026	
Thames Valley LHRP Exec	10/11/2026	

Emergency Preparedness, Resilience and Response (EPRR) Update to Board

This report provides an Emergency Planning Resilience and Response update on the compliance of EPRR Core standards for Thames Valley ICB (TVICB).

To provide the Board with assurance that the organisation has undertaken its annual self-assessment against the NHS England EPRR Core Standards and to outline why this assessment is required.

The NHS Emergency Preparedness, Resilience, and Response Core Assurance process is a critical framework designed to ensure that all NHS organisations are fully prepared to respond to emergencies and incidents, whether they are health-related or otherwise. It is part of the broader resilience planning within the NHS, ensuring that organisations can continue to deliver essential services during a crisis and recover quickly afterwards.

The key Components of NHS EPRR Core Assurance:

- The NHS EPRR Core Standards are a set of requirements that all NHS organisations must meet.
- Assurance Levels: Organisations are rated based on their level of compliance with the EPRR Core Standards. The ratings used include:
    - **Fully Compliant:** The organisation meets all the required standards.
    - **Substantially Compliant:** The organisation meets most of the standards, with minor areas for improvement.
    - **Partially Compliant:** The organisation meets some of the standards but has significant areas for improvement.
    - **Non-Compliant:** The organisation does not meet a considerable number of the standards and requires urgent improvement.
- Improvement Plans:
    - If an organisation is found to be partially compliant or non-compliant, it must develop an improvement plan to address the identified gaps. NHS England monitors this plan to ensure progress is being made, via the regional EPRR meetings**.**

The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies which could affect health or patient care. These could be anything from extreme weather conditions, an infectious disease outbreak, a major transport accident, a cyber security incident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act (2004), the NHS Act 2006 and the Health and Care Act 2022. These require NHS organisations, and providers of NHS-funded services, to show that they can deal with such incidents while maintaining services.

This programme of work is referred to in the health community as emergency preparedness, resilience, and response (EPRR). New arrangements for local health EPRR form some of the changes the Health and Care Act 2022 made to the health system in England.

The Civil Contingencies Act (2004) (CCA) and the NHS England Emergency Preparedness, Resilience and Response Framework (2022) require NHS organisations and providers of NHS-funded care to have plans and arrangements in place to respond to such incidents while maintaining services to patients.

Under the CCA, TV ICB is defined as a Category 1 Responder, meaning it is subjected to the list of statutory duties listed in the Civil Contingencies Act (2004) Contingency Planning Regulations (2005).

In addition to meeting the CCA legislative duties, TV ICB is required to comply with guidance and framework documents, including but not limited to:

- NHS England Emergency Preparedness, Resilience and Response Framework.
- NHS England Core Standards for Emergency Preparedness, Resilience and Response.
- NHS England Business Continuity Framework.
- EPRR requirements laid out in the NHS Standard Contract.
- Minimum Occupational Standards for NHS Emergency Preparedness, Resilience and Response (MOS).
- ISO 22301:2019 Security and resilience – Business continuity management systems.

Why the Assessment is Important:

- **Statutory Compliance:** demonstrates fulfilment of duties under the Civil Contingencies Act and NHS EPRR Framework.
- **Readiness for Emergencies:** confirms capability to respond effectively to incidents such as major incidents, pandemics, cyber-attacks, or critical infrastructure failures.
- **Continuous Improvement:** highlights strengths and areas for development, ensuring resilience plans remain up to date and effective.
- **System-wide Assurance:** provides confidence to NHS England, ICBs and Local Resilience Forums of our contribution to system resilience.
- **Risk Management:** embeds preparedness into organisational governance, reducing patient safety incidents, reputational and operational risks.

Core Standards for EPRR Assurance 2026/27 TV ICB:

In October this year (2026), all NHS organisations conducted a self-assessment of their state of readiness against the NHS England published EPRR core standards.

There are different standards for each type of organisation to ensure the standards are relevant to the services they provide.

For TV ICB, the self-assessment of 47 ICB core standards has been completed, and it has identified that TV ICB is fully compliant in 44 of the standards (94% compliant).

The following three core standards were rated as partially compliant: (Appendix A)

- **Domain 1: Governance – EPRR Resource**

The Thames Valley ICB Consultation noted "capacity challenges were noted but financial requirements need to be met".

To mitigate this, ongoing recruitment will be prioritised during the current ICB restructure plan. Dual training SCC and EPRR team for additional resilience. The EPRR workplace is prioritised with all mandated areas of EPRR currently covered but limited capacity to provide additional duties.

- **Domain 9: Business Continuity – Data Protection and Security Tool Kit**

Thames Valley ICB will submit its next DSP Toolkit in June 2027. Both Frimley ICB and Buckinghamshire, Oxfordshire and Berkshire West ICB submitted their respective toolkits at the end of March 2026, with both receiving an outcome of “Standards Not Met.”

As both legacy ICBs were transitioning to the new Thames Valley ICB, this work has now been incorporated into a Thames Valley ICB workstream. An action plan is being developed to address the outstanding DSP Toolkit assertions and support the organisation in working towards achieving “Standards Met” for the June 2027 submission.

Current areas of focus include:

- ICB supply chain risk

- Information Governance (IG) training
- Completion of data flow mapping.

- **Domain 9: Business Continuity – Assurance of commissioned providers and suppliers BCPs.**

All acute, community and mental health providers have validated their business continuity arrangements through the Core Assurance process. The TVICB Contracting team have confirmed that suppliers who are awarded contracts through Direct Award B, assure the procurement team on their business continuity plans.
There remain many smaller providers who have not assured us of their contracts. To address, the Contracting team are identifying suppliers who provide high value contracts or the service is delivered to deprived populations and service are in place to address health inequalities.
These areas have formed part of the work plan for the remainder of 26-27 and will be part of the EPRR team workplan moving into 2027/28.
This is the first year that Thames Valley ICB (TVICB) has submitted a single organisational rating, with previous assurance submissions made separately through the former Frimley and BOB ICB arrangements. TVICB has achieved an overall rating of Substantially Compliant for the current reporting period. This reflects the continued work of the EPRR Team and the wider organisational commitment to maintaining effective EPRR arrangements. Considerable work has been undertaken to review and consolidate legacy Frimley and BOB documentation, processes and training arrangements, enabling the development of a consistent Thames Valley approach to EPRR across the organisation.
The annual Core Standards assurance process would normally also include a thematic deep dive. However, due to the reorganisation of NHS England, no deep dive will be undertaken this year.

NHS Providers self-assessment
This year the TV ICB EPRR team completed the peer review process with all Thames Valley NHS trusts, via a combined peer review check-and-challenge meeting:

- Undertaken with the Community, Mental Health and Acute Trusts participating in a plenary peer review.
- The Senior EPRR Manager also attend the check-and-challenge with Surrey and Sussex ICB and South-Central Ambulance Service and South East Coast Ambulance Service.

The providers presented their self-assessment submission and resulting action plans, along with key documents for greater scrutiny that included:

- Self-Assessment template
- Duty to Maintain Plans - Core Standard 10 - Incident Response Plan
- Duty to Maintain Plans - Core Standard 17 - Lockdown
- Training & exercising - Core Standard 24 - Training and Exercise Tracker and Commander Training Log
- An area of best practice
- An area for improvement

Thames Valley ICS Provider Core Assurance:

Provider	Core Assurance rating	Core Assurance Standards	Number / Areas of Partial compliance
Buckinghamshire Healthcare Trust.	Fully Compliant	62 / 62	
Frimley Health Foundation Trust	Substantially Compliant	60/62	Infectious Diseases, DPST
Oxford University Hospitals Foundation Trust.	Substantially Compliant	60 / 62	Adverse Weather Plan, Training and Exercising
Royal Berkshire Foundation Trust.	Fully Compliant	62 / 62	
Berkshire Health Foundation Trust	Substantially Compliant	52 / 58	Decision Logging, Business Continuity, and CBRN
Oxford Health Foundation Trust	Fully Compliant	58 / 58	

EPRR Work Programme

Governance

Following the formation of Thames Valley ICB, the EPRR Team developed a new EPRR Policy and Strategy, establishing a single organisational framework for EPRR responsibilities, governance and strategic priorities. Governance and oversight have been strengthened through the Emergency Planning Oversight Board (EPOB), which provides executive oversight of EPRR assurance, risk, planning, on-call arrangements, training and exercising.

A stronger approach to continuous learning and improvement has also been embedded within the governance framework. Learning identified through incidents, exercises, debriefs, Core Standards assurance and wider system activity is used to inform the EPRR work programme and associated improvement priorities. Actions and areas requiring further development are monitored through established governance arrangements, enabling progress, emerging risks and areas of non-compliance to be routinely reviewed and escalated where appropriate.

Together, these arrangements provide a clearer and more systematic cycle of assurance, learning and improvement. This ensures that EPRR arrangements continue to evolve in response to operational experience, exercising, assurance findings and changes in risk, rather than improvement activity being driven solely by the annual Core Standards assurance process.

Duty to Risk Assess

EPRR risks are embedded within organisational and system governance arrangements, with clearer mechanisms for identifying, escalating and monitoring risks. Links between ICB EPRR risks and wider system and multi-agency risks have also been strengthened through the Local Health Resilience Partnership (LHRP) and wider resilience structures.

At system level, the ICB is working through the Local Health Resilience Partnership (LHRP) to develop a more coordinated approach to identifying, assessing and managing risks that have implications across the wider health economy. The LHRP governance review has provided a foundation for moving beyond risks considered solely at individual organisational level towards a more structured and collective approach to system risk management.

This approach will enable identified system risks to inform LHRP priorities, workstreams and assurance activity, supporting greater visibility of shared risks, clearer oversight and a more coordinated approach to mitigation across system partners.

The LHRP has an established risk group, providing a mechanism for health partners to consider shared and emerging risks and determine where coordinated mitigation, planning or escalation is required. The wider LHRP arrangements are also being developed so that the Partnership's work programme is increasingly risk-led, drawing on national and local risk registers, planning assumptions, lessons from incidents and exercises, and intelligence from partner organisations.
The ICB is also strengthening the interface between the LHRP and Thames Valley Local Resilience Forum (LRF). The ICB represents health within LRF structures and has ensured representation across relevant LRF capability groups. This supports two-way risk management, enabling risks identified through the LRF and wider multi-agency partnership to inform health preparedness, while also providing a route for significant health-system risks to be understood and considered within wider multi-agency resilience arrangements.
This is creating a clearer line of sight between national and community risk, multi-agency assessment, health-system risk and ICB organisational risk, allowing the EPRR work programme to be increasingly prioritised according to identified risk.

Duty to Maintain Plans
A significant programme of work has been undertaken to review and harmonise legacy emergency preparedness arrangements and establish a single suite of Thames Valley plans and frameworks. This has strengthened organisational preparedness and created clearer and more consistent arrangements for managing incidents across the ICB.
Alongside the development of the plans, a structured programme is being established to ensure that they are embedded, tested and routinely reviewed. Each key EPRR plan will be supported by appropriate training for the Strategic and Tactical On-Call teams, ensuring responders understand the plan, associated action cards, escalation arrangements and their individual roles and responsibilities.
Plans will subsequently be tested through a programme of exercises and scenario-based activity, providing assurance that the arrangements can be implemented effectively in practice. This will enable TV ICB to test decision-making, command and control, escalation pathways and the practical application of individual plans.
Learning from plan training, exercises, incidents and debriefs will be used to identify improvements and inform subsequent plan reviews. This establishes a continuous cycle of plan development, training, exercising, learning and review, providing greater assurance that the ICB's plans remain current, understood by responders and operationally effective.

Command and Control
Following the formation of Thames Valley ICB, we have continued to develop and strengthen our on-call arrangements. Initially, a dual tactical model was established, with legacy teams providing cover for their respective areas under the oversight of a single Strategic Commander. Following a programme of training to ensure on-call teams had the necessary system-wide knowledge and understanding, we transitioned to a single Thames Valley model, with both Tactical and Strategic Command providing cover across the whole area.
All Thames Valley on-call staff have completed a refreshed Principles of Health Incident Command (PHIC) introduction. This is supported by an ongoing programme of training covering Command, Control, Coordination and Communication; Legal Logging and

Accountability; Local Risks; and Responding to Emergencies. Regular exercises are also undertaken to test knowledge, embed learning and support continued preparedness.

Training and Exercising

A structured programme of EPRR training and exercising has been established, including incident command and coordination training, on-call development and participation in organisational, system and multi-agency exercises. This is increasingly providing a systematic approach to developing and testing responder capability and identifying learning to support continuous improvement.

The ICB has participated in national, regional and multi-agency exercises, including Exercises Toucan and Cedar, the Regional Winter Test Event and Oxfordshire multi-agency exercises, including live testing of Survivor Reception Centre arrangements. This has provided opportunities to test communications cascades, command and control, multi-agency working and the practical application of emergency plans.

Response

The developing Thames Valley arrangements have been applied through the management of a range of incidents and business continuity events. This has provided opportunities to test command and control, system coordination, escalation and communication arrangements in practice and to use learning from incidents and debriefs to inform further development.

TV ICB has responded to and supported a broad range of incidents and disruptions, including major primary care IT disruption, infectious disease incidents, extreme heat, business continuity events, industrial action and provider service disruption. These events have tested the developing Thames Valley command, coordination and escalation arrangements in practice, with learning captured through debriefs and subsequently reflected in plans, action cards and response processes.

Notable events: TV ICB chaired the LRF response to the adverse weather and UKHSA Heat Health Alerts in June 2026.

Warning and Informing

The Communications team provides an on-call capability to support incident response, ensuring that communications advice and support are available outside normal working hours and aligned with Strategic and Tactical On-Call arrangements. This enables the timely development, coordination and dissemination of appropriate messaging to staff, partners, stakeholders, patients and the public, as required.

EPRR and Communications continue to work collaboratively to ensure that warning and informing arrangements are embedded within incident plans and response processes. This includes clearly defined communications roles and responsibilities, appropriate escalation routes, and arrangements for establishing enhanced communications coordination, such as a Media Advisory Cell, where the nature or scale of an incident requires additional support.

These arrangements have been tested and applied during live incidents. For example, during the response to extreme heat, a Media Advisory Cell was established alongside wider system coordination arrangements. Similarly, the response to the meningococcal cluster required coordinated communications across the ICB, UKHSA and wider health partners, demonstrating the importance of established communication and escalation arrangements during multi-agency responses.

Cooperation
The ICB's role within Thames Valley resilience arrangements has been strengthened, including its engagement with the LHRP, Local Resilience Forum and partner organisations. A review of LHRP governance is being progressed into a structured programme of improvement, strengthening links between risk, planning, capability development and assurance across the health system.

Business Continuity
A new Thames Valley ICB Business Continuity Plan has been developed alongside work to establish a more comprehensive Business Continuity Management System. This provides a stronger framework for business continuity governance. Work has also commenced with contracting colleagues to strengthen business continuity assurance relating to commissioned providers and critical suppliers.

Summary
This has been a year of significant transition for EPRR, with the formation of Thames Valley ICB requiring the alignment of different legacy arrangements, plans, governance structures and ways of working alongside the continued delivery of TV ICB's statutory EPRR responsibilities.
Despite this complexity, significant progress has been made in establishing the foundations of a single Thames Valley approach to EPRR. The work undertaken during the year has provided greater clarity around governance, risk, planning, on-call arrangements, and system partnerships, while learning from incidents and exercises has helped to further shape the priorities for the developing EPRR programme.
Importantly, bringing the organisation together has provided an opportunity to establish a clearer and more focused approach to EPRR across Thames Valley, identify the areas requiring further development and set clear priorities for the year ahead. The emphasis will now move from transition and development towards embedding, training, exercising and testing our arrangements, strengthening system resilience and demonstrating continuous improvement.
The ICB therefore enters 2027 with a clearer strategic direction, stronger foundations and a focused programme of work through which to further mature its EPRR capability and preparedness.

Annex 1: NHS England Core Standards for EPRR: Assurance rating thresholds

		Fully compliant	Substantially compliant	Partially compliant	Non-compliant
		100%	99-89%	88-77%	76% or less
Organisation type		Number of fully compliant core standards to achieve the percentage			
Acute providers		62	61-55	54-48	47 -0
NHS ambulance service providers	Core Standards	58	57-51	50-44	43-0
	Interoperable Capability Standards	136	135-121	120-104	103-0
Community service providers		58	57-51	50-44	43-0
Mental health providers		58	57-51	50-44	43-0
Integrated care boards*		47	46-42	41-36	35-0

Audit and Risk Committee Assurance Report

Audit and Risk Committee Escalation and Assurance Report – Alert, Advise, Assure	
Report From:	Audit and Risk Committee
Date of Meeting:	17 September 2026
Committee Chair:	Ilona Blue
Key escalation and discussion points from the meeting	
Alert:	
• Cyber-security assurance remains a significant concern, with six of seven overdue internal-audit actions relating to cyber and gaps noted in recent oversight-group minutes. • ISFE2 invoice backlog continues to present operational and fraud-risk pressures including invoices over 120 days old and anomalies dating back several years. • Single Tender Waiver analysis required to identify long-standing waivers and repeated suppliers, reflecting national concerns about dependency and governance robustness. This presents potential dependency, value-for-money exposure and weakened control robustness, aligning with national concerns and requiring urgent scrutiny.	
Advise:	
• Strengthen cyber-risk governance by ensuring Executive leads address concerns about risk appetite and EPRR-related cyber resilience. • Prioritise alignment of risk reporting across commissioning boards, the Corporate Risk Register and committee-level registers, with a refreshed Corporate Risk Register scheduled for November. • Resolve legacy security management contract duplication ahead of the 2027/28 workplan to ensure clarity of scope across Thames Valley sites.	
Assure:	
• Updated Risk Management Framework approved, with strengthened signposting and clearer reporting lines from the Emergency Planning Oversight Board. • External audit Management-letter action points show substantial follow-up work across legacy organisations, with most issues non-material and relating to documentation or process improvements. • Fraud-prevention controls are operating effectively, with false invoices detected and proactive fraud-check reviews underway across high-risk areas.	

Audit and Risk Committee Assurance Report

Audit and Risk Committee Escalation and Assurance Report – Alert, Advise, Assure	
Report From:	Audit and Risk Committee
Date of Meeting:	10 November 2026
Committee Chair:	Ilona Blue
Key escalation and discussion points from the meeting	
Alert:	

1. Cybersecurity

- Cyber remained an **Alert**, rather than moving to Advise.
- The BAF risk had been revised to reflect that the current position was **outside risk appetite**.
- The Committee welcomed the strengthened governance, RACI work and emerging improvement plan, but wanted measurable KPIs and firm closure of overdue internal audit actions. Updates expected between January and March to demonstrate impact of renewed grip.
- Role of whole organisation in cyber security was highlighted.

2. Individualised Care / invoicing

- Richard Chapman confirmed the root issue in moving the invoice backlog was the **underlying operational processes and systems for Individualised Care**, including CHC, Section 117 and complex care. There was now a viable route forwards having identified the cause of the problem.

Advise:

3. Procurement / supplier resilience

- ARC reviewed the developing work on **supplier resilience and concentration risk**, including plans for a critical-supplier dashboard, improved assurance and benchmarking.

4. Risk management

- ARC noted the **positive progress embedding the risk-management framework**, including development of Commissioning Board risk registers and the corporate risk register.

- The Committee nevertheless wanted future reporting to demonstrate the impact on actual risk exposure, including timescales for mitigation.

5. Counter Fraud

- ARC noted Counter Fraud activity, particularly the work planned around **International Fraud Awareness Week**. It was requested that this be flagged for the Board's attention.

Assure:

6. EPRR

- The ICB's first Thames Valley assurance assessment was **substantially compliant**, with evidence subject to NHS England assurance and improvement plans in place for partially met standards.

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Committee Escalation and Assurance Report – Alert, Advise, Assure	
Report From:	Remuneration & Culture Committee
Date of Meetings:	11 September, 6 October and 21 October 2026
Committee Chair:	Tim Nolan, Non-Executive Member

Key escalation and discussion points from the meeting

Alert:

None

Advise:

11 September 2026 via correspondence:

CEO and Deputy CEO arrangements: The Committee noted that NHS England has formally requested an increase in the secondment commitment of the Chief Executive Officer (CEO) of NHS Thames Valley Integrated Care Board to four days per week, to support delivery of national priorities. The CEO would retain overall accountability for the ICB, with a minimum of 20% dedicated time to provide strategic leadership, governance and system oversight.

To support executive leadership capacity during this period, the Committee approved the establishment of an interim Deputy Chief Executive Officer role, for 1 year from 1 October 2026. The Committee approved the appointment of Sam Burrows to the role on an interim basis.

6 October 2026:

Changes to the Executive Team: The Committee approved the contract for services arrangements in relation to the appointment of Sajjad Khan as an interim Executive Advisor for Commissioning and Strategy. The Committee noted that Sajad Khan had taken a sabbatical from his substantive NEM role for the duration of his interim Executive Advisor role.

The Committee agreed the proposed executive leadership and operating model for the duration of the extension to the CEO secondment arrangements.

The Committee supported the proposed backfill to Chief System Development & Engagement Officer.

Pay arrangements for the Interim Chief Strategy and Commissioning Officer: The Committee approved the pay arrangements for the Interim Chief Strategy and Commissioning Officer.

Clinical and Care Professionals Leadership (CCPL) Pay Arrangements: At its meeting in June 2026 the Committee had 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 (BOB) ICBs. At its meeting in August 2026 members noted the ongoing discussions with members of the CPPL about their concerns in respect of legacy pay arrangements. At

its meeting 6 October 2026 members approved the recommendations on next steps to enable resolution.

Establishing Medical and Dental Terms and Conditions: The Committee endorsed the establishment of Medical and Dental Terms and Conditions to support the employment of Public Health Consultants under nationally recognised NHS contractual arrangements.

21 October 2026:

Pay arrangements for the Interim Chief System Development and Engagement Officer: The Committee approved the pay arrangements for the Interim Chief System Development and Engagement Officer.

Clinical and Care Leadership Pay Framework – Amendments: The Committee approved the recommendation to consolidate the Clinical and Care Leadership (CCL) Pay Framework and the Deputy Chief Medical Officer (DCMO) payrates into a single framework with the inclusion two additional roles Designated Doctor and Named GP for Safeguarding.

Frimley Clinical Leads Pay Uplift 2025/26: The Committee noted that former Frimley ICB Clinical Leads had not received a pay award for 2025/26, while BOB ICB Clinical Leads had received a pay uplift in that year. To ensure equitable treatment, the Committee approved a backdated 2025/26 pay award for all former Frimley Clinical Leads who were employed during the relevant period, including any leavers who were within scope.

Assure:

Chief Officer Portfolios and Objectives 2026/27: The Committee noted the updated portfolios for the Deputy CEO and Chiefs that had resulted from recent changes to the Executive Team. The Committee noted the revised 2026/27 Chief Officer objectives.

Organisational Leadership Capacity and Capability: The Committee was provided with assurance on (i) the organisational design work that was being undertaken to construct teams which enabled high performance as a Strategic Commissioner and (ii) the development of a knowledge, skills, behaviours and leadership standards framework for the ICB. The Committee noted the position in relation to filled and vacant roles by banding and Directorate, as at the end of September.

Statutory and Mandatory Training: Organisational Arrangements and Chair/Non-Executive Member Requirements: The Committee noted the work that had taken place to align legacy BOB and Frimley ICB Statutory and Mandatory Training (StaM) arrangements with the current national framework. The Committee approved the role-based training approach for the Chair and NEMs and endorsed the (i) development of a Thames Valley StaM Training Guidance document and (ii) arrangements to strengthen training compliance and consistency across Thames Valley ICB.

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Committee Escalation and Assurance Report – Alert, Advise, Assure	
Report From:	Quality, Performance and Finance Committee
Date of Meeting:	22 October 2026
Committee Chair:	Tim Nolan, Non-Executive Member

Key escalation and discussion points from the meeting

Alert:

ADHD – Current performance is driving a number of concerns for the Committee. Most importantly patient experience for individuals with ADHD, both adults and children, is not where it should be. This is resulting in a notable increase in terms of complaints received. In addition, there is significant financial pressure associated with ongoing demand for assessment and medication, partly driven by the increasing numbers of independent providers. The Committee was assured that work was ongoing to review diagnostic pathways and ongoing management for ADHD. In addition, measures are being put in place to improve the assessment and guidelines relating to independent providers. It was agreed that a Deep Dive item on ADHD would come to the Committee in Q1 2027.

M06 Finance – The Committee recognised that whilst the ICB was forecasting a breakeven position at M06, significant risk had emerged with cost pressures in a number of areas, including s117/CHC individualised care, ADHD, community equipment and prescribing. Increased financial rigour has been introduced and urgent mitigations will be implemented, but year-end position remains at risk.

Advise:

Complaints – The Committee was pleased to see significant progress had been made in reducing the complaints backlog and response times were also improving. There remains work to do to reach ICB internal targets and the Committee will continue to monitor progress to ensure that a consistent 'business as usual' process and outcomes are achieved.

MH Provider concerns – A number of complaints had been received relating to a specific mental health provider on multiple sites, both from an advocacy service and a neighbouring ICB. TVICB Quality visits were undertaken, and no evidence of urgent safety issues were found but an ongoing improvement plan was being monitored by QOG. NHSE and CQC are sighted on this issue.

Cyber/AI/IG – The Committee noted that three new sub-committees focussing on Cyber, AI and IG would shortly be established, which would report into QPF on a quarterly basis, but could escalate urgent issues at any time.

Performance – The format for an initial performance report was discussed and Committee members provided feedback to support further development.

Risk – The Committee noted the further development work being undertaken on the Board Assurance Framework. Commissioning Boards would be reviewing their own risk registers during November and would escalate any areas of concern.

PSR – The Board noted the PSR update which showed good controls but a number of contracts still needed further management to ensure a satisfactory outcome for the ICB and patients.
Assure:
Freedom to Speak Up (FTSU) - The Committee were assured by the FTSU update for Q1 and Q2 which demonstrated a clear action plan, the addition of extra resource with new Guardians appointed and Ilona Blue as the interim NEM FTSU lead.

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Committee Escalation and Assurance Report – Alert, Advise, Assure	
Report From:	TVICB Commissioning and Population Health Committee
Date of Meeting:	28th September 2026
Committee Chair:	Sajjad Khan

Key escalation and discussion points from the meeting

Alert:

The Committee noted that whilst the Commissioning Intentions provide a strong strategic direction, members were clear that the next phase of work must focus on translating ambition into delivery. The Committee requested visibility of the delivery plan that will sit beneath the intentions, recognising that prioritisation and sequencing will be required given the scale of ambition and resource constraints. Members also highlighted the need to strengthen neighbourhood-level intelligence and incorporate wider system insight, including local authority, social care and VCSE perspectives, into future commissioning decisions.

Advise:

The Committee endorsed the proposed strategic commissioning framework, including the focus on three intervention types and three population cohorts, and advised that future work should further strengthen the links between commissioning priorities, resource allocation, inequalities, whole-system pathways and measurable outcomes.

Assure:

The Committee reviewed and scrutinised the draft Commissioning Intentions ahead of submission to NHS England and was supportive of the overall direction of travel. Members were assured that amendments would be made to strengthen references to inequalities, social care, local government and VCSE contributions, and delegated authority to the Chief Strategy and Commissioning Officer to finalise the document for submission by 30 September 2026.

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Committee Escalation and Assurance Report – Alert, Advise, Assure	
Report From:	System Delivery Committee
Date of Meetings:	22 October 2026
Committee Chair:	Priya Singh – ICB Chair

Key escalation and discussion points from the meeting

Alert:

Advise:

Planning – The Committee was supportive of the Planning process proposed, welcoming the collaborative approach, the alignment of individual organisation's plans and health and care partnerships having greater influence over modifiable areas of spend. The need for a clear timetable and decisions taken early to allow delivery of new services at pace was also discussed.

Maternity Review – The Committee discussed the scope and framing of the review, highlighting the need to utilise the existing evidence base and avoid duplicating work that had already been undertaken as part of national maternity reviews. The importance of engaging with communities and service users to gain insight into their experience was also highlighted, as well as identifying the appropriate title for the work.

Assure:

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THAMES VALLEY INTEGRATED CARE BOARD

Title of Paper	Board Assurance Framework and Board Governance Update		
Agenda Item	15	**Date of meeting**	18 November 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 November 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	Steve Dunn / Lalitha Iyer	Commissioning and Population Health Committee	4	4	16	4	3	12	SEEK / 16	In	=
1B	Financial	Cyber Security	Sajjad Khan	Quality, Performance and Finance Committee	5	4	20	4	4	16	OPEN / 12	Out	Increase 12->16
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	=

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Updates have been made against all outstanding actions, and new revised due dates have been agreed for all outstanding actions where applicable.

There has been one change to BAF scores in the interim Q3 position for risk 1B – Cyber Security. The score has increased since September from 4ix3l = 12, to 4ix4l = 16. This increase brings the score for Cyber Security outside of its tolerance threshold of 12, meaning the risk is now considered outside of the risk appetite threshold set by the Board in July 2026. The Board is asked to note this at and receive assurance that actions are underway to mitigate the risk further and bring the risk back within its tolerance threshold within the next 6 months as described within the BAF document.

The Audit and Risk Committee last reviewed the BAF at its meeting on 10 November.

The Board is also asked to note the following changes to BAF risk ownership:

- Steve Dunn has replaced Hannah Iqbal as the executive co-lead (alongside Lalitha Iyer) for BAF risk A1: Population Health / Health Inequalities.

- Sajjad Khan has replaced Hannah Iqbal as the executive owner for BAF risk 1B: Cyber Security. The Cyber Security risk has also been reassigned for ownership by the Quality, Performance and Finance Committee (previously Commissioning and Population Health Committee).

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 November 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 and Risk Committee	10 November 2026	

NHS Thames Valley ICB

Board Assurance Framework 2026/27

Interim Q3 2026-27 (November 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**	Steve Dunn / Lalitha Iyer	Commissioning and Population Health Committee	**4**	**4**	**16**	**4**	**3**	**12**	**SEEK / 16**	**In**	=
1B	**Financial**	**Cyber Security**	Sajjad Khan	Quality, Performance and Finance Committee	**5**	**4**	**20**	**4**	**4**	**16**	**OPEN / 12**	**Out**	**Increase 12->16**
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

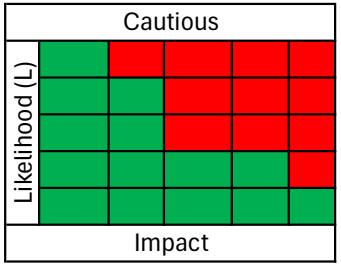
The Board has agreed its risk appetite in the following domains for 2025/26:

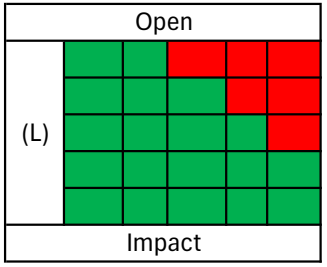
Domains	Risk Appetite	Risk Threshold
FINANCIAL	OPEN	12
PERFORMANCE	OPEN	12
PEOPLE	OPEN	12
REGULATORY	OPEN	12
REPUTATIONAL	OPEN	12
QUALITY	CAUTIOUS	8
TRANSFORMATION	SEEK	16

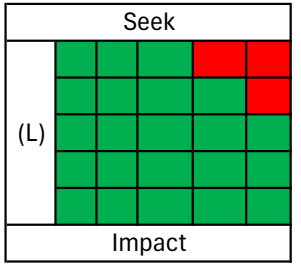
Risk Appetite	Description
None	We have no appetite for decisions or actions that will impact in anyway - avoid risk at all costs and all decisions taken to remove the risk
Minimal	We are only willing to accept the possibility of very limited risk and will avoid any decisions or actions that may result 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 Interim	Q4 26/27	Q1 27/28	Q2 27/8
I	L	Rating (IxL)	I	L	Rating (IxL)								
4	4	16	4	3	12	SEEK / 16	In	Nov-26	12	12	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. **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. **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. **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.	CMO / CSCO SLT meetings	Monthly	Commissioning and Population Health Committee	Quarterly	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, Exec Team meetings	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
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-Mar-27**	Lalitha Iyer / Steve Dunn	**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. **November 2026 Update**: The development of an Integrated Needs Assessment will be an important enabler in addressing this gap. It will bring together wider intelligence to support a more systematic understanding of local needs and inequalities. This will help inform commissioning priorities, service redesign and delivery decisions, although further work is required to ensure these insights, alongside lived experience and community intelligence, are consistently translated into action across the ICB.
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-Mar-27**	Lalitha Iyer / Steve Dunn	**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. **November 2026 update:** action remains ongoing.
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-Mar-27**	Lalitha Iyer / Steve Dunn	**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. **November 2026 update**: The launch of the Thames Valley ICB VCSE Alliance, which has now held its first meeting, provides an important opportunity to strengthen this approach by creating a more coordinated platform for VCSE organisations to share insight, influence priorities and inform service development. Further work is required to ensure that community intelligence and lived experience are 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 a provider supplier) could disrupt the delivery of patient care and affect the ICB's achievement of its strategic objectives.					Risk Domain: FINANCIAL				Current Risk Score: 16 (increase from 12)		
Assurance Committee: Quality, Performance and Finance Committee						Delegated Risk Owner: EA (Sajjad Khan)			Date Added to BAF: July 2026				
Initial Risk Rating (before mitigation)			Current Risk Rating (after mitigation)			Risk Appetite / Threshold	Status (in/out of appetite)	Last updated	Q2 26/27	Q3 26/27 Interim	Q4 26/27	Q1 27/28	Q2 27/28
I	L	Rating (I × L)	I	L	Rating (I × L)								
5	4	20	4	4	16	OPEN / 12	Out	Nov-27	12	16	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) Strategy and improvement planning: The Thames Valley cyber strategy, consolidated 2026/27 Cyber Risk Management Framework and 30-action improvement plan are drafted, drawing together legacy BOB/Frimley controls and both 2026 RSM audits. Formal approval, provider engagement and alignment to the new DSPT requirements remain outstanding. Delivery is tracked against individual action milestones, including the 30 May 2027 specialist-capacity target (CY-01, CY-03 and CY-04).	Cyber sub-committee	Monthly	Exec Team	Monthly	Annual NHSE Oversight Framework	TBC
2) Governance and accountability: SIRO/executive accountability and Digital leadership, Executive, Board and Audit Committee reporting routes are in place. New Thames Valley ICB Cyber and IG governance boards have been established, but the framework/RACI, reporting and assurance-evidence arrangements are not yet fully embedded. CY-01 has a target of 9 November 2026; the governance start date in its update requires confirmation. The tiered ICB, contracted-IT and commissioned-service responsibility framework is due by 31 December 2026 (CY-02). Closure remains subject to agreement.	4Risk Reviews	Ad hoc	Risk Oversight Group	Quarterly	Annual Internal Audit Programme	"Substantial Assurance" 25/26
3) Operational assurance and transition oversight: Quarterly operational assurance covers corporate and primary-care estates, including CareCERT and Microsoft Defender alerts, vulnerability/patching oversight, MFA/RBAC, privileged access, dormant accounts and secure-score monitoring. Backup and recovery testing is operating for the managed corporate estate. TTP Mobilisation Board and SE & SW Oversight Group arrangements are established; transition RACI, testing and handover evidence remain in development, with a 30 November 2026 target (CY-07).			Board, QPF, Audit Committee, Commissioning and Population Health Committee	Bi-monthly	Annual External Audit Programme	"No Control issues Raised" 25/26
4) Staff awareness: Mandatory IG/cyber training and inherited phishing-awareness controls are operating. Wider suspicious-email simulations and cyber-awareness campaigns across ICB staff and GP practices remain planned, with resources, schedule and completion evidence being confirmed. The rollout target is 28 February 2027 (CY-10).						
5) Funding and delivery capacity: More than £2m of national cyber investment has been secured over the 24 months reported in the October 2026 update and allocated into ICS organisations' cyber plans. Prioritisation, specialist capacity and evidence of benefits remain necessary; closure of the funding gap is requested, not confirmed (CY-06). Additional transition support depends on confirmation of Frontline Productivity funding expected in November 2026, with a view to onboarding support by December 2026 (CY-05).						
6) Independent assurance: 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 and one medium-priority supplier-assurance action. Recommendations are being addressed through the consolidated improvement plan; the audit tracker and assurance-evidence repository remain part of the arrangements to be embedded (CY-01 and CY-11).						
7) Supplier and contract assurance: Thames Valley leads the South East third-party risk management (SE TPRM) workstream. A phased model is being developed for critical-supplier registers, risk tiering, due diligence, evidence packs, exceptions and ongoing monitoring, with delivery through January–April 2027 (CY-11). Cyber and IG Minimum Standards are to be embedded in provider contracts by 31 March 2027 (CY-09). Specifications for services going live in February 2027 will be reviewed against new DSPT requirements; the CY-08 target is 28 February 2027.						
8) Provider and supplier resilience: Commissioning, procurement, contract, IG and annual DSPT/CAF evidence routes support oversight, but wider provider/supplier resilience assurance and testing remain incomplete. Updated incident procedures and supplier playbooks will support a supply-chain tabletop exercise due by 28 February 2027 (CY-12 and CY-13). Supplier off-boarding/emergency-revocation testing has a date to be confirmed. The proposed duplicate action remains retained pending agreement.						

Gaps in Control and/or Assurance	Mitigating Action	Target Date	Action Lead	Update
CY-01: 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; and establish the consolidated audit tracker, MI/KRI reporting and cyber assurance evidence repository.**	**09-Nov-26**	SIRO / Mark Sellman / Sajjad Khan	October 2026 update: The consolidated 2026/27 framework and 30-action improvement plan are drafted. Phase 1 covers governance and foundations, including the framework and RACI. The new DSPT was released in October 2026, and the plan will be realigned to the new requirements. The ICB has established new Thames Valley ICB governance boards covering Cyber and IG. These boards will manage and oversee cyber governance and reporting, starting in November 2027. Subject to agreement, closure of this control is requested as governance transfers to the new arrangements.
CY-02: Cyber responsibilities and assurance boundaries between the ICB, GP practices and ICS provider organisations are not sufficiently clear. Without agreed accountability, delivery and escalation arrangements, cyber actions may be duplicated or omitted, leaving gaps in assurance and delivery across the respective improvement plans.	**Establish clear cyber accountability across ICB-operated systems, contracted IT and commissioned services, ensuring each organisation fulfils its responsibilities and that assurance gaps and shared risks are managed through appropriate governance.**	**31-Dec-26**	Mark Sellman	October 2026 update: Introduce and approve a tiered cyber responsibility framework: Tier 1 – directly operated ICB systems; Tier 2 – contracted GP IT and corporate IT; Tier 3 – other commissioned services and contracts. Agree a RACI with GP practices and ICS provider organisations, distinguishing ICB accountability for its own services and commissioning/assurance from practice-owned local controls, staff behaviours and operational use, and providers' responsibility for their own services and cyber controls. Map each action, owner, evidence requirement, milestone and escalation route into the ICB, GP practice and ICS/provider improvement plans. Link shared dependencies and review delivery through the relevant governance forums.
CY-03: Limited engagement among ICS providers to increase cyber assurance across the ICS.	**Allocate funding and resources to work with providers to increase cyber assurance.**	**31-Jan-27**	Mark Sellman	October 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. However, cyber investment is now delivering capabilities across the ICS, and a progress update will be sought in January 2027.
CY-04: 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	October 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. The new cyber improvement plan will include cyber training for ICB digital staff. External support options will be reviewed and funded through Frontline Productivity funding. Subject to ICB support, longer-term staff development plans will be reviewed to incorporate cyber skills training and qualifications.
CY-05: The ICB cyber lead is also supporting the new IT service transition plans. Reliance on a single cyber resource may limit capacity during this period for cyber requirement-setting, assurance and improvement planning across the ICB, TTP and SE & SW infrastructure arrangements.	**Maintain sufficient ICB cyber capacity to support safe migration, clear requirements and delivery of improvement plans throughout the IT transition.**	**18-Dec-26**	Mark Sellman	October 2026 update: A review of priorities and workload for the Head of Infrastructure and Cyber has taken place. Non-critical workstreams are being off-boarded across the team, with senior support and monitoring in place. External cyber support options to bolster the ICB team are being explored in November 2026, with a view to seeking approval to onboard support by December 2026. Frontline Productivity (FP) funding has been approved in principle by NHSE, and FP investment agreements have been completed for approval. Subject to confirmation of FP funding, expected in November 2026, the ICB will go to market to source additional cyber support for migration requirement-setting and improvement plans. In the interim, activity will be prioritised and capacity monitored through internal ICB governance, with dependencies and delivery pressures escalated through the TTP Mobilisation Board and SE & SW Oversight Group.
CY-06: Lack of funding to implement more cyber-secure networks.	**Use NHS England cyber funding to support ICS providers to purchase cyber monitoring tools and proactively monitor their networks.**	**01-Dec-26**	Mark Sellman	October 2026 update: More than £2m of national cyber investment has been secured by Thames Valley 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. Closure of this gap is requested, as funding has now been allocated and incorporated into ICS organisations' cyber plans.
CY-07: The move to TTP and the SE & SW infrastructure model requires coordinated management of cyber responsibilities, service continuity and assurance.	**Agree clear cyber specifications with both providers and manage delivery through the SE & SW Oversight Group, TTP Mobilisation Board and internal ICB governance.**	**30-Nov-26**	Mark Sellman	October 2026 update: Mobilisation workstreams are developing joint testing and handover evidence for inclusion in the mobilisation plan. Readiness will be reviewed through the TTP Mobilisation Board and SE & SW Oversight Group, with material issues and any proposed residual-risk acceptance reported through internal ICB governance. Dates and named owners will be confirmed against the agreed transition timetable. Work is underway through weekly meetings to develop RACI models covering all cyber service specification requirements. Oversight groups are established, and tracking and monitoring reports will be issued in November 2026.
CY-08: Limited cyber requirements in IT service specifications for ICB and GP practice IT suppliers.	**Review and develop existing IT service specifications to document cyber resilience requirements clearly and ensure resources are available to monitor compliance. Ensure the new DSPT requirements are incorporated where applicable.**	**28-Feb-27**	Mark Sellman	October 2026 update: All cyber service specifications, including frontline and back-end infrastructure services going live in February 2027, will be reviewed to incorporate the new DSPT 2026 requirements where applicable. Future enhancements can be addressed through CCN contract changes following further cyber deep-dive reviews undertaken through the Frontline Productivity-funded work in 2027.
CY-09: No contractual requirements for ICS providers to deliver safe, cyber-secure services.	**The contracting team will review and update provider contracts to require cyber-assured and resilient services.**	**31-Mar-27**	Rich Chapman / Ian Murdock	October 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 delivery date of 31 March 2027. Work will also be overseen by the new cyber governance sub-committee.
CY-10: Limited ICB staff awareness of how to prevent cyber incidents.	**Fund resources to roll out suspicious-email and cyber-awareness campaigns across the ICB and GP practices.**	**28-Feb-27**	Mark Sellman	October 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, the schedule and completion evidence are being confirmed. As the ICB is undergoing an IT service transition, the date for this service is being moved to February 2027.
CY-11: No assurance of ICB suppliers' cyber security and resilience.	**The contracting team will assess all ICB suppliers for cyber assurance and resilience.**	**01-Apr-27**	Rich Chapman / Ian Murdock	October 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.
CY-12: Limited oversight of ICS providers' resilience testing.	**Allocate funding and resources to work with providers to undertake resilience testing.**	**28-Feb-27**	Mark Sellman	October 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, with the date to be confirmed.
CY-13: 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	October 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. Review note: The existing draft identifies this action as a potential duplicate of the supplier-assurance action CY-11 and proposes removal. Retained pending confirmation; the tabletop exercise also overlaps with CY-12.

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 Interim	Q4 26/27	Q1 27/28	Q2 27/8
I	L	Rating (IxL)	I	L	Rating (IxL)								
5	4	20	4	3	12	OPEN / 12	In	Nov-26	12	12	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	**31-Dec-26**	Sarah Bellars	**September 2026 update:** The backlog of complaints has reduced demonstarting that our recovery actions has had a positive impact. **November 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	**31-Dec-26**	Sarah Bellars	**September 2026 update:** Awaiting the review. **November 2026 update:** Awaiting the review.
Unclear escalation routes as a result of prolongued organisational change	Implement new structures	**31-Dec-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. **November 2026 update:** The ICB continues to implement the organisational change programme. The team will continue to work with known individuals until such time that the new organsational structures are known.

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 Interim	Q4 26/27	Q1 27/28	Q2 27/8
I	L	Rating (lxL)	I	L	Rating (lxL)								
5	5	25	5	4	20	OPEN / 12	OUT	Nov-26	20	20	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. 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. 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. 4) The Quality, Performance and Finance Committee 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	CFO 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
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.**	**31-Dec-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. **November update**: Capacity in this area remains limited with a number of continuing vacancies, however, the contracting team is now working as per the new organisational structure and some additional interim support in place also. Prioritisation of risk areas is on-going with contractual levers being utilised as appropriate. The ICB has completed the review of the aggregated plan and is assured that the activity levels commissioned were constructed using the same methoology as the operational plan and sufficient activity was commissioned to support delivery of the plan.
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**	**31-Dec-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. **November update**: Work in this area continues and a revised report supporting the amended ICB focus shared with QPF committee in October. There will be on-going review and development to ensure the final functioning suite supports all areas of required focus.
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.**	**31-Dec-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. **November update**: Staff transfer in this area has been enacted, and approval of the paper through audit committee associated with non-ICB emlployees authorisation right to commit expenditure enacted. Work in this area continues to ensure continued focus of the financial risks and actions required in these budget areas alongside the new ways of workings for the teams.

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: CPCAO			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 Interim	Q4 26/27	Q1 27/28	Q2 27/8
I	L	Rating (IxL)	I	L	Rating (IxL)								
4	4	16	4	3	12	Open / 12	In	Nov-26	12	12	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.	CPCAO 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-Dec-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. **November 2026 update**: Good progress continues to be made and stage 2 has now concluded. Stage 3 (restricted recruitment) will progress during November and will conclude (at the latest) before Christmas. Critical vacancies continue to be progressed, via the agreed due diligence route. The Commissioning Academy self-assessment is on track for completion by all four Commissioning Delivery Boards by mid-November 2026. The findings will inform the ICB's capability needs analysis and the design of an accelerated capability development programme, drawing on the national offer and enabling the ICB to participate in the first cohort of national support.
Risk to staff engagement, wellbeing and inclusion	**Deliver structured engagement plan, strengthen wellbeing support, and complete EDI impact assessments.**	**31-Dec-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. **November 2026 update**: The focus remains on maintaining staff engagement and wellbeing through the transition, ensuring EDI considerations continue to inform change activity and that appropriate support is available to staff.
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. **November 2026 update**: The Leadership and Management Framework continues to be embedded, supported by the Senior Managers Network and targeted leadership and team development. The focus is now on consistent application of leadership behaviours and ways of working across the new organisation to support cultural integration.
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. **November 2026 update**: Work is progressing on the ESR build to align workforce structures, positions and reporting arrangements with the new operating model. This will provide a stronger foundation for accurate workforce reporting and support development of the People and OD dashboard, improving workforce intelligence and Executive assurance.

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: CPCAO			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 Interim	Q4 26/27	Q1 27/28	Q2 27/8
I	L	Rating (IxL)	I	L	Rating (IxL)								
4	4	16	4	3	12	OPEN / 12	In	Nov-26	12	12	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-Dec-26	Chief Finance Officer	**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. **November 2026 update:** Submission for stranded costs was made by SCW CSU but as yet there has been no feedback from NHSE as to whether it is accepted. Additional stranded costs are being proposed by the CSU in respect of SE GP and Corporate IT transfers, but these have not yet been quantified and will require robust challenge by both TV ICB and KMSS ICB's
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-Dec-26	Chief People and Corporate Affairs Officer	**September 2026 update:** 14 CSU analytic staff TUPE'd into the ICB. **November 2026 update**: Focus is now on embedding the transferred resource within the ICB operating model and confirming that capacity meets ongoing performance, population health and commissioning requirements.
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-Dec-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. **November 2026 update**: Residual critical vacancies and capacity gaps continue to be monitored through transition arrangements.
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	Chief Finance Officer	**September 2026 update:** Ongoing. **November 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 Interim	Q4 26/27	Q1 27/28	Q2 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

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.

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	
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