NHS
Thames Valley

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

Agenda
Wednesday 20 May 2026 – between 12pm and 1.00pm

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
12pm	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 Joint Committee of BOB and Frimley ICBs held on 10th March 2026	Approve	Paper	Chair
		Reports to note or approve			
12.05pm	4	Chief Executive Officer's report	Note	Paper	Nick Broughton, Chief Executive Officer
12.15pm	5	Thames Valley ICB Case for Change and Strategic Objectives	Approve	Slides	Hannah Iqbal, Chief Strategy & Commissioning Officer
12.35pm	6	Quality Report	Note	Paper	Sarah Bellars, Chief Nursing Officer
		Other items of Business			
12.45pm	7	Public Questions		Verbal	Chair
12.55pm	8	Any other Business	-	Verbal	Chair
1.00pm	9	Close	-	Verbal	Chair

Timing	No.	Item	Action	Delivery	Lead
	10	**Date of next meeting: 15th July 2026**			

Thames Valley ICB Board Register of Interests - May 2026								
Job Title	Firstname	Lastname	Interest	Description of Interest	Type of Interest			Actions agreed with Line Manager to mitigate risk
Chief Nursing Officer	Sarah	Bellars	Son works for FHFT	Son worked for FHFT , currently as a student nurse	Declarations of Interest – Other	Indirect	Indirect	do not discuss work with my son
Partner Member - Local Authority	Sara	Blackmore			Nil Declaration			
Non-Executive Member	Ilona	Blue	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.
Non-Executive Member	Ilona	Blue	Accent Housing Group Limited	Non-executive director	Declarations of Interest – Other	Non-Financial Professional	Direct	I don't anticipate any direct conflicts, but should any discussions arise relating to housing in Frimley I would flag my interest and if necessary recuse myself from any discussions/decisions.

Non-Executive Member	Ilona	Blue	NB Solutions	I am a director (I own 25% and my husband Robert Nichols owns 75%) 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.
Non-Executive Member	Ilona	Blue	Defence Equipment and Support, an arms' length body of the MoD	Non-executive member of the Audit and Risk Assurance Committee	Declarations of Interest – Other	Non-Financial Professional	Direct	No conflicts anticipated.
Non-Executive Member	Ilona	Blue	Active Travel England, an executive agency of the Department for Transport	I am a non-executive director and Audit Chair	Declarations of Interest – Other	Non-Financial Professional	Direct	No conflicts anticipated
Non-Executive Member	Ilona	Blue	Network Rail, an arms' length body of the Department for Transport	I am an independent advisor to the Audit & Risk Committee and the Treasury Committee	Declarations of Interest – Other	Non-Financial Professional	Direct	None anticipated
Non-Executive Member	Ilona	Blue	Maritime and Coastguard Agency, an executive agency of the Department for Transport	Interim Non-executive director and Audit Chair. Term of appointment 1/2/25 to 31/10/25.	Declarations of Interest – Other	Non-Financial Professional	Direct	No conflict anticipated.
Chief Executive	Nick	Broughton	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.
Chief Executive	Nick	Broughton	Oxford Academic Health Partners (formerly AHSN)	Board Member – Oxford Academic Health Partners (AHSN)	Declarations of Interest – Other	Non-Financial Professional	Direct	Standing declarations – actions to be taken as deemed appropriate if conflict identified.
Chief Executive	Nick	Broughton	Oxfordshire Health & Wellbeing Board	Attendee	Declarations of Interest – Other	Non-Financial Professional	Direct	Standing declarations – actions to be taken as deemed appropriate if conflict identified.

Chief Executive	Nick	Broughton	Buckinghamshire Health & Wellbeing Board	Attendee	Declarations of Interest – Other	Non-Financial Professional	Direct	Standing declarations – actions to be taken as deemed appropriate if conflict identified.
Chief Executive	Nick	Broughton	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.
Chief Executive	Nick	Broughton	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.
Chief Executive	Nick	Broughton	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.
Chief Executive	Nick	Broughton	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.
Chief Executive	Nick	Broughton	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.
Chief Executive	Nick	Broughton	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.
Chief System Development & Engagement Officer	Samuel	Burrows	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.
Chief Finance Officer	Richard	Chapman			Nil Declaration			

Chief Transition Officer	Caroline	Corrigan			Nil Declaration			
Partner Member - Acute	Julian	Emms	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
Primary Medical Services Partner Member	George	Gavriel	Swan GP Ltd	Director and Shareholder	Declarations of Interest – Other	Financial	Direct	Standing Declaration - actions to be taken as deemed appropriate if conflict identified
Primary Medical Services Partner Member	George	Gavriel	Buckinghamshire GP Provider Alliance	Director of Partnersip Board	Declarations of Interest – Other	Financial	Direct	Standing Declaration - actions to be taken as deemed appropriate if conflict identified
Primary Medical Services Partner Member	George	Gavriel	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
Primary Medical Services Partner Member	George	Gavriel	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
Primary Medical Services Partner Member	George	Gavriel	Buckingahm 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
Primary Medical Services Partner Member	George	Gavriel	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
Primary Medical Services Partner Member	George	Gavriel	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
Primary Medical Services Partner Member	George	Gavriel	FedBucks	Shareholder on behalf of Swan GP Ltd and employed a spart of Buckinghamshire Primare care Provider Collaborative role	Declarations of Interest – Other	Non-Financial Professional	Direct	Standing Declaration - actions to be taken as deemed appropriate if conflict identified
Chief People Officer	Sandra	Grant	Sophies Legacy- Childrens Cancer Charity	Trustee	Declarations of Interest – Other	Non-Financial Professional	Direct	Standing declaration- to declare potential conflict of interest if engaged in decisions related ot childrens cancer.
Chief Strategy and Commissioning Officer	Hannah	Iqbal	John Radcliffe Hospital- Oxford University Hospitals (OUH)	Spouse employed as senior registrar in peadiatrics	Declarations of Interest – Other		Indirect	Standing declaration – actions to be taken as deemed appropriate if conflict identified

Chief Medical Officer	Lalitha	Iyer	Women's Scan Clinic	Director of private scanning company (company listed as Polar Diagnostics LLP)	Declarations of Interest – Other	Financial	Direct	Will declare COI and leave meetings if any relevant discussions take place
Chief Medical Officer	Lalitha	Iyer	Globe Management Consultants	I am the Secretary of the company which is owned by my spouse. I have no shareholding in this company.	Declarations of Interest – Other	Non-Financial Professional	Indirect	This company has no dealings with the Health Sector/NHS/CCG
Chief Medical Officer	Lalitha	Iyer	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.
Non-Executive Member	Sajjad	Khan	States Consulting Ltd	Director and Shareholder	Declarations of Interest – Other	Financial	Direct	No work currently being done within healthcare or public sector
Non-Executive Member	Sajjad	Khan	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.
Chief Executive - FHFT	Lance	McCarthy	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.
Non-Executive Member	Tim	Nolan	Labour Party	Member	Declarations of Interest – Other	Non-Financial Professional	Direct	Standing declarations – actions to be taken as deemed appropriate if conflict identified
Partner Member - Local Authority	Martin	Reeves	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.

Partner Member - Local Authority	Martin	Reeves	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.
Partner Member - Local Authority	Martin	Reeves	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.
Non-Executive Member	Gareth	Shepherd			Nil Declaration			
Chair	Priya	Singh	National Council for Voluntary Organisations	Appointed November 2020 - Chair of Board of Trustees	Outside Employment			
Chair	Priya	Singh	Society for Assistance of Medical Families	Appointed January 2018 - Executive Director	Outside Employment			
Chair	Priya	Singh	PG Mutual Insurance	Non-Executive Director	Declarations of Interest – Other	Financial	Indirect	Manage in accordance with COI policy.
Chair	Priya	Singh	CAF Nominees	Charitable Trustee	Declarations of Interest – Other	Non-Financial Professional	Direct	
Chair	Priya	Singh	Royal Trinity Hospice	Trustee	Declarations of Interest – Other	Non-Financial Professional	Indirect	In line of the COI policy.
Chair	Priya	Singh	Regulatory Oversight Board (Cricket Regulator)	Non Executive Director	Declarations of Interest – Other	Non-Financial Professional	Indirect	In line with the COI policy.
Chair	Priya	Singh	BOB ICB	Chair	Declarations of Interest – Other	Financial	Direct	Managed in accordance with policy.
Place Clinical Lead RBWM	Huw	Thomas	Claremont and Holyport practice	Partner in the practice	Declarations of Interest – Other	Financial	Direct	Will be managed in accordance with policy
Place Clinical Lead RBWM	Huw	Thomas	Maidenhead Primary Care Network	Practice is a member of Maidenhead PCN	Declarations of Interest – Other	Financial	Direct	Will be managed in accordance with policy
Place Clinical Lead RBWM	Huw	Thomas	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

Place Clinical Lead RBWM	Huw	Thomas	East Berkshire Primary Care	Work on sessional basis for East Berkshire Primary Care. EBPC provide out of hours care and other primary care services.	Declarations of Interest – Other	Financial	Direct	Will be managed in accordance with policy
Place Clinical Lead RBWM	Huw	Thomas	Holy Trinity Primary School, Cookham	Governor at school	Declarations of Interest – Other	Indirect	Indirect	Will be managed in accordance with policy
Place Clinical Lead RBWM	Huw	Thomas	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
Attendees:								
ED & I System Lead	Safina	Nadeem	Lancashire Cricket Foundation	ED & I System Lead	Declarations of Interest – Other	Non-Financial Professional	Indirect	
ED & I System Lead	Safina	Nadeem	Purfle Infusion Ltd	ED & I System Lead	Declarations of Interest – Other	Non-Financial Professional	Indirect	
ED & I System Lead	Safina	Nadeem	University of Surrey on Wellbeing Initiatives for NHS	Co-investigator on a research project	Declarations of Interest – Other	Non-Financial Professional	Indirect	

Minutes

Joint Committee meeting between NHS Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care Board and NHS Frimley Integrated Care Board – Meeting in Public

Tuesday 10 March 2026, 10.22-12.36

Held online via MS Teams

Chair – Priya Singh

Name	Role	Organisation
Members		
Priya Singh	Chair	BOB and Frimley
Sim Scavazza	Non-Executive Director (Deputy Chair BOB)	BOB
Paul Farmer	Non-Executive Member (Deputy Chair Frimley)	Frimley
Nick Broughton	Chief Executive Officer	BOB and Frimley
Sarah Bellars	Chief Nursing Officer	BOB and Frimley
Caroline Corrigan	Chief Transition Officer	BOB and Frimley
Saqhib Ali	Non-Executive Director	BOB
Ilona Blue	Non-Executive Member	Frimley
Sajjad Khan	Non-Executive Member	Frimley
Tim Nolan	Non-Executive Director	BOB
Lance McCarthy	Provider Partner Member – FH FT	Frimley
Graham Wareham	Provider Partner Member – SABP	Frimley
George Gavriel	Primary Care Partner Member	BOB
Prash Patel	Primary Care Partner Member	Frimley
Huw Thomas	Primary Care Partner Member	Frimley
Karen Edwards	Local Authority Partner member – RBC	Frimley
Grainne Siggins	Local Authority Partner Member – BFC	Frimley
Attendees		
Sam Burrows	Chief System Development and Engagement Officer	BOB and Frimley
Sandra Grant	Chief People Officer	BOB and Frimley
Hannah Iqbal	Chief Strategy and Commissioning Officer	BOB and Frimley
Matthew Tait	Executive Delivery Officer	BOB
Safina Nadeem	EDI Advisor	BOB and Frimley
Ollie White	Director of System Financial Sustainability	Frimley
Kelly Sutherland	Senior Corporate Office Manager (Minutes)	BOB
Sam Branscombe	Governance Support Officer	Frimley
MJ Steijger	Head of Governance	Frimley
Apologies		
Rich Chapman	Chief Finance Officer	BOB and Frimley
Lalitha Iyer	Chief Medical Officer	BOB and Frimley
Simon Crowther	Provider Partner member – OUHFT	BOB
Alex Gild	Provider Partner member – BHFT	Frimley
Grant Macdonald	Provider Partner Member – Mental Health	BOB
Susan Parsonage	Local Authority Partner Member – WBC	BOB
Aidan Rave	Non-Executive Director	BOB

Joint Committee Business

1. Welcome, Apologies for absence and Introductions

Priya Singh, Chair, welcomed everyone to the meeting.

Introductions were made and apologies were received as detailed above. The meeting was confirmed to be quorate.

The meeting was recorded, and the recording would be uploaded to both BOB and Frimley websites.

Ten members of the public had signed up to attend the meeting.

One public question had been received which would be answered at the end of the meeting.

2. Declarations of Conflicts of Interest

The Joint Committee noted the conflicts of interest registers for BOB and Frimley.

3.1	**Draft Minutes of the Previous Meetings**	
	The Joint Committee approved the following items: • *Draft minutes Joint Committee Meeting in Public – 13 January 2026*	
3.2	**Chair and CEO update**	
	The Chair reminded everyone that this would be the last public meeting of the Joint Committee of the BOB ICB and Frimley ICB Boards and advised that some people would be leaving as the new Thames Valley ICB Board was established. The Chair and Nick Broughton, Chief Executive Officer, wished to thank all Board members for their guidance and support since the ICBs were established in 2022 and especially through this recent transformation journey. Nick Broughton, Chief Executive Officer introduced the report, noting that he had now begun his secondment to Department of Health and Social Care (DHSC) as the National Priority Programme Director for Mental Health, Learning Disabilities and Neurodevelopmental conditions. This was a part-time role which Nick would be undertaking along his CEO role at the ICB. He also highlighted the significant organisational change at the ICBs, which was impacting a number of colleagues who would be leaving via the voluntary redundancy scheme at the end of March and thanked them for their service. It was noted that key appointments had recently been announced with James Blythe appointed as CEO at Royal Berkshire Foundation Trust and Raghuv Bhasin appointed as CEO at Buckinghamshire Healthcare Trust, having acted as Interim CEO since October 2025. Finally, it was reported that largely positive feedback had been received at the regional assurance meeting for the third quarter, with regards to the performance of both BOB and Frimley ICBs and the creation of the new Thames Valley ICB. *The Joint Committee noted the update.*	
Delivery of 2025/26 Priorities		
4.1	**Integrated Finance and Performance Reports for BOB and Frimley**	
	Ollie White presented the Finance and Performance reports for BOB and Frimley as at Month 10 (M10). Key headlines were reported as follows: • Both ICBs on Plan for 2025/26 • Both ICBs were forecasting to breakeven at year end and Finance teams were closely monitoring this and continuing to mitigate any in year risks that might arise. Matthew Tait provided an overview of performance, highlighting that local improvements, combined with the national focussed support programme for Urgent and Emergency Care (UEC) had resulted in achievement of the 78% target so far in March and this looked positive for year-end outcomes across the system. All Trusts had also agreed stretch targets for referral to treatment (RTT) and overall waiting list targets, with an additional £5m of national funding being invested to secure these improvements. It was noted that 62 day waits for Cancer remained challenging, but it was hoped that additional investment in the last quarter would lead to improved outcomes by the end of March. *The Joint Committee noted the Integrated Finance and Performance Report.*	
4.2	**Quality Reports for BOB and Frimley**	
	Sarah Bellars provided the Quality Report for BOB and Frimley which detailed high level updates against developing quality issues and current concerns. The following main points were highlighted:	

	• Never Events – there had been two Never Events reported at Royal Berkshire Hospital – one occurred there and one was following a procedure which had been undertaken abroad. • Additional funding had been invested in wheelchair services in Berkshire West in order to support waiting list issues and work was underway to resolve individual cases. In response to a question regarding how long it would take to reduce the waiting list, Sarah Bellars explained that the aim was to be compliant with the national framework, which stipulated an 18-week target. It was hoped that the additional investment would reduce the waiting list back to the national 18-week target within 12 months and individuals on the waiting list were currently being prioritised in terms of harm or potential harm. • EMED Patient Transport had previously been raised as an issue with the provider underperforming on KPIs. A contract performance notice was now in place and a recovery plan had been agreed. • Both BOB and Frimley were experiencing significant pressure on mental health beds, a trend that was replicated across the wider southeast region. • In response to a question about mental health beds, it was noted that the underlying problem was a lack of flow through the system, with discharges from acute beds being delayed. Nick Broughton reported that 10% of service users didn't require a mental health bed, but there was a lack of accommodation for those with complex care needs to be discharged to. Health needed to work closely with local authority colleagues on capacity and demand modelling in this area. • A member asked a general question regarding supplier failure and the impacts across the system. Matthew Tait advised that it was important to be sighted on potential supplier issues – he noted that the impact of the Equipment Services failure earlier in the year had been effectively managed by working closely with local authority and other partners to identify alternative suppliers. Sarah Bellars also noted that the impact of that failure had been monitored through safeguarding referrals. *The Joint Committee noted the update.*
4.3	**Workforce Reports for BOB and Frimley**
	Sandra Grant presented the Workforce Report for BOB and Frimley and the following main points were noted: • At regional level, improvements to workforce planning was being discussed. • The workforce team had been focussing on supporting the transition programme, e.g. ensuring safe transfer of staff records and payroll. *The Joint Committee noted the update.*
ICB Transition	
5.1	**Transition Programme Director's Report**
	Caroline Corrigan presented the Transition Director's Report and the following main points were noted: • All was on track for the safe close down of BOB and Frimley ICBs and the launch of Thames Valley ICB on 1st April. It was noted that Thames Valley ICB would be one of a few ICBs launching by 1st April and with Frimley boundary changes, staff now leaving under the VR scheme and the staff consultation live from 24th February, the complexities of the change programme were acknowledged. • Priya Singh had been confirmed as the Chair of the Thames Valley ICB Board and arrangements were in place for the appointment of Nick Broughton as CEO and other board members on 1st April. • Staff were being supported through the consultation process and had been briefed that further redundancies would be needed, in order to achieve the nationally determined reduction in ICB funding. • Caroline Corrigan was also working very closely with Frimley Health Foundation Trust to enable a safe transfer of several key services to them as a provider partner.

	The Chair thanked Caroline and her team and wider colleagues across both ICBs who had been involved in this programme of work. She also thanked Ilona Blue and Sim Scavazza who had co-chaired the Transition Programme Board which had overseen the programme. Sim Scavazza paid tribute to the huge amount of work that had been undertaken in order to reach this point and Paul Farmer, Chair of the Remuneration Committee also commented on the support that had been provided to all staff who had been impacted by the change programme, particularly those who had been part of the Southern Transfer, where Frimley staff were being transferred to Hampshire and Isle of Wight ICB or Surrey and Sussex ICB. Paul Farmer expressed the view that it was vital to capture learning from this process after April and also to think about how best to communicate the implications of this transition for staff, volunteers and the public who use our health services. Caroline Corrigan assured the Board that learning would be taken forward for any future change programmes. *The Joint Committee noted the report.*	
5.2	**Planning Submission – Final Version**	
	Hannah Iqbal, Chief Strategy and Commissioning Officer and Ollie White, Director of System Financial Sustainability, gave an overview of the Thames Valley ICB's Planning submission. The following main points were noted: • The new Thames Valley ICB would be established on 1st April with the core purpose of improving population health, reducing health inequalities and ensuring access to high quality services. The planning submission had tried to balance long term aspirations to deliver this core purpose, whilst also recognising short term needs of providers to deliver services to residents, in a challenging financial climate. • The Innovation Fund launch had been well-received and the number of expressions of interest was very encouraging. There was a further £15m left to allocate. • The final plan submission was financially compliant – there were risks around reaching a break-even position, with challenging efficiency targets and an alignment gap between contract assumptions held by the ICB and Providers, which were currently being worked through. • On a positive note, contracts could be in place for the new financial year. • Nick Broughton commended the Planning team for all their hard work and was pleased with the collaborative working that had been seen across the system. The Innovation Fund was exciting, had generated a lot of interest from partners and would be positive for the new ICB's future role. • Board members were also supportive of the Innovation Fund as a way of encouraging partners to think differently about how best to deliver services to support prevention and to support a shift from Hospital to Community. The priority of young people's mental health was also strongly endorsed and a data-led approach to commissioning was supported. • A non-executive member advised that the Thames Valley ICB Board should be cognisant of the importance of monitoring performance against the financial plan and the ICB's strategic objectives. It was important that metrics should demonstrate if an effective left-shift was occurring. *The Joint Committee noted the update.*	
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB		
6.1	**PSED Report**	
	The Joint Committee considered and discussed the Public Sector Equality Duty and Gender Pay Gap reports for both BOB ICB and Frimley ICB together. During the presentation, in answers to members' questions and during the subsequent discussions, the following main points were noted: • Under the Equality Act of 2010, BOB and Frimley ICBs were required to report annually to demonstrate compliance with the general equality duty through a PSED report. In addition, organisations of over 250 employees were required to publish a Gender Pay Gap report annually.	

	• The gender pay gap in Frimley for 2025/26 was reported as 21.9% mean and 26.2% median. This represented a slight increase in the pay gap from 2024. The workforce was made up of 72% women and 28% men. • The gender pay gap in BOB for 2025/26 was reported as 21.08% mean and 11.15% median. This represented a slight decrease in the pay gap since 2024. The workforce was made up of 74.5% women and 25.5% men. • An action plan would be developed for Thames Valley ICB to improve the gender pay gap. • The PSED reports set out system-wide progress in delivering the public sector equality duty through strengthened governance, partnership working and increased Equality, Diversity and Inclusion activities. • BOB's highlights included a programme of Antiracism webinars, production and promotion of reasonable adjustments guidance and a Joint ICS Black History month conference. • In Frimley, the Mirror Board programme had increased the confidence of participants, which for some, had resulted in meaningful career progression. Also, the 'Beyond Boundaries' systemwide antiracism framework had seen genuine engagement across partners, with the framework now well-embedded. • In addition, BOB and Frimley had worked together to develop inclusive recruitment and career progression practices across both ICBs. • Thames Valley ICB had agreed three priorities to enable EDI to be embedded in the culture of the new organisation – i) inclusive and compassionate leadership, ii) inclusive culture and belonging and iii) inclusive policies and practices. • There was a discussion about how the Board could better understand the reasons for the pay gap, in order to deliver tangible improvements. It was noted that in the UK the gender pay gap was systemic and existed across all industries. A report had suggested that it could take 30 years to close the gender pay gap. Therefore, it was perhaps more realistic to focus on certain aspects that might be contributing to the gender pay gap, such as understanding caring responsibilities of staff and how best to support carers at work. • It had been disappointing to see reports of discrimination in the recent staff survey. Sandra Grant, Chief People Officer commented that staff needed to feel well supported and able to progress in the new Thames Valley ICB and line managers should feel confident and supported in managing diversity. • Nick Broughton agreed that Thames Valley ICB should have an inclusive culture and emphasised the importance of Board leadership on the EDI agenda. He was very supportive of the Mirror Board programme, which he described as a great experience. • A non-executive member commented that it was important to keep momentum up particularly in inclusive recruitment. It was agreed that inclusion was everyone's business and that the Board needed to lead and deliver on this. • With a predominantly female workforce, it was important that the ICB also looked to combat violence against women and girls and promote safety in the workplace as well. Safina Nadeem explained that this could be incorporated via the Sexual Safety policy. *The Joint Committee noted and approved the PSED report for BOB ICB.*	
6.2	**Gender Pay Gap Report**	
	This item was discussed under item 6.1. *The Joint Committee noted and approved the Gender Pay Gap report for BOB ICB.*	
NHS Frimley ICB		
7.1	**PSED Report**	
	This item was discussed under item 6.1. *The Joint Committee noted and approved the PSED report for Frimley ICB.*	
7.2	**Gender Pay Gap Report**	
	This item was discussed under item 6.1. *The Joint Committee noted and approved the Gender Pay Gap report for Frimley ICB.*	
7.3	**Work Well Report**	

	Caroline Corrigan gave a short presentation on the Work Well programme. During the presentation and subsequent discussions, the following main points were noted: • One in five working age adults were out of the workforce due to ill health. Keep Britain Working proposed reform of the fit note process and workplace health provision to try and return people to work. • Frimley ICB was chosen as one of 15 pilot areas for the Work Well initiative in 2024-25. This pilot was now being expanded to all ICBs, with a phased rollout between April and November 2026, supported by £30million across the South East region. • Work Well aligned with the ICBs strategic commissioning work and links to priorities such as reducing health inequalities and prevention and early intervention. • The Work Well team would sit under the Chief People Officer and would not be counted in the £19 per head of population cost for Thames Valley ICB. In the longer term, a regional approach to Work Well was being considered to maximise resources and to make the South East an exemplar for Work Well 2.0. • The success of the Frimley Work Well scheme was applauded and it was hoped that learning could be shared to enable further success for Work Well 2.0. It was noted that all pilot sites had struggled to generate referrals early on and the team were now working with DWP to establish if number of referrals was the best performance indicator or whether a different metric should be used to evaluate success. • In response to a question on funding, it was noted that funding levels would be linked to the geographical size of the ICB, which would enable the Work Well team to expand. • A non-executive member commented that as the NHS was a significant employer across Thames Valley this could be a way of affecting powerful conversations with other larger employers across the region, to secure support for Work Well 2.0. • He also highlighted the need to support young people with mental health issues in securing employment, as well as supporting older people in their 50s to get back into work after a health issue. • A primary care partner member raised concerns about added pressure on GPs in terms of referring people into the Work Well 2.0 scheme. It was important that the programme was properly resourced and that the referral mechanism should not be too onerous. The Chair thanked everyone for their contributions to the discussion. *The Joint Committee noted the report.*	
Board Assurance Frameworks		
8.	**Board Assurance Frameworks Review**	
	Caroline Corrigan provided an overview of the Board Assurance Frameworks review and took members' questions. The following main points were noted: • The Board Assurance Frameworks (BAFs) for BOB and Frimley ICBs would be closed down and a new BAF established for Thames Valley ICB, as part of the wider Risk Management Framework. The Risk Management Framework would be agreed quickly in Quarter 1 and reported back to a public Board meeting. *The Joint Committee noted the report.*	
9.	**Joint Committee Assurance Reports**	
9.1/9.2/9.3	*Assurance Reports for the following committees were noted and taken as read, and detailed issues for escalation or notice for the period January -February 2026:* • *BOB Audit and Risk Committee* • *Frimley Audit Committee* • *Joint Finance and Performance Committee*	

Close of Business		
10.1	**Any Other Business**	
	Sim Scavazza, Deputy Chair of BOB ICB, particularly thanked BOB colleagues for all their support and highlighted Nick Broughton's progression from Partner Member for Mental Health on the BOB ICB Board to Chief Executive Officer for BOB ICB and more recently his new national role as National Priority Programme Director for Mental Health, Learning Disability and Neuro-developmental Conditions. She also thanked Priya Singh and Nick Broughton for their leadership during the transition period and Frimley colleagues, from who she had learned a lot. She would be watching on with interest as a resident to see how Thames Valley ICB would develop and deliver in the future.	
10.2	**Questions received from the Public** A member of the public had referred to a couple of extracts from the Thames Valley ICB Commissioning Intention's document and asked for clarity on the new ICB's approach to patient and public involvement. Sam Burrows, Chief System Development and Engagement Officer advised that the ICB would be committed to patient and public involvement and further information would be shared in the coming months.	
11	**Date of Next Meeting**	
	First public meeting of the Thames Valley ICB Board: Wednesday 20th May 2026 at 11am	
12.	**Close**	
	The Chair closed the meeting at 12.36pm.	

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Thames Valley Integrated Care Board

Title of Paper	Chief Executive and Chief Officer's Report		
Agenda Item	4	**Date of meeting**	20 May 2026
Exec Lead	Nick Broughton, Thames Valley ICB CEO		
Author(s)	All Chief Officers		

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 report provides an update to the Board on key topics and themes for escalation, that are not covered in other items on the agenda.	
Recommendation	The Board is asked to note the updates within the report.

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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Chief Executive and Chief Officers' Report

Context

1. This report provides an update to the Board regarding key topics of relevance in the Integrated Care Systems (ICS) and items for escalation.

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

3. Today's agenda includes sharing our Strategic Objectives and commissioning intentions for 2026/27.

Chief Executive update

Transition Programme Board

4. The last meeting of the Transition Programme Board took place on Friday, 17 April 2026. The BOB and Frimley ICBs' closedown report is appended to this document. The purpose of the board, which was jointly chaired by a Non-Executive Director from each ICB, was to oversee the safe transition to the new Thames Valley ICB on 1st April.

The Executive Team

5. From 18th May Sandra Grant, the ICB's Chief People Officer, will be seconded on a full-time basis to the NHS South-East region for the remainder of this financial year as the region's Interim Director of Workforce, Training and Education. Caroline Corrigan will cover the Chief People Officer role on an interim basis alongside continuing to be responsible for corporate governance and the broader change programme for which she is currently the Senior Responsible Officer. Having previously served as Chief People Officer for both the BOB and Frimley ICBs she is ideally placed to assume this role and will provide vital continuity of leadership during the next phase of transition.

Stakeholder Engagement

6. Since the last public Joint Committee meeting of the two ICBs I and fellow Chief Officers have held meetings with a number of our local MPs, chief executives and executive colleagues from our Local Authority partners, and senior NHS leaders from primary care and both NHS and Foundation Trusts.

Publication of 2025/26 ICB Annual Assessment Guidance

7. NHS England has published the supporting guidance for the 2025/26 annual assessment of integrated care boards (ICBs). This year's guidance sets out a streamlined, approach, reflecting the evolving role of ICBs and recent changes across the system. It provides details on the areas the annual assessment will cover, as well as information on timing and process, and is intended to support regional teams and ICBs in preparing for the 2025/26 assessment cycle.

System Leadership

8. South Central Ambulance Service NHS Foundation Trust (SCAS) and South East Coast Ambulance Service NHS Foundation Trust (SECAmb) have announced the appointment of Simon Ashton as Group Chief Executive and Colin Dennis as Group Chair. They will provide leadership across both organisations so further strengthening collaborative working between the two trusts.

   Oxford Health NHS Foundation Trust has announced that Dr Michael Holland will succeed Grant Macdonald and become the organisation's Chief Executive later this year subject to the completion of pre-employment checks.

Organisational Change

9. Our focus for ICB staff for quarter one is to continue to provide support during the change process, conclude our new structure plans and clarify the employment position for each staff member. We will

finalise our detailed HR and organisational development roadmap to share with staff so that they are clear about the timelines for both the HR process and the developmental support we will be providing to them, including how each person understands the role they will play in delivering our new operating model and the contribution individual roles will make towards the strategic commissioning of NHS services across the system.

Mount Vernon Cancer Centre – Public Consultation Update – Thames Valley

10. The public consultation regarding proposals for the future of the Mount Vernon Cancer Centre in Rickmansworth was launched on 19 January 2026, following national and ICB approval to proceed. The consultation, which ran until 29 March 2026, sought views on the proposed relocation of the cancer centre to Watford and on the options for an additional satellite radiotherapy unit.

    A comprehensive engagement programme ensured broad participation. This included a series of online and in person events, with general discussion sessions, topic specific sessions on travel and access, and dedicated sessions for clinical and professional groups. Events were held across the two ICB footprints supported by targeted promotion through system and community networks. A microgrants scheme was also in place to enable voluntary and community organisations to engage seldom heard groups and facilitate local discussions.

    For some residents, particularly those living further from Watford, the proposals may result in longer travel times to the main cancer centre. The consultation was therefore explicitly seeking views on travel, access and the potential role of networked and local models of care to minimise disruption and support care closer to home when clinically appropriate.

    All feedback gathered through the consultation directly informed the Decision-Making Business Case (DMBC), which is scheduled to be completed during the second quarter of this financial year. Thames Valley ICB continues to be represented on the Mount Vernon Cancer Centre Programme Board to ensure that the proposals reflect the needs of local populations and support equitable access to high quality cancer services.

Regional Governance

11. I am pleased to announce that the interviews that took place to appoint a Chair for the NHSE South-East region resulted in the appointment of Sir Jonathan Montgomery, previously Chair of Oxford University Hospitals NHS Foundation Trust. Sir Jonathan took up his appointment as of 1st April.

    Sarah Hordern has become the Acting Chair for the Trust pending a permanent appointment. She was previously a Non-Executive Director and Chair of the Trust's Investment Committee.

Peer Support and Organisational Development / SE Region ICBs update

12. The South-East Integrated Commissioning Boards' Chief Executive Officers Joint Committee met on 14 April 2026. A copy of the report from this meeting is attached as appendix A. At this meeting we strengthened governance and collaboration arrangements, approved core enablers including refreshed Terms of Reference, a Memorandum of Understanding and shared resourcing, progressed delegated specialised commissioning and the Office of Pan ICB Commissioning programme, and endorsed the continued development of priority regional transformation programmes to deliver improved outcomes, efficiency and commissioning capability at scale across the South-East

Chief Officer updates

Chief Medical Officer

13. Following an Expressions of Interest process led by the former NHS Buckinghamshire, Oxfordshire and Berkshire West ICB to find an affordable and compliant alternative developer, Woodlands Medical Centre has appointed London based Apsley Henley Med Ltd to deliver the new Great Western Park GP surgery. The developer will work with the practice, Thames Valley ICB and Vale of White Horse District Council to finalise legal agreements, complete the land transfer to the district council, and ensure regulatory compliance is met. Thames Valley ICB remains fully committed to delivering the new surgery.

Chief People Officer

14. As we report Month 12 performance, for the last financial year it is important to note that the BOB providers delivered their annual workforce plans as forecast and that we were the only system in the South-East to achieve this. For both BOB and Frimley there continue to be reductions in agency usage with Frimley ending the year 33% below plan, and BOB 40% below plan. Greater focus needs to be given this year to improve the control of bank usage and to deliver plans which demonstrate workforce transformation. There will no longer be a team in the ICB to guide and support Trusts with workforce planning and performance, but greater resource is planned for this within the regional People Team.

Chief System Development and Engagement Officer

15. Work continues with our providers in primary, community and secondary care to explore new ways of working in both physical and mental health care delivery. These approaches are being worked up and will be presented to a future meeting of the board, demonstrate a close alignment with the national Integrated Health Organisation development / delivery programme which seeks to use greater collaboration to deliver more integrated and effective care.

    We continue to put engagement at the heart of our work and have held a number of positive sessions with Healthwatch, the broader VCSE community, MPs, elected councillors and partners over the last two months. The Frimley Integrated Care Partnership (ICP) met and brought a range of local stakeholders together to celebrate success and identify programmes of work to be transitioned into the Thames Valley geography.

    We continue to engage positively with the Frimley New Hospital Programme and are working with our colleagues at Frimley Health Foundation Trust towards being able to announce the preferred site for the new hospital in the months ahead. Sam Burrows our CSDEO and Lalitha Iyer CMO attended a New Hospital Programme focused working session in London at the end of April to define some of the clinical transformation opportunities which will make this development a success.

Chief Strategy and Commissioning

16. At March's board the planning update paper included a detailed report of the progress made to establish the Thames Valley Innovation Fund. Phase one of the fund allocated £37 million, and phase two had commenced to enable the remaining balance of the fund to be allocated.

    As part of phase two, five priority areas have now been identified and seven workshops have taken place throughout March and April, with input from over 150 system partners. The workshops enabled a collective consideration of the priority areas and have helped to develop a set of specific proposals, all of which support the three common themes which emerged – that the innovation fund should target populations experiencing inequalities, should reduce the unwarranted variation in provision of services, and should support neighbourhood and partnership development.

    As a result of the workshops, we have nine specific interventions proposed across the five priority themes, each of which has defined the expected impact on the outcomes of cohorts of our Thames Valley population. Work has commenced to agree further detail for each proposal, establish a process to ensure relevant local partners are fully involved and to finalise the resource requirements. This will continue throughout May in readiness for relevant procurement and delivery governance.

Equality, Diversity & Inclusion Advisor

17. EDI remains central to the organisation’s change agenda and a key priority for the ICB going forward. To support this commitment, a series of workshops has been scheduled over the coming months for line managers and staff, focusing on inclusive recruitment practices and interview skills development.

    An internal Equality Staff Network Chairs Forum has been established to strengthen EDI engagement across the ICB, providing a structured mechanism for collective feedback, insight, and collaboration on key EDI priorities.

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Thames Valley Integrated Care Board

Title of Paper	Thames Valley ICB Case for Change and Strategic Objectives		
Agenda Item	5	**Date of meeting**	20 May 2026
Exec Lead	Hannah Iqbal - Chief Strategy and Commissioning Officer		
Author(s)	Paul Swan – Head of Strategic Commissioning and Planning		

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

Link to Strategic Objective	*All*

Executive Summary	
This paper sets out the new Thames Valley ICB strategic objectives following its formal constitution from 1 April 2026. Part 1 and Annex A of the paper outlines the developing the Thames Valley case for change informed by our population segmentation approach, which tells about our population needs today and how they will change over time. The first insights from this analysis are included at Annex A of the paper. They form the foundation of our strategic commissioning approach. Part 2 of the paper sets out how we are approaching our long-term population health strategy development, framed around the three ICB strategic objectives and three population health interventions.	
Recommendation	The Board is asked to endorse the approach outlined and to specifically approve the Thames Valley ICB strategic objectives for adoption as set out in the paper.

Conflict of interest identified
Yes ☐ No ☒
Detail

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

Thames Valley ICB Case for Change and Strategic Objectives

Overview

1. The Thames Valley ICB was established on 1 April 2026 with a refined purpose of strategic commissioning. Strategic commissioning is the continuous, evidence-based process through which ICBs plan, purchase, monitor and evaluate services to improve population health, tackle inequalities and secure equitable access to high quality care.

2. Since the establishment of the new organisation, the Board have been reviewing data about our population and using this to inform the ambition we set for the organisation, through its strategic objectives. These strategic objectives will form the central frame for the work of the ICB, as organising principles for:

    - Metrics and outcomes we measure, using our measurement framework
    - Risks we identify and track mitigations against
    - Strategic programmes we develop to drive change

3. This briefing paper summarises the work we have undertaken during the first month of the organisation, focusing on the first two stages of the strategic commissioning cycle:

    - Part 1: Understanding our local context
    - Part 2: Setting long term population health strategy

Part 1: Understanding our local context

4. We have developed a detailed case for change setting out what the data tells us about our population needs today and how they will change over time. This is the baseline for understanding our population and is the foundation of our approach to strategic commissioning.

5. We have developed this using population segmentation. Segmentation is the systematic grouping of a population into cohorts with similar needs, risks, or characteristics (e.g. frailty and multi-morbidity). These groups are mutually exclusive, and patients can move up and down segments as their needs change. In Thames Valley we segment our population using the Johns Hopkins Patient Need Groups (PNG) approach – a well-established, clinically meaningful method used internationally. PNG allows us to group residents by similar health needs, supporting both strategic planning and practical action. It can be used at system level to shape services and at patient level to tailor care, pathways and interventions.

6. By connecting across primary, secondary and commissioning data, we can build a deep picture of our population's needs today, how they will change over time and how this relates to how healthcare resources are utilised across our geography.

7. **Annex A** sets out this case for change and illustrates how we are starting to turn insights into action and turn our strategic objectives into programmes of work which shift the dial for our population.

8. This initial case for change analysis was discussed at a Board Development Day on 22 April. We are sharing it in public today as the foundation of our work as a strategic commissioner.

Part 2: Setting long term population health strategy

9. Our case for change analysis sets out how our Thames Valley population is ageing, their needs are growing more complex, and we have significant inequalities of outcome across different geographies. This all has an impact on how we use resources today and how we need to redistribute them and reorganise ourselves in the future.

10. If we treat this as our diagnosis, our strategy needs to define our approach to grappling with these fundamental challenges. We are framing this around our **three strategic objectives** (set out on the final page) and **three population health interventions** (set out below). These will frame our work over the next three years.

11. Thames Valley Population Health Interventions:

    - **Optimise pathways:** We will optimise the offer to our population within each segment to improve experience and value (model of care, pathway, resources)
    - **Slow progression:** Slow progression from lower to higher need segments through prevention and proactive care, reversing progression where possible.
    - **Target hidden need:** Address underrepresentation of certain populations from the data. Work to better identify and drive improvement for these groups (e.g. unregistered; Core20Plus5).

Recommendation

12. The Board is asked to endorse the approach outlined and to specifically approve the Thames Valley ICB strategic objectives for adoption.

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

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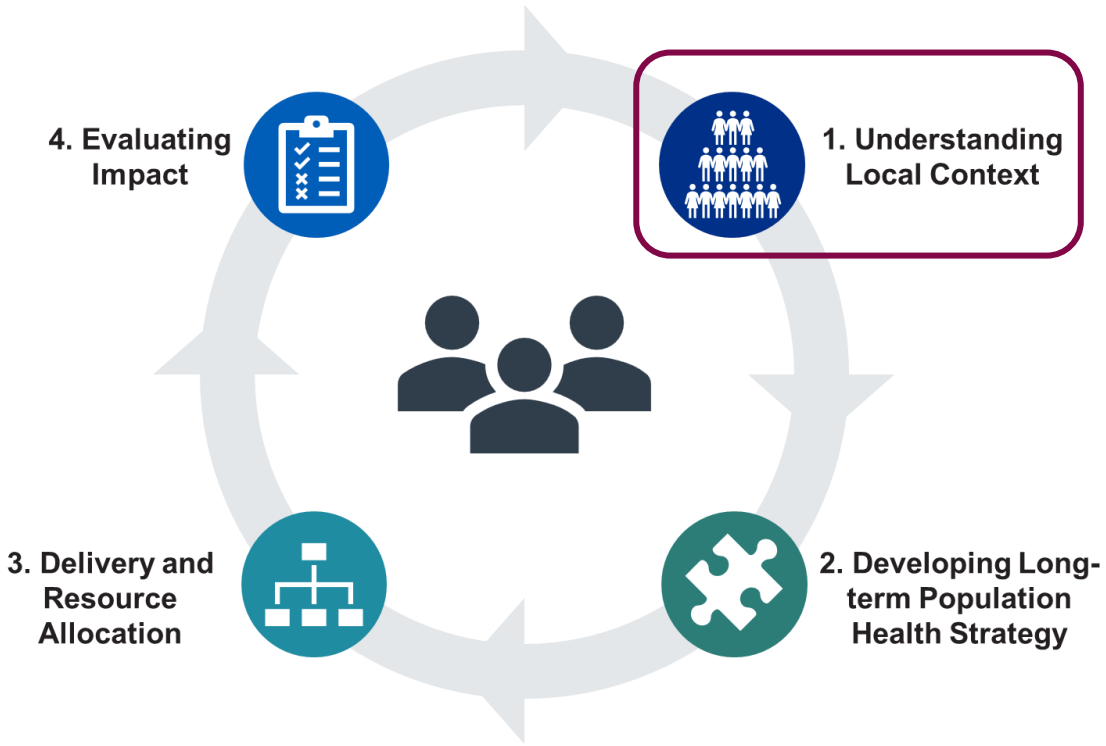
Thames Valley Case for Change

Thames Valley ICB Board

20 May 2026

Annex A

The strategic commissioning cycle



- Strategic commissioning is the **continuous, evidence-based process** through which ICBs plan, purchase, monitor and evaluate services to improve population health, tackle inequalities and secure equitable access to high-quality care.
- It requires using public resources to **create the greatest value for local populations**, in line with the NHS Constitution and with a clear focus on long-term outcomes.
- ICBs act as strategic commissioners **on behalf of their populations**, working with local government and partners to address the wider determinants of health and support wider socioeconomic development.
- Strategic commissioning is **central to the NHS's shift from sickness to prevention, hospital to community, and analogue to digital** - improving both allocative efficiency (ensuring resources flow to the most effective mix of activities) and technical efficiency (supporting providers to deliver care more productively).

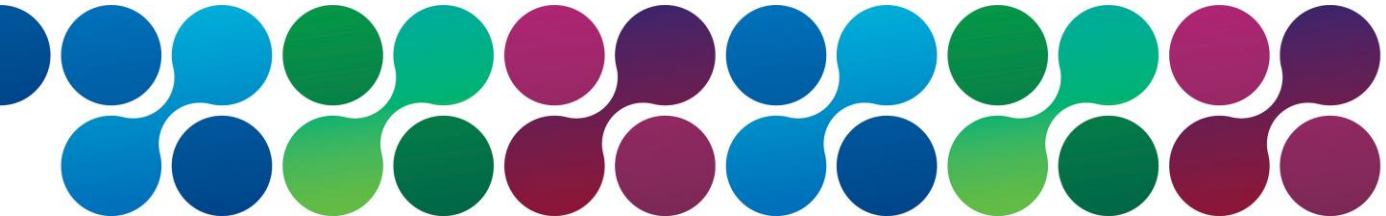
Overview

Understanding the context is the foundation of strategic commissioning, bringing together population insight, unmet need and future demand to build a clear view on what is driving outcomes across the system

To support this, we have created a **new analysis of the Thames Valley population**. It tells us five strategically important points:

1. That segmentation is a key enabler to shift us to outcome-based commissioning
2. How the needs of our population will change over time
3. The rising complexity of need which requires us to shift from reactive to proactive
4. How deprivation and inequalities impact outcomes and how services are used
5. That we need to use these insights to shape our decisions and actions.

Section 1: Why segmentation matters



What is segmentation?

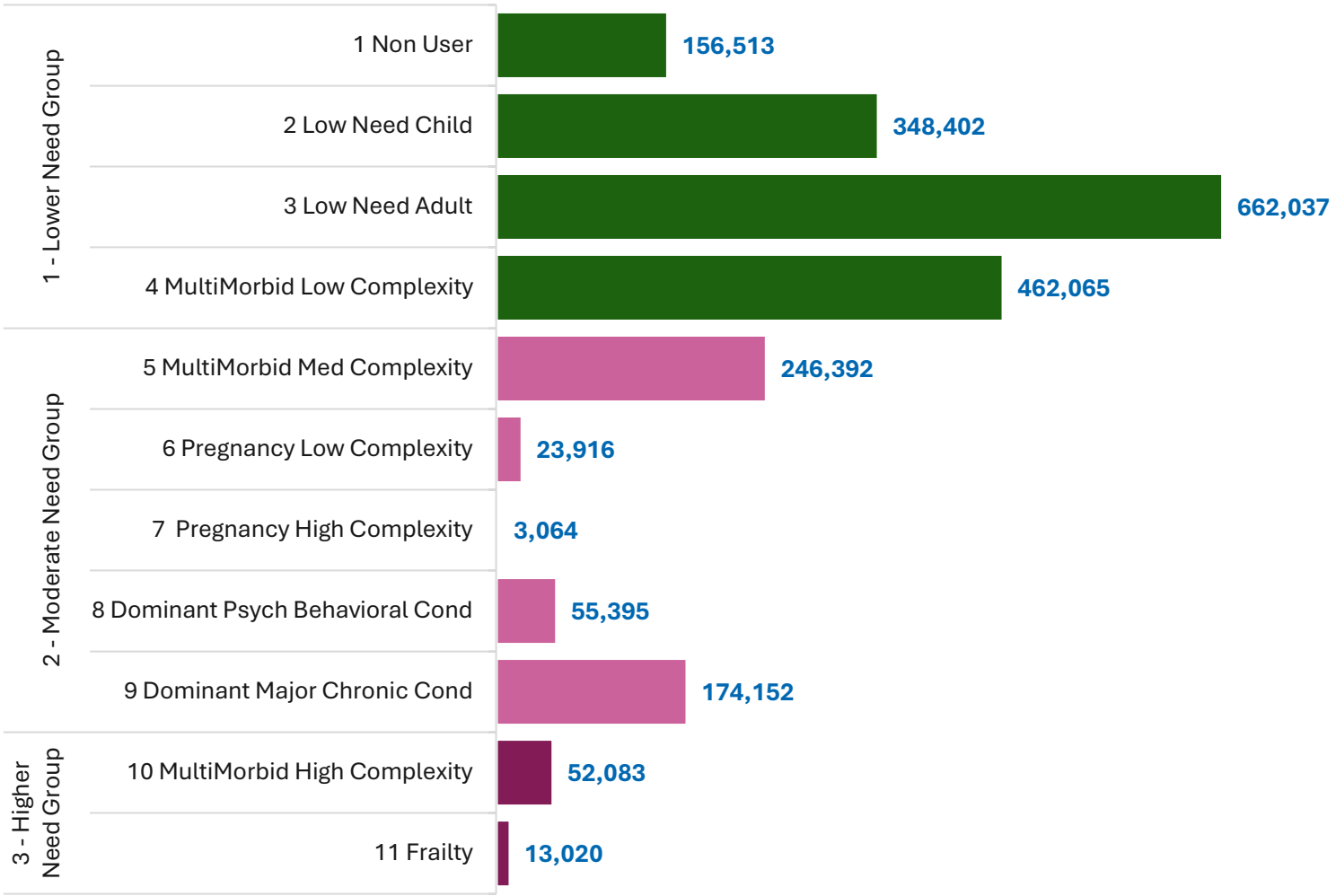
Segmentation groups our population into mutually exclusive groups that incorporates the needs of our population to support outcome-based decision making

- Segmentation is the systematic grouping of a population into **cohorts with similar needs, risks, or characteristics** (e.g. frailty and multi-morbidity). These groups are mutually exclusive, and patients can move up and down segments as their needs change.

- In Thames Valley we segment our population using the Johns Hopkins Patient Need Groups (PNG) approach – a well-established, clinically meaningful method used internationally. PNG allows us to group residents by similar health needs, supporting both **strategic planning and practical action**. It can be used at system level to shape services and at patient level to tailor care, pathways and interventions.

- This **capability** to be able to go from 2.5 million patients at a Thames Valley level to places, LSOA or small cohorts of patients to intervene is critical in linking strategy to action.

The Thames Valley population segmented into Patient Need Groups



Size of cohorts by Patient Need Group

Interpretation:

- Our **Low Need** segment comprises of low need children, adults and non-users as well as residents with a small number of morbidities that are low complexity.
- Our **Moderate Need** segment comprises of residents with more complex multi-morbidity, pregnancy or dominant psychological or chronic conditions.
- Our **High Need** segment comprises of patients with highly complex multi-morbidity or frailty.

Why this matters:

Breaking this down by 11 segments into mutually exclusive groups enables us to focus on commissioning services that effectively meet the needs of that segment of our population and to prevent unwarranted progression into more complex segments.

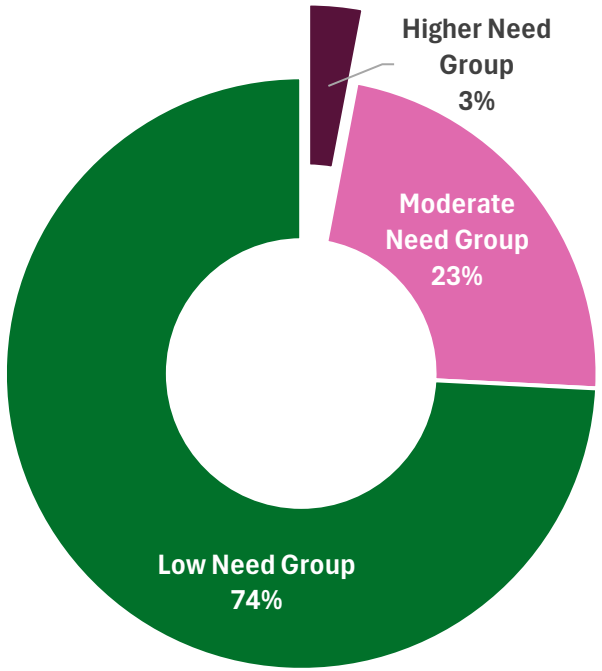
The Patient Need Groups Definitions

Higher need group	High Complexity; Multi-Morbidity	11	Frailty	*Adults aged 65 and older with evidence of 2 or more frailty concepts such as such as difficulty walking, weight loss, cognitive impairment of incontinence.*
		10	Multi-Morbidity, High Complexity	*Multi-morbidity with high complexity (major and unstable chronic conditions)*
Moderate need group	Dominant Chronic	09	Dominant Major Chronic Condition	*Somatic condition with high impact on health, without treatment the condition is progressive and unstable over time. For example: chronic liver disease; sickle cell disease; type 1 diabetes with complications.*
		08	Dominant Psychiatric/Behavioral Condition	*Psychiatric condition with high impact on health, without treatment the condition is progressive and unstable. For example: bipolar disorder; personality disorders; major depression.*
	Pregnancy	07	Pregnancy, High Complexity	*Pregnancy with or without delivery among women with high morbidity burden*
		06	Pregnancy, Low Complexity	*Pregnancy with or without delivery among women with low morbidity burden*
	Moderate Needs	05	Multi-Morbidity, Medium Complexity	*Multi-morbidity with moderate complexity conditions*
Lower need group		04	Multi-Morbidity, Low Complexity	*Multi-morbidity with low complexity conditions*
	Healthy	03	Low Need Adult	*Adults aged 18 and older with acute morbidity and no more than one low complexity condition*
		02	Low Need Child	*Children aged 0 to 17 with acute morbidity and no more than one low complexity condition*
		01	Non-User	*Individuals who have no diagnosis*

Increasing complexity

Our different segments use NHS services very differently

Our higher need group accounts for 3% of our total population…



…yet lead to a 1/3 of all emergency calls and hospital bed days.

12% *of GP contacts*
4x their population share

35% *of 999 calls*
12x their population share

32% *of total bed days*
11x their population share

13% *of 111 calls*
4x their population share

15% *of ED attendances*
5x their population share

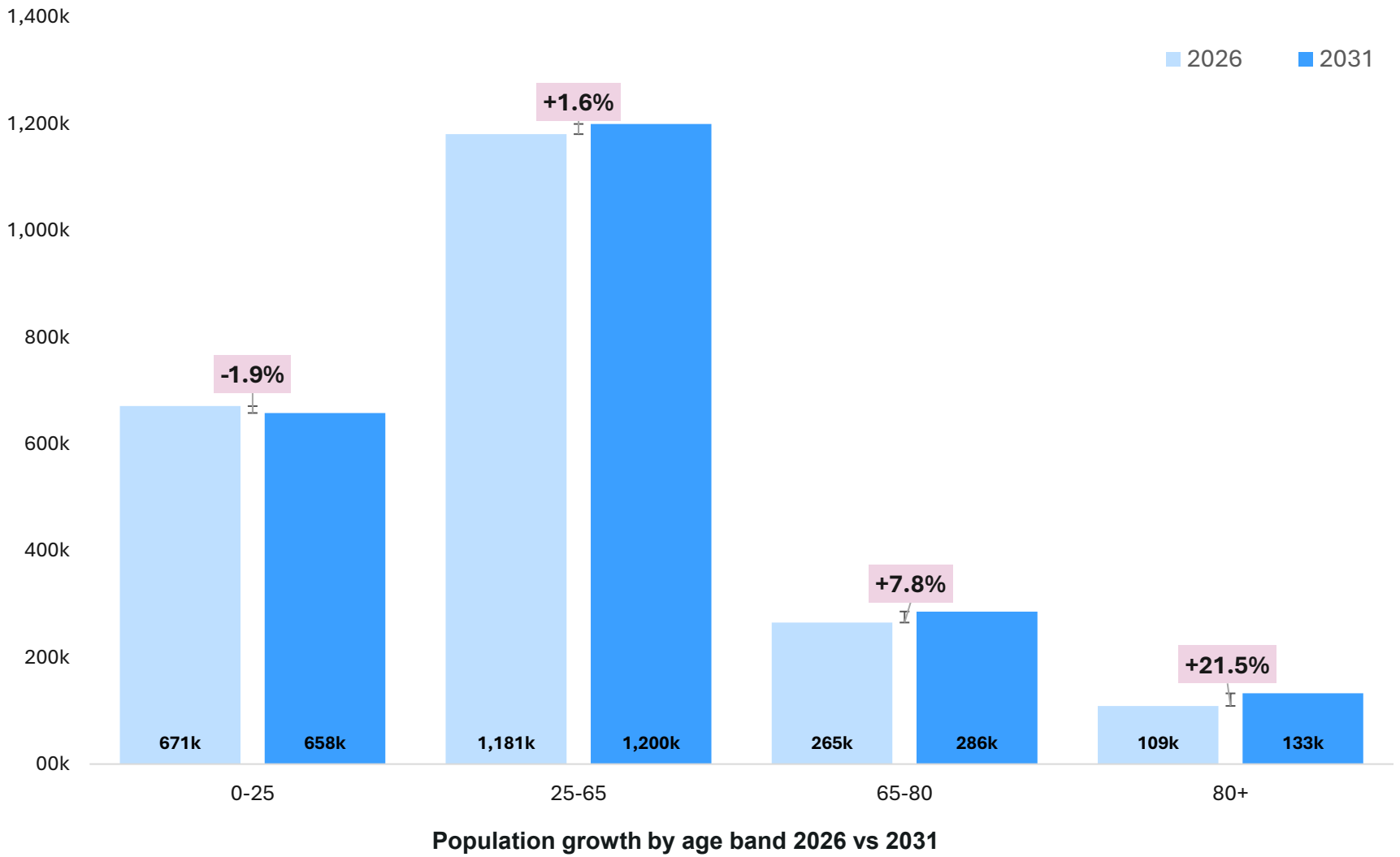
Section 2: How the needs of our population will change over time

Changing needs of our population

Growing pressure from demographic changes means we will have more high need patients and unsustainable demand if we do nothing

- We face growing pressure from **demographic changes** that mean we can expect to see rapid growth in our highest need segments over the next five years.
- We have seen that our high need population consume a **larger amount of activity**. Ensuring we are best meeting the needs of our population in each segment will help prevent patients unnecessarily moving between segments.
- We will have more high need patients and **unsustainable health demand** to support if we do nothing, purely due to demographic pressure.

Our population is ageing

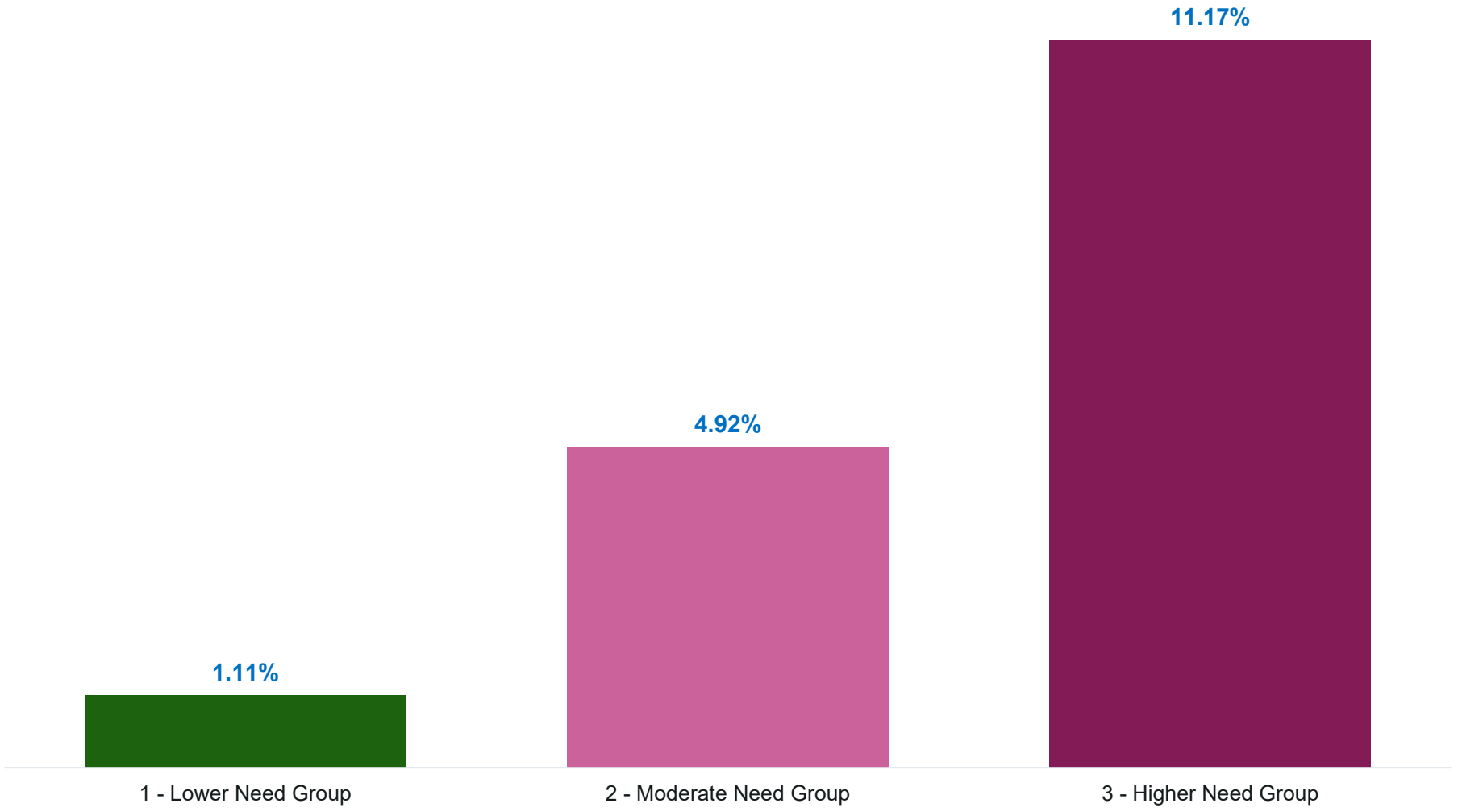


Population growth by age band 2026 vs 2031

Interpretation:
The 80+ age group is set to grow by over 21% over the next 5 years. 65-80s are also set to grow by almost 8%. CYP are set to decrease slightly by 1.9% and working age adults will only increase marginally by around 1.6%.

Why this matters:
Our population is ageing, and this is going to result in significantly larger cohorts of older people. It means that for every working age adult, there will be more older people in need of support.

Our population with higher health needs is due to grow the most

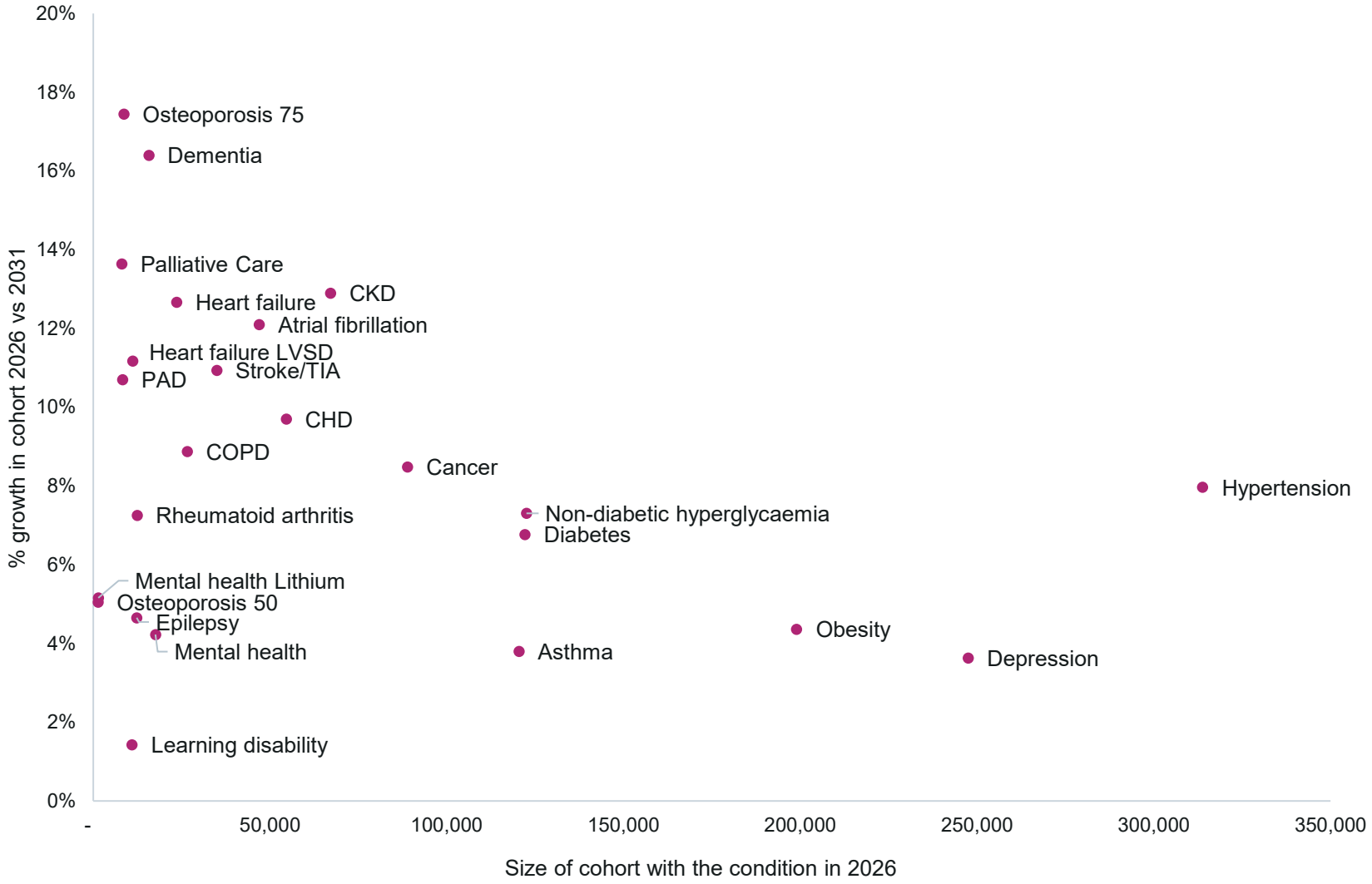


Predicted % change in segment sizes 2026 vs 2031 due to ageing population

Interpretation:
Based on our ageing population, we can expect this to translate to an 11% increase in the size of our higher need group and a 5% increase in our moderate need group. Our lower need group will only rise by around 1%.

Why this matters:
The segment of the population with the most complex and substantial health needs is also growing the most.

Prevalence of long-term conditions will grow, linked to population ageing



Projected change in QOF condition cohorts due to aging population

Interpretation:

Age-related conditions such as osteoporosis, dementia, heart failure, palliative care and CKD are set to rise by well over 10% over the next five years. Some of our most prevalent conditions such as hypertension, depression and obesity are also going to see meaningful growth pressure of 4-8% due to an ageing population.

Why this matters:

These conditions drive a need for health and care services and highlight the importance of prevention in delaying or avoiding their onset. Significant prevention effort would be needed just to maintain current register sizes and offset the demographic pressure of an ageing population.

Section 3: The rising complexity of need

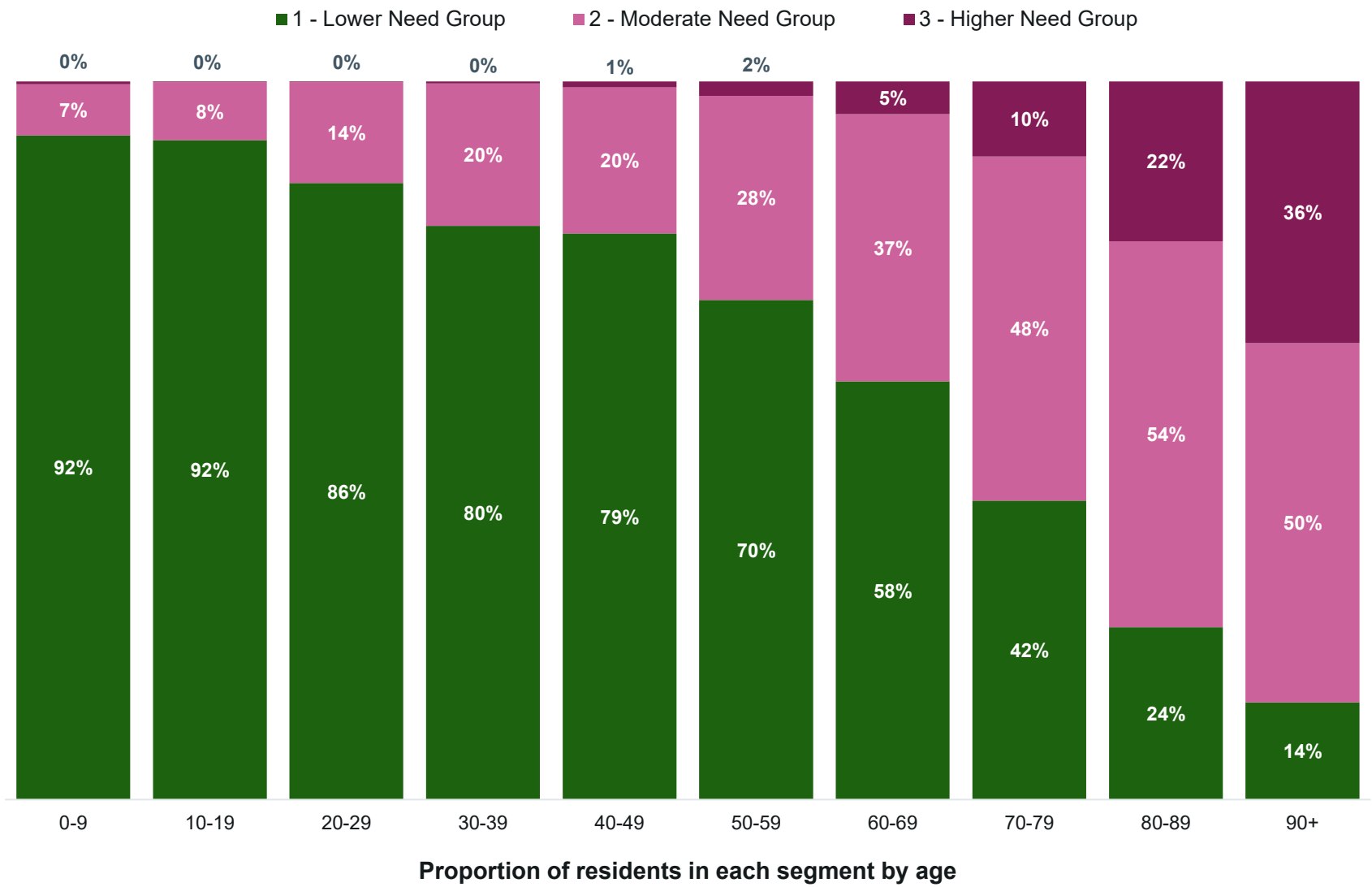
The rising complexity of need

We can prevent the progression of ill health, intervening to prevent patients moving into higher need segments, will result in better outcomes and lower cost

Across the country, reactive, acute-focused services are disproportionately consumed by a relatively **small number of high need segments** who often cycle through unplanned admissions, A&E attendances and crisis care. This pattern reflects a model that intervenes late, once deterioration has already occurred, **driving both poorer outcomes and escalating cost.**

The opportunity for ICBs is to **shift upstream** by identifying these cohorts earlier through segmentation and risk stratification, and proactively managing their needs through strengthened primary, community and preventative services. By **investing in anticipatory care, multidisciplinary support, and targeted prevention**, systems can stabilise high-risk populations, reduce avoidable acute utilisation, and rebalance care towards earlier, more effective intervention.

As residents age, they move from lower need groups to higher need groups, but it is not an inevitability



Interpretation:
Most young people (>90%) are healthy. As we age, we acquire conditions and move into the moderate need segments. As we age further, particularly from retirement age onwards, patients begin to move into the highest need segments as we inevitably age and approach the end of life.

Why this matters:
The progression of health is intrinsically linked to ageing, but it is also important to observe that some residents remain broadly healthy through to their 80s and even 90s. The more that patients can remain healthier for longer, the greater their quality of life as well as the lower their use of health and care services.

We can map the distribution of our resources across population segments

Per person cost
Proportion of pop.
Proportion of spend

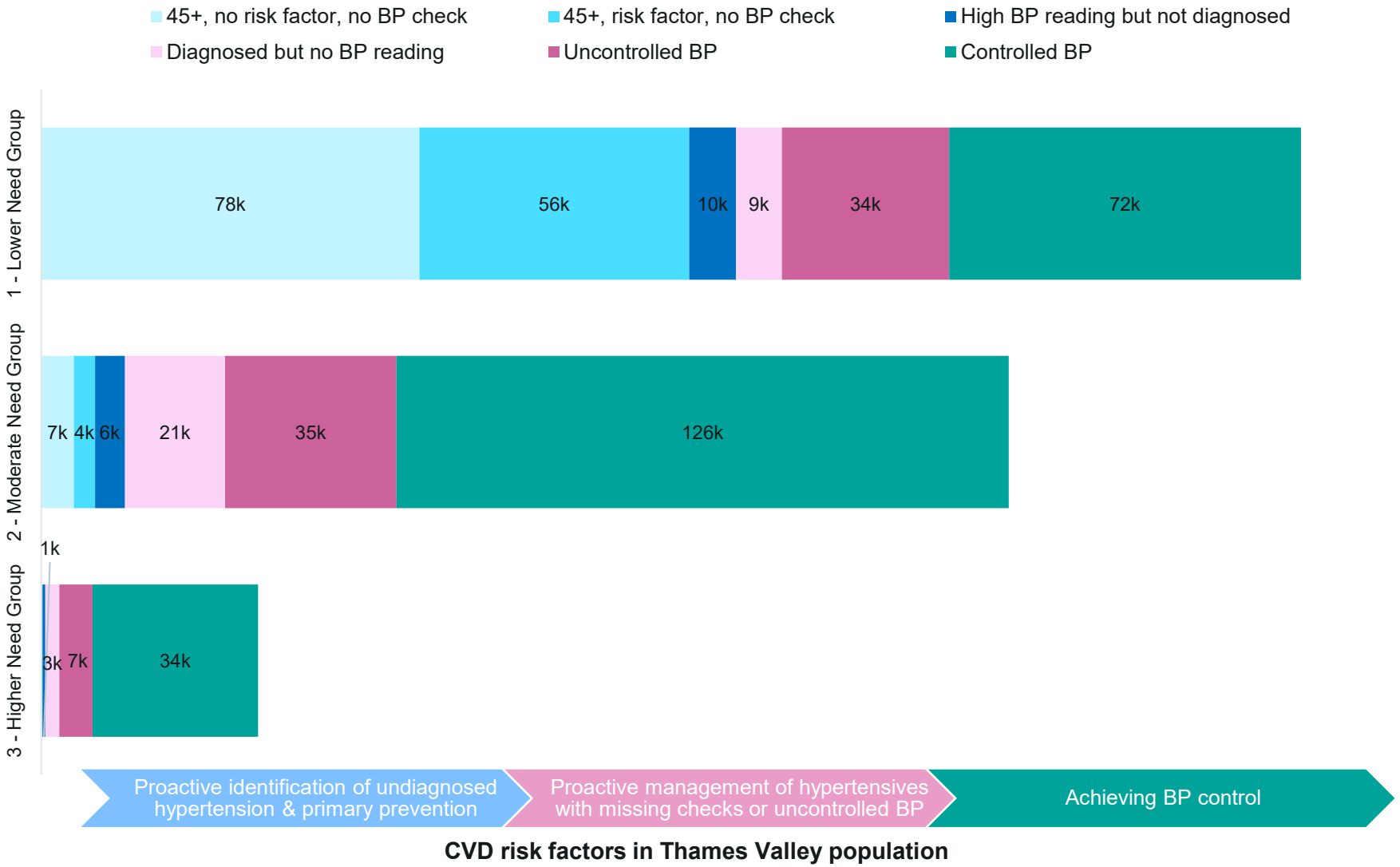
Age band	Lower Need Group	Moderate Need Group	Higher Need Group	Unknown PNG
0-19 Pop: 534.9k Total cost: £246.4m	**Size: 489.1k** £352.8 22.0% 6.3%	**Size: 39.5k** £1.7k 1.8% 2.5%	**Size: 1.0k** £4.6k 0.0% 0.2%	**Size: 5.4k** £169.2 0.2% 0.0%
20-64 Pop: 1.3m Total cost: £1.1bn	**Size: 1.0m** £340.2 45.4% 12.6%	**Size: 280.4k** £2.4k 12.6% 25.0%	**Size: 12.7k** £7.9k 0.6% 3.7%	**Size: 12.8k** £170.6 0.6% 0.1%
65+ Pop: 374.3k Total cost: £1.1bn	**Size: 149.1k** £721.9 6.7% 4.0%	**Size: 174.3k** £3.0k 7.8% 18.9%	**Size: 47.9k** £9.5k 2.2% 16.7%	**Size: 3.1k** £242.0 0.1% 0.0%

Proportion of residents in each segment by age

Interpretation:
This chart shows that our different need groups, broken down by age, consume different amounts of healthcare cost. As an example, 2.2% of our population are aged over 65 and are in our high need group (circa 364k patients) and use 16.7% of our healthcare budget (circa £1bn).

Why this matters:
We need to understand if we are maximising the funding we are spending on our population. There are opportunities to reduce avoidable health utilisation and maximise the impact of resource (e.g. optimal pathways of care).

There are opportunities across the segments to focus on proactive care and prevention



CVD risk factors in Thames Valley population

Interpretation:
Across our segments, we can see there are different intervention opportunities. In the low need segments, there are many potential undiagnosed patients who could be diagnosed and treated early.

Why this matters:
The better controlled these patients are, the less likely they will progress along the complexity segments. Cardiovascular disease (CVD) is widely recognised as the single biggest clinical opportunity to reduce premature and unwarranted deaths in the UK and improving blood pressure control is one of the most impactful levers within that.

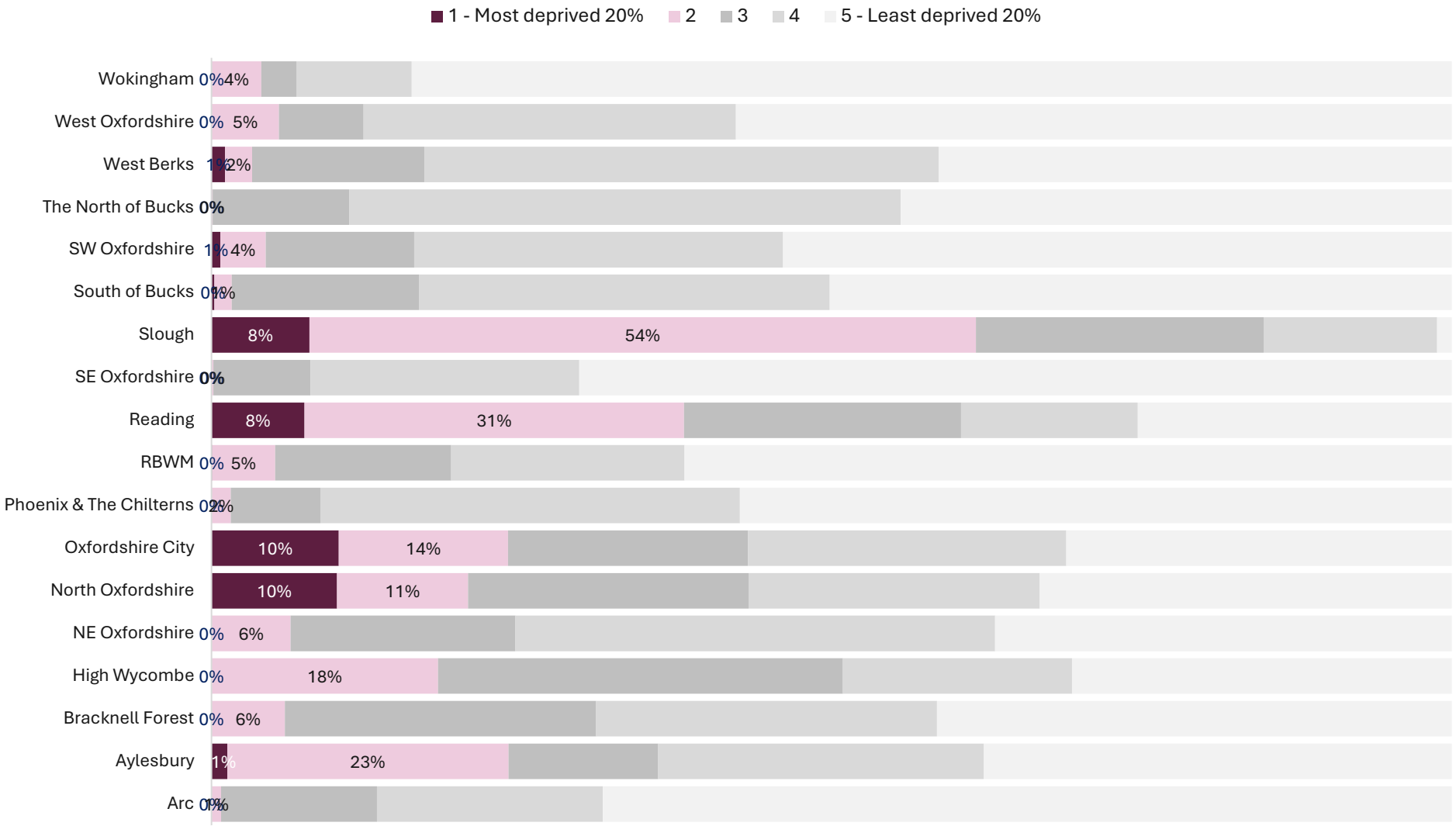
Section 4: How deprivation and inequalities impact outcomes and how services are used

Impact of deprivation and health inequalities

Deprivation and inequalities impact outcomes and how services are used across the Thames Valley

- Deprivation and health inequalities are **linked** to our population becoming more unwell, earlier in life, and accumulating more life limiting conditions.
- Residents in more deprived areas move more quickly from low to moderate and high need, while those in less deprived areas stay **healthier for longer**.
- This translates into a stark **inequality in healthy life expectancy** which has worsened in recent years.

Deprivation varies across areas and impacts health needs

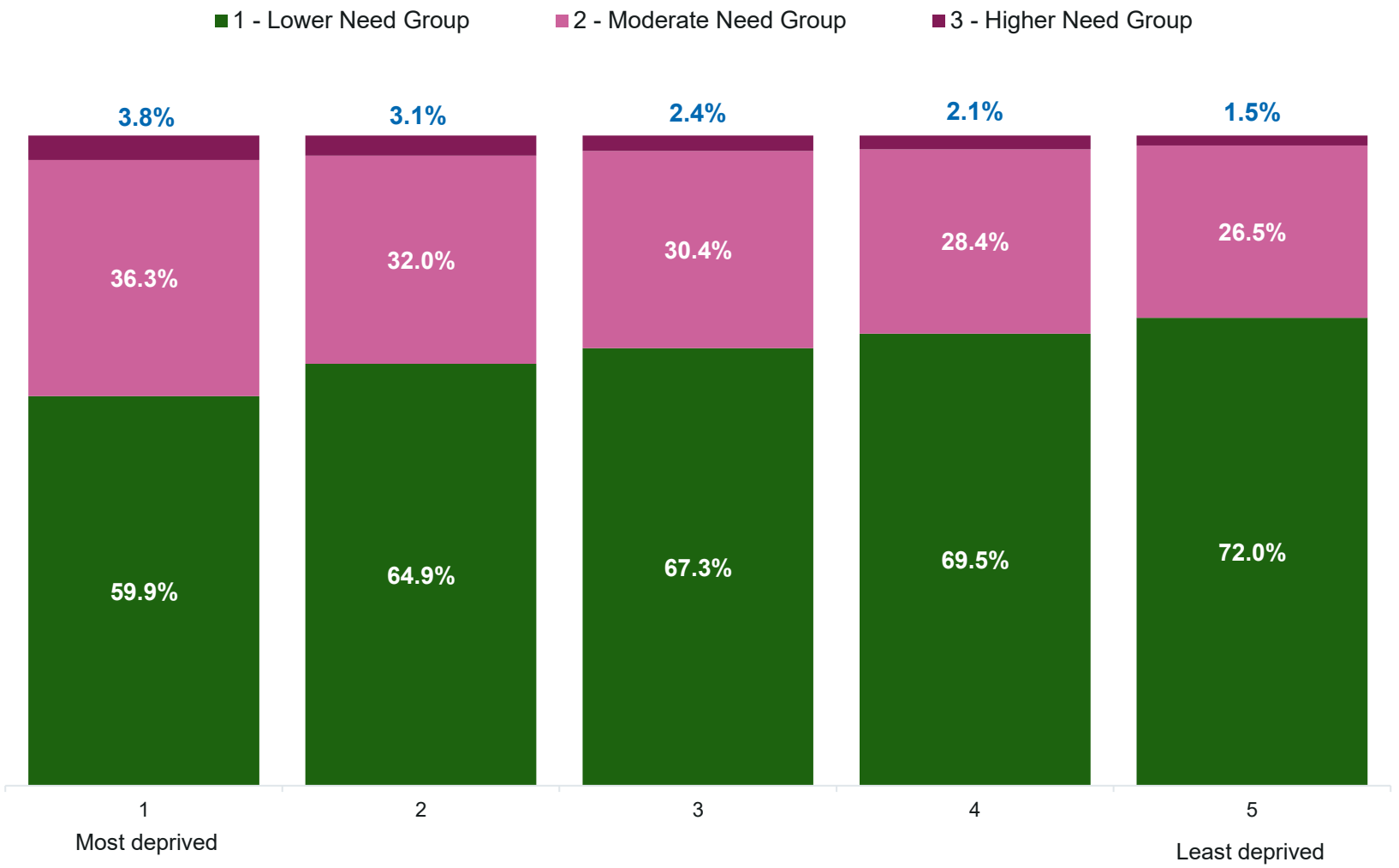


Deprivation distribution across Thames Valley ICB

Interpretation:
Slough, Reading, Oxfordshire City, North Oxfordshire, Aylesbury and High Wycombe have the largest deprived populations in our system; however, every area has pockets of deprivation.

Why this matters:
Every area needs to consider how to identify and support residents impacted by deprivation and the increased health needs driven by a wide range of determinants.

People in deprived areas approaching retirement age are more likely to have higher health needs

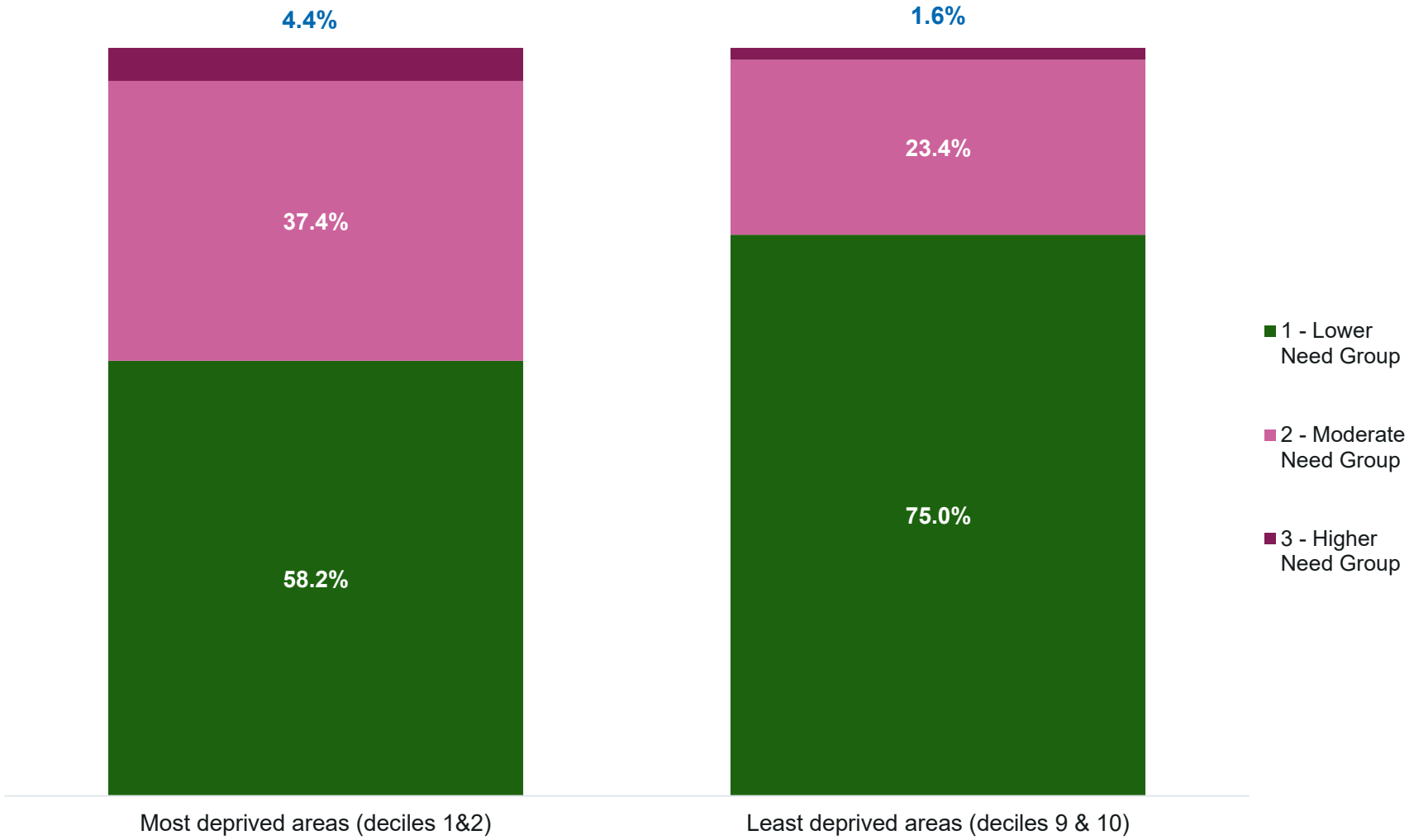


Percentage of 50-59 year olds per PNG based on deprivation area

Interpretation:
There is a clear trend where residents of the same age are less healthy if they live in deprived areas. In our least deprived areas, around 72% of 50-59s are in the low need group, whereas this figure is only 60% in the most deprived areas. Similarly, residents in deprived areas are more than twice as likely to be in the higher need group compared to residents in less deprived areas (3.8% vs 1.5% of the cohort).

Why this matters:
This is the key driver of why we observe inequality in healthy life expectancy. By the time residents are approaching retirement age, they will be much more likely to have accumulated life limiting conditions if they live in deprived areas.

Residents living near to each other with the same services have different health status due to deprivation

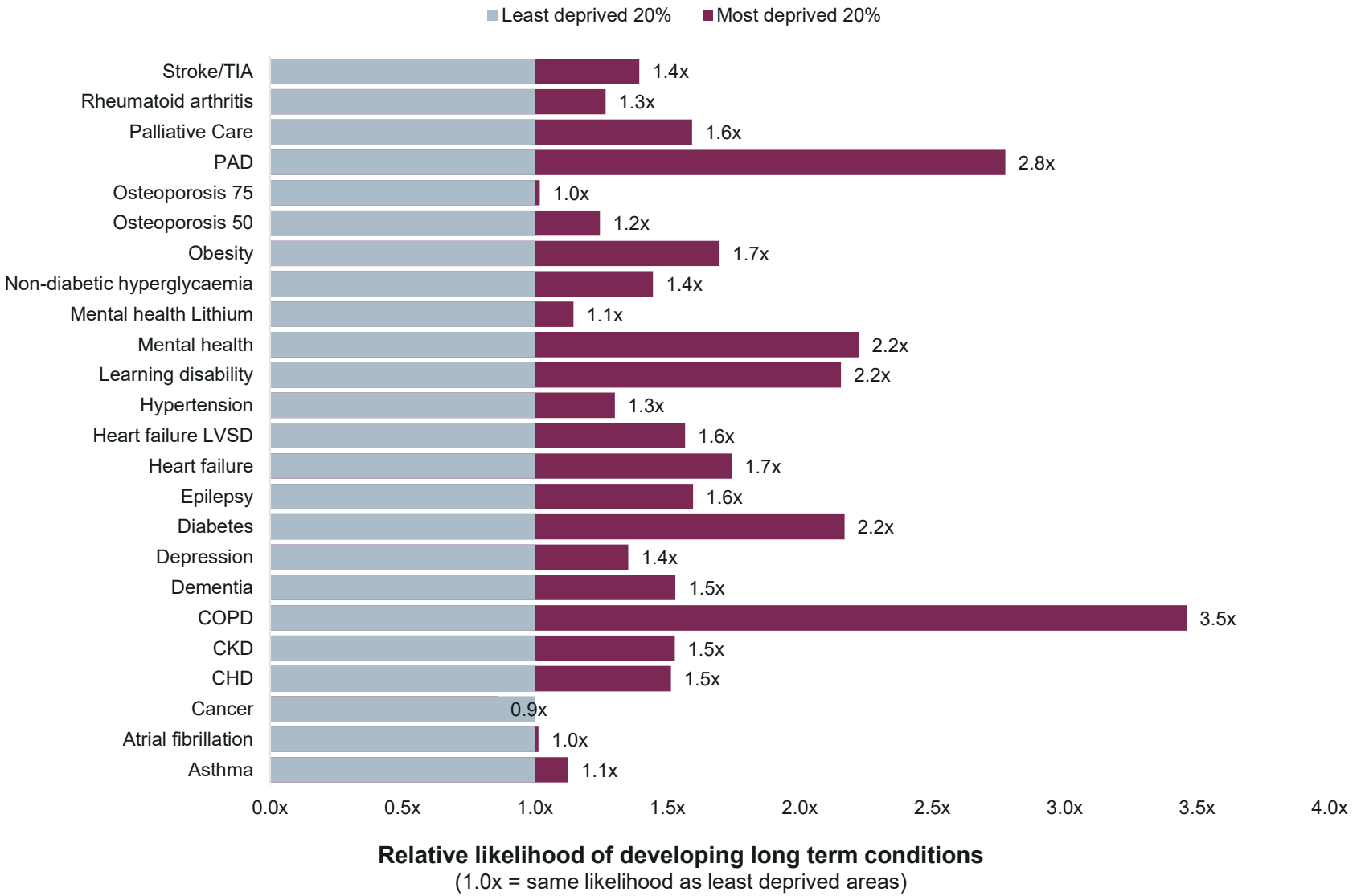


Health of 50-59 year olds and their PNGs by area of deprivation

Interpretation:
50-59 year olds in the most deprived areas of Oxford are three times more likely to be in the high need group and almost twice as likely to be in the moderate need group.

Why this matters:
Residents living within 10 minutes of each other in the same district, receiving the same public services, achieve a vastly different health status by the time they are approaching retirement.

People in deprived areas are generally younger but more likely to develop long term conditions



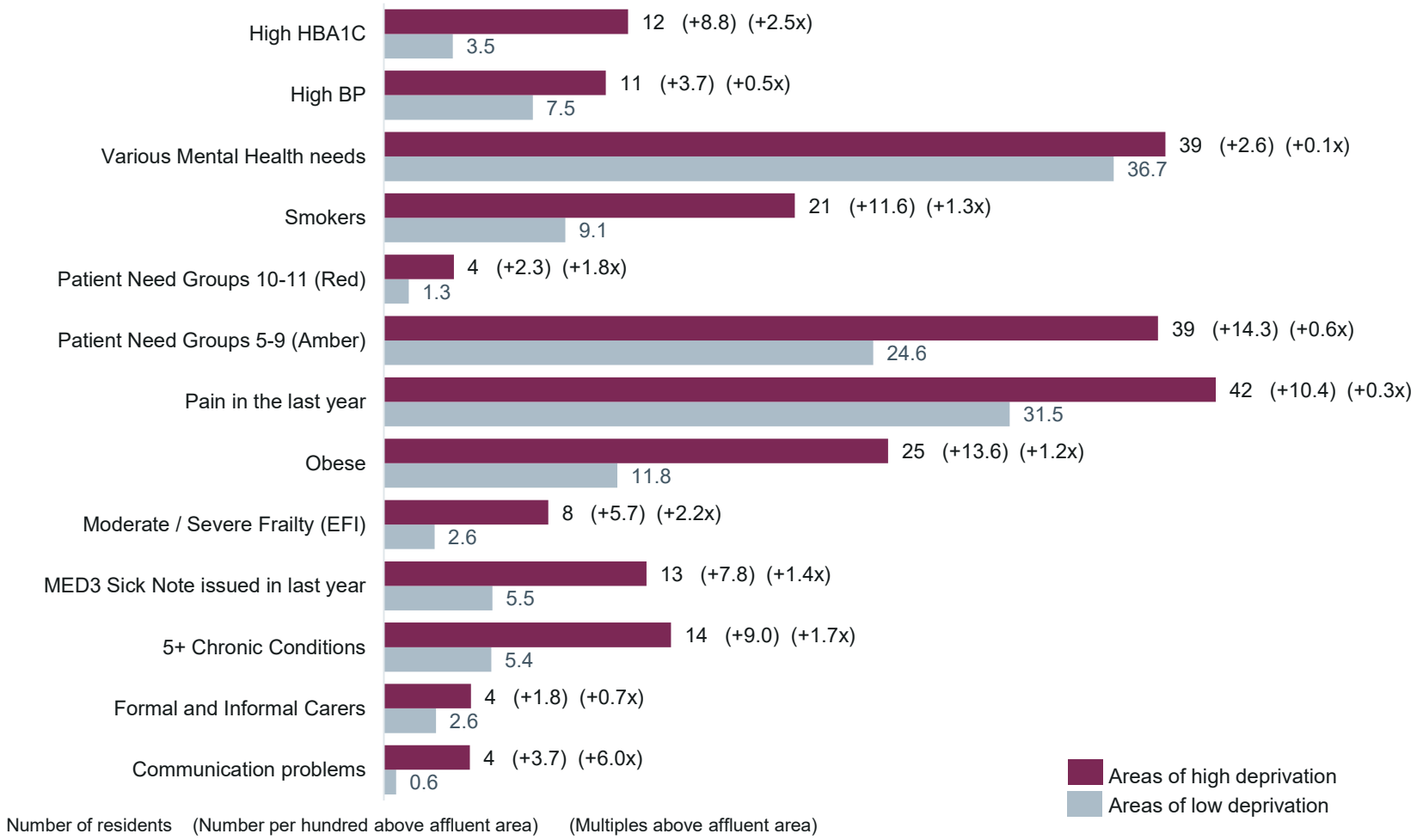
Interpretation:

People living in the most deprived areas are much more likely to develop long-term conditions than those in the least deprived areas. This is true across many conditions. For example, residents in deprived areas are around 3.5 times more likely to have COPD.

Why this matters:

The impact of deprivation is wide ranging, as well as having common themes around preventable conditions linked to risk factors such as smoking, obesity or diet and other factors. When combined with the fact that the populations in deprived areas are currently younger on average than in affluent areas, this demonstrates that as our deprived populations age, it may result in a less healthy population than we have today.

People in deprived areas approaching retirement age are more likely to have health needs of greater complexity with greater service demands



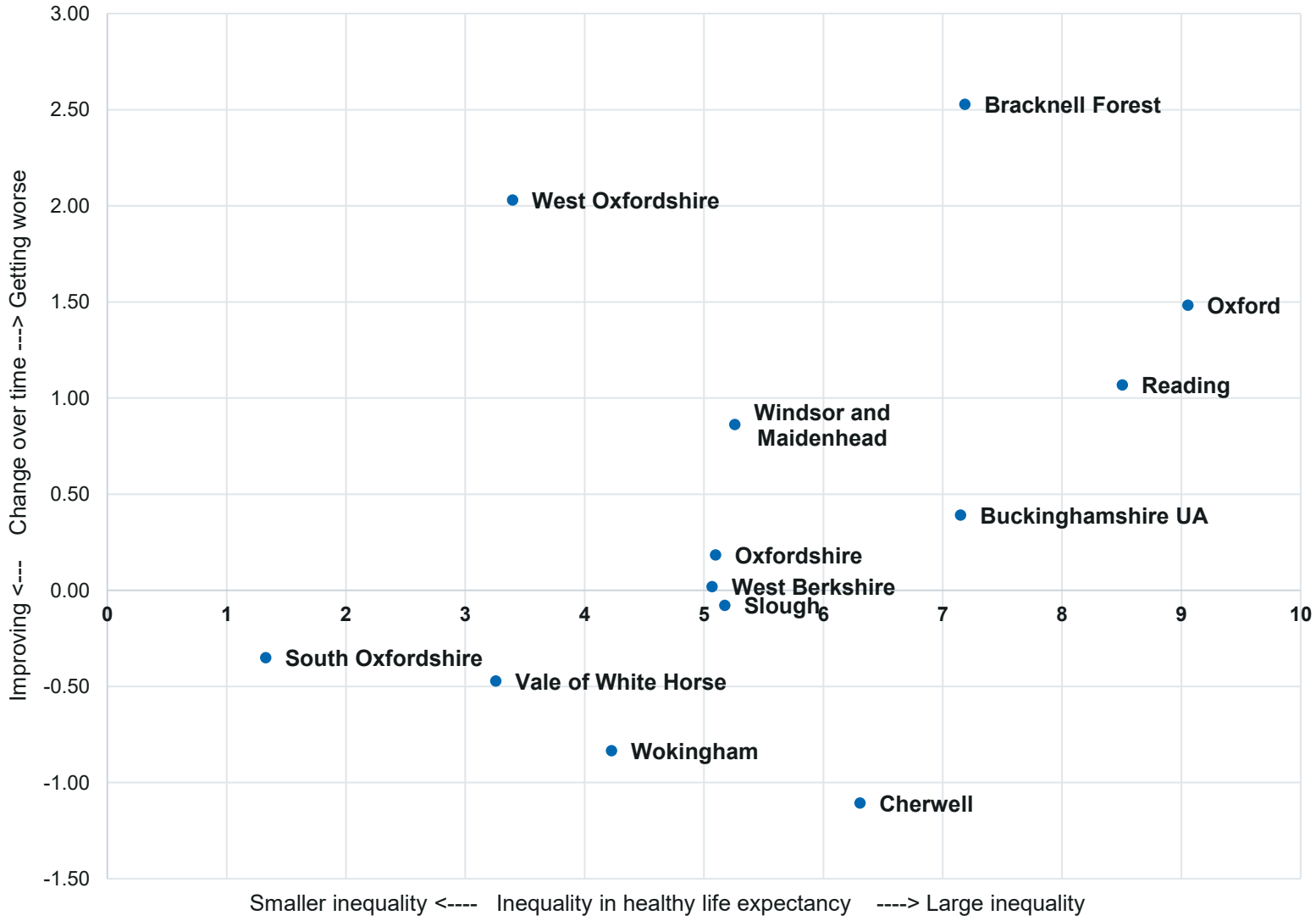
Profile of 100 average 50-59 year old residents - affluent versus deprived areas

Interpretation:
Across a range of metrics, 50-59 year olds are much more likely to have higher health needs in deprived areas.

Why this matters:
For every 100 registered 50-59 year olds, a typical GP practice in Slough will need to support five high need patients for every one high need patient in Windsor.

Each of these patients have significantly higher needs; they will have 4.5x as many patients with out-of-control HBA1C and 2.5x as many patients with high blood pressure, contributing to greater CVD risks.

Inequality in healthy life expectancy is generally flat or getting worse



Areas with large and growing inequality in healthy life expectancy

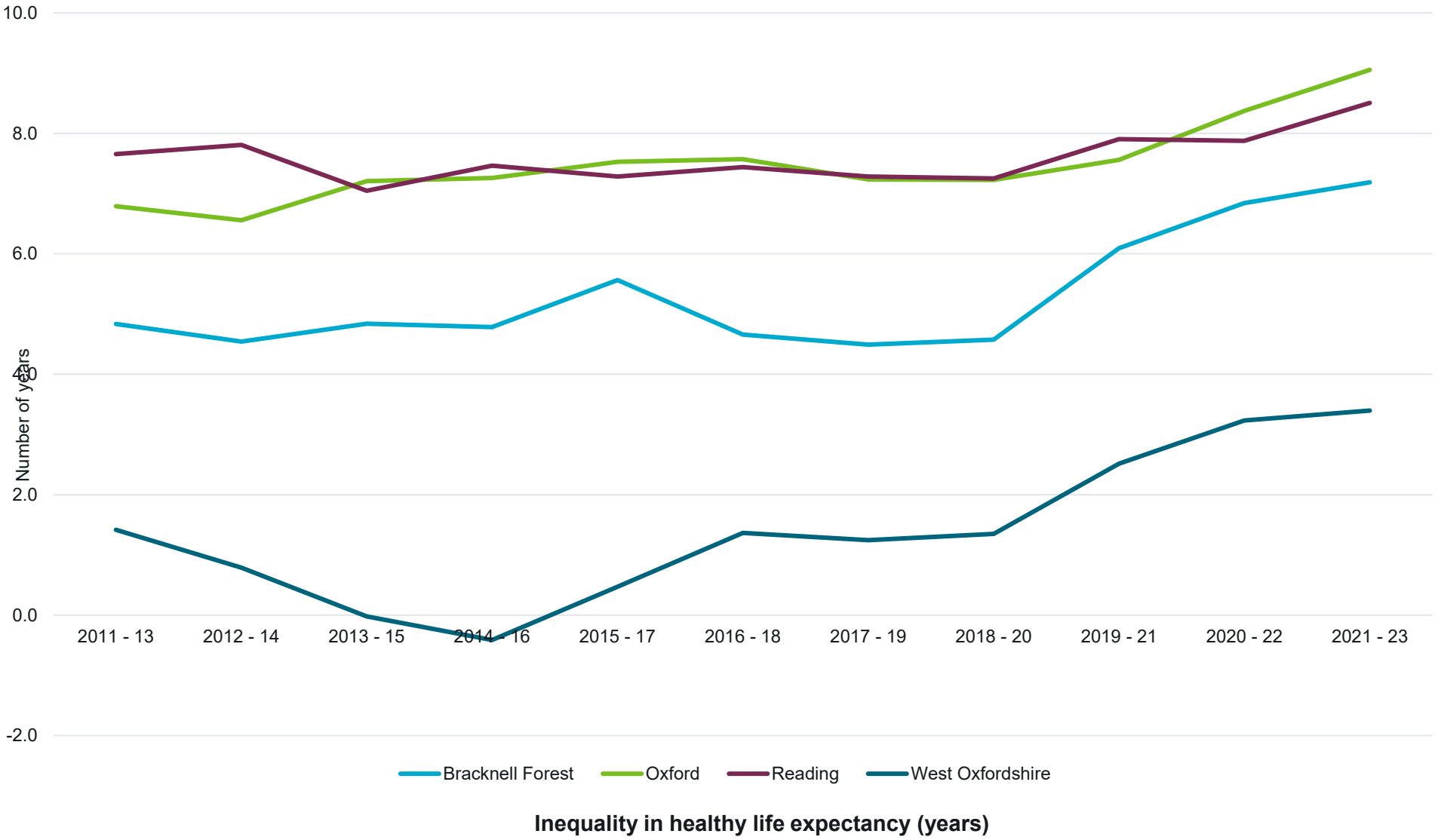
Interpretation:

Oxford has the largest gap in healthy life expectancy, with people in the most affluent areas living over 9 more healthy years than those in the most deprived areas. This gap has widened by 1.5 years since 2016-18. A similar story is also seen in Reading, Bracknell Forest and West Oxfordshire. In Buckinghamshire, Oxfordshire, West Berkshire and Slough the inequality has been more stable, and in Cherwell, Wokingham, Vale of the White Horse and South Oxfordshire there have been some signs of a narrowing in health inequalities.

Why this matters:

Health inequalities are largely flat or getting worse across the system. This shows we need to go further and faster if we are to make meaningful progress on one of our most important strategic goals.

Inequality in healthy life expectancy is getting worse in particular areas



Interpretation:
The inequality in healthy life expectancy in the areas shown have notably gotten worse over the last five years.

Why this matters:
The step change in deterioration coincides with the Covid-19 pandemic, highlighting the lasting and disproportionate effect that Covid-19 had on the population, particularly in deprived areas where a disproportionate impact on mortality was observed.

Glossary

- BP: Blood Pressure
- CHD: Coronary Heart Disease
- CKD: Chronic Kidney Disease
- COPD: Chronic Obstructive Pulmonary Disease
- EFI: Electronic Frailty Index
- HBA1C: Glycated Haemoglobin. A high HBA1C means there is too much sugar in the blood.
- Heart Failure LVSD: Left Ventricular Systolic Dysfunction
- PAD: Peripheral Artery Disease
- TIA: Transient Ischemic Attack sometime referred to as ‘mini-stroke’

NHS
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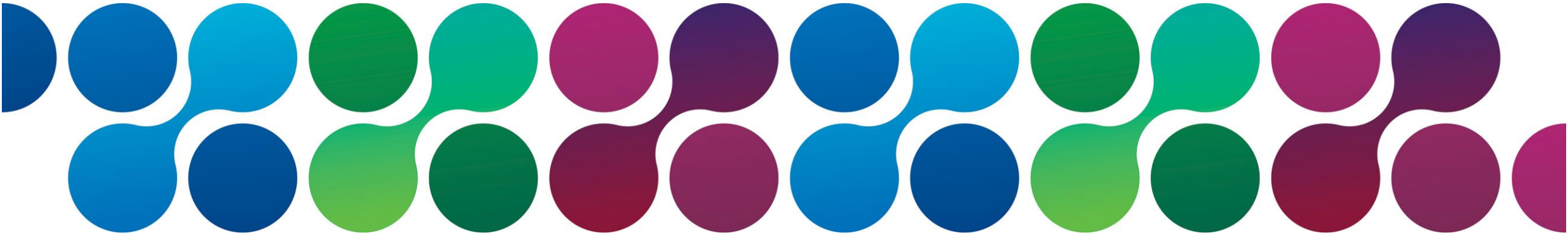
Turning insight into action



Using segmentation to drive strategy

NHS Thames Valley

- Our TVS & Connected Care population health approach links **commissioning, primary care and provider data** to provide a holistic picture of our 2.5m population.
- We have not yet **maximised the potential of this capability** to drive strategy, using data to identify and help us tackle our fundamental challenges.

Opportunity 1:
Optimise offer within each segment (*model of care, pathways, resources*) *e.g. 2.2% use c.£1bn*

Opportunity 2:
Slow the progression from lower to higher need segments, with a focus on deprived areas where this happens more quickly

Per person cost
Proportion of pop.
Proportion of spend

Age band	Lower Need Group	Moderate Need Group	Higher Need Group
0-19 Pop: 534.9k Total cost: £246.4m	Size: 489.1k £352.8 22.0% 6.3%	Size: 39.5k £1.7k 1.8% 2.5%	Size: 1.0k £4.6k 0.0% 0.2%
20-64 Pop: 1.3m Total cost: £1.1bn	Size: 1.0m £340.2 45.4% 12.6%	Size: 280.4k £2.4k 12.6% 25.0%	Size: 12.7k £7.9k 0.6% 3.7%
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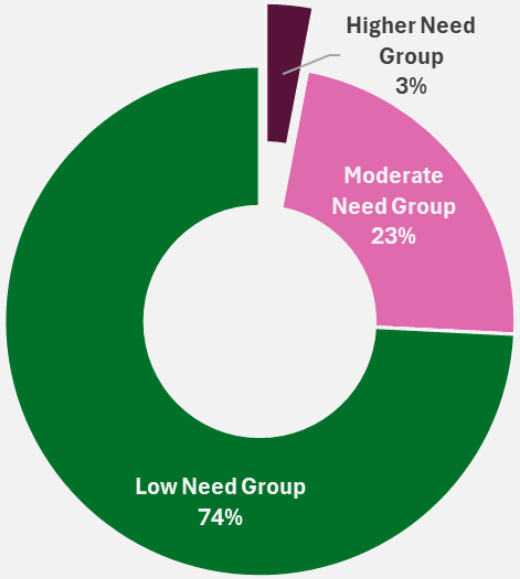
Figure 1. *Distribution of resources across John Hopkins population segments (simplified)*

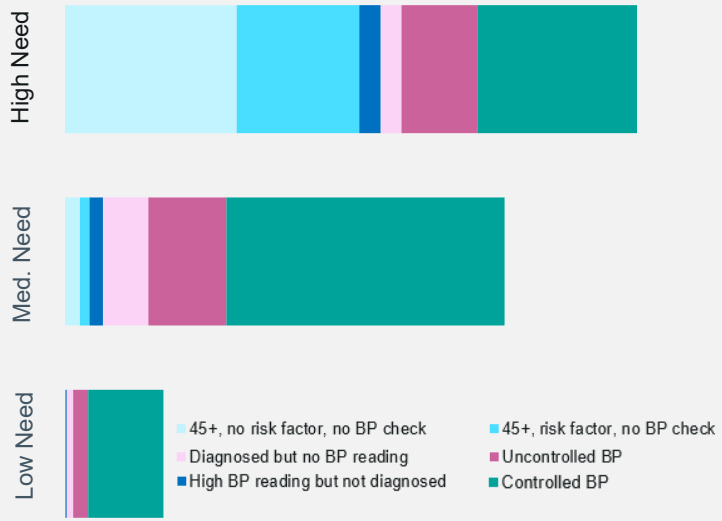
Example insights that underpin action

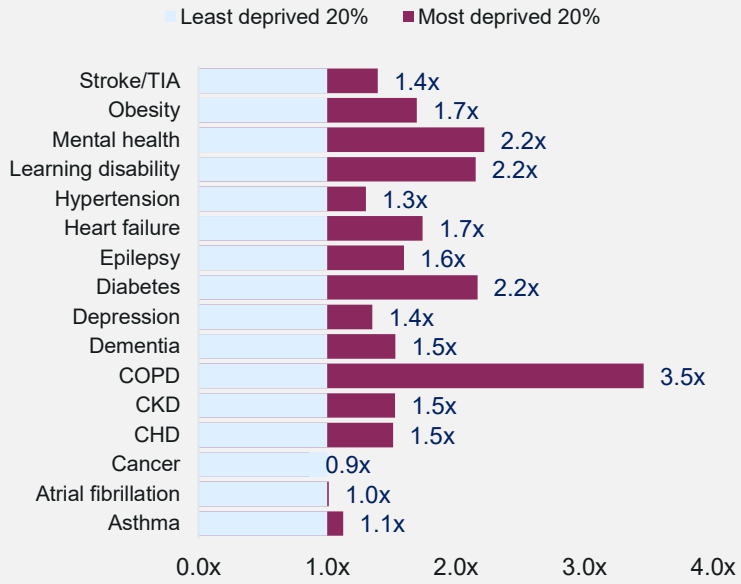
1. Our highest need segment (3%) use **1/3 of bed days and emergency calls**. This group will grow by **11%** in the next 5 years.

2. We face a **rising burden of long-term conditions** and can map opportunity to intervene early across cohorts to prevent this.

3. Residents in more deprived areas **progress more quickly** from low to moderate/high need, while those in less deprived areas stay healthier for longer.





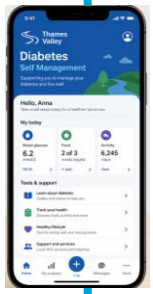


Working differently to drive change

1

Scaling what works: Population Health Digital Solutions

- **High need cohorts** – remote monitoring, scaling from 8k to 30k residents.
- **Impact** – 50% drop admissions; 38% drop in A&E attendances & 25% outpatient activity.
- **Lower need cohorts** – through industry partnerships we are rolling out NICE accredited clinical apps to 400k residents to support self management of LTCs.
- **Expected impact** – improved outcomes and reduced progression into higher need population health segments.



2

Seed funding the left shift: Thames Valley Innovation Fund

- **Prioritising growth funding** – £53m into fund to disrupt commissioning to drive the left shift.
- **Partner engagement** – sought ideas from partners, with 196 submissions of what we could do differently.
- **Workshops** – system workshops to define priorities and identify opportunities to scale proven interventions.
- **Funded interventions** – CYP INTs; frailty INTs, CHWWs in Core20 areas; CVD outreach; remote monitoring & CYP EoL TV offer.

3

Building partnerships & capability: Value Lab & Public Health Joint Unit

- **Thames Valley Population Health Unit** – joint ICB & Public Health unit, with shared posts to reduce inequalities & improve outcomes.
- **Thames Valley Value Lab** – driving understanding of value-based care, through building joint health economics capability and ensuring impactful join up with universities to drive population health improvement.

Buckinghamshire Council
Bracknell Forest Council
West Berkshire Council
Reading Borough Council
Working better with you
Wokingham Borough Council
University of Oxford
Nuffield Department of Primary Care Health Sciences
Slough Borough Council
Royal Borough of Windsor & Maidenhead
NIHR | Applied Research Collaboration Oxford and Thames Valley
Oxfordshire County Council

NHS
Thames Valley

Thames Valley Integrated Care Board

Title of Paper	Quality Report		
Agenda Item	6	**Date of meeting**	20 May 2026
Exec Lead	Sarah Bellars, Chief Nursing Officer		
Author(s)	Melanie Bessant, Deputy Chief Nursing Officer and Jane Thomson-Smith, Associate Director of Quality and Clinical Standards		

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 will provide high level surveillance of developing quality issues and a precis of current issues and concerns. Areas acknowledged in the report includes Patient Advice & Complaints (PACT) data, escalations of provider and ICB quality issues, Never Events and/or patient safety incidents, CQC updates and external reviews or visits.	
Recommendation	The Board is asked to note the quality issues and mitigations highlighted in this report.

Conflict of interest identified
Yes ☐ No ☐
Detail

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

NHS
Thames Valley

Thames Valley ICB Board

Public Quality Report

Date of Writing: 30th April 2026

1. Introduction

The purpose of this report is to provide the Boards in Common with high level surveillance of developing quality issues and soft intelligence. The report provides a precis of current issues and concerns that may not be covered in the Quality Report due to the nature of the concern or level of quantifiable assurance at the time of writing.

2. Surveillance Update

2.1. Complaints

The PALS and Complaints Team covering West Berkshire, Buckinghamshire and Oxfordshire, are dealing with patients and the public when they are most vulnerable and distressed. People turn to Commissioners of NHS services when care is absent, or they believe it has failed them.

The team are experiencing a high volume of contacts and complaints, and whilst some may be of similar theme such as ADHD and waiting times, these still need a response or to sign post, correctly.

This and organisational change is putting significant pressure on the ability of the team to meet KPIs. A recovery plan is in place to support the reduction of the complaints backlog.

2.2. Never Events or Patient Safety Incidents

Since the last report, there have been the following Never Events reported:

FHFT – There have two never events reported, a retained swab and a wrong site surgery.

Berkshire Independent Hospital have declared a never event, in relation to 'artefact in soft tissue', which is under investigation. The ICB quality lead is supporting this investigation.

3. Escalations by Provider

AJM Healthcare

In August 2025, Berkshire West Wheelchair service transitioned from RBHFT to AJM Healthcare for a number of reasons including long waits for assessment and delayed discharges. This has impacted mobilisation and is continuing to impact service delivery by AJM Healthcare negatively. The service is in enhanced oversight, to support the quality, performance and clinical MDT processes, to gain assurance and support.

EMED (Non-Emergency Patient Transport)

EMED remains in enhanced oversight with weekly meetings to ascertain trajectory towards performance compliance which is improving. There has been increased interface with Provider Organisations, which is a positive step.

The ICB Quality Team are working with EMED to support a broader piece of improvement work to improve complaint compliance in addition to overall strengthening their quality reporting.

4. ICB Escalations

Thames Valley LeDeR Programme

The LeDeR programme across West Berkshire, Buckinghamshire and Oxfordshire, as previously been escalated to the ICB Board but remains an ongoing risk.

As a new organisation, we have brought the two LeDeR programmes together, which have a clear purpose and governance routes. There is now a standard operating framework in place and dedicated team to support, including 10 Bank Clinical Reviewers.

The LeDeR Sign-Off Group is chaired by the Deputy Chief Nursing Officer. This group meets monthly at a minimum for a multi-disciplinary review which includes Quality and Safeguarding Leads, Clinical Reviewers and an Expert by Experience, to ensure sign off and closure can be supported.

There is a plan in place to reduce the backlog of cases which occurred due to the pause in programme. For this, a triage process has been introduced and is seen as good practice by NHS England and is now being adopted across the South East Region. This enables the fast-tracking of older outstanding reviews through a triage process to identify any learning. Should any cases highlight any 'red flags' in the supporting evidence a full review would be initiated.

The trajectory currently is to have cleared the backlog of all legacy cases by the end of September 2026, at which point the aim is to move into 'business as usual'.

Vaccination Programme

Flu - The Flu programme ended on the 31st of March 2026. For the Thames valley System, there was a lower performance in the over 65 age category and care home residents than the previous year, however, this has been a trend nationally. There was a higher performance in other eligible cohorts compared to the previous year, and with Frontline Healthcare Workers uptake exceeding national target.

Covid – The Spring 26 Covid campaign commenced on the 13th of April. Mitigations have been put in place to address gaps in vaccine coverage for housebound patients/care home residents, where GPs are not signed up to the programme. This will be monitored throughout the programme.

RSV - The adult RSV vaccination programme has expanded from 1st of April 2026, to include adults over 80 years and residents living in an older adult care home.

Vaccination remains one of the most effective ways to protect yourself and your loved ones against serious illnesses, including Covid. With vaccines now easily accessible at GP practices, and local pharmacies, the ICB would encourage where eligible to come forward for their vaccinations to build immunity.

5. External Reviews or Visits

RBH - The Thames Valley & Wessex Adult Critical Care Network visited the Royal Berkshire Hospital Critical Care Unit on the 25th of March 2026. The report is being written and will be received at the Quality Oversight Committee on publication.

6. CQC Updates

Oxford Health NHS Foundation Trust (OH)
During November 2025, CQC carried out an unannounced inspection of the inpatient child and adolescent mental health (CAMHS) wards. The report has now been published with a Requires Improvement rating. This however has not impacted the overall Trust rating of Good. The area for improvement relates to medication, communication relating to being detained under the Mental Health Act and management and audit processes to identify concerns.

Oxford University Hospitals NHS Foundation Trust
The Trust is still awaiting the publication of their CQC inspection

Ringmead Medical Group
During December 2025, the CQC carried out an inspection to follow up on 2 breaches of regulation identified at their last assessment in January 2024 in relation to safe care and treatment and good governance. The CQC Team assessed 16 quality statements across the safe, effective, responsive, and well-led key questions. The report has now been published with an overall Good rating and received Good in all 5 areas.

The service is no longer in breach of the legal regulations relating to safe care and treatment and good governance. Therefore, CQC have removed the conditions placed on the provider's registration following the January 2024 assessment.

7. Conclusion

This report has outlined a number of quality issues and concerns that the teams will be working with system partner organisations on during January 2025. Progress on these concerns will be reported to the Boards in Common through either the Quality Report or a future private report.

Authors:

Melanie Bessant, Deputy CNO

Jane Thomson-Smith, Associate Director of Quality and Clinical Standards