

Cover Sheet

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Title: Overview of ICB Commissioning Intentions

Status: For Discussion

History: N/A

Board Lead: Chief Finance Officer

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Confidential: No

Key Purpose: Strategy, Assurance

Executive Summary

1. This paper presents a strategic overview of the commissioning intentions for the Thames Valley Integrated Care Board (ICB), which will be established in April 2026 and oversee a £5.6bn health budget across Berkshire, Buckinghamshire, and Oxfordshire.
2. The ICB's emerging strategy, developed in response to the NHS 10 Year Plan, signals a significant shift towards value-based, integrated, and preventative care, with direct implications for OUH as a provider of acute and specialised services.
3. The key strategic objectives set out in the Commissioning Intentions are:
 - The intent to prioritise outcomes over volume to maximise value through ICB commissioning activities. This includes the decommissioning of services assessed to be low value.
 - Developing integrated care at the neighbourhood level. This is to address increasing demand from frail elderly patient cohorts and prevent admission to acute hospital care.
 - Focusing on prevention and promoting equity. Targeted investment in particular patient cohorts and addressing geographic/demographic health inequality.
4. There are a range of strategic considerations for the Trust in response to these intentions. These include its positioning against the emerging neighbourhood models, the proposed consolidation of activity across acute Trusts to drive better value, our approach to demonstrating value of our provision and options for decommissioning of services.
5. The Trust is engaging positively with the ICB on opportunities to expand its community provision, realise benefits to reduce acute demand and repatriate care to the ICB. There is also an opportunity to address historical underfunding.
6. There are risks associated with mis-aligned targets. The ICB appears unlikely to be held to account for commissioning performance standards. It may focus exclusively on its own financial balance, on prevention and shifting care to non-acute settings while the Trust is held to account primarily for short term delivery of operational standards.

Recommendations

7. The Trust Board is asked to:
 - Note the content of the paper and agree:
 - The requirement to evaluate options for expansion/entry into neighbourhood provision to strengthen community partnerships

- A similar requirement for options to leverage value from the stated ICB objectives to rebalance, consolidate or exit some services across the acute providers in the system.
- Scenario Planning for Income Risk

Overview of ICB Commissioning Intentions

1. Purpose

- 1.1. Thames Valley ICB is to be established in April 2026, managing a £5.6bn health budget covering Berkshire, Buckinghamshire, and Oxfordshire. Its commissioning priorities indicate a strategic move towards value-based, integrated, and preventative care, which will have considerable impact on OUH as a provider of acute and specialised services.
- 1.2. The ICB and partner organisations are expected to prepare plans that show delivery of the NHS 10 Year Plan. A value-based approach that aligns resources to achieve better health outcomes and delivers three strategic shifts; hospital to community, sickness to prevention and analogue to digital.
- 1.3. This paper attempts to summarise the key themes and aims of the ICB Intentions and draw out those that have a potential impact on the Trust for consideration. The ICB document is a strategy document and therefore merits our consideration and response through this lens.

2. ICB Strategic Intentions

- 2.1. The ICB have identified the following three main challenges for the local system:
 - Inequality and unwarranted variation
 - inequalities in life expectancy and healthy life expectancy with deprivation a root cause
 - Rising demand
 - due to an aging population and the changing prevalence of disease
 - the changing needs of the population will outstrip the resources available using the current service models
 - Unsustainable and outdated models of care and delivery
- 2.2. The ICB's emerging commissioning strategy emphasizes the following key strategic objectives:
 - Prioritising outcomes over volume to maximise value
 - Developing integrated care at the neighbourhood level
 - Focusing on prevention and promoting equity
- 2.3. These are summarised in the following table:

Strategic Objective	Theme	Activity or Outcome (as relevant to the Trust)
<p>Commissioning to maximise value (decision making using evidence-based decision support frameworks that weigh multiple criteria including outcomes, resources, and patient needs)</p>	<p>Commissioning and Contracting Review</p>	<p>fewer more outcome focused contracts, reducing unwarranted variation in service access and delivery</p>
	<p>Decommissioning Programme</p>	<p>rebase the cost of services to establish core, funded activities vs and discretionary or other spending.</p>
		<p>Decommission where there is a significant imbalance of resource investment for marginal outcome improvement.</p>
	<p>Addressing unwarranted variation in service provision and outcome</p>	<p>addressing unwarranted variation to ensure equitable access, experience of services, and equitable health outcomes.</p>
		<p>delivery aligned with national standards.</p>
	<p>Investing for equity</p>	<p>allocate funding according to need to commission for equitable outcomes at neighbourhood level.</p>
	<p>Thames Valley Clinical Services Review</p>	<p>to concentrate volume in fewer locations to maximise economies of scale, improve outcomes and reduce costs.</p>
		<p>review of: fragile and low volume services, high volume low complexity services, maternity services, specialised provision and use of community hospitals.</p>
		<p>lead provider models for certain specialties repatriate out of area activity into the Thames Valley.</p>
	<p>Leveraging specialist networks</p>	<p>commission pathways that integrate tertiary, secondary and primary care</p>
<p>commission cancer services to be planned and delivered at regional scale to reduce duplication with shared diagnostic and treatment capacity.</p>		
<p>Commissioning for integrated and proactive neighbourhood health (Frailty and complex needs)</p>	<p>Ensuring effective frailty and care coordination for residents with complex needs</p>	<p>(see Appendix for list of actions)</p>
	<p>Integrated Urgent Care</p>	<p>(see Appendix for list of actions)</p>
	<p>Pilot pathway approaches</p>	<p>faster diagnostics and optimising use of Community Diagnostic Centres (CDC) to accelerate diagnosis and treatment.</p>
		<p>integrated pathway commissioning for long term conditions, such as diabetes.</p>
<p>New contracting and funding mechanisms e.g. ‘year-of-care’ payments</p>	<p>New contracting and funding mechanisms e.g. ‘year-of-care’ payments</p>	

	Expanded community workforce	
	Digitally enabled neighbourhood care	Assessment and care will be undertaken virtually wherever appropriate. Expanded Virtual Hospital model
	Commissioning integrated neighbourhood working	Neighbourhood Team core specification and outcomes framework
Commissioning to prioritise prevention	Improving cardiovascular health	
	Reducing obesity and diabetes	
	Improving children and young people’s mental health	

2.4. In addition, ensuring financial sustainability remains a key objective, with the statement that commissioning to be closely aligned to budget constraints.

3. Trust Considerations

3.1. An initial assessment of the risks and opportunities for the Trust as a result of the Intentions follows in sections 4 and 5 of this paper. However, the ICB document would appear to pose some key questions that the Trust may need to consider a strategic response to. These are:

Development of Neighbourhood Models

3.2. The Trust is already a provider of a number of services that outreach into the community e.g. CDC, community echocardiogram, sexual health services, MLUs, outpatient provision at community hospitals. If community/neighbourhood services are a priority for future investment how does the Trust want to position itself against this potential are of growth? What is the contract or provider models for consideration?

Trust Role and Leverage in the Acute Provider Collaborative

3.3. The ICB document includes intentions that will impact directly on acute trust services and activity. These include the intention to consolidate services to achieve benefits of scale, redistribute activity across providers, repatriate activity from out of area (including specialised services) and to decommission ‘low value’ services. How should the Trust position itself against these aims and work effectively within the APC to achieve these? What services would we look to exit/propose for decommissioning?

Trust role as a Tertiary Provider

- 3.4. The ICB document suggests opportunities for consolidation and potential expansion from e.g. repatriation. There will be capacity considerations to this. The Trust's position may require review considering the two previous issues. Expansion into neighbourhoods will require capacity and 'bandwidth to deliver, if this is a constraint what is the priority? Leveraging the APC could provide the opportunity to shift services and activity to create internal capacity. Some ICB tertiary activity goes to London, but could be provided by OUH at a lower cost to the ICB and closer to home (e.g. Buckinghamshire cardiology)

Financial Rebalancing and Contract Reform

- 3.5. Historical block contracts under review: OUH is underpaid by the ICB by c£8m primarily due to unfunded NEL growth. This is unusual as most providers locally and nationally are over-paid as a result of the legacy of the pandemic funding regime. OUH should seek to have non-recurrent funding made recurrent to cover this gap.
- 3.6. Allocation growth to be ringfenced for transformation – there is a risk that acute activity growth is not recognised and funded, putting either operational or financial targets at risk.
- 3.7. Deficit support phased out (£18m for OUH) — commissioning strictly within envelope. We expect deficit support funding to be phased out over the years.
- 3.8. Longer-term contracts that reward value – it is unclear if the ICB will be able to proceed with this ambition without changes to national contracts which appear to be moving slowly.
- 3.9. Decommissioning programme – the ICB is likely to look at historical patterns of provision that vary by place across the ICB. Given the funding backdrop, this is likely to lead to levelling down not levelling up.

4. Opportunities

4.1. To enhance the Trust's role in delivering integrated care

- Responding to the following statement; 'ICBs will develop new neighbourhood health services and will be responsible for commissioning the most suitable and high-quality neighbourhood providers within their areas. To achieve this, ICBs must actively foster strong providers capable of delivering care in integrated and proactive ways.'

4.2. **To shape commissioning strategies to safeguard specialised services, balance demand and capacity, expand target services, and phase out less effective ones**

- ‘We will identify opportunities to optimize the service offerings and delivery models across multiple locations.’
- Repatriation of specialised activities from London.

4.3. **To advance population health initiatives focused on high-need groups (such as those with frailty and multimorbidity)**

4.4. **To integrate our digital and data capabilities with ICB innovation objectives**

5. Risks

- 5.1. Reduced acute activity may impact income
- 5.2. An approach to equity that involves levelling down rather than up e.g. wheelchair services, sleep services
- 5.3. Stranded fixed costs and in-year impact of reducing semi-fixed costs.
- 5.4. Performance improvement asks with now increase in funding/recognition of demand growth
- 5.5. Contract reform increases scrutiny on cost-effectiveness
- 5.6. Equity focus may divert resources from tertiary services
- 5.7. Delegation of specialised commissioning could fragment funding.

6. Recommended Actions

- 6.1. In addition to consideration of the Trust’s response to the strategic issues raised, an initial set of recommended actions is as follows:

Engage with TV ICB Commissioning Design

- 6.2. On the decommissioning framework (prioritisation criteria, engagement process, value assessment and equality and quality impact assessment).
- 6.3. Influence what counts as “value” – to be informed by evidence, co-produced with clinicians
- 6.4. Identify opportunities to streamline the service offer and delivery model across locations – to optimise service configuration across the geography (APC lead?)

- 6.5. To review fragile and low volume services, high volume low complexity services, maternity services, specialised provision and use of community hospitals.
- 6.6. Recommend specialties creating centres of excellence.
- 6.7. Advise on opportunities to repatriate out of area (specialised) activity into the Thames Valley.
- 6.8. Prepare for cancer services to planned and delivered at regional scale
- 6.9. Review data and analysis on understanding of challenges, opportunities and expected benefits.
- 6.10. Contribute to the outline of a core neighbourhood offer.

Demonstrate OUHs Value & Equity Impact

- 6.11. Develop the OUH view on 'innovative value-based payment models' and incentives
- 6.12. Develop provider side value indicators

7. Conclusion

- 7.1. TV ICB Commissioning intentions signal a strategic pivot with direct implications for OUH.
- 7.2. Proactive engagement, evidence of value, and system collaboration will be key.
- 7.3. OUH must position itself as a strategic partner in delivering equitable, high-value care.

8. Recommendations

- 8.1. The Trust Board is asked to:
 - Note the content of the paper and agree:
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APPENDIX 1

Detail of Commissioning Intentions on UEC and Neighbourhood Health that impact OUH

UEC and Neighbourhood Health

Integrated frailty units and pathways across acute and community providers

Coordinated outreach, proactive planning and interventions for frail people, prioritising deprived neighbourhoods and care homes.

Virtual assessment and care approach wherever appropriate including support to minimise digital exclusion.

Expanded virtual wards and urgent community response. Higher acuity patients to be managed at home, using AI and digital tools to support remote monitoring across all places.

Expanded Urgent Community Response (UCR) 2hr services

Comprehensive geriatric assessment (CGA) in community and acute settings to standardise care.

Increase dementia diagnosis capacity and ensure early identification, MDT support and connections to formal and informal support.

Increase same-day emergency care (SDEC) access for older people, avoiding unnecessary overnight admissions.

Improve links between frailty pathways and end-of-life care including hospices.

Expand falls prevention services and strength/balance programmes in the community to reduce injury and admission risk.

Intermediate care and reablement: invest in local step-up and step-down care and support, particularly where hospital admission rates are highest.

UEC Integration

One integrated urgent care service specification for each place in line with national requirements. To include:

- Reduced number of same day access points.
- An integrated end-to-end UEC pathway to support patients in the right setting, first time.
- In optometry ... expanded urgent care pathways
- Seven-day urgent care services offering same-day access to primary, community and voluntary sector services.

- Maintaining flow out of our acute beds and ensure consistent delivery of 7 day a week discharge services and ensuring patients are discharged in a timely manner.
- A “recovery loop” with neighbourhood health teams following up all emergency episodes to reduce recurrence.
- Expanded integrated Multidisciplinary Team (MDT) approaches across primary and secondary care,