BOB ICB BOARD MEETING

Title	BOB System Plan 2025/26		
Paper Date:	05 May 2025	**Board Meeting Date:**	13 May 2025
Purpose:	Discussion	**Agenda Item:**	08
Author:	Paul Swan, Head of Strategic Commissioning and Planning. Ben Gattlin, Associate Director Performance Oversight	**Exec Lead/ Senior Responsible Officer:**	Hannah Iqbal, Chief Strategy, Digital and Transformation Officer

Executive Summary

This paper builds on our planning updates provided at the public board in November 2024, January 2025 and March 2025 and summarises:

- The national planning process
- Finalisation and submission to NHS England
- Confirmation of system plan priorities and plan adjustments for 30 April resubmission

National planning guidance
Nationally, 2025/2026 is intended as a financial reset for the NHS, in particular for systems who have historically been in deficit. To achieve this, there is an expectation that systems will drive productivity, use greater flexibility within allocations to agree how to manage constrained budgets and progress with the *"radical reform and reprioritisation"* required to move to a more sustainable position longer term.

The national planning guidance, published at the end of January, set out a smaller number of national priorities than in previous years.

The operational headlines include:

- Reducing the time people wait for elective care
- Improving patients access to general practice and urgent dental care
- Improving A&E waiting times and ambulance response times
- Improving patient flow through mental health crisis and acute pathways
- Improving access to children and young people's (CYP) mental health services

The national ambition for the 2025/2026 planning process was for ICBs and providers to develop and submit robust, appropriately triangulated, and deliverable operational, workforce and finance plans, signed off by provider and ICB boards by the end of March 2025.

System Planning 2025/26
This annual NHS planning process was coordinated by the Integrated Care Board (ICB), to agree how we will use our system resources across Buckinghamshire, Oxfordshire and Berkshire West (BOB) to provide services for our population over the coming financial year.

The ICB worked closely with our BOB system partners, convening regular system-wide discussions to ensure alignment and a shared understanding of the plans that were developed across the system.

The annual NHS planning round for 2025/26 is now complete. The substantive system plan was submitted to NHS England on 27 March, however NHS England issued national guidance and a request for re-submission of final plans on 30 April to enable the improvement in accuracy and quality of numerical submissions based on additional technical guidance from NHS England. The final BOB system plan with technical revisions was submitted to NHS England on 30 April 2025.

BOB System Plan 2025/26
The BOB system plan for 2025/26 submitted to NHS England focuses on:

- **Living within the money** – moving the system to a breakeven financial position in line with the national ask to live within the budget allocated.
- **System performance** - committing to achieve the 2025/26 national planning priorities and key operational performance targets at a system level.
- **Building a foundation for strategic commissioning** – building our evidence base to support strategic commissioning and longer-term reform through a system-wide programme on allocative and technical efficiency.
- **Developing a shared understanding of system and organisational savings opportunities** – improving our collective understanding and peer challenge around baselines, technical efficiency and productivity opportunities across our system.
- **Ensuring a consistent focus on quality** – ensuring effective Equality and Quality Impact Assessment (EQIA) processes are embedded across organisations and we have a shared system view of any risks and mitigations.

The adjustments to the system plan between the 27 March and 30 April submissions were minor with no change to the overall financial position. The changes include:

Operational activity and performance	- RTT 18 week performance – minor percentage decimal change to achieve compliance - Time to First OP – minor percentage decimal change to achieve compliance 4 Hour ED performance – removal of mapped activity added to RBFT submission incorrectly 4 Hour ED performance – OUH improvement to performance due to capital decision to proceed with 'Emergency Village' - Individual Placement Support – improvement to maintain current performance level
Finance	- Minor adjustments to finance templates as required by template fixers. Better alignment to workforce. No change to overall position. - Reclassifying previously unidentified CIP items under the appropriate programme/schemes.
Workforce	M12 WTE outturn amended to actuals rather than FOT for all providers – higher reduction in WTE.

Further detail of the BOB system plan for 2025/26 is set out in the Plan Summary document updated in line with these changes.

Action Required

The Board Members are asked to note the update and confirmation of the BOB system plan 2025/26.

Conflicts of Interest:	Conflict noted: conflicted party can participate in discussion and decision
The system plan 2025/26 informs the prioritisation of the use of NHS resources. This will have an impact on organisations that members of the Board lead/work for. The perspective of these members is an important aspect to development and delivery of our priorities and plans.	

Date/Name of Committee/ Meeting, Where Last Reviewed:	BOB ICB Public Board Meeting, 11 March 2025.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

2025/2026 plan overview

Introduction

In 2024/2025, the Buckingham, Oxfordshire, Berkshire West Integrated Care System (BOB ICS) had a challenging planning round and committed, in the spirit of system improvement, to take stock and learn from this, conducting a structured review as a foundation to working differently this year. Our approach towards 2025/2026 planning was therefore designed in light of this learning and centred on establishing a new regular System Planning Leadership Group to support a more aligned and coordinated approach.

The work set out in this document is the collective output of the System Planning Leadership Group, whose membership includes Executive planning leads from each of the Trusts and Integrated Care Board (ICB), alongside members of our General Practice Leadership Group. Members of this group have led intensive planning activities within their own organisation and contributed to the system-wide debate on how we might deliver the best value for our population this year and set the foundations for a more sustainable healthcare system in the future.

As a system, we have been working hard to meet the national 2025/2026 planning ask to live within the money available and demonstrate what it would take to do so. Following the Headline planning submission which identified a large projected deficit, the system stepped up its planning activities to close the gap. This has included significant and stretching work

within and across all organisations, including through Cost Improvement Plan (CIP) review sessions and peer challenge to better understand the underlying position and align on key assumptions. This work has been coordinated through a daily system planning call to maintain momentum and alignment across organisations.

As the detail of this document sets out, our BOB system plan for 2025/2026 has focused on:

- **Living within the money** – Moving the system to breakeven in line with the national ask to live within the budget allocated.

- **Building a foundation for strategic commissioning** – Building our evidence base to support strategic commissioning and longer-term reform through a system-wide programme on allocative and technical efficiency.

- **Developing a shared understanding of system and organisational savings opportunities** – Improving our collective understanding and peer challenge around baselines, technical efficiency and productivity opportunities across our system.

- **Ensuring a consistent focus on quality** – Ensuring effective Equality and Quality Impact Assessment (EQIA) processes are embedded across organisations and we have a shared system view of any risks and mitigations.

System financial plan

The overall system financial position is a **breakeven position**. **Table 1** shows how we aim to deliver this across the system.

This represents a significant improvement on the February submission that forecast a system deficit of £243m. Improvement in the 2025/26 position has been driven through mitigation of cost pressures, prioritisation of decisions on investments and increased levels of efficiencies across all organisations.

Table 1: Financial plan submission system breakdown, Apr-25

	BHFT	BHT	OH	OUH	RBFT	ICB*	BOB System
Income**	£394	£672	£708	£1,684	£654	£1,268	£5,380
Costs (after CIPs)	£393	£673	£703	£1,682	£662	£1,268	£5,380
Plan Position	£1.7	(£0.8)	£4.8	£2.0	(£7.8)	£0.0	£0.0

	BHFT	BHT	OH	OUH	RBFT	ICB*	BOB System
CIP planned	£17.5	£37.9	£36.0	£99.0	£40.6	£67.7	£298.7
System CIP							£24.0
% CIP planned	4.3%	5.3%	4.9%	5.6%	5.8%	5.1%	5.7%

* ICB excludes payments to in-system providers and delegated passthrough funding (i.e. Primary care Co-Commissioning and Delegated POD)

** BOB System is the sum of all income and expenditure for BOB providers and the ICB, therefore including NHSE and non-BOB funding.

Productivity and Efficiency

As a system we have developed stretching productivity and efficiency targets. On average, BOB providers have achieved an efficiency level of 5.4% and in total the system has planned efficiencies worth £298.7m. This includes £24m CIP that will need to be delivered through collaborative system opportunities. This equates to a 5.7% efficiency.

BOB will deliver 74% of this opportunity with providers delivering 62% and the ICB delivering over four times the NHS England opportunity value.

Productivity and efficiency packs provided by NHS England (NHSE) identified £168.6m of opportunities within providers and £6.2m within the ICB. We have undertaken significant work to ensure we are maximising the key opportunities identified within the benchmarking data, ensuring that these are reflected in the plans of each partner organisation within the system.

Table 2 provides an overview of the productivity and efficiency opportunities submitted compared to the NHS E estimate of opportunities.

The submitted plans include a CIP value of £**129.7** aligned to the £**174.8**m of opportunities identified in the NHSE analysis, that equates to 74% of the total opportunities. This reflects a significant improvement on the February position of £44.2m. The areas showing the most significant increases are:

- For providers in Elective (8.4m), Other Acute (£5.2m), temporary staffing and corporate services (£10.6m).
- The ICB has significantly increased its plan against delivery of Continuing Health Care (CHC) and prescribing. The total efficiencies identified have increased by £9m to £25.4m, which is over four times the opportunity identified by NHSE.

A further £**126.7m** of CIP has been included by other providers that aligns to areas other than the NHSE identified opportunities.

Table 2: Productivity and Efficiency submission system breakdown, Apr-25

	Total NHSE Opportunity Value (£m)	Estimate of NHSE Opportunities(£m)	Estimate of NHSE opportunity, %
Non-elective overnight stays	£23.5	£9.1	39%
A&E and SDEC	£6.1	£2.1	34%
Elective opportunity	£15.1	£12.9	85%
Outpatient opportunity	£11.1	£5.7	51%
Other acute	£7.7	£6.3	81%
Temporary staffing	£38.0	£25.5	67%

Corporate services	£49.0	£20.0	41%
Medicines	£5.7	£7.8	138%
Commercial	£12.4	£15.1	122%
Continuing care	£4.5	£9.0	200%
Primary care prescribing	£1.7	£16.4	965%
Total NHSE areas	**£174.8**	£129.9	**74%**
Total NHSE provider efficiencies	£168.6	£104.4	62%
Other provider efficiencies		£126.6	
Total provider efficiencies NHSE + Local		**£231.0**	
ICB NHSE	£6.2	£25.4	410%
Other ICB		42.3	
Total ICB Local +NHSE		**67.7**	
Total system efficiencies		**£298.7**	

Table 3 provides an overview of the productivity and efficiency opportunities across organisations in the system.

This table shows the % of plan development and the level of risk associated with the delivery of these efficiencies. This is a system risk which is being mitigated as outlined in the risks section.

Table 3: Productivity and Efficiency submission organisational breakdown, Apr-25

Metric		BHFT	BHT	OH	OUH	RBFT	All providers	ICB
Efficiencies by organisation	**Total Efficiencies**	£17.5m	£37.9m	£36.0m	£99.0m	£40.6m	£231.0m	£66.7m
	% Efficiency	4.3%	5.3%	4.9%	5.7%	5.8%	5.4%	5.1%
	% Recurrent	84%	72%	42%	61%	25%	55%	63%
	% High Risk	24%	40%	13%	82%	74%	59%	14%
	% Fully developed	62%	3%	23%	0%	20%	12%	28%
NHSE Opportunity	**NHSE Stated Opportunity**	£22.0m	£32.0m	£29.2m	£60.2m	£25.1m	£168.5m	£6.2m
	Provider / ICB	£4.5m	£29.9m	£10.8m	£38.2m	£21.0m	£104.4m	£25.4m

	Delivery of NHSE opportunity							
	% NHSE Opportunity	20%	93%	37%	63%	84%	62%	410%
Other / Local Efficiency	Local Efficiency	£13.0m	£8.0m	£25.2m	£60.8m	£19.6m	£126.6m	£18.6m

System workforce plan

BOB has a large, highly skilled and diverse workforce. In our bid to 'Live within the money' the system is challenging providers to improve productivity and do more with less. Overall real term cost growth is seen within non-pay areas whilst pay areas see a reduction, combining at 0.6%. At the same time, activity plans display growth of 3.6% implying a productivity gain of 3%.

Summary

- The system's providers plan **a reduction in total workforce of 661** Whole Time Equivalents (WTE) between March 2025 and March 2026. See **Table 4** for a detailed organisational breakdown of this reduction.

- All trusts except Berkshire Healthcare Foundation Trust (BHFT) are anticipating a reduction in WTE use. The increase is linked to new business (partly funded by Local Authority) and partially offset by efficiencies across multiple service areas.

- Reductions are planned in all workforce categories although the key focus is a movement from temporary to substantive with a focus on filling vacancies.

- Adjusted for inflation **system pay costs** are planned to be **£27.3m lower in 2025/26**. This will be achieved by a continued focus on rates (particularly medical bank) and plan to reduce temporary staffing use by improving medical job planning and filling priority substantive vacancies.

- The System plans to achieve the 10% required reduction in Bank pay (12%) whilst also achieving the 30% reduction in agency pay (40%).

Workforce productivity

During 2025-26 the cross-cutting system programmes below aim to achieve improved productivity:

System programme to align clinical staffing levels in acute trusts based on system benchmarking review

System Programme to improve medical job planning, review consultant sessional payments and align/remove salary add-ons

Reduce medical bank staff rates

Reducing corporate costs through delivery of our Scaling People Services Programme and strengthen recruitment controls

Workforce assurance

25-26 plans will build on the current process to assure workforce WTE and costs against plans this will include a monthly workforce assurance meeting linked to the existing Financial Oversight Meetings.

Table 4 - Total workforce performance by provider, 2024/25 Forecast Outturn (FOT) and 2025/26 plan

Metric	BHFT	BHT	OHFT	OUHFT	RBFT	BOB System
Total WTE SIP variance 25/26 (%)*	-0.3%	-2.4%	+0.7%	-0.6%	-1.9%	**-0.8%**
Total Pay Cost Variance (%)	+2.2%	-1.75%	+0.1%	-1.8%	-2.2%	**-1.1%**
Total Pay Cost Variance (£m)	**+£6.7m**	**-£7.3m**	**+£0.5m**	**-£17.9m**	**-£9.2m**	**-£27.3m**
2025/26 Total Pay Plan Cost (£m)	£311m	£411.5m	£418.3m	£977.1m	£404.9m	**£2,523m**
2024/25 Total Forecast Pay +4.7% (£m)	£304.3m	£418.8m	£417.9m	£995.1m	£414.1m	**£2,550m**

*March 2025 actual vs April 2025 – March 2026 average

System performance plan

> BOB is committed to achieving the 2025/26 national planning priorities and key operational performance targets at system level. We have reviewed plans including the actions against the national delivery plan 'checklists and benchmarking data to ensure we are maximising opportunities to meet the key national deliverables.

Activity

To achieve the national priorities and key operational performance targets the system must see and treat more patients; this is accomplished through a combination of:

- **Improving access to general practice** BOB plans to carry out almost 11 million GP appointments in 2025/26, more than ever before.
- **Reducing Accident & Emergency (A&E) waiting times –** at system level BOB plans to see over 79% of attendances with 4 hours. Ensuring alternatives to A&E like 'Same Day Emergency Care' (SDEC) are available and accessible.
- **Reducing non-elective length of stay**, through the increased use of our virtual wards, enables us to **do more elective activity** BOB plans to do more outpatient appointments more day cases and more elective operations in 2025/26 at the same time as reducing the number of non-elective spells of 1 or more days.

Elective

- **Referral to Treatment (RTT):** At system level BOB plans aim to achieve 65% of patients waiting no longer than 18 weeks for treatment by March 2026 and plans to achieve the national ambition of 72% of patients waiting no longer than 18 weeks for a first appointment. The total waiting list size is to reduce and the number waiting over 52 weeks for treatment is to reduce to no more than 1% of the total waiting list.
- **Cancer:** The System will achieve the 62-day standard of 75% of cancer treatments to take place within 62-days of a referral being received. To support achievement of this the System will improve performance against the faster diagnosis standard (FDS) to the planning guidance required target of 80%.
- The system will continue to work with those providers not yet planning to achieve all elective standards and seek both regional and national improvement support to strengthen plans.

Urgent and Emergency Care

- **A&E Waiting times:** By March 2026 the BOB system plans to achieve the target of 78% of patients being admitted, discharged or transferred from A&E within 4 hours.
- **Ambulance Response times:** South Central Ambulance Service (SCAS) plans seek to continue achieving a Category 2 response time of under 30 mins.

Mental Health and learning disability care

- **Length of stay in acute mental health beds:** Both mental health trusts in BOB are committed to reducing length of stay for adults in acute mental health beds.
- **Improving Children and Young People (CYP) access:** BOB has continued to expand access to mental health services for children and young people seeing 18

months of continuous increase. The plan for 2025/26 achieves the BOB proportion of the national ambition of 345k additional children and young people accessing mental health services.

- **Reduce reliance on mental health inpatient care for people with a learning disability and autistic people:** Despite already benchmarking well with low numbers of inpatients, BOB plans align with the national ambition in delivering a minimum 10% reduction in number of patients with learning disabilities or autism reliant on mental health inpatient care.

Table 5 - Key Acute Operational performance targets by provider, 2025/26 plan

Success measure	25/26 Target	2025/26 Plan (March 2026)			
		BOB ICB	OUH	BHT	RBFT
Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% improvement*	65.0%	67.6%	63.0%	65.0%	80.0%*
Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% improvement*	72.0%	72.0%	69.1%	62.3%	72.0%
Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026	1.0%	1.0%	2.0%	0.8%	0.0%
Improve performance against the headline 62-day cancer standard to 75% by March 2026	75.0%	75.4%	71.1%	75.0%	75.2%
Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026	80.0%	81.3%	80.0%	80.0%	80%
Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026	78%	79.6%	78.0%	78.1%	78.0%
and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25	Reduce	3.2%	4.4%	6.11%	1.0%

*RBFT Amber – meeting Ops planning standards however not achieving 5% improvement

Table 6 - Additional Operational performance targets, 2025/26 plan

Success measure	Data month	25/26 Target	2024/25 Actuals BOB ICB		2025/26 Plan (March 2026) BOB ICB
Improve Category 2 ambulance response times to an average of 30 minutes across 2025/26	Mar-25	<30mins	30 mins		<30mins (SCAS)
Increase the number of urgent dental appointments in line with the national ambition to provide 700,000 more	Mar-25	15,454 more	95,003		110,457
Reduce average length of stay in adult acute mental health beds	Nov-24	<57 days	57 days		50 days
Increase the number of CYP accessing services to achieve the national ambition for 345,000 additional CYP aged 0–25 compared to 2019	Jan-25	26,531	21,483		26,842
Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, delivering a minimum 10% reduction – Learning Disability	Q4 2023/24	25	20		20
Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, delivering a minimum 10% reduction – Autistic Adults	Q4 2023/24	30	24		24

Quality & EQIA approach

> We are committed to continuous improvement of the quality of healthcare services provided to the population of BOB. The BOB ICB quality assurance framework is a whole system framework, agreed by partners to set out responsibilities and accountabilities across the system to improve the quality of services, experience and outcomes.
>
> The framework is underpinned within each organisation by robust clinically led governance and assurance arrangements, quality improvement processes and approaches, delivery of initiatives and programmes aligned to strategic quality objectives and regular monitoring and reporting of impact and outcomes metrics.

System-wide quality assurance

Our system plans to improve the quality of our services are further enabled by data-driven insights and a data-led approach to quality assurance. Quality assurance approaches across the system use data, public, patient and staff feedback, peer reviews and visits and triangulate all this information regularly to inform quality improvement priorities.

Across BOB, we have reviewed and analysed the provider patient safety incident response plans (PSIRP's), Never Events, quality accounts and Learning from Patient Safety Events (LFPSE) data to identify themes for wider system improvement. Areas identified include pressure area care, safer surgery, the deteriorating patient, and falls. Through our quality visits we have also identified areas for improvement and shared learning regarding care in Emergency Departments, infection prevention and control and paediatric hearing.

Key to our approach is hearing the views of our patients, enabling co-designed approaches to quality improvement and development of services that are responsive to patient preferences. Patients experience insights are gained through proactive public involvement and engagement and analysis of public, patient and staff feedback.

Data and feedback are reviewed in a continuous way to develop our quality improvement plans. Through leveraging data, we aim to continuously improve service quality and patient outcomes and ensure services reflect the needs of our population.

Prioritisation Decisions & EQIA Process

> A continued focus on quality and patient experience has been reflected in our planning process through our EQIA and prioritisation of decisions approach.

The ICB planning process has been supported by clinical governance to develop and review plans. Senior quality leads including the Chief Nursing Officer and Chief Medical Officer have been involved in the planning decision-making forums.

Over the financial year 2025/2026 there will be an established ICB EQIA (Equality and Quality Impact Assessment) process which will require the detail of any decommissioning or service

provision change decisions to be brought through further scrutiny to ensure appropriate mitigations.

The ICB has reviewed the Trusts EQIA process to ensure all decisions have appropriate oversight and assurance of mitigations in place to maintain safety and quality of services. The ICB is assured that all Trusts have Board oversight of the EQIA process with the CNO's being responsible for ensuring quality and safety is maintained during the planning rounds.
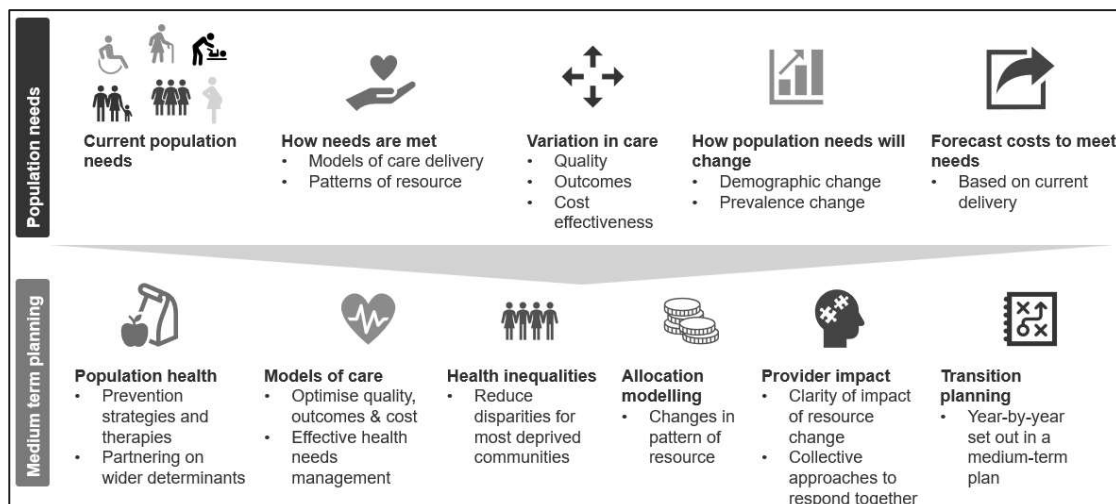
Trust EQIA processes and have already identified some potential impacts of the prioritisation decisions taken in plans such as impacts on patient experience, waiting times and outcomes in some services and potential of negative impact of staff wellbeing. These impacts have been mitigated against through the organisation's EQIA process where appropriate. Proposals with unmitigated risks have been declined by provider CNO's. Where organisations have not yet conducted full EQIAs for plans, these will take place following more detailed plans being developed.

The ICB will be utilising Trust quality committees and System Quality Boards to monitor for any unintended implications on quality and safety ensuring mitigations can be supported across the ICS, utilising risk sharing across partners.
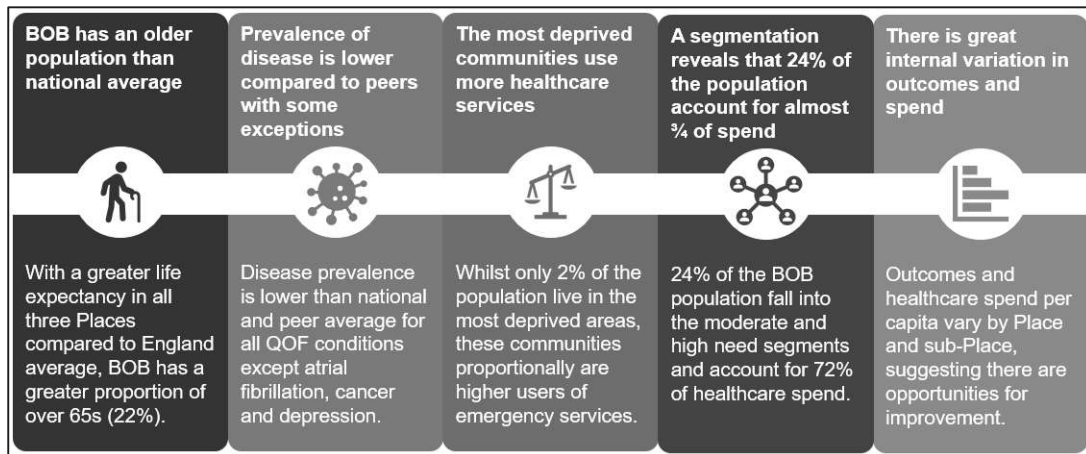
Building a foundation for system transformation and strategic commissioning

> We have been using the 2025/2026 planning round to develop a strong data-led foundation for system transformation and strategic commissioning. This work has been sponsored by the System Planning Leadership Group and has focused at identifying how we might use our system resources to deliver the greatest value for our population (allocative efficiency) and opportunities to improve the way we deliver services across the system and within organisations (technical efficiency).

The outline of the programme of work we have undertaken to build a baseline for system strategic commissioning is set out below:

The analysis has shown some of the specific challenges facing our population now:

BOB has an older population than national average	Prevalence of disease is lower compared to peers with some exceptions	The most deprived communities use more healthcare services	A segmentation reveals that 24% of the population account for almost ¾ of spend	There is great internal variation in outcomes and spend
With a greater life expectancy in all three Places compared to England average, BOB has a greater proportion of over 65s (22%).	Disease prevalence is lower than national and peer average for all QOF conditions except atrial fibrillation, cancer and depression.	Whilst only 2% of the population live in the most deprived areas, these communities proportionally are higher users of emergency services.	24% of the BOB population fall into the moderate and high need segments and account for 72% of healthcare spend.	Outcomes and healthcare spend per capita vary by Place and sub-Place, suggesting there are opportunities for improvement.

System Transformation approach

From this work, we have been able to identify our priority areas for cost reduction and for system transformation. These cover two main areas of opportunity:

1. Collaborative productivity and efficiency opportunities

We have identified a number of opportunities from our analysis through the planning process. Analysis has included best practice, provider submissions, drivers analysis and bilateral discussions.

The analysis points to areas where providers can *collaborate at Place or through Provider Collaboratives* to deliver savings next year and include:

Multi provider collaboration opportunities:

- **System elective reform** – Ambitious elective targets and a more coordinated approach to elective care and outpatient working creates system opportunity to balance demand and deliver higher throughput models, including high volume, low complexity (HVLC).
- **Substantive workforce** – There is an imperative to reduce headcount and develop programmes focused on skill mix and aligned staffing levels. Work must include job planning to maximise medical capacity.
- **Out of area placements** – Providers identified opportunities for repatriation where there are inappropriate out of area placements and the opportunity to reduce length of stay enabled through closer integration with local services.
- **Corporate services consolidation** – We will accelerate work within Acute Provider Collaborative (APC) workstreams including specific work in people services and procurement functions.

Place collaboration opportunities:

- **Urgent and Emergency Care admission avoidance** – This is the largest clinical opportunity area based on drivers. Providers identified a need to work with local partners to manage growth in non-elective demand.

- **Alternative discharge (No criteria to reside - NCTR)** – This is the most significant NHSE clinical opportunity area. In BOB providers identified the need to focus on NCTR pathways and aligned action on neighbourhood health models.

The analysis of these opportunities is still in progress to define and validate the scale and scope of the financial improvement for each opportunity area.

2. Medium term transformation programmes

Our analysis also identified opportunities areas which have shaped our medium-term strategic transformation ambitions within the system. These require *system level co-ordination or leadership from the ICB* to deliver over the medium term.

The three greatest opportunity areas identified from our analysis relate to:

Opportunity	Rationale	Description
1. Reduce growth in prevalence and progression of ill health	Prevalence of some diseases (e.g. CVD, cancer) are increasing faster than national average leading to preventable complexities in patient need	Reduce prevalence and progression of ill health relative to the current trend based **on targeted prevention and early detection** activities, focused on making the shift from reactive to proactive care
2. Transforming models of care	Variation in models of care between Places, with no corelation between per capita cost and outcomes, indicates scope for improvement	Change models of care to **deliver consistent proactive care and support effective population health management**, making the shift from acute to community and analogue to digital care
3. Optimising the efficiency and configuration of care delivery	Inconsistent models of commissioning are resulting in different service offers across our places and neighbourhoods	Define an affordable 'core BOB system service offering' by using data to ensure we **consistently allocate our resources to the most impactful interventions** aligned to the 3 shifts and population need.

These opportunities have been developed into system-wide transformation programmes. These are still being developed and refined with system partners.

The programmes are:

- **BOB neighbourhood health programme** - Working with system partners we are developing a systematic approach to meeting people's health and care needs across primary care, community, mental health and acute using the neighbourhood health model. Key focus on optimising health and care resource through the Government's 3 key shifts.

- **BOB clinical services strategy** - We will define a clinical strategy for BOB, working with our partners, the public and clinicians to review our current service provision and ensure optimal provider and service configuration to deliver sustainability and meet the needs of our population

- **Strategic commissioning programme** – We will baseline our existing cost and commissioning position before using data and evidence to inform the strategic allocation of resources, supporting 'left shift'. Our approach will mean commissioning with an understanding of healthcare value, affordability, return on investment and to reduce unwarranted variation.

Reducing health inequalities

Our strategic commissioning baseline has included a targeted focus on how we might improve outcomes for our population. Of particular note within the analysis are our populations living in the greatest levels of deprivation (Core20 population). In BOB this population represents approximately 50,000 people.

While BOB has a relatively small Core20 population, the health challenges facing these communities are similar to those affecting the wider population. However, the trends on healthcare usage point to a continued inequity of access, particularly with regard to planned or proactive care, pushing people to later reactive unplanned care.

Evidence has shown that across nearly all cohorts of individuals with similar healthcare needs (segments) those identified as the Core20 population have higher per capita expenditure than those not in the Core20 population. This reflects a higher use of healthcare resources driven by the increased use of more acute services in response to more progressed illness.

Analysis of resource use by point of delivery provides evidence that those living in deprivation use planned healthcare resource (inpatient elective spells) less than those in living in areas defined as more affluent.

The system is committed in its focus on the Core20Plus5 framework and Inclusion Health principles to deliver on prevention priorities, and to maximise our impact by serving as anchor institutions in the local community.

As the collaborative opportunities and transformation programmes are defined in more detail, we are committed to working with the Core20 population, and other communities that experience inequality of access, outcome and experience, to describe and tailor improved models of support and care and prioritise these groups.

As the programmes are established, we will set targeted goals and then measure progress by regularly evaluating outcomes and key metrics (e.g. access, quality, outcomes) for the targeted, priority population groups.

Risks, mitigations & system governance

Overall approach

The BOB system has been working hard to meet the national 2025/2026 planning ask to live within the money available and demonstrate what it would take to do so.

Following the Headline planning submission which identified a large projected deficit, the system stepped up its planning activities to close the gap. This has included significant and stretching work within and across all organisations, including through CIP review sessions and peer challenge to better understand the underlying position and align on key assumptions. In the latter stages of the process, this work was coordinated through a daily system planning call to maintain momentum and alignment across organisations.

Given our system starting position, we have had to accept a level of system risk to move to breakeven. Through our work together we have identified multiple areas of opportunity to

streamline our resources, review our provision and unify our approach to financial planning and management. These include:

a) *Further baseline analysis work*
b) *Further CIPs comparison analysis*
c) *Further work to identify collaborative system productivity and efficiency opportunities*
d) *Initiation of clinical service redesign programme (including infrastructure implications)*

In light of the above, the system has agreed to take on this additional system risk to close the gap and meet the national ask of living within the money available. All organisations in BOB are committed to collaboratively identifying the route to achieving these additional savings, working to deliver them and tracking this monthly through the System Recovery and Transformation Board.

Risks and mitigations

More detailed risks and mitigations are set out below:

Risk Area	Risk	Mitigations
Cash	Suspension of process for Trusts to access cash in April, coupled with NHSE directive that recovery plans must be adhered to, with delivery evenly distributed throughout the year, brings a risk of cash shortfall for provider organisations, with impact on timely payments to suppliers and, in extremis, on payroll payments.	Mitigations to this risk include: • Regular monitoring of organisational cash positions within the system. • NHS E are keen for systems to maximise cash management within systems by transferring cash within the system. This will likely be challenging for organisations holding cash as they may not be able to recover it. Providers will need to further delay payments to suppliers and take other measures to ensure payroll is safeguarded.
Elective Delivery	There are a number of risks to the delivery of elective activity targets within the system including: • Elective recovery plans are constrained by the Elective Recovery Fund ceiling. Therefore, plans are unable to maximise all activity and are reliant on productivity improvements across all elements of the pathway in order to deliver submitted plans. • There is a risk of overperformance of Independent Sector Activity and legal challenge to implementing	Mitigations for these risks include: • Acceleration of system-wide plans to maximise productivity, and in addition, access improvement support and funding for validation. • We have budgeted for 2024/25 plan for IS and Out of area activity with a £10m reserve by ICB to cover required elective activity and contract risk. If the NHS standard contract includes a clause to enable the ICB to cap activity we could attempt to further reduce activity and spend. • Ensure system-wide initiatives are delivered and pathway transfers are enacted at the earliest point possible.

	caps on contracts. This could put at risk RTT targets and could result in cost pressure to the ICB if challenged. • System plans are predicated on a set of assumptions around transfer of patients and activity away from Oxford, there is a risk that patient choice may impact on these plans.	
Managing Non-Elective Demand	Some providers have assumed 0% growth into plans. If we are not able to successfully manage demand at this level this could impact across a wide range of services putting pressure back onto primary care, increasing cat 2 response time due to longer ambulance holds, longer ED waits and reduction in Elective activity.	To manage NEL demand many levers are in place and will continue to be so through 2025/26 • Work is underway develop a system-wide programme to support Neighbourhood health as outline in earlier sections. • All three places have mobilised Single Point of Access for a range of acute and community led services to minimise conveyance/admission to hospital via clinically appropriate alternatives. • Place based partnerships are using Better Care Funds and health inequalities schemes to reduce NEL demand or keep it at 0%. • Working with Primary Care to understand and address variations in referral patterns.
Workforce Reductions	• Plans are reliant on significant workforce reductions with likely redundancies and significant restrictions on recruitment required. There is a risk that consultation and any associated redundancy schemes required will pose significant challenges in delivering an in-year payback from restructuring programmes. • Impact of organisational change on Trust staff, resulting in increased turnover. • Adequacy of staffing remains a challenge to continue to provide quality and safe care.	Mitigations to this risk include: • Change programmes supported by robust people and organisational change policies. • Access to a nationally funded scheme such as that provided to NHSE and ICBs and/or an alternative would significantly enhance the deliverability of the Trusts workforce plan. • People plans with focus on staff retention. • To mitigate potential quality impacts, proposals in plans will be managed through well-established quality governance frameworks and processes (including EQIAs) which will provide visibility of any quality and safety and mitigations. Ongoing monitoring of patient safety, patient experience, and clinical effectiveness

		will take place via the existing governance frameworks.

Plan Governance

The Board is asked to approve the plan submitted. There are potential for further updates and changes required following final approvals from providers. If changes are required to the plan the Board is asked to give delegated authority to make these changes and submit a revised plan outside of formal governance arrangements.