

BOARD MEETING

Title	BOB ICB Annual Report and Annual Accounts 2024/25		
Paper Date:	1 July 2025	Meeting Date:	8 July 2025
Purpose:	Assurance	Agenda Item:	08
Author:	Annual Report compiled by Sarah Adair, Associate Director of Communications & Engagement with contributions from colleagues across the ICB & Annual Accounts produced by Noreen Kanyangarara, Associate Director of Financial Accounts	Exec Lead/ Senior Responsible Officer:	Hannah Iqbal, Chief Strategy, Digital and Transformation Officer (Annual Report) & Alastair Groom, Chief Finance Officer (Annual Accounts)
Executive Summary			
<p>Following national guidance, annual reports and accounts include three sections:</p> <ul style="list-style-type: none"> • The Performance Report • The Accountability Report • The Financial Statements <p>The BOB ICB Annual Report and Accounts 2024/25 has been drafted in line with national guidance and templates.</p> <p>The Audit and Risk Committee approved the Annual Report and Accounts on 19 June 2025 for submission to NHS England on 20 June 2025.</p>			
Action Required			
The board are asked to receive and be assured that the Annual Report and Accounts provide a true and fair reflection of the organisation's performance and financial position for the reporting period 2024/25.			
Conflicts of Interest:	No conflict identified		
Date/Name of Committee/ Meeting, Where Last Reviewed:	Audit and Risk Committee 19 June 2025		



**Buckinghamshire, Oxfordshire
and Berkshire West**
Integrated Care Board

NHS Buckinghamshire, Oxfordshire & Berkshire West Integrated Care Board

Annual Report 2024/2025

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Performance Report

The following performance report consists of a performance overview and a performance analysis. It outlines what the Buckinghamshire, Oxfordshire Berkshire West Integrated Board (BOB ICB) is; its purpose, statutory duties and how the ICB has executed those duties. It looks at the work of ICB between 1 April 2024 until the end of March 2025, how the organisation has performed and outlines the risks it faces.

Performance Overview

About our system

The BOB ICB holds the statutory duty to plan, fund, and oversee health services for approximately 1.8 million people, using a variety of NHS, voluntary, charitable, community, and private sector providers. The ICB continues to lead the development of the BOB Integrated Care System (ICS) to remove traditional barriers between services so people can access the support and care from the NHS and wider care services when they need them.

The BOB Integrated Care Partnership (ICP) serves as the statutory committee linking the ICB with our five local authorities across BOB. Its membership includes all local NHS organisations and representation from primary care providers (GPs, dentists, pharmacists, and optometrists), public health, Healthwatch, voluntary and community groups, and the Oxford Academic Health Science Network. The ICP's role is to formulate and agree on an [integrated care strategy](#) and to foster collaboration among all partners to implement it.

Our integrated care system is located in the heart of the Thames Valley, encompassing rural areas and more densely populated regions around towns and cities such as High Wycombe, Aylesbury, Oxford, and Reading. Our partner NHS provider Trusts include:

- Buckinghamshire Healthcare NHS Trust (BHT)
- Berkshire Healthcare NHS Foundation Trust (BHFT)
- Oxford University Hospitals NHS FT (OUHFT)
- Oxford Health NHS FT (OHFT)
- Royal Berkshire NHS FT (RBHFT)
- South Central Ambulance Service NHS FT (SCAS)

In addition to these organisations, we collaborate closely with primary care providers who directly deliver health and care services. We also maintain connections with schools, universities, businesses, and research partners involved in health or care within our area. There are more than 8,000 registered charities in our region, with potentially up to 5,000 more informal community groups.

Most of these registered charities are small and volunteer-run. Besides contributing to the health and wellbeing of our population, these voluntary and community groups offer a strong link to our communities and provide valuable insights into local needs.

Population

There are 1.8 million people living in BOB. Compared to the rest of England, BOB has a higher proportion of people over the age of 65 and this population is growing at a faster rate. Life expectancy and healthy life expectancy is higher in each of BOB's three places compared to the UK average.

This year we have completed some detailed population analysis about our population.

The deprived population in BOB overall is small, equal to 50k people or 3% of the population. These areas are focused in Reading, Oxford and Cherwell (North Oxfordshire). There are significant inequalities for this Core20¹ group, particularly in life expectancy.

Population demographics inform the health needs of the population with the older population driving greater prevalence in cancer and cardiovascular disease (CVD) conditions such as arterial fibrillation (AF), which exceed the national average. CVD conditions are also growing at a higher rate than the national average. The considerably more affluent make-up of the population may be a factor for otherwise lower rates of prevalence. However, drilling down to sub-place there is further variation, with prevalence in asthma exceeding national rates in Oxfordshire and Berkshire West, and higher rates of dementia and depression in Oxfordshire and the Reading area.

According to the 2021 census, the ethnic profile for our combined area is very similar to the national average. This masks differences at local authority level. People who responded that they were White British make up 73% of residents overall which is like the national average but this ranges from 53% in Reading to 85% in West Berkshire. People from many different ethnic groups live in our area including 3.5% of the population who describe themselves as Indian, 3.1% as Pakistani, 1.6% as Black African and 0.8% as Black Caribbean. These relative proportions vary between local authorities and ethnic diversity tends to be higher in our major towns and cities.

Better understanding our population

This year we have completed some detailed analysis of our population, part of which was to better understand the health needs and healthcare use of different segments of our population as categorised using the [John Hopkins Adjusted Clinical Group \(ACG\) system](#). This segments the population into 11 cohorts which are then broadly grouped into low, moderate and high need segments. This segmentation was combined with other data to link healthcare activity and costs to the population cohorts and broader segments.

The analysis revealed that in 2023/2024, 24% of the BOB population fell into the moderate and high need segments but accounted for 72% of total healthcare cost. People in these cohorts have higher rates of chronic conditions and experience deteriorating health, resulting in both higher usage of primary care to manage conditions, and emergency resources when experiencing crisis. ED and non-elective usage is 20 times higher in the highest need (frailty) cohort compared with the lowest, and seven-times greater for primary care appointments.

While the actual number of people is low, there is significant variation in the expenditure on high needs segments in the Core20 group compared with the non-Core20. People in the Core20 frailty cohort have a higher healthcare cost of £10k more per year than the non-

¹ Core20 - the most deprived 20% of the national population as identified by the national [Index of Multiple Deprivation \(IMD\)](#). The IMD has seven domains with indicators accounting for a wide range of social determinants of health.

Core20 population. This reflects how people in Core20 communities have poorer access to healthcare, engage with the system later in the progression of disease and have worse outcomes as a result.

Overview from Dr Nick Broughton Chief Executive

2024/2025 has been a time of significant change. Nationally and locally, with a new government and a new operating model for the ICB. More changes are on the horizon as we await the publication of the 10 Year Plan for the NHS and address the ask of Government to reduce our running costs and focus on being strategic commissioners.

While we can look to the future with optimism, the focus of this report is the past year - 2024/2025. Our main achievements and challenges are detailed in this report, but I want to highlight a few that I believe will positively affect patients and continue to build a stable and sustainable health and social care system across Buckinghamshire, Oxfordshire, and Berkshire West.

- **Planned care** – In the area of planned (elective) care, the ICB has focused on reducing waiting times and improving the quality of care. Buckinghamshire Healthcare NHS Trust and Royal Berkshire Hospital NHS Foundation Trust have successfully treated all patients who had been waiting 65 weeks or more by March 2025. System-wide initiatives have been implemented to match demand with available capacity, secure additional capacity with independent sector providers, and Trusts have been using digital tools to streamline processes to reduce waiting times.
- **Urgent and Emergency Care** – Efforts to improve urgent and emergency care have been extensive. Trusts in BOB have faced high demand and complex cases, but sustainable improvements in ambulance handover delays have been made. The Hospital at Home service has been expanded to include children, providing hospital-level care at home where appropriate. Transfer of Care Hubs have been coordinated to ensure timely discharges, reducing hospital stays.
- **Primary Care** – A significant amount of work was undertaken in 2023/24 to develop a Primary Care Strategy for BOB. In May 2024, the [strategy](#) was agreed by the ICB Board and progress to implement the strategy and shift towards a preventative and community-based model of care has been made. We have seen the roll out of the Pharmacy First initiative so patients can access some prescription medicines without needing to visit a GP and we have commissioned an additional 70,000 units of dental activity to improve access to high street dentistry.
- **Developing a greater understanding of the population we serve** – We have completed detailed analysis of our population's health needs and the current use of healthcare resources and cost (Pathway to Sustainable Healthcare). This analysis has also forecast trends for our population and health service use over the next five years, which has highlighted significant implications for our system if we do not change. It further identifies opportunities for a healthier population and more sustainable healthcare by addressing health inequalities and focusing on three key areas: (1) reducing the growth in prevalence and progression of ill health, (2) transforming models of care, and (3) optimizing the efficiency and configuration of care delivery. This will inform system transformation planning and strategic commissioning developments going forward.
- **Health inequalities, long-term conditions and prevention** – We have made significant strides in addressing health inequalities and

promoting prevention. While integrated into all our work, the ICB's Prevention and Health Inequalities Team has been working with partners to tackle ill health and reduce disparities in access, experience, and outcomes. Notable efforts include £4 million allocated to schemes like improving maternal health and service access for younger and ethnic minority women in deprived areas; multi-agency support for homeless residents as they leave hospital and community a wellness outreach service which offers NHS Health Checks targeting priority groups, with referrals for weight management, mental health support, and smoking cessation. Our Long-Term Conditions Integrated Delivery Networks across BOB for cardiovascular (cardiac and stroke), respiratory and diabetes continue to bring together our providers with clinical leadership to drive forward our priorities including prevention, improving health, prioritising areas of health inequalities, reducing variation and co-designing integrated pathways.

- **Quality** – The ICB has strengthened its commitment to high-quality care by publishing and updating the Quality Assurance Framework to reflect new oversight mechanisms. Patient experience has been made integral to quality assurance and improvement work. Safety initiatives such as Martha's Rule, preterm birth optimisation, and transforming wound care have also been implemented.
- **Digital** – This year, the ICB has made significant strides in digital transformation. Several key initiatives have been implemented to enhance the efficiency and accessibility of healthcare services. One of the major achievements is the digitisation of patient records in several GP practices, which has greatly improved access and efficiency. Additionally, online consultation platforms for GP practices have been enhanced, improving patient access and workload management.
- **Vaccinations** Significant work has been undertaken over the past year to ensure our eligible populations have been vaccinated for Covid-19, Flu and Respiratory Syncytial Virus (RSV). The estimated number of BOB patients eligible for 2024 spring boosters was 229,184 with a regional target of 62%; we achieved a total of 146,157 patients vaccinated, which equates to 63.8% of the eligible population. The average in the Southeast region was 61.7 and this exceeded the national average of 56.3%.

All this has been achieved while the ICB has undergone a significant change programme to optimise its operating model and reduce running costs by 30%. This included two staff consultations and the implementation of a new operating model, focusing on delivering strategic functions at the system level, place-based partnerships, and provider collaboratives.

In terms of our financial position, the ICB ended the year with a £9k surplus. Despite challenges, including high demand, operational pressures, and financial constraints, the ICB has made good progress. We should be proud of our achievements outlined in this report. Our commitment to providing safe, equitable, and personalised care has driven positive changes across the system. Together, we have navigated a challenging year and laid a strong foundation for future success.

Performance Analysis

The following performance analysis report looks at the work of the ICB between 1 April 2024 until the end of March 2025, how the organisation has performed and outlines the risks it faces.

Improving the health and wellbeing of people across Buckinghamshire, Oxfordshire & Berkshire West

The BOB Integrated Care Partnership (ICP) aims for everyone in Buckinghamshire, Oxfordshire, and Berkshire West to have the best start in life, live healthier and happier for longer, and receive timely support. In 2023, after extensive engagement, the ICP published the Integrated Care Strategy, followed by the NHS Joint Forward Plan, detailing our approach to achieving the strategy's goals.

Recognising the impact of housing, environment, cost of living, employment, and community life on health, the ICP is committed to addressing these collaboratively. The Integrated Care Strategy builds on existing Joint Local Health and Wellbeing Strategies (JHLWS) across the region and aligns with local plans to meet residents' health and wellbeing needs. It is founded on a commitment from partner organisations to work together to improve health and reduce inequalities, identifying five key priorities.

Published on June 30, 2023, the NHS Joint Forward Plan outlines how we will organise and provide NHS services to meet physical and mental health needs, focusing on actions by the NHS in BOB (ICB, NHS Trusts, primary care, etc.). Future plans are expected to reflect broader partnership activities.

The JFP identifies key challenges that, if addressed, will significantly improve services. Tackling these requires long-term changes, new collaborative approaches, and a shift from treating illness to prioritising prevention and maintaining health in communities. Both the Integrated Care Strategy and NHS JFP provide the framework and direction for the wider Integrated Care System, including relevant NHS organisations.

Delivering the JFP across our three 'Places' is a priority for the ICB. Each place has established a Place based executive partnership which is accountable to the relevant place Health and Wellbeing Board. Membership varies on the partnership boards, but all include health and local authority partners. The Place Partnerships have taken on a variety of functions and include agreement on how to prioritise place-based funding i.e: urgent and emergency care allocation, Better Care Fund, and prioritising focus on strategic areas where greater gain can be achieved through partnership approach. For example, health inequalities, special education needs disabilities, hospital admission avoidance and discharge from hospital.

Place updates with detailed information about initiatives and performance of services at Place are regular agenda items at the ICB Board in public and can be found on our website through the links outlined below.

- [Buckinghamshire](#)
- [Oxfordshire](#)
- [Berkshire West](#)

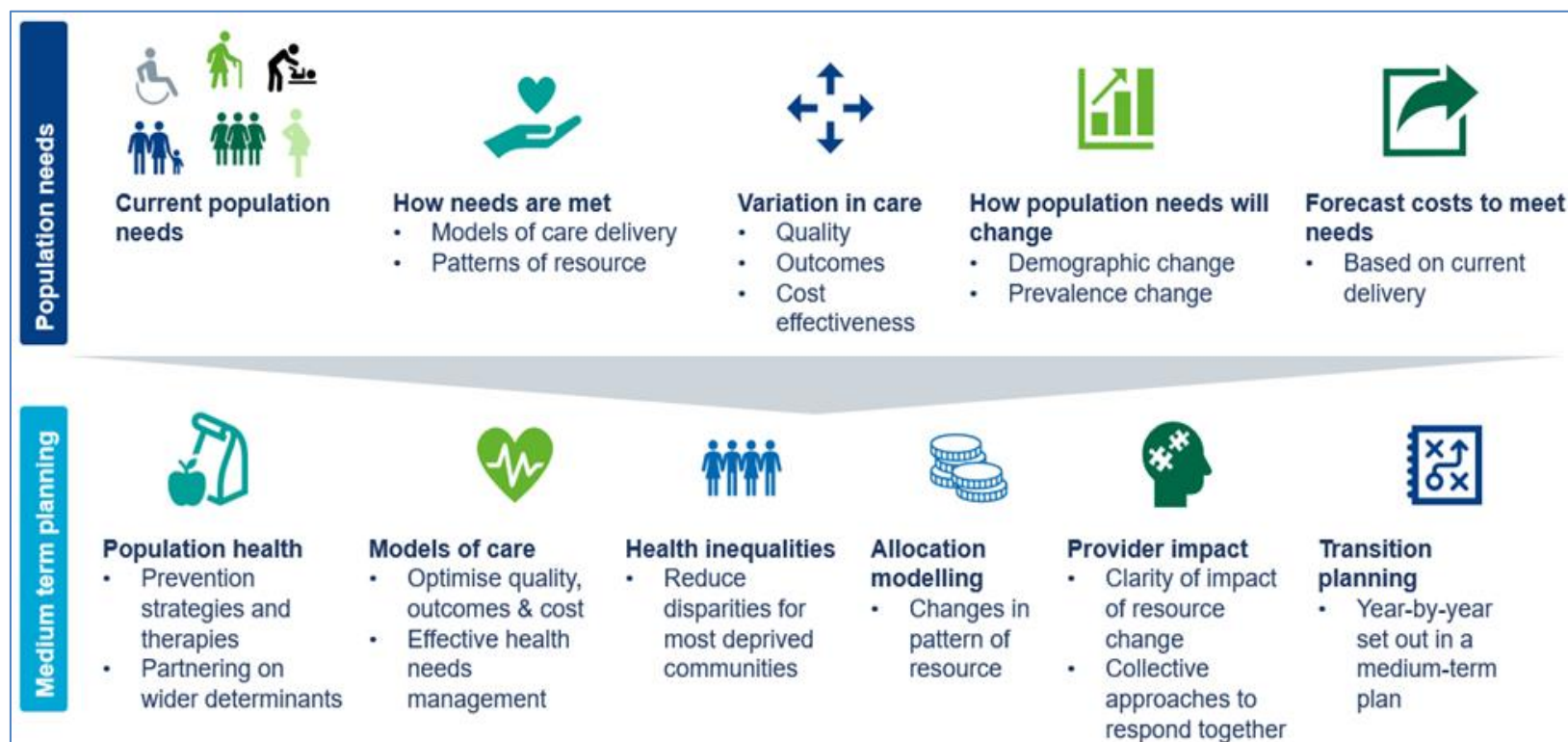
The 'Pathway to Sustainable Healthcare' analysis completed this year will inform our approach to improving the health and wellbeing of the BOB population over the next year and beyond.

Population Health Management

The 'Pathway to Sustainable Healthcare' project has now given BOB a new analytical baseline for the system. This seeks to align partners around a common understanding of the most significant health challenges affecting our population and the key opportunities to work together to make improvements. This includes:

- **An analysis of our population's needs** – building an analytical baseline of our population health needs and how our services are accessed to inform prioritisation of focus and resource.
- **Agreeing a clear medium term system plan** – developing a clear medium-term plan for sustainability, transformation and improvement, based on a shared understanding of our population.

Our approach to developing the medium term system plan is outlined below:



To understand population needs and how they will change over time, we looked at a number of sources of data. To segment the population of BOB into population groups with similar levels of health needs, activity data from hospital statistics and patient level data held in primary care has been combined with finance data from the system. The current state is projected forward five years using demographic growth from the Office of National Statistics and non-demographic growth based on historical trends in health needs. This produces the 'do-nothing' scenario for activity and finance. The "do-nothing" scenario is a forecast which reflects the expected change in the health requirements of the population if there is no major transformation. Population growth rates and excess death rates are applied and movements between segments are captured to produce the forecast and then estimate the "do-nothing" financial position of the ICB.

The 2023/2024 segmentation snapshot shows 24% of the population of BOB fall into the moderate and high need segments which account for 72% of the total cost.

The diagram below outlines the total population health baseline in 2023/2024 for BOB ICB:

Total population health baseline in 2023/24 for BOB ICB										
Age band	Non-User	Low Needs	Low Complexity Morbidity	Medium Complexity Morbidity	Pregnancy Low Complexity	Pregnancy High Complexity	Dominant Psychiatric Condition	Dominant Major Chronic Condition	Multi-Morbidity High Complexity	Frailty
0-17 Pop: 411k Total cost: £340m	£3.1m	£163.8m	£76.5m	£37.5m	£199K	£8K	£19.4m	£26.6m	£12.8m	
	19.8k	312.1k	48.0k	14.2k	110	8	4.9k	10.8k	1.4k	
	1.1%	17.1%	2.6%	0.8%	0.0%	0.0%	0.3%	0.6%	0.1%	
	0.1%	5.9%	2.7%	1.3%	0.0%	0.0%	0.7%	1.0%	0.5%	
18-64 Pop: 1.1m Total cost: £1.3bn	£7.2m	£156.6m	£245.4m	£216.3m	£77.5m	£22.4m	£126.1m	£299.0m	£158.6m	
	63.5k	549.1k	254.1k	86.8k	19.1k	3.5k	33.4k	78.8k	11.0k	
	3.5%	30.1%	13.9%	4.8%	1.0%	0.2%	1.8%	4.3%	0.6%	
	0.3%	5.6%	8.8%	7.7%	2.8%	0.8%	4.5%	10.7%	5.7%	
65+ Pop: 314k Total cost: £1.2bn	£6.8m	£31.4m	£106.2m	£293.6m			£26.9m	£239.0m	£298.1m	£148.6m
	7.4k	47.7k	77.7k	90.3k			6.5k	44.9k	29.4k	9.7k
	0.4%	2.6%	4.3%	5.0%			0.4%	2.5%	1.6%	0.5%
	0.2%	1.1%	3.8%	10.5%			1.0%	8.5%	10.6%	5.3%

24% of the population are in the moderate and high need segments (cohorts) and account for 72% of cost

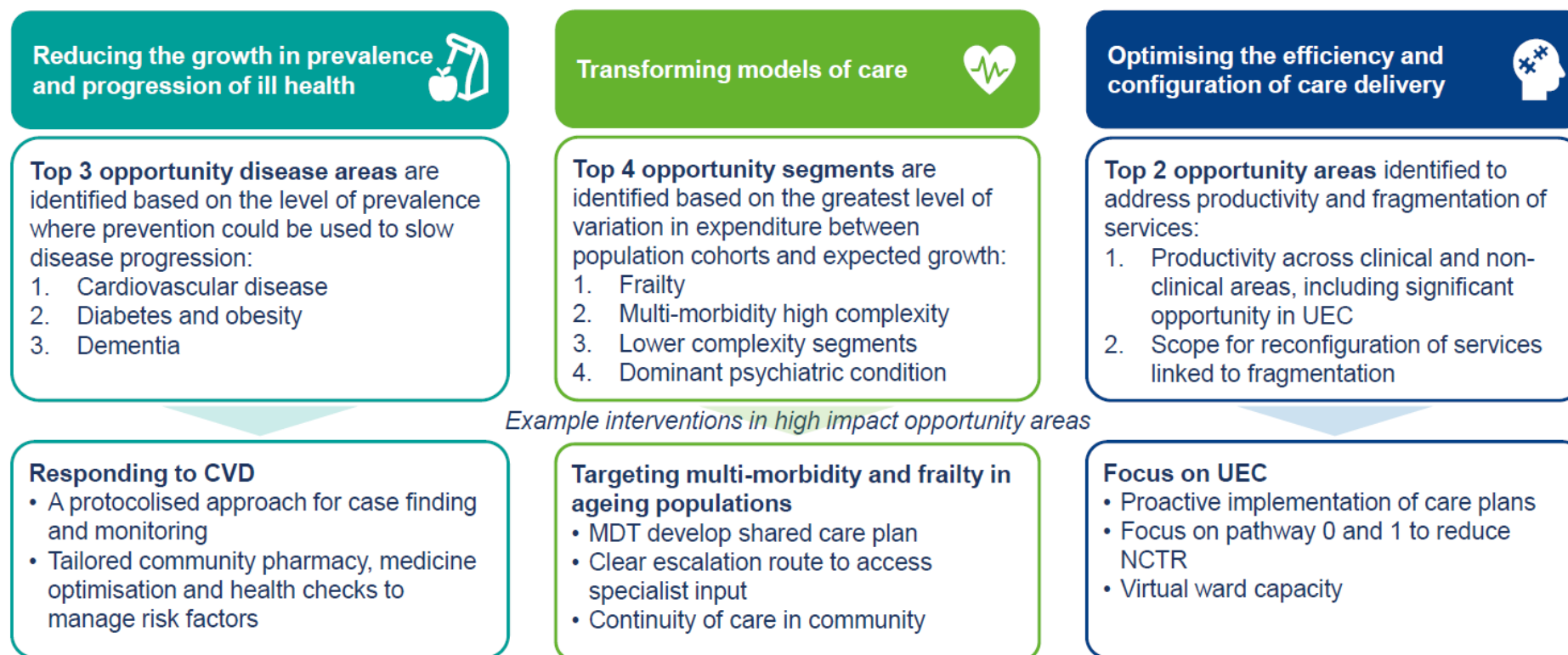
In 2029/2030, in a “do nothing” scenario, the health of the population will worsen and the moderate and high need segments will grow to account for 80% of total cost.

The diagram below outlines the total population health baseline for 2029/2030:

Total population health baseline in 2029/30 for BOB ICB										
Age band	Non-User	Low Needs	Low Complexity Morbidity	Medium Complexity Morbidity	Pregnancy Low Complexity	Pregnancy High Complexity	Dominant Psychiatric Condition	Dominant Major Chronic Condition	Multi-Morbidity High Complexity	Frailty
0-17 Pop: 389k Total cost: £354m	£4.3m	£179.8m	£72.7m	£46.2m	£429K	£7K	£30.9m	£12.2m	£7.5m	
	↑ 23.3K	↓ 299.0K	↓ 40.0K	↑ 15.3K	↑ 154	↓ 6	↑ 6.8K	↓ 4.3K	↓ 683	
	1.3%	16.3%	2.2%	0.8%	0.0%	0.0%	0.4%	0.2%	0.0%	
18-64 Pop: 1.1m Total cost: £1.9bn	£8.5m	£146.8m	£304.9m	£341.7m	£79.7m	£27.9m	£228.8m	£448.1m	£294.8m	
	↓ 57.0K	↓ 449.2K	↑ 275.5K	↑ 119.7K	↓ 17.2K	↑ 3.7K	↑ 53.0K	↑ 103.3K	↑ 18.0K	
	3.1%	24.4%	15.0%	6.5%	0.9%	0.2%	2.9%	5.6%	1.0%	
65+ Pop: 352k Total cost: £1.9bn	£8.7m	£24.1m	£105.1m	£372.6m			£45.5m	£394.7m	£576.1m	£361.6m
	↑ 8.4K	↓ 32.0K	↓ 67.0K	↑ 100.1K			↑ 9.7K	↑ 64.9K	↑ 49.7K	↑ 20.7K
	0.5%	1.7%	3.6%	5.4%			0.5%	3.5%	2.7%	1.1%
	0.1%	4.4%	1.8%	1.1%	0.0%	0.0%	0.8%	0.3%	0.2%	
	0.2%	3.6%	7.4%	8.3%	1.9%	0.7%	5.5%	10.9%	7.1%	
	0.2%	0.6%	2.5%	9.0%			1.1%	9.6%	14.0%	8.8%

Three opportunity areas have been identified to respond to the quality and financial implications associated with the demographic and prevalence of disease challenge outlined in our analysis:

1. Opportunities to reduce prevalence and progression of ill health relative to the current trend based on targeted prevention and early detection activities, making the shift from reactive to proactive care.
2. Opportunities to transform models of care to deliver more consistent proactive care to support effective population health management, making the shift from acute to community and analogue to digital care.
3. Opportunities for more efficient use of existing resources including collective approaches for providers to work together.



We will now use this analysis to build programmes of work to deliver transformational change and help create a more resilient and sustainable system, harnessing the capabilities and capacity of local partners including local authorities and VCSE sector.

In many parts of BOB, population health management is enabling people to be directed to the most appropriate health and care service, based

on their needs. Placing patients in groups based around the risks their illnesses pose (segmentation) so they can be seen by the most appropriate health professional on the same day they contact the surgery (triaging).

Practice staff use a list of medical conditions to understand a patient's health needs and instructions on which service or team is the most appropriate to manage the patient, and how to book them a same day appointment. This ensures patients with less serious conditions are seen and treated quickly but those with more serious conditions receive continuous care with the same medical team who will know and understand their needs.

This approach should allow GP surgeries to meet patient demand by making best use of all their health professionals such as pharmacists, paramedics and social prescribers to deliver care.

Improving access and delivery of elective care

By the end of March 2025, BHT and the RBHFT successfully treated all patients who had been waiting 65 weeks or more, meeting the national standard for elective performance. OUHFT has also made significant progress, reducing the number of patients waiting 65 weeks or more to 120, down from a higher number at the start of the year.










In early 2025, NHS England refreshed the national elective recovery plan, emphasising the goal of meeting the 18-week standard by March 2029. By March 2026, the aim is for 65% of patients to wait less than 18 weeks for elective treatment, with each Trust required to achieve at least a 5 percentage point improvement. These improvements are expected to be achieved by empowering patients, reforming delivery methods, and ensuring care is provided in the most appropriate settings.

Addressing the backlog of elective care and reducing waiting times remains a priority for the ICB and our provider Trusts. The Elective Care Board oversees the delivery and management of these goals through system-wide initiatives, including:

- A focus on matching demand for appointments with the shortest waiting times and available capacity across our three provider organisations. We are initially focused on the areas with the longest waiting times: ENT, Gynaecology and Urology. This will be expanded to other specialties as needed throughout the year.
- Securing additional capacity with our independent sector providers in a timely and efficient manner.
- Delivering a joined-up approach to High Volume, Low Complexity Procedures (HVLC), following best practice that is set out nationally for use of surgical hubs.
- Use of digital tools and innovative technology to streamline processes, free up clinical and administrative time, and communicate with patients in a way that suits them best.
- Development of a workforce model to enable staff to work across our Trusts.

At year end, overall elective activity levels remained below planned levels for elective work but above plan for outpatient work.

Indicator (latest published month Jan 2025)	Standard	BHT	OUH	RBFT

Incomplete pathways over 52 weeks at month end	Rated against plan	 1072	 3061	 36
Incomplete pathways over 65 weeks at month end		 4	 509	 0
Incomplete pathways over 78 weeks at month end		 0	 74	 0

Across our acute providers there were over 6,544 patients waiting over 52 weeks at the end of March 2024; at the end of March 2025 the number of patients had fallen to 4,557².

Tackling urgent and emergency care pressures across Buckinghamshire, Oxfordshire & Berkshire West

Across the BOB ICS, teams from hospital and community Trusts, the ICB and local authorities work together to ensure people who need urgent/same day and emergency medical treatment can access services. Extensive work has been done during 2024/2025 to help alleviate pressures and improve patient flow through the hospitals across BOB.

Like many Trusts and integrated care systems across England, our urgent and emergency care providers have faced high demand and complex cases. The Trusts in BOB achieved 79.5% (BHT), 75.5% (OUHFT), and 71.3% (RBHFT) against the accident and emergency 4-hour NHSE Operating Plan requirement of 78% by year-end. Including community settings like Minor Injury Units, Urgent Care Centres, and Urgent Treatment Centres, the system achieved 77.6%.

Ambulance handover delays remain a challenge, but we have seen sustainable improvements this year. Efforts continue to enhance the situation through the Release to Respond initiative, which supports earlier escalation and collaboration between SCAS and Emergency Departments to reduce extended handover delays, especially those over 45 minutes. This initiative is backed by a system-wide working group led by the ICB, with input from SCAS and Acute leads to share learning and identify further improvement opportunities.

Handover delays impact SCAS's ability to improve response times for category 2 calls—999 calls for serious conditions like stroke or chest pain that require rapid assessment and/or urgent transport. These calls should be responded to within 30 minutes.

Across the BOB ICS, teams from hospital and community Trusts, the ICB, and local authorities collaborate to ensure people needing urgent or emergency medical treatment can access services. Significant efforts have been made during 2024/2025 to alleviate pressures and improve patient flow through BOB hospitals.

² Unpublished weekly data via WLMDS

The initiatives outlined below support people to stay at home when they have an urgent care need and how people return home more quickly if they need hospital admission.

In 2024/2025, more than 40k Urgent Community Response contacts were made. BOB has been doing well, meeting the 80% target for responding to referrals within two hours. We have also seen more patients being helped by the Hospital at Home (Virtual Wards) services, which provide safe and efficient hospital care at home. This helps avoid hospital admissions or supports earlier discharge.

Hospital at Home mainly helps frail people with conditions like respiratory and heart disorders. We are also expanding these services to include children in some areas. In the last quarter, we provided 546 beds with an average occupancy of 88%, with more than 90% of patients using tech enabled services.

We are working with partners to make it easier to refer patients for same-day or urgent services. Each area now has a single contact phone number for referrals, which helps direct patients to the right service and can reduce the need for ambulance transfers. We will continue to improve this system in 2025/2026 to prevent unnecessary hospital visits.

For patients needing hospital admission, our Transfer of Care Hubs help manage timely discharges. These hubs coordinate with health and social care partners to reduce the length of hospital stays.

Local partners are working to improve urgent and emergency care pathways:

- **Buckinghamshire:** Opened an Emergency Medical Receiving Unit in Winter 2024 with about 20 beds and additional space for SCAS handovers. This unit helps stabilise patients for discharge within 120 hours and can refer to specialists if needed.
- **Oxfordshire:** Developed six Integrated Neighbourhood Teams (INTs) focusing on older people with complex needs. These teams have reduced Emergency Department visits by 52% and emergency admissions by 47%. They also support children and young people, working closely with schools and mental health services.
- **Royal Berkshire Hospital:** Launched a pilot service to assess patients as they arrive and direct them to suitable alternatives if needed. This service has helped reduce overcrowding and waiting times in the Emergency Department.

Developing Services Across Primary Care

Primary Care includes general practice, community pharmacy, optometry and dentistry services. These services provide the first point of contact, have an ongoing connection with local communities, and lead on improving the 'whole person' health of our population.

Our primary care system has many strengths, with lots of outstanding practice in BOB, and unique capabilities across the area. Below are some key highlights where the system has strengths that can be built upon.

General Practice access and quality metrics are in line with or above the national average; the proportion of GP appointments seen within 14 days is higher than the national and regional average. Most GP practices have either good or outstanding Care Quality Commission (CQC) ratings. Quality and Outcomes Framework scores are just above the national average.

GP practices at work across BOB April 2024 – March 2025



All GP consultations 8,903,100



Face to face consultations 5,528,575



Blood Tests 1,309,122



Diabetes reviews 74,389



Heart health (BP/ECG) 4,429,009



Medication reviews 690,735



Flu vaccinations 602,161



Cervical screening 120,889



COPD/Asthma reviews 170,860



Children's immunisations 675,616

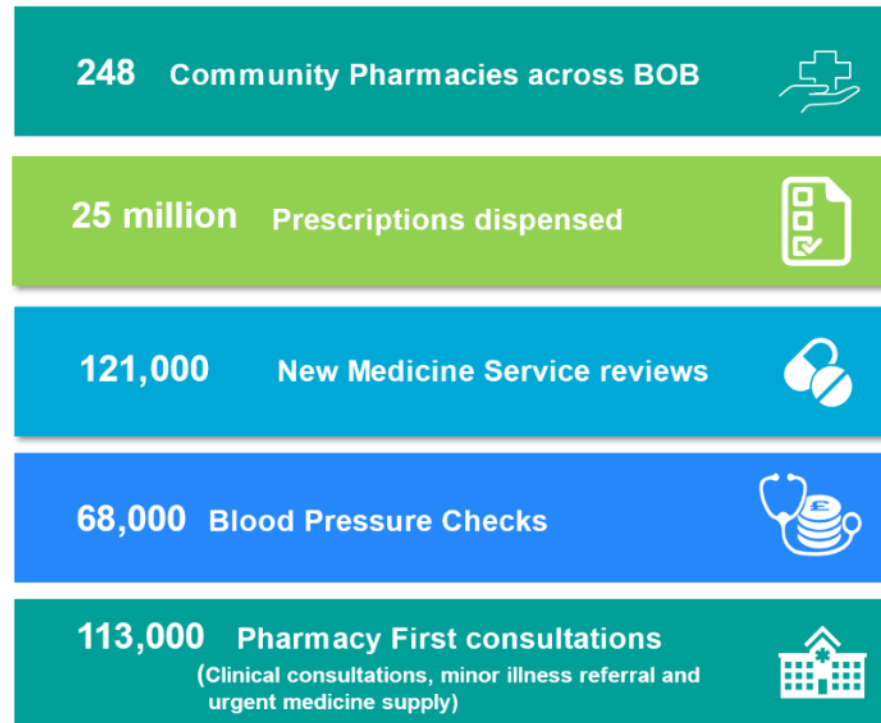


Learning Disability health checks 6,777

NHS community pharmacy services

In January 2024, the NHS Pharmacy First Advanced Service was launched to enable community pharmacists to supply prescription-only medicines, including antibiotics and antivirals where clinically appropriate, to treat seven common health conditions without the need to visit a GP.

Community Pharmacy in Numbers April 24- March 25



NHS dentist services

Although access to NHS dental services in BOB has been improving after the delays caused by the pandemic, some people have continued to have difficulties in getting treatment. Access has been particularly challenging for people who have not attended local dental practices in the last few years. In June 2023, BOB ICB piloted the Flexible Commissioning scheme where dental practices could set aside a proportion of their working time to see these patients. The service was extended for another year in 2024/2025, to give access to:

- People who have not attended a dental practice for two years
- People who have relocated to the area
- Looked After Children
- Families of Armed Forces personnel
- Asylum Seekers
- Those with clinical/medical need that requires attendance at a dental practice
- Patients who need dental check-ups in support of hospital treatment
- Pregnant and nursing mothers

The service aims to see patients on a planned basis, bringing them into NHS care on an on-going basis, but practices may also be able to see patients with an urgent treatment need.

Flexible Commissioning is one of a few actions being taken to increase dental capacity and support patient access. An additional 70,000 units of dental activity were commissioned from existing practices in April 2024 to replace some of the activity lost because of contract hand-backs.

The ICB also commissioned additional urgent appointments provided by 32 dental practices across BOB between January and March 2025. Participating dental practices treat people who have an identified urgent treatment need (normally pain, swelling or bleeding).

Update on the Primary Care Strategy for Buckinghamshire, Oxfordshire and Berkshire West

In 2023, the ICB began developing a Primary Care Strategy for BOB, aiming to shift towards a more preventative and community-based model of health and care services. This strategy focuses on helping people stay well in their communities.

The strategy was shaped by research, analysis, and extensive engagement with professionals and the public through focus groups, surveys, and workshops. The insights gathered informed the final strategy, which was approved by the ICB Board in May 2024.

Key principles of the Primary Care Strategy include:

- Patient Involvement: Engaging patients in co-designing health services to improve their care.
- Staff Training: Investing in staff training to ensure a wide range of skills, alternative working methods, and a focus on staff wellbeing.
- Efficient Use of Buildings: Making better use of healthcare buildings, potentially sharing services and facilities with other health providers.
- Public Awareness: Raising awareness of the strategy through communication and engagement campaigns.
- Children's Health: Focusing on children's health and wellbeing through public health teams and prevention work in schools.
- Preventative Health Programs: Committing to various health programs, including cardiovascular disease (CVD) prevention, to reduce the risk of heart attacks and strokes.
- Monitoring and Rollout: Detailing how the strategy will be implemented and monitored to improve patient health.

Since the strategy's approval, the BOB Primary and Community Care Strategic Transformation Oversight Group has been responsible for ensuring its implementation, managing risks, and providing support.

BOB-wide working groups and delivery teams have been established in each of our three areas, including:

- First Access Working Group: Setting guidelines for same-day access and sharing best practices.
- CVD Network Forum: Supporting efforts to tackle cardiovascular disease.
- Integrated Neighbourhood Team Working Group: Launching initiatives to improve community care.

Working groups have also been introduced to support and align efforts in communications, estates, workforce, resources, partnerships, and digital programmes.

How we are managing Long Term Conditions

The NHS has set out clear and costed improvement priorities for the biggest killers and disablers of our population including Long Term Conditions (LTCs). The Global Burden of Disease study showed that the top five causes of early death for the people of England are: heart disease and stroke, cancer, respiratory conditions, dementias, and self-harm.

Many LTCs are preventable. For example, up to 70% of heart disease and stroke, up to 50% of Type 2 diabetes and 38% of cancer cases could be prevented. The BOB Integrated Care Strategy and NHS Joint Forward Plan outline the ambitions for everyone in BOB to have the opportunity to live a healthy life by tackling the factors that influence people's health and how the ICB and partners can support people to make healthy changes to their lifestyle.

To support people to live healthier and happier lives we have worked to supplement this with targeted preventative work around health conditions that affect large numbers of people across our area. We have prioritised cardiovascular disease, respiratory conditions and diabetes while supporting those most at risk of developing these conditions; we also offer extra support to the people in our communities who we know currently have poorer health outcomes.

We have established LTCs Integrated Delivery Networks across BOB for cardiovascular (cardiac and stroke), respiratory and diabetes to bring together our providers with clinical leadership to drive forward our priorities including prevention, improving health, prioritising areas of health inequalities, reducing variation and co-designing integrated pathways.

The ICB plans to support people to prevent, detect earlier and better manage LTCs:

- We have been identifying those at risk of developing LTCs and providing support to address lifestyle factors and earlier detection of those with LTCs and provision of support to avoid unplanned care.
- Our focus is on supporting people to manage LTCs and delivering more proactive and joined up care with personalised care and support plans.
- Cardiovascular disease is one of the most common causes of death in BOB and a major contributor to the gap in life expectancy between people living in our most and our least deprived areas. Therefore, we have been identifying more people with risk factors and supporting them to take action, increasing the number of people with high blood pressure we detect and supporting them to keep this under control as well as cholesterol under control to prevent heart attacks and stroke.
- Improving diabetes care for all ages with a focus on transitioning from children/young people to adult care. This includes improving access to technology to manage diabetes better to reduce future complications (e.g. hybrid closed loop considered an 'artificial pancreas')
- Improving the diagnosis of people with Chronic Obstructive Pulmonary Disease (COPD) symptoms and providing better management of

the condition to avoid admissions to hospital.

We plan to continue working towards delivering our aims over the coming years taking a collaborative and consistent approach through the BOB LTCs Integrated Delivery Networks to deliver on priorities, identify and address variation, share best practice and enable integrated care that is high quality and patient-centered and address health inequalities. Below are examples of work from our CVD prevention workstream and four Integrated Delivery Networks:

CVD prevention:

The BOB CVD Champions programme involves 40 of 51 Primary Care Networks (PCNs) and supports projects to control cholesterol and manage high blood pressure, while also encouraging the sharing of best practices. The projects have contributed to improvement in blood pressure management, reaching 65.24% of our population being managed to target in September 2024 (CVD Prevent national data).

The prescribing quality scheme to target cholesterol control in general practices. We have seen an improvement as our local data for January 2025 show that three out of four of our adult patients with known CVD are on cholesterol lowering therapy, and nine out of 10 of these patients are on high intensity therapy. Therefore, we can estimate that around 1,610 cardiovascular events (CVD death, heart attacks or strokes) would be avoided over five years. This incentive has shown significant improvement in lipid (cholesterol) management in the latest national data 58.15% (Sept 2024) compared with 55% (Sept 2023) of our population being treated with lipid lowering therapy (CVD Prevent data).

Patient education resources on cholesterol were translated into the seven most spoken languages in BOB (Portuguese, Arabic, Polish, Ukrainian, Albanian, Urdu, and Hindi), and have been actively promoted and distributed widely with all partners and voluntary sector colleagues.

There are 234 community pharmacies now participating in the community pharmacy hypertension identification service, carrying out approximately 8,000 opportunistic blood pressure checks each month. This service provides convenient access to BP checks outside of GP surgeries, aiding in the detection as well as management of hypertension.

NHS Health Checks for our NHS staff continue in all three of our acute trusts. For example, the Royal Berkshire Hospital has completed over 1,400 staff health checks in the first two years, reaching approximately four out of 10 of eligible staff aged 40 and over. They are now looking to expand their health check offerings to better address CVD risks and incorporate menopause support into a 'staff health check plus' initiative.

In the community, projects supporting health checks for patients with severe mental illness and learning disabilities continued and the Community Wellness Outreach project in Berkshire West has significantly increased the volume of outreach sessions, delivering approximately 600 between January and October 2024

Tobacco Dependency Advisers continue work in each acute NHS Trust to support smoking cessation in inpatient services continuing a targeted focus in cardiac, stroke and respiratory wards to support those at highest risk from cardiovascular disease.

Integrated Cardiac Delivery Network:

An electrocardiogram, or ECG, is a simple and useful test which records the rhythm, rate and electrical activity of your heart. Routine ECGs diagnostics are available closer to home for our patients at nearly all our GP practices to enable detection of common cardiology conditions.

A key service improvement includes Managing Heart Failure@Home programme, which continues to see high uptake with 198 referrals in April 2024—the highest recorded month this year. The programme has maintained timely patient access, with more than half of people seen within two

weeks and a 100% six-week target achievement from January to March 2024. Caseloads remain high, with 387 clinic-based and 167 home-based patients in July 2024, balancing community and home care models.

We continue to build on our efforts to enhance heart failure care. We have started work to focus on standardising medicines optimisation, better joined up care and strengthening clinician education to increase the length and quality of life for people with heart failure.

The BeatBetter Cardiac Rehabilitation app has been rolled out to all our Trusts. The app aims to reduce relapse rates and improve adherence to cardiac rehabilitation programmes, supporting a blended rehab model. Initial uptake includes 173 pre-registrations, 120 installs, and 67 registrations, with platform adoption evenly split between Android (55.2%) and iOS (44.8%).

TAVI (Transcatheter aortic valve implantation) is a common procedure that improves the blood flow in the heart by replacing an aortic valve that does not open fully. A rapid outpatient TAVI pathway has been tested in one of our Trusts to reduce the time for referral to treatment and it has a baseline cohort of 50 patients. This pathway change should reduce hospital length of stay, maintain patient mobility, and optimise treatment. Many people have a better quality of life after having TAVI and their symptoms, such as chest pain and breathlessness, can improve.

Integrated Stroke Delivery Network:

Mechanical Thrombectomy (MT) is an effective way of treating strokes caused by a clot. Undergoing this procedure gives around 45% chance of regaining independence. The sooner it is performed the better the chance of recovery, including greater chance of improving current stroke symptoms. A year after launching 24/7 MT provision at OUHFT, referrals across BOB are maintained at around 8.5%. The Sentinel Stroke National Audit Programme (SSNAP) 23-24 report highlighted Thames Valley (BOB) as the national leader in overall MT rate (8.7%).

The SSNAP latest results (July - September 24) indicate all our acute trust providers are achieving an A-rating, demonstrating high-quality care and excellent performance across the entire stroke pathway. This reflects an improvement in access to stroke services and reduction in variation of care. To support further improvement in the acute Stroke pathway, pre-hospital video triage is now embedded at one of our acute provider sites with plans to roll out to a second Trust in the next six months.

National funding supported two projects aimed at improving stroke rehabilitation consistency. In Oxfordshire, a year-long 'Life After Stroke' service, provided by the Stroke Association, significantly benefited patients and more than tripled the uptake of six-month reviews, from 6% to 20%. The Buckinghamshire 'Bridging' Service pilot (running until March 2025) is demonstrating similar positive outcomes, with a 78% improvement in both stroke quality of life and recovery scale scores.

Patient engagement remains a priority, with active Patient Public Voice (PPV) groups in Oxfordshire and Buckinghamshire. Berkshire West is also working with Stroke Association partners to establish a PPV group.

Integrated Diabetes Delivery Network:

Across BOB, around 90,000 of our adult residents have a diagnosis of Type 2 diabetes and around 9,000 are living with Type 1 diabetes. Nearly seven in 10 people with diabetes have one or more other long term condition.

Evidence shows that patients who received all eight care processes have better outcomes and reduced mortality. Therefore, we have focused on eight care processes for management of Type 2 diabetes in all GP practices with an emphasis on practices in areas of higher deprivation. Most BOB practices achieved a higher attainment of the eight care processes for people with Type 2 diabetes than the England average for both Type 1 and Type 2 diabetes, however there is variation within each place.

A BOB-wide locally commissioned service (LCS) for Type 2 diabetes began in June 2024 which aims to standardise primary care across the system. The LCS also aims to join up primary, community and secondary care to manage patients seamlessly.

2024/2025 saw a continued focus to improve outcomes for people aged under 40 with Early Onset Type 2 diabetes. This is more aggressive than later onset Type 2 diabetes and is more prevalent in people living within deprived areas and in minority ethnic groups. It has been associated with premature mortality, worse long-term health outcomes and higher risk of diabetes-related health complications such as sight loss, kidney failure, amputation, heart attacks and strokes.

The ICB has worked closely with Trust colleagues to set out a robust plan for the implementation of hybrid closed loop systems for people with Type 1 diabetes in line with a NICE Technology Appraisal. The plan will see this life-changing technology rolled out to adults and children over a five-year period at an achievable and sustainable pace. Hybrid closed loop will reduce low sugar episodes (hypoglycemia) and the risk of future diabetes complications e.g. foot and eye problems.

Integrated Respiratory Delivery Network:

The availability of respiratory diagnostics for all ages in the community has continued to improve. Reported to date since April 2024, 8,586 spirometry tests and 3,495 fractional exhaled nitric oxide (FeNO) tests have been delivered in primary care and Community Diagnostic Centres. This enables testing closer to home for patients and the timely and accurate diagnosis of respiratory conditions such as COPD and Asthma.

The OUHFT and Oxford Community Diagnostic Centre breathlessness pilot enables a fast-track pathway for multiple diagnostics and specialist multidisciplinary team review, with 200 patients now having been seen through the pilot. Analysis of the pilot has demonstrated effectiveness and efficiency with clear benefits for patients by diagnosing early and accurately, keeping people healthy and out of hospital.

Our Long Covid Assessment and Rehabilitation Services continue and received 711 referrals adult referrals and 47 children and young people referrals over the 12-month period Jan-Dec 2024. These services are working increasingly closely with Chronic Fatigue Syndrome Service to meet the needs of patients.

Cancer Care

The Thames Valley Cancer Alliance (TVCA) plays a key role in improving cancer outcomes across BOB. In 2024/2025, its focus continued to be on performance and faster diagnosis, early diagnosis and personalised care.

In 2024/2025, TVCA made progress toward meeting the Faster Diagnosis Standard (77% by March 2025) through targeted pathway improvements and sustained collaboration with Trusts. Joint efforts across clinical, non-clinical, and Getting It Right First Time teams supported the roll-out of Best Practice Timed Pathways in key areas: breast, prostate and skin cancer. These NHS guidelines streamline and standardise cancer diagnosis pathways. For the Skin pathway, teledermatology and a nurse-led dermoscopy clinic were introduced to support earlier diagnosis. In Gynaecology, a training needs assessment informed the development of GP training resources, and referral proformas were updated for post- menopausal bleeding in HRT cases.

TVCA continues to boost early detection rates, with a focus on high-risk groups:

- **Targeted lung health checks:** Following success in 2023/2024 with over 100 diagnoses, the programme has expanded in 2024/2025.

- **Liver surveillance and community liver health checks pilots:** In 2024/2025, one PCN and one Trust have taken part to identify people at risk of advanced fibrosis/cirrhosis and ensure they are enrolled into the liver surveillance programme for regular six-monthly surveillance. The programme has been rolled out across all Trusts.
- **Pancreatic cancer primary care case finding pilot:** TVCA was selected to take part in the second phase of this pilot starting in November 2025. Six PCNs will be participating under the TVCA umbrella.
- **Screening:** TVCA produced screening videos in six languages to increase screening participation. We collaborated with selected Primary Care Networks (PCNs) to develop targeted initiatives, including roadshows, community events, weekend smear clinics, and outreach to high-risk men for PSA (prostate) testing. The PCNs also implemented safety netting tools, leading to 64 referrals.

Key outcomes have included:

- 190 attendees at two community education sessions.
- In December 2024, across five funded PCNs:
 - Cervical screening: 3,733 invited, 1,876 screened.
 - Bowel screening: 4,377 invited, 2,935 screened.

TVCA continued to enhance personalised cancer care in 2024/2025 with several key initiatives:

- **Personalised Support Pathways:** tailored follow-up plans were introduced for breast, colorectal, endometrial, and prostate cancer patients. Psychology services were mapped, and recommendations for Level 2 training and clinical supervision for key workers were implemented.
- **Prehabilitation Pathways:** these pathways, which are designed to improve physical and mental wellbeing for patients before surgery, were mapped for both universal and specialist services, with plans for 2025/2026, and resources were added to the website.
- **Genomics:** A Macmillan-funded programme manager was appointed to map genomic pathways and identify staff training needs. CT-DNA and preventive breast cancer projects were launched.
- **Systemic Anti Cancer Therapy task group:** A task group was created to implement recommendations from the TVCA/EDGE Health report, including closer-to-home subcutaneous SACT and workforce development. SACT refers to the use of medications to treat or control cancer, including drugs like chemotherapy, immunotherapy, and targeted therapies. These treatments work throughout the body to reach cancer cells in different parts of the body.
- **Workforce Development:** Two programme managers were recruited to implement the Aspirant Cancer Career and Education Development framework.
- **NHSE funding** supported Clinical Nurse Specialist (CNS) and SACT nurse training.
- **National CNS Day:** celebrated CNS teams across TVCA, highlighting innovative projects improving patient care.

In 2024/2025, patient voice remained central to service improvement. A key achievement was the launch of the Radiotherapy Late Side Effects service at Oxford University Hospitals, co-developed with patient partners. The alliance worked closely with each Trust's cancer patient partnership group to ensure patients and carers helped shape service changes. Annual reviews of National Cancer Patient Experience Survey results informed targeted improvements and shared learning across Trusts, supported by the alliance, helped drive a consistent, patient-centred

approach to cancer care.

Our communications efforts have focused on strengthening digital infrastructure, enhancing engagement, and aligning with TVCA's evolving vision and values.

Key developments include:

- **Website and stakeholder bulletin:** We improved the TVCA website content and launched a redesigned weekly stakeholder bulletin. These changes enhanced accessibility, evaluation data, and clarity of information for partners and stakeholders.
- **Social media expansion:** To better reach diverse community segments, we launched new social media channels on Facebook, Nextdoor, and Instagram. Following a strategic review we established a new presence on BlueSky.
- **Community involvement:** Community engagement remains a core focus. We have continued supporting co-production with key groups, including Patient Participation Groups (PPGs) and local community networks across the BOB region. To increase reach and efficiency, we are adopting tools that streamline engagement and avoid duplication of effort.





Delivering improvements in mental health services

Over the last past year work has continued to support mental wellbeing and improve outcomes for people suffering from mental health conditions, noting continuous improvements in productivity and operational effectiveness.

The publication of the national Commissioning Framework for Mental Health Inpatient Services requires us to produce a three-year transformation programme across all mental health services. This work has started, focusing on mental health care and crisis in the community, adult inpatient transformation and localising mental health care rolling out good practice across areas, developed through engagement with Trust representatives, including consultation with provider collaborative colleagues. This plan places co-production at the centre of our approach over the next three years.

Across BOB work has progressed to improve access to NHS Talking Therapies for anxiety and depression and has exceeded the national treatment targets as outlined below:

Talking Therapies Metrics

Category	Metric	Period	Target	Value	Variance	Assurance
Mental Health	Talking Therapies: Treated within 6 weeks	Jan 25	75.0%	97.1%		
	Talking Therapies: Treated within 18 weeks	Jan 25	95.0%	99.7%		

BOB ICB has a total of 24 mental health support teams, who work in schools and colleges, with current coverage reaching more than 60% of

school age population, noting the new national target of 100% of school age population by 2029/2030. There are currently eight teams in Buckinghamshire, nine in Oxfordshire, and seven in Berkshire West after the start of training in September 2024. Berkshire West is going through a procurement exercise in 2025 to allocate a preferred provider.

Table 3	Total pupil number 22/23	Number accessing by W11 allocation	% against total pupil	Number of teams
Oxfordshire	118857	72,000	61%	9
Buckinghamshire	98377	64,000	65%	8
Berkshire West	92262	56,000	61%	7
Total	309496	192,000	62%	24

Work has continued through the year to achieve the national target of 60% of people with serious mental illness (SMI) to have a physical health check. We work with GP practices to optimise the health checks through Quality Outcomes Framework (QOF) and BOB ICB collectively achieved 60% for each QOF indicator (weight, smoking, cholesterol, sugar, BP and alcohol).

There has been continuous improvement in the diagnosis of dementia. The rate in BOB has moved closer (at 60%) to the 66.7% national standard, noting the national standard has been removed for 2025/26. The ICB has achieved this increase in dementia diagnosis through delivery of the Dementia Work Plan, addressing gaps in services. This includes integrating and streamlining Urgent and Emergency Care pathways with particular focus on the management of older people with complex needs and frailty.

The ICB met the Mental Health Investment standard (a 7.46% increase in investment compared with a 6.86% growth in allocations).

Learning disability and Autism

The ICB has been working with partners and local authorities to reduce the number of people with learning disabilities and autism who are in inpatient settings, and we are on course to meet national targets this year. Where inpatient treatment is unavoidable, BOB is committed to ensuring that out of area placements are used only where essential and ensuring improved oversight by commissioners and better patient and family experiences.

The ICB has also taken part in a national pilot around Commissioner Oversight Visits for inpatients to improve the quality and assurance around inpatient treatment and reduce lengths of stay.

Work has been undertaken with commissioners and providers from across the ICB to develop a new standardised policy and procedures for

delivery of Dynamic Support Registers and Care (Education) and Treatment Reviews, in line with the national policy guidance. This has ensured that good practice at place has been identified and implemented across all partners in the ICB. This will ensure consistent outcomes for BOB residents who are at risk of mental health inpatient admission or supporting timely discharge following inpatient admission.

The number of children and young people currently awaiting assessment and the length of wait for an assessment continues to be challenging as outlined below:

Latest number of CYP waiting for assessment (waiting list)	
Oxfordshire CYP (Autism & ADHD)	3,792 (January 2025)
Buckinghamshire CYP (Autism & ADHD)	3,608 (January 2025)
Berkshire West (Reading, West Berks and Wokingham)	7,738 (January 2025)

Average (Mean) waiting time to assessment for CYP seen	
Oxfordshire CYP (Autism & ADHD)	90 weeks (January 2025)
Buckinghamshire CYP (Autism & ADHD)	84 weeks (January 2025)
Berkshire West (Reading, West Berks and Wokingham)	Autism – 64 weeks (January 2025)
Berkshire West (Reading, West Berks and Wokingham)	ADHD – 68 weeks (January 2025)

Several workstreams are in place with local authorities and providers to support the pathways associated with Special Educational Needs and Disabilities to reduce waiting times and develop services to address the growing demand and backlogs. This includes:

- A standardised initial 'request for help' form across the neurodevelopment assessment services in BOB which has reduced time required for triage and provides early signposting and support information.
- The BOB NDQ Neurodevelopmental Questionnaire is in development with OHFT, using technology to support assessment pathways, reduce admin time and maximise the resources currently available. The method has been coproduced, and small-scale successful pilots have taken place, with plans for larger pilots during 2025/2026.
- The Partnerships in Neurodiversity in Schools Pilot Programme, funded by the Department for Education and NHS England, has been rolled out across 40 primary schools in Reading. Working with Reading Borough Council, Reading Families Forum, and Berkshire

Healthcare Foundation Trust, the ICB has led the project to enable schools to support children with neurodiversity needs.

A delivery model was co-produced, using evidence-based practice to develop a 'learning walk' and toolkit to support schools in improving knowledge and practice around sensory, environmental, and speech and language needs. The multidisciplinary team approach involved occupational therapists, speech and language therapists, and specialist educational consultants from the RISE team, working with school leaders to co-produce an action plan for areas of development.

This support will continue via the RISE team in 2025/2026. Early outcomes from the pilot demonstrate the promotion and embedding of consistent best practices as a whole-school approach, increased confidence in delivering whole-school SALT and OT approaches, heightened awareness of neurodiversity support, and increased participation in training sessions for neurodiversity. Early feedback from parents/carers indicates a more positive experience for families.

The Support Hope and Recovery/Resources Online Network (SHaRON), delivered by BHFT, provides a digital space for parent/carer peer support and has been opened to all families waiting for assessment in 2024/2025. The platform is supported by the neurodiversity clinical teams, alongside peer support. There are 1,486 members since launch in April 2024. Plans are in place for an evaluation of the service in 2025/2026.

The ICB is currently undertaking projects to introduce reasonable adjustments for neurodivergent service users as an approach to improve access and reduce health inequalities. A neurodiversity passport has been co-produced and implemented across our mental health system for adults, alongside a suite of additional resources for staff to support them in providing adjustments.

A reasonable adjustment passport was piloted and evaluated in our community specialised dentistry services. Evaluation demonstrated a positive impact for dental patients and dental clinicians providing the appointment. Over this year we will be working to embed this into the new patient registration process.

The ICB and South Central Ambulance Service have worked alongside people with autism to understand the challenges and develop recommendations for improving the ambulance experience. Communication booklets and tools have been introduced and we are currently trialing the use of sensory kits in ambulances and will be co-producing a training video for SCAS staff.

We have worked alongside SCAS and the Lions Club of Winslow to introduce an autism specific alert sheet for paramedics which has details of adjustments to be considered.

Co-production is a central tenet to our approach, respecting the different lived experience of our neurodivergent population. BOB has established a co-production forum 'Think Neurodivergent' which is a space to understand the barriers and challenges to accessing our health care services and identify solutions.

We are incorporating mental health care and support into discharge planning to ensure safer discharge and ongoing physical health monitoring in the community. Although we are currently meeting national targets, BOB is pushing to increase the number of people with autism and/or those with a learning disability getting an annual health check in the community.

The roll-out of the Reasonable Adjustments Digital Flag (RADF) has started successfully and the first phase has been completed. The notification will help GPs identify patients eligible for health checks and allow this to be embedded into the patient record. These initiatives are supported by bi-monthly, ICB-wide health webinars to help clinicians deal with common LDA health issues.

Maternity and Neonatal care

Ensuring maternity and neonatal services in BOB are safe, fair, personalised, kind, and sustainable is key to achieving the ICB Joint Forward Plan's vision. This vision aims for everyone in our area to have the best start in life, live healthier and happier for longer, and access the right support when needed.

Through the Local Maternity and Neonatal System (LMNS), the ICB has continued to build on existing relationships and collaborative working with the three acute Trusts providing maternity and neonatal care, and Maternity and Neonatal Voices Partnerships (MNVP). Incorporating the neonatal service user in the work of the LMNS has been embedded over the last year and has strengthened the voice of parents experiencing neonatal care.

Through the LMNS, BOB ICB has continued to drive forward the five strategic ambitions for maternity and neonatal services:

Safety, Workforce, Personalisation, Equity, Digital and Data:

Alongside the JFP, implementation of the national three-year single delivery plan for maternity and neonatal services, in collaboration with system partners, has been the key enabler for continuous improvement. In regard to the four key themes of the single delivery plan, BOB ICB has actively supported and facilitated multiple projects as follows:

Listening to and working with women and families with compassion: The delivery of the LMNS equity and equality plan continues to draw attention to its success and its positive impact in our communities. The Equal Start Oxford initiative has been running successfully over the last two years. Projects have reached out to communities in BOB, including the Raham Project podcasts, inclusive language workshops and training, neonatal journey cars and easy English material. Maternity vaccine champions have improved access to and uptake of Covid, flu, RSV and whooping cough vaccinations.

The LMNS has continued to work on the development of perinatal pelvic health services as part of the national rollout with a focus on recruitment of critical roles for each area. This will provide further capacity in physiotherapy services across the three acute Trusts and is part of our expanding work to deliver the three-year delivery plan.

Growing, retaining, and supporting our workforce: Trusts have undertaken midwifery establishment reviews and have uplifted staffing levels/skill mix as appropriate. Midwifery vacancies have been reduced across the system through increased student retention, increased placement capacity and recruitment of internationally educated midwives. Accompanying this, Trusts have engaged in a series of initiatives to improve retention including:

- Preceptorship programmes
- Retire and return initiatives
- Health and wellbeing support
- Career development
- Flexible working
- Restorative clinical supervision
- Freedom to speak up champions

- Advancing the equality, diversity and inclusion of staffing
- Training opportunities,
- Listening events

The Maternity and Neonatal Safety Improvement Programme (MATNEO SIP) hosted by the Health Innovation Network (HIN) organises regular learning and sharing best practice days in Oxford for clinicians. The HIN supports the LMNS by leading on workstreams including the optimisation of preterm births (the story of Baby Luna, who featured as a case study for how this initiative has improved patient outcomes received positive media attention), and the perinatal culture and leadership programme.

Developing and sustaining a culture of safety learning and support: The evolving role of the LMNS was referenced in the ICB annual report 2022/2023 and it continues to develop with increasing focus on assurance and oversight which continues to gain importance in the context of national maternity safety concerns. The LMNS supports our system partners in the delivery of maternity and neonatal services, maintaining quality and safety oversight including the national perinatal quality surveillance model (PQSM) and ICB governance structures.

This enables oversight of good practice, emerging risks and lessons learned. The maternity and neonatal daily safety huddle led by the ICB, has been embedded across all three BOB acute Trusts to provide a system-wide view of the pressures in services and monitor demand and capacity to evaluate trends over time. A service evaluation has been completed with feedback overwhelmingly positive for the safety huddle, in terms of system oversight, clinical discussions and with requests for mutual aid easier to raise.

The LMNS has continued to work closely with the Trusts to gain assurance for the Saving Babies Lives Care Bundle version 3 (SBLCBv3). This forms part of the Maternity and Perinatal Incentive Scheme (M(P)IS). On a quarterly basis, the LMNS reviews the SBL evidence through assurance visits which evaluate compliance with the SBLCBv3 implementation toolkit.

For M(P)IS Year 6, all three Trusts submitted full compliance with the 10 safety actions of the scheme.

OUHFT will transition from the Maternity Safety Support Programme to Regional and ICB oversight in 2025/2026.

Standards and structures that underpin safer, more personalised and more equitable care: The ICB has a well embedded maternity and neonatal governance structure that enables system partners and service users to have sight of all work programmes of the LMNS that relate to safety, personalisation and equity. This enables open, transparent working, co-designed and co-produced solutions and improvements.

Established MNVPs across the three places in BOB are integral to the ICB hearing the voice and experiences of service users. MNVPs ensure that service users' voices are at the heart of decision-making in maternity and neonatal services by being embedded within the leadership of provider Trusts and feeding into the LMNS (which in turn feed into ICB decision-making). Ultimately, this influences improvements in the safety, quality, and experience of maternity and neonatal care.

Safeguarding our most vulnerable

Safeguarding adults, children and looked after children (LAC) involves a range of activities spanning the prevention of harm to those at risk, through to actions taken when harm occurs. It remains the responsibility of every NHS funded organisation and each individual healthcare professional working in the NHS to ensure that the principles and duties of safeguarding adults and children are holistically, consistently, and conscientiously applied, with the wellbeing of adults and children at the heart of what we do.

Section 11 of The Children Act (2004) places responsibilities on a range of organisations and individuals to make arrangements for ensuring that their functions, and any services that they contract out to others, are discharged to safeguard and promote the welfare of children.

The Chief Nursing Officer is the ICB Board-level Executive Director who holds accountability for ensuring that effective safeguarding processes are in place and that the statutory responsibilities and duties of the ICB are met. This includes oversight of the three Place-based partnerships, as equal partner with Thames Valley Police and the Local Authorities, providing financial and expert support, to ensure that the safeguarding arrangements at each geographical 'Place' footprint are safe and robust. The Director of Safeguarding leads the ICB Safeguarding Team, which works in partnership with statutory and non-statutory agencies at Place and at a system-wide level to ensure and support safeguarding practice and strategy.

The three Safeguarding Children Partnerships and three Safeguarding Adult Boards at Place have their individual responsibilities to the local populations: thresholds, risks, practice (how services work together). Regulation and inspection are important to the ICB to demonstrate safeguarding assurance and accountability arrangements across the health system, to celebrate best practice and embed new learning. This is achieved through a variety of audits, reports, assessments, including: statutory reviews and learning; CQC Inspections; Joint Targeted Area Inspections; Section 11 self-assessment audits; data sets and reporting. Below lists the partnerships and boards across BOB:

- [Buckinghamshire Safeguarding Children Partnership](#)
- [Buckinghamshire Safeguarding Adult Board](#)
- [Oxfordshire Safeguarding Children Partnership](#)
- [Oxfordshire Safeguarding Adult Board](#)
- [Berkshire West Safeguarding Children Partnership](#)
- [Berkshire West Safeguarding Adult Board](#)

BOB ICB Safeguarding and LAC Team works in collaboration with the Regional NHSE Safeguarding Team to escalate and manage system risks, provide and seek assurance through routine reporting aligned with the Safeguarding Accountability and Assurance Framework (2024) (SAAF). In addition, the ICB participates in well-established peer groups, forums, communities of practice, and regional and national NHSE safeguarding networks. Regional NHSE staff also attend the BOB ICB Safeguarding Committee, and the ICB Director for Safeguarding and Looked After Children represents the organisation at the NHSE Regional Safeguarding and Looked After Children Steering Group.

ICB designated professionals are clinical experts and strategic leaders for safeguarding to support commissioners in the ICB, Local Authorities and NHS England, other health professionals, regulators, the Local Safeguarding Adults Boards (LSABs) and the Local Safeguarding Children's Partnerships (LSCPs).

ICB activity to evidence SAAF compliance included:

- Maintained oversight of commissioned providers and their standards to safeguard adults, children and LAC.
- Successfully integrated the new safeguarding adults, children, and LAC requirements for commissioned services into the procurement process for new services.
- Promoted and chaired LSABs and LSCP sub-groups to ensure that learning is taken from cases to drive improvement across the system.
- Provided expert advice in relation to complex cases, including allegations against staff, ensuring that the response is person-centered, proportionate and timely.

- Responded to identified learning from local and national safeguarding reviews to ensure that improvements are made and embedded across the system.
- Worked with integrated care system leaders, primary care network leaders and GPs to ensure that safeguarding and the Mental Capacity Act are considered and embedded in frontline practice, training, and learning. Facilitated safeguarding involvement in all parts of the commissioning cycle, from procurement to quality assurance.
- Supported Domestic Abuse agenda across BOB and across all ages including dissemination of key learning to support assurance processes. Established Domestic Abuse Network chaired by the ICB Designate team.
- Responded to the interface between Child Death Overview Panel (CDOP), Learning Disability Mortality Reviews, statutory reviews and serious incidents in relation to safeguarding.
- Initiated and implemented a project to provide prepayment prescriptions certificate for Care Leavers.
- The ICB Safeguarding Team is piloting with local authorities a new process regarding placement change notifications to improve continuity of healthcare for LAC.
- Designated nurses attend local Corporate Parenting Boards whose responsibility is to hold partners accountable for high quality response to ensure that the health needs of Looked After Children are considered consistently, including statutory health assessments, identifying and addressing gaps in service and ensuring strategic plans for Looked After Children and Care Leavers are being effectively delivered.
- Designated nurses collaborate with providers to facilitate the development of a new NHSE national data set for Assurance of Statutory Health Assessments for looked after children.
- Compliance with reporting female genital mutilation or cutting requirements monitored and supported by the ICB safeguarding team. to ensure risk assessment and safeguarding duties to report are fulfilled effectively.
- Designated nurses for safeguarding adults and children provide safeguarding representation at Place-based and ICB health meetings for refugees and asylum seekers, including unaccompanied asylum-seeking children with designates collaborating with local authorities.
- Designated professionals are proactive members of all statutory reviews; Children Safeguarding Practitioner Reviews, Domestic Homicide Reviews and Serious Adult Reviews, including the chairing and leading of workshops for learning.
- Completed the annual NHSE Safeguarding Commissioning Assurance Toolkit.
- Compliance and reporting to the NHSE Case Tracker, to identify themes from statutory reviews and ensure they drive improvement.

Place based activity to evidence SAAF compliance includes:

Buckinghamshire

- Looked After Children health team awarded funding to enable one year project to explore health needs for care leavers.
- Local charities are funding HOPE boxes for mothers who have had a child removed after birth.
- Presented at a national event to showcase joint working with the local youth justice service.

Oxfordshire

- Collaboration with mental health providers to develop a safeguarding guide for practitioners - regionally and nationally recognised.
- Independent Domestic Violence Abuse Advocate project based in OUHFT maternity unit. Further one year of funding agreed.
- Expansion of commissioning support for parents, carers and families affected by drugs and alcohol.

Berkshire West

- Provider 'walk and talk' audits focused on safeguarding have shown evidence of workforce understanding of safeguarding and MCA/DoLS
- Local domestic abuse services supporting in Emergency Departments.
- Lead on the Mental Capacity Act programme of events which has engagement from across the integrated system.
- Local domestic abuse service support in Emergency Department setting.

The ICB Safeguarding and LAC Team continues to support wider ICB compliance with statutory duties and best practice guidance. The team provides supervision, advice, and guidance to ICB colleagues as required. During the year, the ICB Safeguarding and LAC Team collaborated with providers and commissioners to monitor activity and ensure that provider service procurement, contracts and policies embed safeguarding requirements. This has included:

- Specialist expertise for commissioning teams within procurement processes to ensure any service is assessed against statutory safeguarding duties. Maintaining assurance conversations and oversight for all health care Trusts through our place-based safeguarding provider meetings.
- Developing relationships, building support, and agreeing reporting plans with the independent provider hospitals, diagnostic services and other independent providers delivering inpatient and outpatient services to our population.

The ICB-appointed and deputy safeguarding delegates serve the ICB at Place-based Domestic Abuse (DA) Partnership Boards. The ICB has committed portfolio leads for DA, and they have supervision of system-based initiatives across BOB. The ICB assisted the system during a DA-focused Joint Targeted Area Review (JTAI) in March 2025 in one local authority area. This evaluation underscored efforts being made to support both adult and child victims of DA and emphasised the need to continue capturing the lived experiences of children. The ICB will continue to back providers in enhancing services and support.

Both nationally and across BOB, safeguarding demand and capacity continue to rise. The current financial landscape and constraints on investment in new services add further challenges, necessitating innovative approaches to collaboration and more efficient safeguarding support.

Delivering our Vaccination Programmes

COVID-19 vaccinations:

During 2024/25, the vaccination programme continued across the BOB area via a network of centres comprising GP practices, community pharmacies, hospital hubs and pop-up clinics. The Covid-19 spring booster campaign 2024 was a 13-week programme, with the initial two weeks focusing on care homes only.

The estimated number of BOB patients eligible for 2024 spring boosters was 229,184 with a regional target of 62%; we achieved a total of 146,157 patients vaccinated, which equates to 63.8% of the eligible population. The average in the Southeast region was 61.7% and this exceeded the national average of 56.3%. The 2024/2025 autumn/winter campaign had a strong emphasis on co-administration of flu and Covid vaccination.

Those eligible were:

- residents in a care home for older adults
- all adults aged 65 years and over
- those aged 6 months to 64 years in a clinical risk group
- frontline health and social care workers

More than 350,000 autumn/winter COVID boosters were given across BOB by 31 January 2025, meaning nearly six out of 10 people eligible for the jab took advantage of the offer.

As this report is compiled, the Spring 2025 Covid booster campaign has been launched to offer top-up protection to those eligible:

- adults aged 75 years and over
- residents in care homes for older adults
- individuals aged 6 months and over who are immunosuppressed.

Flu and RSV vaccinations:

For the first time, from September 2024, the NHS began offering vaccinations for Respiratory Syncytial Virus (RSV), a major cause of respiratory illness in the UK which can be dangerous to older people and infants. The jab was available to those aged 75 to 79, and was offered to pregnant women from 28 weeks, to protect their baby. These vaccination programmes will save lives and significantly reduce the burden on the NHS during the challenging winter months. The RSV offer is still open.

Flu vaccinations for children and pregnant women began at the start of the school year in September 2024 and were then open to everyone aged 65 and over and those under 65 with certain medical conditions.

Since July 2024, BOB ICB has delivered a robust, data-driven communications campaign supporting the NHS winter vaccination programme, aligned with the BOB ICB Urgent Care Winter Plan. The campaign promoted Covid-19, flu, and the newly launched RSV vaccine, aiming to reduce seasonal pressure on NHS services. A flexible, targeted strategy raised awareness, supported uptake, and reached priority groups effectively through tailored resources for health professionals, community leaders, and partner organisations.

Key communications were concentrated in October and November, supported by a £72K budget, with a focus on flu and Covid-19 offers to children, pregnant women, and at-risk individuals.



We amplified reach through digital platforms including StayWell, Padlet, and social media, achieving stronger engagement year-on-year. Offline channels included translated flyers, pharmacy bags, public transport ads, and ad vans in low-uptake areas.

The campaign's success was bolstered by close collaboration with more than 50 partners across local government, public health, and community groups. Trusted voices and timely updates helped ensure consistent messaging and reassurance to those hesitant or unsure.

Digital Data and Transformation

Over the past year, the ICB has continued to develop and strengthen partnerships with NHS and local authorities across BOB to deliver our shared vision and [strategy for digital and data](#) which was agreed by the ICB Board in May 2023.

We have also completed a restructure of the digital, data and technology directorate so we are better placed to deliver the digital and data strategy, and realise the benefits of working as a system, by building on collaboration opportunities which already exist. Our digital transformation programme has been extensive for 2024/2025 and has improved the way care is provided and accessed across BOB.

Primary Care:

We have worked with primary care colleagues to implement digital technologies and initiatives during 2024/2025 including:

- Successfully completed a pilot to support several GP practices to digitise patient records, to improve access, free valuable premises space for added clinics or meeting spaces, improve efficiency, enable safer storage and easier sharing of information.
- Supported the effective provision of online consultation solutions for our GP practices which help patients and staff with improved access to services and improved workload management. We are looking to develop these platforms to further improve patient access and triage.
- Re-procured a cost effective SMS (text messaging) solution for GP practices, making it easier for patients to get appointment reminders, health alerts, and information via the NHS App, and contributing to a more efficient service.
- Supported GP practices to migrate to a new clinical system while maintaining uninterrupted services for patients.
- Working with GP practices to develop new models of care which focus on using data to understand someone's health background (segmentation) to help patients access the right service, first time, and to help prevent ill health from occurring. This year we have been able to make this technology available in Oxfordshire, ensuring full coverage of BOB.
- Upgrading infrastructure in GP practices so all GP networks are now able to deal with increased data flow demands.
- Implemented advanced telephony systems across GP practices to include patient call-back, reduced wait times, improved response times and access to up-to-date patient information during phone consultations.

The ICB has also started to pilot and implement a small range of artificial intelligence (AI) tools to maximise efficiencies in the organisation, while ensuring safety and security. The functions are limited to administrative tools, while the technology adoption is gradually brought in. Wider testing of AI tools is expected, as more solutions are nationally approved.

The ICB is working with partners across BOB to deliver the ICS Digital and Data Strategy through building collective digital and data maturity across our partners and providers. during 2024/2025, we have:

- Spearheaded a collaborative initiative to consolidate five separate electronic document transfer contracts, previously held by individual local NHS Trusts, into one unified agreement with the supplier. This collaborative approach reduces administrative overheads and improves the electronic transfer of patient documents between hospitals and GP practices.
- Formed two new teams within the ICB with a focus on improving how care is delivered by the [Primary Care Strategy](#) through improving access, supporting Integrated Neighbourhood Teams and preventing cardiovascular disease and integrating care across the ICS.
- Merged three of our historical shared care records into one record that now covers BOB, Frimley and Surrey Heartlands Integrated Care Systems (ICSs). One example of improved care is that information about patients who live in Buckinghamshire is now available to doctors in Wexham Park Hospital in Slough.
- Worked with South Central Ambulance Service (SCAS) to make more patient information available to paramedics so they can see a fuller history of health and social care for a patient to make better treatment decisions.
- Worked in partnership with BHFT and OHFT to improve their electronic patient records, signing off millions of pounds of investment in new digital systems which will improve the experience for staff and improve the safety/delivery of patient care.
- Led on the development of an Integrated Care System Cyber Security Strategy with our partner organisations, which include the hospitals and community providers. The strategy aims to embed high standards of cyber security across the BOB digital landscape.
- To bolster security and protect user data, we have implemented Multi-Factor Authentication (MFA) across all individual NHS Mail accounts for head office and GP practice staff, significantly reducing unauthorised access and strengthening cyber security by further protecting confidential and sensitive information.

Digital Inclusion:

We have established a Digital Inclusion Programme Board to oversee the planning, delivery and governance of the digital inclusion programme to support people with digital access to NHS services. Since January 2024, we have established four projects:

- Digital Cafes have supported citizens with accessing and using the NHS App.
- The Laptop Recycle Project has recycled old BOB ICB laptops to people in our communities.
- The NHS App Engagement project has delivered training and support to primary care staff, so they are better placed to support patients with using the NHS App.
- The Digital Maternity project has supported maternity unit patients with digital skills and information technology.

To date, the digital inclusion programme has supported more than 2,000 people, increased NHS App usage among our population to 66% compared with the national average of 62%, and supported more than 40 organisations across our integrated care system to access and use digital technologies.

Adult Social Care:

We have been working with adult social care providers across BOB to support their own digital transformation ambitions through funding provided by NHS England Digitising Social Care programme.

This enables selection and implementation of various technologies including digital social care records and sensor-based falls technology. Interested care providers have been supported with funding to enable better outcomes for residents and improving staff satisfaction levels. Nine

out of 10 providers have moved from paper care plans to digital care planning systems and we are working with some care homes to pilot sensor-based falls technology to help prevent falls and detect falls earlier.

The benefits are:

- Residents receive a higher quality service because carers have more time to care.
- Improved satisfaction levels among staff who are now spending less time on admin.
- Management staff have better visibility of their care services due to the reporting capabilities of the digital solution, which enables them to provide more proactive care.
- Enhanced quality of care provided in care homes and a reduction in hospital conveyances, Emergency Department visits and admissions due to a fall.

This programme is key to our digital strategy to deliver high quality outcomes for our population. Digitising social care is helping to progress our ambition of supporting our most vulnerable people and joining up our health and care systems more widely by enabling closer partnership working and seamless data sharing.

Improving quality

The ICB aims to ensure that patients receive safe, high quality, clinically effective care that is positively experienced. Our ongoing commitment with health and social care providers, and wider system partners is to achieve nationally and locally agreed quality indicators, deliver sustainable quality improvements and reduce the inequalities gap.

Over the last year, the ICB's quality and patient safety oversight and assurance mechanisms have been strengthened through increased direct engagement with providers, closer working with provider collaboratives, quality insight visits and enhanced surveillance when needed. Quality insights and intelligence are triangulated with patient experience feedback and patient safety data and reported up through the ICB governance structures into the System Quality Group (SQG)

The SQG provides a strategic forum that is integral to bringing providers, service user representatives, regulators, ICB, NHSE, local authority, Health Innovation Networks, together to share intelligence, identify quality concerns and drive improvements across the health and care system. The SQG reports into ICB Board subcommittee Population Health and Patient Experience Committee (PHPEC) and escalates as appropriate to the regional system quality group (RSQG).

Quality and Patient Safety Governance Architecture



Our progress in respect to our quality priorities for 2024/2025:

- **To publish a Quality Strategy to support improvement which will incorporate the National Patient Safety Strategy:** The ICB Quality Strategy was intended to be fully developed in 2023/2024. However, a national quality strategy is due to be published in conjunction with the forthcoming NHS 10-Year Plan and this will underpin strategic direction for the ICB.
- **Develop a system-wide quality assurance framework to underpin our improvement work:** The ICB Quality Assurance Framework was originally published in September 2023 and has been further strengthened over the last year with updates that reflect the additional oversight and assurance mechanisms introduced and a supporting framework for primary care. The quality assurance framework was designed in collaboration with partners across the system and sets out a shared single view of quality for safe, effective, positive, well led, sustainably resourced and equitable care. It describes the approaches the ICB takes in gaining quality assurance and a clear set of responsibilities and accountabilities so we can all respect the roles of each partner organisation and understand how the system interacts and forms part of the contractual agreements with providers.
- **Ensure patient experience and co-design is fully embedded in our quality assurance/improvement work and our quality strategy:** The voice of the patient, carer or family has been integral to quality assurance and improvement work undertaken in the last year. Our thanks to Healthwatch partners, maternity and neonatal voice partnerships, the voluntary sector, charities and service user representatives for their contributions and the added value they bring to quality insights and improvement work across the ICS.

During the last year, despite the challenges faced by the NHS including operational pressures, industrial action and GP collective action; healthcare providers have mitigated the impact of these challenges, and many quality improvements have been made within individual healthcare provider organisations and across the ICS with system partners.

Examples include:

- Learning Disability Standards Framework to ensure that reasonable adjustments are made to ensure equity to healthcare services.
- Catheter passports - a booklet that provides information to patients and healthcare professionals about urinary catheter care, aiming to improve communication and ensure proper management to prevent complications like urinary tract infections.
- Increasing Freedom to Speak Up capacity to strengthen positive safety cultures.
- Online bereavement services to provide further support to families.
- Co-produced jaundice home phototherapy service providing a virtual ward pathway that is a better patient experience.
- Co-produced aftercare pathway for children's cancer to better support families.
- Health on the High Street multifunctional facilities that provide health, social and voluntary sector services focusing on prevention and health promotion in an accessible location.
- Maternity tobacco dependency pathway successfully reducing the number of women smoking during pregnancy to below national targets.
- Reducing waiting times for people with Parkinson's to improve access to assessment and support.

The ICB has continued to work closely with Health Innovation Oxford and Thames Valley to implement and pilot safety improvements including Martha's Rule, recognition of the deteriorating patient and transforming wound care.

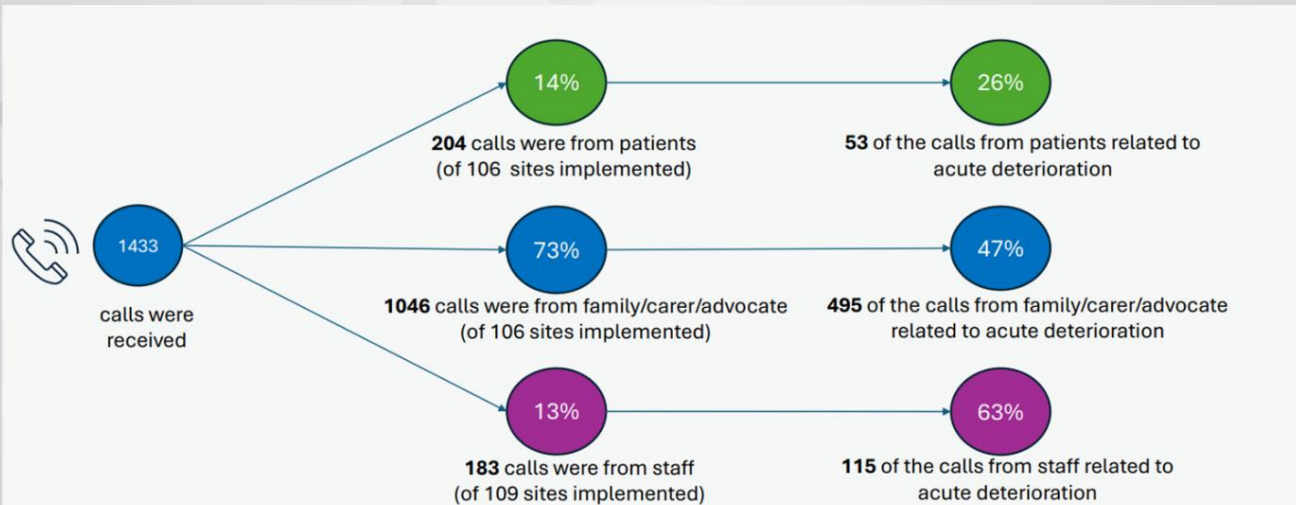
Martha's Rule

The primary aim of Martha's Rule, a pilot program in England, is to empower patients, families, and staff to seek an independent medical review when concerns about a patient's care are not being adequately addressed. This is achieved by providing a formalised route for escalation, allowing for quicker identification and resolution of deteriorating conditions. There are 143 trusts involved in the Martha's Rule Pilot.

RBH and Stoke Mandeville are the two Pilot Sites in BOB and work is underway with BHFT who are interested in implementing the principles of Martha's Rule in mental health and community settings.

Data from the pilot so far has identified the incidence of escalation calls, who is making the calls, the nature of the call and the outcome of those calls that are made related to acute deterioration. Further analysis of the pilot findings is ongoing including patient and family experience, but early indicators are demonstrating the value of the pilot in enhancing safety.

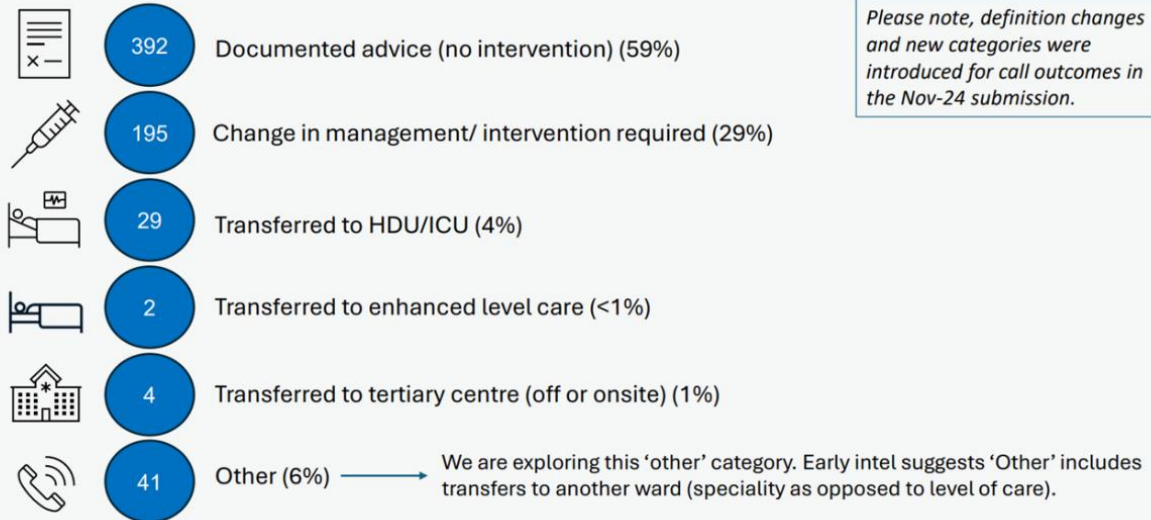
Calls: From Sep-Dec, sites received 1433 call. 633 (46%) related to acute deterioration



Theme: From Sep-Dec 770 (54%) of calls did not relate to acute deterioration

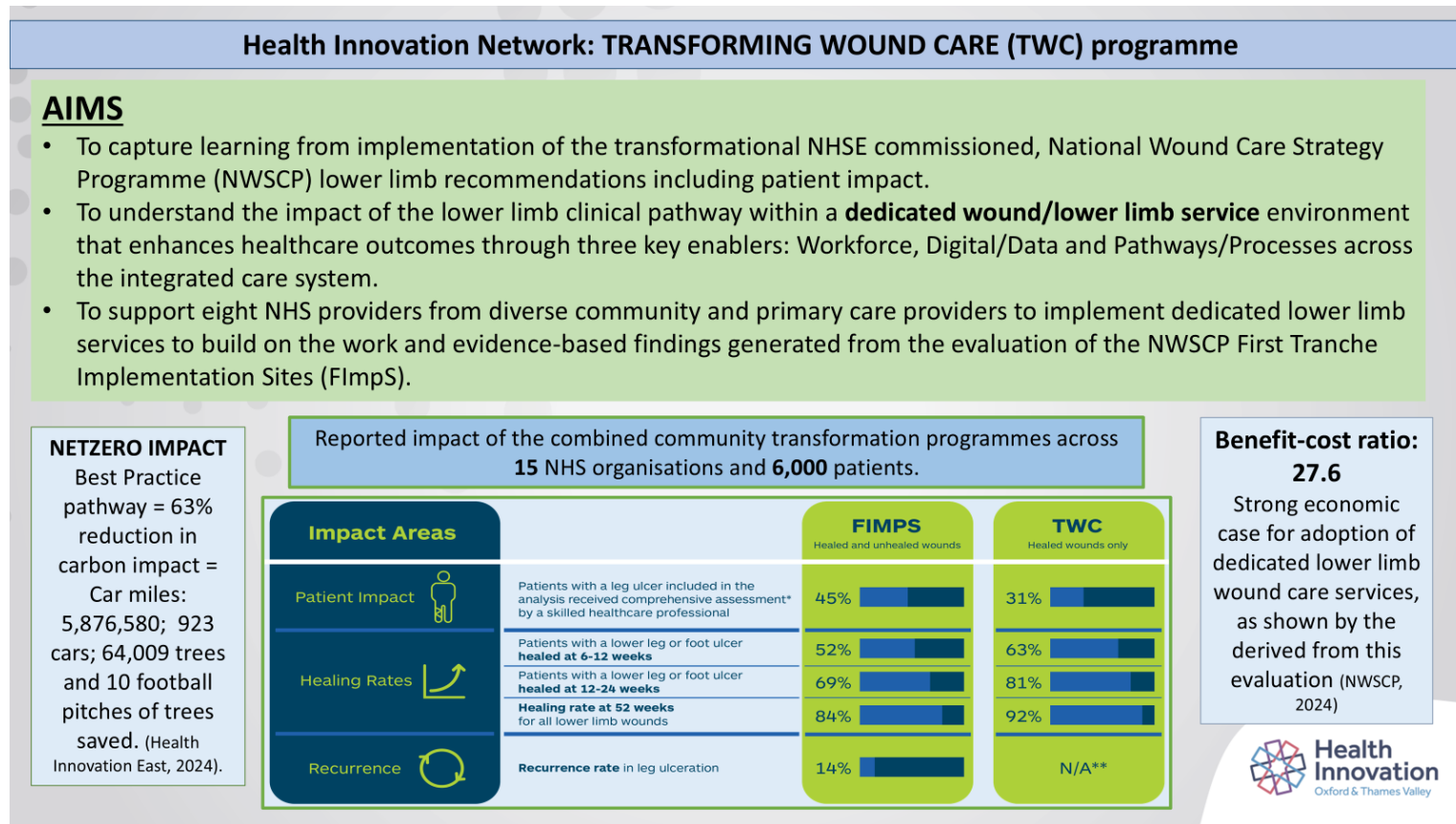


Outcome: Sep-Dec 633 (46%) calls related to acute deterioration



Transforming Wound Care

In preparation for the impact of GP collective action on wound care provision the ICB convened a roundtable with Tissue Viability Nurses to understand the scope of the impact this would have. A programme of work commenced to establish an equitable locally commissioned service for surgical wound care and leg ulcers. Ninety three percent of Primary Care have signed up since the launch. Impact analysis will be undertaken in 25/26.



Patient Safety oversight and learning from patient safety events is integral to improving the quality of care patients receive. NHS Trusts across BOB transitioned from the Serious Incident (SI) Framework to the Patient Safety Incident Response Framework (PSIRF) by April 2024. Independent providers are transitioning to PSIRF with support from the ICB, which is also working closely with primary care colleagues in preparation for the roll out of PSIRF in primary care.

PSIRF has a greater focus on system approaches to incident investigation. It enables proportionate learning responses and the use of variable methods to gain learning from when things go well or when things did not go as planned. Adopting PSIRF has strengthened family engagement and involvement in patient safety learning responses. Staff report it is a more positive approach to reviewing care, focused on improvement rather than blame.

Looking to 2025/2026 our quality and patient safety priorities include:

- A fully developed quality strategy in line with the national quality strategy.
- Ensuring that quality and patient safety insights and intelligence are directly linked to the strategic commissioning function of the ICB.
- Achieving the quality deliverables set out in the ICB Joint Forward Plan.
- Meeting the requirements of the national ICB quality functions framework.
- Ensuring the work of the ICB aligns with the regulatory standards of the CQC.
- Continuing to develop and embed co-design and co-production in quality improvement work across the Integrated Care System.
- Creating improvement collaboratives to achieve system-wide solutions to quality and patient safety issues across BOB.

Addressing health inequalities

BOB ICB is committed to increasing its focus of preventing ill-health as well as treating it. We are also committed to reducing inequality of access, experience and outcomes across our population and communities. Our JFP recognises the importance of prevention and addressing inequalities in BOB.

BOB ICB established a Prevention and Health Inequalities Team in 2023 to tackle ill health and reduce variation in access, experience, and outcomes across our communities. Our goal is to ensure equal access to care and support while promoting better health through enhanced prevention efforts.

Key highlights from the past year 2024/2025 include:

- Strengthened governance to oversee prevention and health inequalities at system and local levels.
- Continued focus on population health management to address health disparities.
- £4 million allocated to locally developed schemes, including workforce training in Buckinghamshire and investment in the digital health tool Joy.
- £1 million in grants for grassroots projects in Oxfordshire to address neighbourhood-level health challenges.
- A large Community Wellness Outreach programme in Berkshire West, delivering over 4,000 health checks for vulnerable communities, aiming for 10,000 by June 2025.
- Establishment of an Inclusion Health Oversight Group to improve access and experience in healthcare services for vulnerable groups, building on the work of the Asylum Seeker and Vulnerable Migrants Forum.

The ICB's 2024/2025 approach to health inequalities focused on governance, population health, resourced activities, and engagement, guided by

national frameworks like Core20PLUS5 and Inclusion Health. Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the ‘Core20PLUS’ – and identifies five focus clinical areas requiring accelerated improvement. In BOB ICB we continue to align our priorities to the Core20PLUS5 approach.

The Prevention, Population Health and Reducing Health Inequalities Group oversees governance of the programme, addressing smoking, asylum seeker health, screening, immunisations, women’s health, and inclusion health. To support the work, prevention networks and Place-based partnerships have maintained oversight over local initiatives and collaborations within Buckinghamshire Oxfordshire and Berkshire West.

The Population Health Management Collaboration Group brings together professionals to focus on intelligence, infrastructure, incentives, and interventions, supporting analytics and targeted interventions.

Joint Strategic Needs Assessments have been updated, particularly for socially excluded groups, using data to better understand population needs. A new dashboard has been developed to support planning and decision-making and the ICB continues to promote population health management as a key strategy for reducing health inequalities across services.

BOB ICB allocated £4 million to local initiatives addressing health inequalities across its three Places, these are outlined below:

Buckinghamshire:

- A three-year Women’s Community Health Worker Service focuses on improving maternal health and service access for younger and ethnic minority women in deprived areas (Opportunity Bucks);
- the ‘Getting Ready for Surgery’ service supports high-risk patients with lifestyle interventions during surgical waiting times. Early success includes a 300% increase in smoking cessation referrals and extensive staff training in smoking cessation advice.
- Severe Mental Illness: A nurse-led outreach model provides physical health checks for people who have not had one in 3+ years. Research is also being conducted to understand barriers to attendance, with OHFT leading the project until March 2025.
- Mental Health Grants (£120,000) funded 11 voluntary sector organisations supporting underserved communities, including Asian women, Gypsy, Roma & Traveller (GRT) groups, Muslim communities, and LGBTQ+ individuals with Severe Mental Illness. Co-produced training for OHFT staff aims to improve access and outcomes for GRT individuals.
- Mental Health Training and Support: 11 VCSE projects continue delivering extended mental health services, with 112 attendees in GRT awareness training and 140 OHFT staff completing GRT Champion training.
- Making Every Adult Matter: A partnership project improving support for people facing multiple disadvantages, linking with emergency care and homelessness services. Successes include securing housing for two entrenched rough sleepers, with continued funding in 2025/2026.
- Joy App: A digital referral platform for social prescribing is being rolled out with a five-year investment, improving access to preventative services across health, local authorities, and the VCSE sector.
- Communities of Practice: A health inequalities network for frontline workers, offering themed sessions on issues like SEND and GRT inclusion. A dedicated stakeholder session in October focused on Core20PLUS5 and Inclusion Health insights.
- Community Researchers: Trained three community researchers using the Core20PLUS5 approach to engage marginalised communities in research.

- Health Coaching Training: Equipped 58 professionals in Opportunity Bucks areas with skills to support patients in managing long-term health conditions, improving care and engagement.
Deep End Network: A GP-led initiative enhancing collaboration, health awareness, and services for deprived communities, including support for homeless health.

Oxfordshire

- Place-Based Funding: Focused on Core20Plus5 clinical priorities to streamline projects addressing health inequalities.
- Out of Hospital Care Team offers multi-agency support for homeless residents to prevent hospital admissions and rough sleeping.
- Oxfordshire Community and Voluntary Action: £1m in grants distributed to grassroots initiatives in deprived wards.
- Active Oxfordshire: Supported 'Move Together' and 'Move Medicine' programmes, with 2,052 referrals in 2023/2024 and increased physical activity levels.
- Early Start Oxfordshire: Supports vulnerable families in the OX4 (Cowley, Blackbird Leys, Littlemore, Rose Hill, Iffley and Sandford area) through maternity advocacy, community-based antenatal education, social prescribing with a focus on anti-poverty and legal literacy.
- Asylum Seeker Care Coordinator: Funded to reduce clinical workload by improving support and service navigation for asylum seekers in BOB.

Berkshire West

Our Community Wellness Outreach Service offers NHS Health Checks in Berkshire West, targeting priority groups using a population health management approach. Around 10,000 residents are expected to benefit from this service and 4,779 checks were completed by November 2024. Of those who came forward for checks, 700+ referrals were made into NHS services, including 52% for weight management, 28% for mental health support, and 10% for smoking cessation. In addition, exercise schemes and free gym memberships have been provided to people with high BMI.

Engaging people and our communities

At BOB ICB, we aim to create meaningful and inclusive opportunities for public involvement, ensuring that our residents' voices are heard and valued in our decision-making processes. We are committed to harnessing the significant potential of community engagement to shape and improve our health and care services.

To do this, as part of our work to develop a new operating model for the ICB, we have reviewed our resourcing and capability to ensure we have the right team in place to deliver this important engagement and partnership work and develop a culture across the organisation of working with our residents.

The new community involvement team, which formed on 6 January 2025, will work collaboratively with our partners to deepen our understanding of the diverse needs and priorities of the people we serve. Our common ambition is to ensure that the health and care system in BOB is meeting these needs and actively enhancing the quality of life for all residents. The team has already made good connections within our system and are

continuing to build meaningful trusted relationships with partners and people in our system; examples of this include work with young people who have additional needs, working with local partners to ensure that involvement is using trusted relationships already established.

The ICB continues to develop its digital engagement platform to give people across BOB the opportunity to get involved and help shape the future of health and care. '[Your Voice in Buckinghamshire, Oxfordshire & Berkshire West](#)' enables people to have their say on projects and proposals related to health and care. People can register to be regular users of the platform and can be kept informed on the work of the ICB and partners. We currently have 1,269 people registered.

Work has also started in the past year to scope and develop an insight bank for the system to enhance decision making and improve service design. This is a joint project with Healthwatch, the BOB VCSE Health Alliance, local authority colleagues and representatives from communities identified by Healthwatch and VCSE partners. We have also set up an ICB community insight and patient experience working group to ensure we are turning insight into action within the organisation.

Key Engagement Activities

Developing Our Partnerships: We recognise the value of Healthwatch's contributions for our engagement and involvement ambitions and ensuring we can meet the needs of our population. We work closely with our five Healthwatch organisations across BOB which support Place-based projects, providing essential access to patient voices, and offering detailed analysis and recommendations. Healthwatch continues to provide independent scrutiny and challenge on behalf of our communities. Our collaboration is demonstrated through our regular meetings and the integration of their insights and public feedback into our plans.

Our collaboration with the BOB Voluntary Community & Social Enterprise (VCSE) Health Alliance is important to successful public involvement. The BOB VCSE Health Alliance serves as a key channel for engagement, allowing us to work closely with voluntary and community organisations, address inequalities, build trust, and ensure the voices of people and communities are heard.

Primary Care Strategy Engagement: From November 2023 to March 2024, BOB ICB conducted a two-phase [engagement process](#) to involve the local population in developing the Primary Care Strategy. This included surveys, public events, focus groups, and Patient Public Group sessions. Over 600 people across BOB got involved in this work. Key themes from the [feedback](#) included the need for better communication, continuity of care, and addressing digital exclusion. The insights gathered were used to [refine](#) the strategy, ensuring it meets local needs and takes pressure off services.

10-Year Plan Engagement: In October 2024, the Government launched a public engagement initiative to shape the 10-Year Health Plan for the NHS. BOB ICB supported this initiative by summarising existing insights from local engagement work, collaborating with the BOB Voluntary, Community and Social Enterprise Health Alliance (BOB VCSE) to facilitate workshops, and running 10 community workshops. These efforts ensured that diverse community voices were included in shaping the future of the NHS.

Listening event: We undertook a listening event with local patients and public to help us understand how General Practice communicates with patients on the various staff members they may see during an appointment. We want to make it easier for patients to recognise the health and care professionals they may see or speak to at their GP practice by designing an awareness campaign that works for them. The [feedback](#) focuses on accessibility, clarity, and inclusivity of information, as well as the need for improved communications.

Online Access to General Practice: The ICB sought the views of patients to support the procurement of a new online consultations system for

GP practices across our area. A short survey was conducted with 1,176 responses received. The feedback will inform the requirements for a new system.

Developing our links with young people: We have been making a concerted effort to reach out to young people and held a workshop to discuss health and care services with a group of people with a special educational need or disability in Buckinghamshire. Further work is ongoing because of the feedback we received, including Autism awareness training for ICB staff.

The ICB attended the Youth Voice event in Bucks which over 200 young people attended; 78 of the young people took part in our poll to vote on their priority for the NHS and some expressed an interest in being part of an advisory group for the ICB which is in the process of being set up.

Health and Social Care Connections: The Oxfordshire Health and Social Care Connections listening events program connected senior managers with residents, supported by Age UK Oxfordshire, Oxfordshire Community Voluntary Association, and Active Oxfordshire. This initiative aimed to better understand community needs and improve service provision.

Healthwatch Public Webinars: A series of webinars with Healthwatch Oxfordshire covered topics such as men's health, healthcare closer to home, pharmacy first, and the primary care strategy. These webinars raised awareness of local services and provided opportunities for public input.

Winter Communications Campaign: The #Staywell-BOB urgent care campaign directed patients to appropriate services during high-demand winter periods, ensuring effective use of NHS resources.

Immunisation Campaigns: Throughout the year, campaign materials and information for vaccination and immunisation were provided, including seasonal vaccines like Covid, flu, and RSV. Engagement with these campaigns increased significantly compared to the previous year.

Integrated Delivery Networks: Various integrated delivery networks, such as the Cardiac, Diabetes, Respiratory, and Stroke networks, have been active in community outreach and education. These networks have delivered patient education events, supported lifestyle interventions, and set up patient and public voice groups to gather feedback and improve services.

These initiatives demonstrate our commitment to involving the public in shaping healthcare services and policies, ensuring that our strategies and actions are aligned with the needs and priorities of our communities. We will continue to build on these efforts to create a responsive, inclusive, and effective health and care system for all residents in BOB.

Responding to an emergency

Within the NHS Emergency Preparedness, Resilience, and Response (EPRR) is a critical framework for the ICB, ensuring healthcare organisations can effectively plan for, respond to, and recover from emergencies. The EPRR team evaluates how well NHS provider organisations comply with national standards, enabling them to maintain services during disruptions and protect patient safety.

Each year, all NHS organisations, including the ICB, complete a self-assessment against the Core Standards for EPRR, covering areas like risk assessment, incident response, business continuity, training, and partnership working. These standards ensure preparedness for events such as pandemics, severe weather, cyberattacks, or mass casualty incidents.

Key components include developing robust incident response plans, regular training exercises, and collaboration with local resilience forums

(LRFs). The assurance process involves a formal review by regional NHS England teams, highlighting strengths and identifying areas for improvement. Organisations must achieve a rating of 'substantial compliance' or higher to demonstrate readiness.

The EPRR process fosters accountability and continuous improvement, ensuring alignment with national priorities and legal requirements. By embedding resilience into healthcare operations, EPRR assurance supports the NHS in safeguarding patient care and public health during emergencies.

The key Components of NHS EPRR Core Assurance:

Core Standards are a set of requirements that all NHS organisations must meet. The ratings include:

Fully Compliant:	Substantially Compliant:	Partially Compliant:	Non-Compliant:
The organisation meets all the required standards.	The organisation meets most of the standards, with minor areas for improvement.	The organisation meets some of the standards but has significant areas for improvement.	The organisation does not meet a significant number of the standards and requires urgent improvement.

The ICB is rated as Substantially Compliant as a Category 1 responder under the Civil contingencies act 2004.

Over the past 12 months, the EPRR team has created a new induction training programme for all on-call colleagues. This has been rolled out successfully with helpful feedback from the On-Call Forum. From March 2025, on-call colleagues have been provided with a Command Portfolio, to refresh on a triennial basis, to ensure that they can monitor their own professional development with incident management.

In addition, the team has welcomed five new on-call directors to the Rota. Three tactical and two strategic directors will assist with balancing the demands of on-call, while ensuring that the ICB maintains a state of readiness.

The team has delivered one Principles of Health Incident Command session, with a further one scheduled for April 2025. This covers the minimum occupational standards required by NHS England of those in health incident command positions, and forms part of our on-call mandatory training. New dates have been set for participation in 2025/2026 and there is a view to deliver 'Part B' this year as well.

Through 2024, the ICB has participated in a range of exercises, both NHS and multi-agency. These include:

- Exercise Spider (June 2024) – tabletop exercise (specifically focusing on cyber), in partnership with NHS England
- Exercise Astra Endeavour (July 2024) – command post exercise ran by Gloucestershire ICB in preparation for Royal International Air Tattoo
- Exercise Holler (August 2024) – communications exercise, in partnership with Frimley ICB
- Exercise Buzzard (September 2024) – tabletop exercise ran by West Berkshire Council focusing on petrol storage depot leak
- Exercise Alder (September 2024) – command post exercise, detailing HCID, ran by NHS England

Through 2024 the ICB has directly responded, or supported the response to, a range of incident and emergencies, including:

- Industrial action:
 - Junior Doctors
 - General Practice Collective action
- Measles
- NRS Cyber outage
- Crowd Strike
- M-Pox: -
 - With a focus from the EPRR and IPC teams to deliver a pathway way for the access to the vaccination post exposure.
- Flooding in the Thames valley:
 - There have been three periods of flooding within Thames Valley this year both in early January and September, these incidents both required a Thames Valley TCG to be established, the learning from these events allow us to assess and review our combined response.

Working toward a Net Zero NHS

Throughout the past year the Net Zero Programme Board (NZPB) has supported stakeholders from across our system and geography to progress the actions set out in the BOB ICS Net Zero Green Plan and associated action plan. In addition, the ICB team working with the NZPB, has commenced work to refresh the BOB Green Plan, which was originally published in July 2022 and updated in September 2023. This follows the call from NHS England for systems and organisations to provide a refreshed Green Plan in 2025, with a renewed focus on creating a more collaborative approach to sustainability, including updated system ambition statements and SMART actions to align organisational approaches and move forward as a system. As a result of this, in the latter part of 2024/25 we commenced work to update our plan, identify the new targets and areas of focus, work towards an increasingly cohesive governance structure and agree clearer data metrics to support positive movement towards Net Zero and build on the work undertaken since 2022.

Through 2024/25 we have seen steady improvements in our environmental ambitions and progress as we work to deliver on our Green Plan objectives.

- In Medicines Management we have initiated the '*Only order what you need*' campaign, in which GP surgeries and pharmacies remind patients to regularly check what medicines they are requesting on repeat prescription, and whether they are needed. They are further encouraging patients to dispose of unused or unwanted medicines at their pharmacy to prevent unnecessary waste in domestic landfill and to check their prescription bags before leaving the pharmacy, to prevent mistakes leaving the building. This campaign was started by Dorset ICB and has had great success. We are confident that we will see positive outcomes from this campaign in the first quarter of 2025.
- Building on the work in 2023/24 that successfully delivered a 25% reduction in carbon emissions from inhalers against the 2019/20

baseline, we have continued to see a decline in the prescribing of metered dose inhalers and an increase in soft mist inhalers/dry powder Inhalers. As a system, we have achieved a 28% decrease in inhaler emissions, making BOB one of the leading systems in the south east region for reducing high-carbon SABA (short acting beta-2 agonist) prescriptions.

- Across the NHS, anaesthetic gases are commonly used as a part of everyday surgeries and 2% of the NHS carbon footprint comes from anaesthetic and analgesic practices. The NHS Long Term plan commits to lowering this by 40% by “transforming anaesthetic practices” such as using alternatives to desflurane. In recent months, we have been able to report that we have seen zero uses of volatile anaesthetic gases by NHS Trusts in BOB ICS since January 2025, building on work since 2022 to eliminate routine desflurane use across our geography.
- Across our system, our total Fleet emissions have reduced from 1564 tCO₂e to 399 tCO₂e, a testament to the work happening at our trusts as they switch their fleets over to LEV/ZEV. In addition, three of our trusts have worked closely with local transport companies to ensure an easier commute for staff, encouraging the use of public transport and reducing commuter emissions.
- We are seeing a steady decrease in our overall energy consumption as an ICS from 525kWh/m² in 2019/20 down to 428kWh/m² in 2023/24. This is an area where we are planning for further heat system modifications and Heat Decarbonisation Plans with our trusts and will be part of the newer collaborative approach as we work more closely amongst all of our partner organisations.
- To support our development, a study at Oxford University Hospitals (OUH) was conducted to determine the extent environment and social considerations are incorporated into business planning in NHS trusts, using Environmental and Social Impact Assessments as a quantifier. The study concluded that there is a high degree of variance between trusts on the use of Impact Assessments and suggested that a clear process with direct purpose and reflecting organisation values will have a higher degree of impact and encourage greater use moving forward. The work also enabled the development an Environmental and Social Impact Assessment Tool for one of our Trusts, using the findings from the study.

With the refresh of the NHS trust and ICB Green Plans and the new guidance from NHS England, the Net Zero Programme Board (NZPB) will be updating action plans to more accurately reflect the needs of our system. The previous Green Plan confirms the Director of Strategy and Partnerships as the ICB Executive and the Net Zero Programme Board reporting to the Place and System Development Committee (ICB Board Sub Committee). We are currently in the process of reviewing the governance for the delivery of the refreshed Green Plan following changes to the ICB management structure in 2024. In collaboration with our trusts we will continue to adapt to the changing NHS and Local Authority landscape. As a result, the primary focus of the NZPB will be to facilitate the collaborative efforts of the system and to provide an assurance of progress towards our Net Zero targets.

Task Force on Climate-related Financial Disclosures (TCFD):

As part of the phased approach to sustainability annual reporting requirements, disclosure requirements for 24/25 include a focus on:

- governance arrangements in relation to climate issues, including board oversight and management’s role in assessing and managing those issues

- risk management arrangements for identifying and managing climate related risks
- metrics and targets that are used to assess and manage climate related risks

Governance:

As set out above, we have a clear governance structure to provide oversight and accountability for the delivery of the Green Plan throughout 2024/25, with ICB executive leadership from the Director of Strategy and Partnerships (now Chief of Strategy, Digital and Transformation) and a reporting route from the Net Zero Programme Board. There are arrangements in place to facilitate board oversight through the ICB executive team. This has enabled in-year escalation where necessary in relation to climate issues and their associated management. The Net Zero Programme Board has coordinated progress of the Green Plan delivery which, through the actions set out in the plan, has enabled the ICB to manage climate-related issues that the plan seeks to address.

Risk management:

The organisation has a well-established and well-structured approach emergency planning and resilience, which recognises our role and requirement as a single organisation but also enables us to meet our responsibilities as part of the Thames Valley Local Resilience Forum (LRF).

The BOB ICB risk register and board assurance framework is managed as part of our Emergency preparedness, resilience and response (EPRR) processes and, as highlighted in January 2025 ICB Board meeting, the ICB is substantially compliant against the self-assessment core standards process. Climate-related risks are integrated into the organisation's overall risk management approach through the ICB risk register and categorised at directorate level. This includes an adverse weather plan, which mitigates some of the identified challenges associated with climate adaptation. The specific ICB climate related risks are associated with non-delivery of the ICB's net zero and Green programme or as risks that form part of the ICB's emergency response to a climate event or emergency. These risks are reviewed and updated on a regular basis throughout the year.

In addition to the organisational risk management approach, the LRF holds a community risk register. It describes risks for the community and assesses how likely they are to lead to an emergency and the potential impact they would have. The register is created through a risk assessment, and the information is used by the LRF to plan and prepare for emergencies that may occur. This process enables national issues to be considered alongside the local risk context. Each identified risk is analysed and given a rating according to how likely the risk is to lead to an emergency, and its potential impact on criteria such as safety and security, health, economy, environment, and society. As a result of this process, joint plans are in place regarding climate-related areas including flooding, severe weather, environmental pollution and major fire.

Metrics and targets:

The organisation assesses climate-related risks and opportunities in line with its overall risk management process, with directorate risk registers,

ICB-wide register and a board assurance framework.

The organisation uses metrics such as those listed below to manage climate-related opportunities and meet Greener NHS reporting requirements:

- Ultra-low and zero emission vehicle purchases and leases
- Salary sacrifice schemes for low or zero emission vehicles
- Procurement and contracting processes aligned with net zero, carbon reduction and social value

How does BOB ICB manage its money and coordinate system finances?

BOB ICB is responsible for investing the funding we receive to maximise the health of the local population.

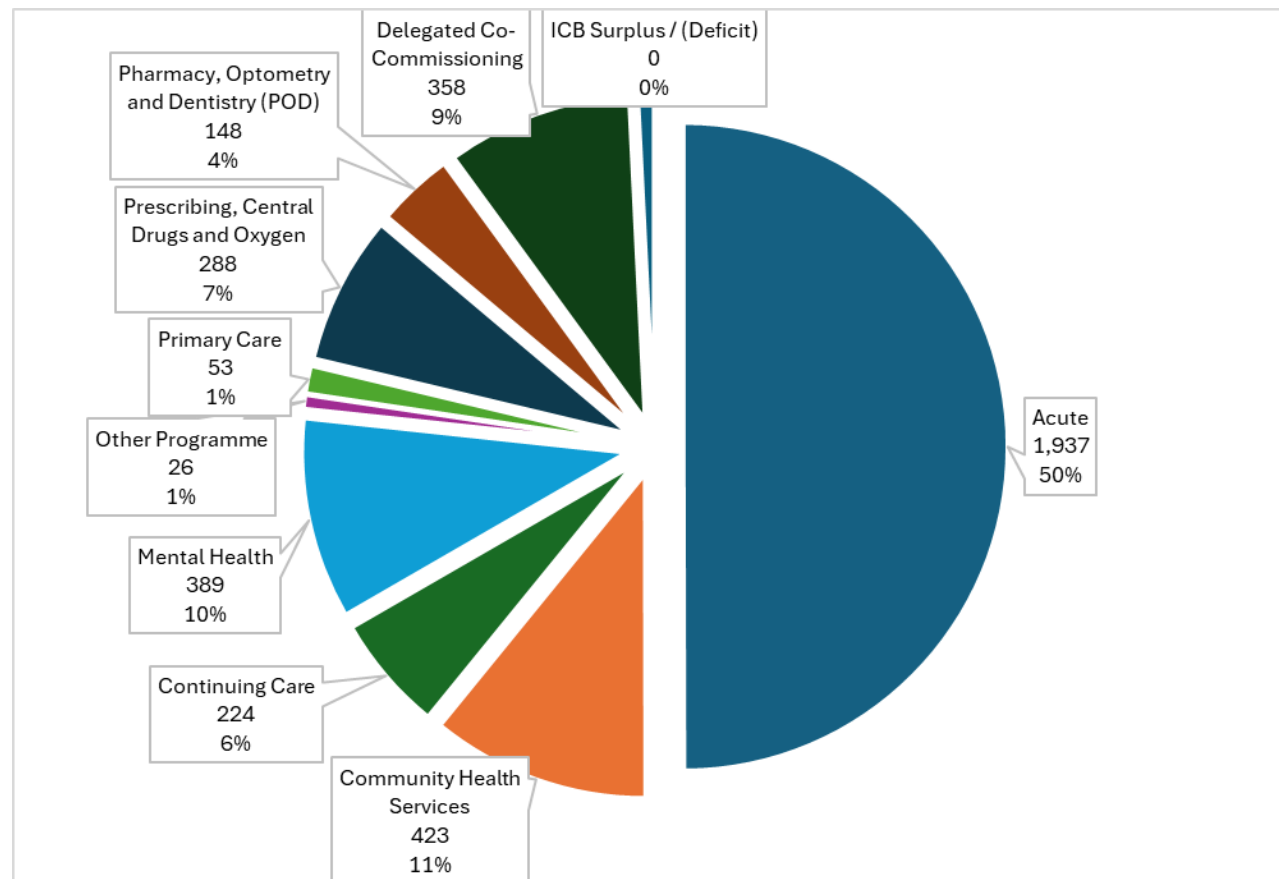
The financial statements contained within the report provide a summary of the ICB's financial position and performance for the 12-month period to end 31 March 2025. They have been prepared on a Going Concern basis and therefore will continue to provide the services in the future. Hence, this section of the report talks about how we manage our money and how our financial performance is measured.

In 2024/25 financial year, we received £3,875m of funding, of which, more than half of this expenditure was on acute services (£1.9bn). The remainder (£389m) was spent on Mental Health & Learning Disabilities services, (£423m) on Community Health Services and (£224m) on Continuing Health Care packages of care. We also invested (£698m) in primary care, including prescribing (£288m), and (£148m) on Dental, Optometry and Pharmacy services. The ICB remained within its Running Cost Allowance of £30.8m with a small underspend of £0.5m.

2024-25

BOB ICB OVERALL by Service Line M12	YTD Budget	YTD Actual	YTD Variance
	£'m	£'m	£'m
Acute	1,929.8	1,936.7	(6.9)
Community Health Services	419.3	422.7	(3.4)
Continuing Care	224.5	224.4	0.2
Mental Health	368.9	388.8	(19.9)
Other Programme	59.0	26.2	32.9
Primary Care	54.9	52.7	2.1
Prescribing, Central Drugs and Oxygen	282.2	287.5	(5.3)
Pharmacy, Optometry and Dentistry (POD)	148.3	148.0	0.3
Delegated Co-Commissioning	358.4	358.4	(0.0)
Total Programme Commissioned Costs	3,845.3	3,845.4	(0.1)
Admin Costs	30.8	30.3	0.5
Total before ICB Surplus/(Deficit)	3,876.1	3,875.6	0.5
ICB Surplus / (Deficit)	(0.5)	0.0	(0.5)
Total after Surfplus/ (Deficit)	3,875.6	3,875.6	0.0

How we spent the money:



Throughout the year, the ICB was under constant scrutiny to meet financial targets set and agreed by NHSE. These financial challenges were as a result of factors such as slippage against efficiency plans, the impact of industrial action, and increased demand for high cost drugs, devices and elective recovery work.

Within the funding received, the ICB has continued to ensure the following areas are managed and maintained to ensure value for money and meet patient and service needs:

- Continuing to increase our investment in Mental Health Investment Standard (MHIS) £47 million year-on-year.
- Primary Care delivery of services at £846m.
- Remain within the funds allocated for running the ICB (£30.8 million).

As a system, the year-end position agreed with the system partners was a £15.5m deficit, which is £0.5m favorable to plan. The ICB reported a breakeven position with two system partners reporting a surplus, and three system partners reporting a deficit.

Organisation	Annual Plan	Forecast Outturn	Forecast Variance
	£'m	£'m	£'m
Berkshire Healthcare NHS Foundation Trust	1,900.0	4,919.5	3,019.5
Buckinghamshire Healthcare NHS Trust	(658.0)	1,982.0	2,640.0
Oxford Health NHS Foundation Trust	(83.0)	2,193.3	2,276.3
Oxford University Hospitals NHS Foundation Trust	(249.0)	(6,794.0)	(6,545.0)
Royal Berkshire NHS Foundation Trust	(444.1)	(17,920.0)	(17,475.9)
TOTAL In-System Providers Surplus/ (Deficit)	465.9	(15,619.1)	(16,085.0)
Buckinghamshire, Oxfordshire and Berkshire West ICB	(465.0)	107.6	572.6
BOB ICS Surplus/ (Deficit)	0.9	(15,511.6)	(15,512.4)

Some of the key financial risks that were managed during the financial year were, the contract triangulation variance of £11m between the ICB and RBFT, that required a system solution to ensure delivery. This was a non-recurrent risk to the system in the year, with contract triangulations exercises addressing the issues in the new financial year. The system also saw significant overperformance in elective recovery and advice and guidance to ensure 65 week wait targets were achieved. Whilst elective recovery activity was monitored via value weighted SUS dataset in 2024/25, this is reverted back to SLAM activity that will be underpinned by an Indicative Activity Plan (IAP) for 2025/26.

Whilst the ICB has achieved its statutory financial targets in 2024/25, it will endeavor through continued engagement and collaborative working with partners across the system, to deliver the actions and mitigations required to deliver the plan set.

Capital:

Under the Health and Care Act 2022 (the 2006 Act) there is an obligation for ICBs and their partner NHS trusts and NHS foundation trusts to produce and publish annual joint capital resource use plans. The plans are intended to ensure there is transparency for local residents, patients, NHS health workers and other NHS stakeholders on how the capital funding provided to ICBs is being prioritised and spent to achieve the ICB's strategic aims. This aligns with the ICB financial duty to ensure that allocated capital is not overspent and the obligation to report annually on our use of resources.

BOB ICB and partner Trusts published a Joint Capital Plan for 2024/25 in accordance with this requirement. This is available on the ICB [website](#).

The capital allocation to the ICB is small with most funding being allocated to providers as shown below. The year end position against plan is as follows:

ICB charge against capital allocation:

ICB charge against capital allocation	Plan Year Ending 31/3/25 '000	In Year allocation adjustment	Outturn Year Ending 31/3/25 '000	Variance '000	Variance %
Buckinghamshire, Oxfordshire And Berkshire West ICB charge against allocation	2,995	5,009	8,004	0	0.00%
Capital Allocation			8,004		
Variance to allocation			0		
Allocation met			Yes		

System charge against capital allocation:

System charge against capital allocation	Plan Year Ending 31/3/25 '000	In Year allocation adjustment	Outturn Year Ending 31/3/25 '000	Variance '000	Variance %
System charge against allocation	165,193	-3,311	160,238	1,644	1.00%
Capital Allocation			161,882		
Variance to allocation			1,644		
Allocation met			Yes		

The system achieved the target of not overspending the capital allocation in year, delivering a £1.6m underspend against its capital allocation due to the delay of IFRS16 impact.

The Joint Capital Plan for 2025/26 is available on our [website](#).

Performance targets

The ICB works collaboratively with providers in the BOB health economy, to deliver timely and robust healthcare provision. Meetings are held to provide assurance on actions being taken by providers to ensure performance achievement. Where performance is not achieved, we work together in partnership to resolve the issues and to develop remedial actions plans to recover performance.

The tables below outlines the performance in Buckinghamshire, Oxfordshire and Berkshire West from 1 April 2024 to 31 March 2025:

Metric	Period	Target	Berkshire West	Buckinghamshire	Oxfordshire	BHT	OUH	RBFT	BOB ICB	South East	England
Cancer Referral/Upgrade to First Treatment Standard (62-day standard) - Commissioner	Mar 2025	85%	79.4%	57.1%	66.8%	54.8%	60.7%	79.2%	67.4%	74.2%	74.4%
GP appointments - percentage of regular appointments within 14 days.	Mar 2025		88.4%	87.1%	89.5%				88.4%	87.7%	88.1%
Adult inpatients with a learning disability and/or autism per million head of population	Apr 2025	30									41
Under 18 inpatients with a learning disability and/or autism per million head of population	Apr 2025	15									20
Percentage of patients who spent 4 hours or less in A&E	Apr 2025	78%				79.5%	75.5%	71.3%	77.6%	77.4%	74.8%

Planned Care Metrics

Category	Metric	Period	Target	Value
Activity	RTT 65 Week Waits	Mar 25	0	85
Quality of Care, Access and Outcomes	GP appointments - percentage of regular appointments within 14 days.	Mar 25		88.4%

Learning Disabilities and Autism

Category	Metric	Period	Target	Value
Learning Disabilities & Autism	Adult inpatients with a learning disability and/or autism per million head of population	Feb 25	30	40
	Under 18 inpatients with a learning disability and/or autism per million	Feb 25	15	13

Cancer Metrics

Category	Metric	Period	Target	Value
Cancer	Cancer Referral/Upgrade to First Treatment Standard (62-day standard) - Commissioner	Mar 25	85.0%	67.4%

Urgent Care Metrics

Category	Metric	Period	Target	Value
Urgent Care	Percentage of patients who spent 4 hours or less in A&E	Apr 25	78.0%	77.6%

How does the ICB monitor performance?

The ICB Board is responsible for discharging the duties of its constitution, which includes monitoring and scrutinising the performance of service providers. The Board receives a performance and quality report at the bi-monthly meetings in public.

Formal committees of the Board scrutinise in more detail how the ICB and health providers are delivering contracted services; these are the Audit and Risk Committee, Place and System Development Committee, Population Health and Patient Experience Committee and System Productivity Committee (for more information about the committees and their purpose please see page 63).

The ICB also has a memorandum of understanding with NHSE which outlines how we work together to discharge the formal regulatory responsibilities of NHSE, in terms of the national oversight framework for NHS Trusts, through regular tripartite review meetings.

NHS England has a statutory duty to undertake annual assessment of ICBs. This is undertaken using the [NHS Oversight Framework](#). The framework is intended as a focal point for joint work, support and dialogue between NHS England, ICBs, providers and their integrated care systems. NHSE oversees the ICB through this framework through quarterly review meetings.

The 2024/2025 Annual Assurance Assessment takes place in April / May 2025. The ICB is responsible for submitting an evidence portfolio to NHS England, demonstrating how the organisation has achieved and continues to work towards providing high quality healthcare, focusing on:

- The health of the local population
- Improving unequal access to services and health outcomes
- The leadership of the BOB system
- Enhancing productivity and increasing value for money
- Broader social and economic development of the system.

By the end of May, NHS England provides feedback on the evidence provided, which is incorporated into the BOB 2025/2026 system plans.

Managing risk

Reducing risk across the health system is a priority for ICB to ensure patients receive high standards of care. Risks are events or scenarios which can hamper the ICB's ability to achieve its objectives. These risks, divided into strategic/principal, corporate and directorate, are identified, assessed and managed by the organisation and reviewed at the ICB Board meeting in public. They are reviewed at Board committee meetings including the Audit and Risk Committee, People Committee, Place and System Development Committee, Population Health and Patient Experience Committee and System Productivity Committee.

There is a regular review of risk through directorates, the bi-monthly Operational Risk Management Group and the ICB's Executive Management Committee (renamed Senior Leadership Group). The ICB Board Assurance Framework and strategic risks is available [here](#).

Dr Nick Broughton
Accountable Officer
20 June 2025

Accountability Report

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 April 2024 to 31 March 2025 including membership and organisation of our governance structures and how they supported the achievement of our objectives.

The **Remuneration and Staff Report** describes our remuneration policies for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

Corporate Governance Report

The names of the Chair and Chief Executive Officer for the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board are:

- Dr Priya Singh, ICB Chair (appointed November 2024)
- Sim Scavazza, Acting Chair (from April 2023 – October 2024)
- Dr Nick Broughton, Chief Executive Officer

Along with the Chair and Chief Executive Officer, the Board comprises five Non-Executive Directors (NEDs), Executive Directors, a Mental Health Member and Partner Members for NHS Trusts and Foundation Trusts, Local Authorities and Providers of Primary Medical Services.

The composition of the board as of 31 March 2025 includes:

- • Dr Priya Singh, ICB Chair – November 2024
- • Sim Scavazza, Acting Chair and Chair of the People Committee (April – October 2024)
- • Dr Nick Broughton, Chief Executive

Non-Executive Directors:

- Saqhib Ali, Chair of Audit and Risk Committee
- Margaret Batty, Chair of the Population Health and Patient Experience Committee
- Tim Nolan, Chair of the System Productivity Committee
- Aidan Rave, Senior Independent Director and Chair of the Place and System Development Committee and the Remuneration Committee
- Sim Scavazza, Deputy Chair and Chair of People Committee

Partner Members:

- George Gavriel, Partner Member – Providers of Primary Medical Services
- Minoo Irani, Mental Health Member - from July 2023 (retired December 2024)
- Grant MacDonald, Mental Health Member – from January 2025
- Steve McManus, Partner Member – NHS Trusts and Foundation Trusts - from August 2023
- Susan Parsonage, Partner Member – local authorities – from January 2025
- Rachael Shimmin, Partner Member – local authorities - from July 2023 (resigned December 2024)

Executive Directors:

- Dr Rachael De Caux, Chief Medical Officer (resigned October 2024)
- Rachael Corser, Chief Nursing Officer
- Alastair Groom, Interim Chief Finance Officer (from February 2025)
- Dr Abid Ifran, Interim Chief Medical Director (from November 2024-February 2025)
- Hannah Iqbal, Chief Strategy, Digital and Transformation Officer
- Matthew Metcalfe, Chief Finance Officer (resigned January 2025)
- Catherine Mountford, Director of Governance (retired June 2024)
- Victoria Otley-Groom, Chief Digital Information Officer (stepped down November 2024)
- Dr Ben Riley, Chief Medical Officer (from March 2025)

Profiles of the board are kept updated removing those Officers who have resigned or retired. The profiles available on the website are correct at time of writing this report are available [here](#)

There are six committees of the ICB Board:

- Audit and Risk Committee
- People Committee
- Place and System Development Committee
- Population Health and Patient Experience Committee
- Remuneration Committee
- System Productivity Committee

Details of the committees can be found in the annual governance statement on page 63.

Register of Interests

The Board members Register of Interests is available on the ICB website [here](#).

Personal data related incidents

There have been no personal data related incidents formally reported to the Information Commissioner's Office.

Modern Slavery Act

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the period ending 31 March 2025 is published on our website and can be found [here](#).

Dr Nick Broughton
Accountable Officer
20 June 2025

Statement of Accountable Officer's Responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Buckinghamshire, Oxfordshire and Berkshire West ICB and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The National Health Service Act 2006 (as amended) states that each Integrated Care Board shall have an Accountable Officer and that Officer shall be appointed by NHS England.

NHS England has appointed Dr Nick Broughton to be the Accountable Officer of Buckinghamshire, Oxfordshire and Berkshire West ICB. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding Buckinghamshire, Oxfordshire and Berkshire West ICB's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that Buckinghamshire, Oxfordshire and Berkshire West ICB's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Dr Nick Broughton
Accountable Officer
20 June 2025

Annual Governance Statement

Introduction and context

Buckinghamshire, Oxfordshire and Berkshire West ICB, hereafter 'the ICB' is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended).

The ICB statutory functions are set out under the National Health Service Act 2006 (as amended).

The ICB's general function is arranging the provision of services for persons for the purposes of the health service in England. The ICB is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population.

Between 1 April 2024 and 31 March 2025 the Integrated Care Board was not subject to any directions from NHS England issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended).

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the ICB's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in the ICB's Accountable Officer Appointment Letter.

I am responsible for ensuring that the ICB is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the ICB as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically, and complies with such generally accepted principles of good governance as are relevant to it.

The main features that support regular monitoring, review and assurance, are the Constitution, which was last updated and approved by NHSE in November 2024. Letter of approval can be found [here](#). Our Constitution and Governance Handbook sets out the arrangements we have made to meet our responsibilities for commissioning care for our patients and the principles we will operate by with our partners. It describes the governing principles, rules and procedures that we operate by to ensure probity and accountability in the day-to-day running of the ICB to ensure that decisions are made in an open and transparent way with the interests of our residents and staff central to our goals and ambitions. The matters reserved to the Board are clearly defined in the Constitution and Scheme of Reservation and Delegation (SoRD), amendments to our schedule of matters reserved for senior officers was approved at our March 2025 Board. Our Governance arrangements are available [here](#).

The Board has met six times in the period of this report. All meetings were quorate, and any conflicts of interest managed in line with policy. A table of members attendance is included in Appendix 1.

The meetings have considered continued development of the ICB governance and its functions, performance and quality, financial performance, development of the ICB operational plan, public engagement, development of arrangements within Place, change programme, re-establishment of the BOB Integrated Care Partnership, and more recently an independent governance review to improve and strengthen its arrangements with a view to a governance refresh of committees in 2025/2026.

The ICB has the following statutory committees:

- Audit and Risk Committee
- Remuneration Committee

It has also established:

- People Committee
- Place and System Development Committee
- Population Health and Patient Experience Committee
- System Productivity Committee

The terms of reference for each of these committees sets out the role and purpose, and have been ratified by the Board. Committee Escalation and Assurance Reports are publicly available as part of the Board meeting papers. As set out in their terms of reference, each committee submits an annual report to the Board giving assurance that they are fulfilling their duties. To support this a committee effectiveness review for each of the committees has also been undertaken during 2024/2025 to improve and strengthen each committee's performance.

The Standing Financial Instructions (SFIs) regulate the proceedings of the ICB, as set out in the Health and Social Care Act 2012 (HSCA). The SFIs, together with the SoRD provide the procedural framework within which the ICB discharges its business.

Board Committees

Audit and Risk Committee

The Audit and Risk Committee ensures that all the ICB's activities are managed in accordance with legislation and regulations governing the NHS; and provides assurance to the Board on governance, risk management and internal control processes ensuring appropriate relationships with both internal and external auditors are maintained.

The Committee's duty is to assure the Board on:

- Other assurance functions
- Counter Fraud
- Financial Reporting
- Freedom to Speak Up
- Information Governance
- Conflicts of Interest
- Emergency Planning, Resilience and Response

The Chair and Chief Executive Officer (CEO), also known as the Accountable Officer, of the ICB may attend any meeting to contribute and gain an understanding of the Committee's operations. Other executive directors attend meetings as requested. Representative(s) of internal audit and

external audit and local counter fraud services attend each meeting. The Agenda of the Audit and Risk Committee is governed by its annual business cycle.

The Committee met 7 times during the period of this report, this was due to resetting of the corporate calendar during Q4 following the appointment of a new ICB Chair. A table of members attendance is included in Appendix 1.

Remuneration Committee

The main purpose of the Remuneration Committee is to exercise the functions of the ICB in relation to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006: set executive pay policy and frameworks; approve executive remuneration and terms of employment. The Committee's duties include:

- Board nominations and appointments
- Executive remuneration policy
- Performance evaluation
- Succession planning
- ICB workforce (members and employees)

The CEO, or nominated deputy, may attend meetings, only when their own remuneration is not being discussed. The Chair may request attendance by other individuals or subject matter experts where necessary.

Due to the ICB change programme the Committee met 6 times during the period of this report. A table of members attendance is included in Appendix 1.

People Committee

Since April 2023 the Chair of the People Committee has also been acting Chair of the ICB until October 2024 when Dr Priya Singh was formally appointed as ICB Chair. During the year 2024/25 the committee have met 5 times to fulfil its duties. There have been several changes in Chief People Officer, and as part of the governance review, the Board determined that the committee as set up, was an amalgamation of both assurance role as well as the system workforce programme board. The committee's duties include:

- ICB People Strategy and Plan including implementation of people priorities aligned to the NHS People Plan and People Promise
- Provide oversight of the development of the ICBs People Strategy, seeking assurance on workforce recruitment, development and retention plans
- ICB workforce matters including compliance with requirements to Equality, Diversity and Inclusion, Health and Safety, Workforce Policies
- Annual reports on ICB health and safety; equality and diversity (Workforce Race Equality Standard, Workforce Disability Equality Standard, Gender pay gap)

The Chair and CEO may attend any meetings of the Committee. Other individuals may be invited to attend as and when appropriate to assist with discussion on particular matters including representatives from workforce related ICS working groups, secondary, mental health and community providers and primary care subject matter experts.

A table of members attendance is included in Appendix 1.

Place and System Development Committee

The Place and System Development Committee provides assurance that our places and system working arrangements across BOB are being developed and fulfil the aims of improving health and wellbeing, reducing health inequalities, increasing system productivity, and supporting local socio-economic development. The duty of the Committee is to assure the board on place and system development.

The Chair of the Committee may invite others to attend if they would bring important perspectives to a particular discussion. The CEO of the ICB may attend any meeting of the Committee and may be invited to attend to gain an understanding of the Committee's operations.

The Committee met 5 times during the period of this report. A table of members attendance is included in Appendix 1.

Population Health and Patient Experience Committee

The Population Health and Patient Experience Committee provides assurance to the Board on service quality and performance, Population Health Management (PHM), and patient and public involvement. The Committee also provides assurance to the Board on governance for quality groups and matrix working.

The Chair and CEO of the ICB may attend any meeting to contribute and gain an understanding of the Committee's operations. Other executive directors or senior officers of the ICB may be required to attend at the Committee's request. Other individuals including representatives from the Health and Wellbeing Board(s), and NHS Providers, may be invited to attend all or part of any meeting to assist it with its discussions on specific matters.

The Committee met 6 times during the period of this report. A table of members attendance is included in Appendix 1.

System Productivity Committee

The System Productivity Committee provides assurance to the Board in relation to the financial sustainability of the system and its partners, and the achievement of system financial and productivity goals. The Committee's duty is to assure the Board on:

- Financial planning and oversight
- Performance against the delivery of the ICB's Strategy and Operational Plan
- System Oversight Framework
- Sustainability and innovation, including digital and procurement

The Chair of the ICB may be invited to attend one meeting each year to gain an understanding of the Committee's operations. Other executive directors or senior officers of the ICB may be required to attend at the request of the Committee.

The Committee met six times during the period of this report. A table of members attendance is included in Appendix 1

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance. However, we have reported on governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code considered relevant to ICBs. For the period covered by this report we complied with the provisions set out in the Code and applied the principles of the Code.

Discharge of Statutory Functions

The ICB has reviewed all of the statutory duties and powers conferred to it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that the ICB is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions. Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake the ICB's statutory duties. To strengthen this the ICB Board have undertaken an independent governance and partnership review to ensure arrangements are both effective and appropriate.

Risk management arrangements and effectiveness

The Audit and Risk Committee (ARC) have approved a Risk Management Framework (RMF) in June 2024 and overseen the internal management and development of the ICB Board Assurance Framework (BAF) and ICB Corporate Risk Register (CRR). This has been supported through regular reporting to Board public meetings, with emphasis on mitigating key strategic and emerging risks; based around the Integrated Care System (ICS) four core goals and NHSE Oversight Framework Themes.

The ICB is committed to a risk framework that minimises and/or accepts risks to the organisation, staff and patients and stakeholders through a comprehensive system of internal control, while providing maximum potential for flexibility, innovation and best practice in delivery of its core objectives. The ICB works to all applicable legislation and NHS guidance, and where risk forms a part of the ICB's work, this is assessed and recorded on the ICBs strategic and operational risk registers.

The ICB has a comprehensive and established approach to risk management, which for this financial year has been assessed by internal audit as 'Significant assurance with minor improvement opportunities. The ICB maintains risk registers for all identified and emerging risks (horizon scanning) which are linked to the relevant element of the ICB's Corporate Objectives/its four goals/NHSE oversight themes. A 5 x 5 risk scoring matrix is applied to all risks; the impact and likelihood of all risks are regularly assessed; and the actions and controls assigned to each risk are scored and weighted, identifying gaps in controls and providing additional assurance in the mitigation of risk. This ensures that risks across different functions (e.g. finance, patient safety, data security) are objectively rated and assessed as part of the internal risk governance review process.

The full Board Assurance Framework and Corporate Risk Register are reviewed no less than six times a year at Executive Management Committee (now Senior Leadership Team (SLT)) and Audit and Risk Committee, as delegated by Board. All risks recorded on the Registers are assigned to one of the ICB's Chief Officers, a Risk Owner who is an Officer within the ICB and are supported by a directorate Risk Coordinator/Lead who is a member of the Operational Risk Management Group (ORMG), which meets no less than six times a year in line with the cadence of our corporate calendar. Risks are reviewed at least monthly by directorate leads/risk owners, with particular focus on the length of time a risk has remained at its current risk score; the effectiveness of the controls and actions in place, and the links between individual risks across multi-disciplined areas is reported along with its assurance rating.

In 2024/25 Committees reporting into Board received regular reports (bi-monthly) providing relevant assurances regarding the risk process that is embedded within BOB ICB through the Risk Management Framework to consider the activities undertaken across all business areas within the reporting period.

Capacity to Handle Risk

All ICB staff are involved in risk management – the Chief Officers have responsibility to approve risks onto the ICB corporate risk register and the Board approves those risks on the Board Assurance Framework. Senior managers as risk-owners have responsibility for ensuring that risks are operationally managed, and risk coordinators have responsibility for everyday management of risks, recording and updating agreed controls, actions and assurances.

Guidance on risk management and frequency of training is contained in the ICB's Risk Management Framework, Handbook, training library, and staff intranet. The ICB has a Senior Governance Manager who supports the Director of Governance in providing advice and guidance to the executive team as well as training and guidance to the risk coordinators and all other staff members.

The Board is assured of the effectiveness of risk management within the ICB by the Audit and Risk Committee (ARC). ARC receives regular reports on risk and assurances and/or recommendations from its internal auditors. The Audit and Risk Committee Chair includes areas for alert, advice and assurance as part of the chairs report to the Board.

To manage its risks effectively, and in line with its Risk Management Framework, we have enhanced the fully embedded Risk Management Reporting System (4Risk), enabling risk management and reporting across the organisation. The management and evaluation of risk are now fully embedded within our core business decisions and transactions and assists in the identification, preventing and deterring of risks in relation to fraud. We are further strengthening our approach to risk management by recommending and undertaking targeted deep dives across directorates which are reported to the relevant Committee.

Risk management governance is overseen by a series of meetings at Directorate, Senior Management and Executive; allowing for comprehensive discussion, risk reporting, sharing and highlighting of areas of good practice and 'lessons learnt'; and are reported into the Audit and Risk Committee and then to Board.

Directorate/team risks to be escalated to the Corporate Risk Register require Executive approval, as does any recommended change in risk score. Risks escalated to the Corporate Risk Register will result in a risk score change in agreement with the relevant Directorate Executive/Senior Leadership Team, these are discussed at Senior Leadership Team (previously Executive Management Committee) in line with the agreed risk reporting schedule outlined in the Risk Management Framework policy.

The management and process supporting risk is overseen and supported by the Governance Team. The Governance Team co-ordinate production of risk reports, offer advice and carry out training, organise and facilitate the Operational Risk Management Group's (ORMG) agenda, and will work with designated risk owners and Executive Directors in the management of risk.

Discussions with our system partners are in development in relation to management of system risk, to ensure that the ICB is cognisant of those risks in common which may impact the ICB, specifically on delivery of services, workforce, finance and reputation.

Risk Assessment

ICB staff are responsible for their risks and for maintaining risk awareness and identifying and reporting risks via an agreed reporting route. Staff ensure they familiarise themselves with the Risk Management Framework and Handbook and undertake risk management training appropriate to their role.

The Operational Risk Management Group (ORMG) has been put in place to provide a wider organisational oversight and review of risk to ensure alignment and consistency of risk rating, review any directorate risks for escalation to the Corporate Risk Register and make recommendations to the Senior Leadership Team. The Group's duties, authority, accountability, and reporting is defined within its Terms of Reference (ToR). The Governance Risk Management Leads with support from governance oversee the management of risk ensuring risks are being reviewed in a timely and structured fashion and adhere to the organisational reporting cycle (Operational Risk Management Group/Senior Leadership Team/Audit and Risk Committee/Committees reporting into Board/Board).

The ICBs risk appetite is outlined in its [risk management framework](#) (section 5). The ICB supports well managed risk taking and will ensure that the skill, ability, and knowledge is in place to support innovation and maximise opportunities to improve its service.

The Board Assurance Framework (BAF) sets out the principal risks to the achievement of the ICB's strategic objectives and is a practical means through which the Board can assess controls against delivery. The BAF is a primary source of evidence in describing how the ICB is discharging its responsibilities for internal control. The BAF sets out the controls and gaps in controls and assurance in place to manage these risks and the assurances available to support judgements on whether the controls are having the desired impact and describes the actions to further reduce each risk against its applied risk appetite.

The ICB currently holds nine risks on the Board Assurance Framework and 32 open risks on the Corporate Risk Register as at time of writing this report.

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the ICB, to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

Conflicts of interest management

The ICBs conflict of interest (including sponsorship, gifts and hospitality) policy can be found [here](#) and forms part of our governance handbook requirements. This policy was reviewed in May 2024 and approved by the Audit and Risk Committee.

BOB ICB has embedded a comprehensive Conflict of Interest management process within BOB which seeks to: provide annual (minimum) conflict of interest review reminders; publication of [Register of Interests](#) on the BOB ICB website; New starter and Leaver process; and reminders and information relating to the declaration of Gifts, Hospitality & Sponsorship.

During February 2024 NHS England provided national e-learning modules on managing conflicts of interest in the context of the new ICB arrangements. In January 2025, NHS England made available modules 2 and 3 for ICBs. These additional modules will complement module 1 (already in place) aimed at all staff and committee/board members. The ICB during 2025/26 will further revise its conflicts of interest policy to incorporate the recently published guidance. No conflict of interest audits were undertaken during 2024/25 and there are no scheduled audits of our management of conflicts of interest for 2025/26.

Governance and Partnership Review

In line with good practice and as part of our constitutional requirements we have independently reviewed our governance arrangements with support from the Good Governance Institute during 2024/25. The areas considered included reviewing the skills, knowledge and experience necessary for the board to effectively carry out its functions. The review also considered whether the ICB committee structure remains appropriate to deliver the needs of the organisation. As a result of the review the Board identified that a governance refresh was required, given the recent announcement from NHS England on the future of ICBs within the context of the 10 Year Health Plan, this is planned for early 2025/26.

Data Quality

A data quality group has been established across the ICB to standardise data collection and reporting. This will give us a more accurate and equitable picture across our providers, highlighting inequalities in care dependent on geography and allowing the correct interventions in the right place to ensure better outcomes for our population.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees particularly personal identifiable information. The NHS Information Governance Framework is supported by the Data Security and Protection Toolkit (DSPT) and the annual submission process provides assurances to the ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

The ICB places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have developed information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities. There are processes in place for incident reporting and investigation of serious incidents. Information governance is reported to the Audit and Risk committee as a standing agenda item and is reviewed regularly through the Information Governance Steering Group.

The ICB has also established an ICS information Governance Steering Group which is made up of health and social care, strengthening the matrix working and knowledge of IG and EIR functions across the BOB geography and an ability to do things consistently and once where we can.

The ICB submitted its Data Security and Protection Toolkit (DSPT) submission in June 2024 'standards exceeded'. We are building on this work for the new Cyber Assessment Framework DSPT for our June 2025 submission. This new DSPT introduced by NHS England enables organisations to have better understanding and ownership of information risk, effectiveness of practices, and creates opportunities for better practice. In this first year of introduction NHS England only expect organisations to achieve 'standards met'.

Business Critical Models

The ICB is aware of the Macpherson Report on government business critical models and quality assurance mechanisms, and of its findings. The ICB does not operate any business-critical models as defined in the report.

Third party assurances

Where the ICB relies on third party providers, it gains assurance through service level agreements and contract specifications; regular review meetings with providers on multiple levels; the use of performance data and external regulatory inspection reports; and monitoring and review by appropriate programme boards and committees. Third party assurances are reported to the Audit and Risk Committee and informs this governance statement and external audit conclusion.

Control Issues

Despite seeing improvements across multiple programme areas through 2024/2025, performance against national constitutional standards remains under pressure, particularly in relation to access to services/capacity such as urgent and emergency care and average waiting times for autism and attention deficit hyperactivity disorder (ADHD); cancer performance with regards those patients waiting over 62 days for treatment, and elective long waiters with 195 patients waiting over 65 weeks at the end of March 2025 (*latest unvalidated weekly figures as at 3 April 2025*)

97.4% of the 171,822 patients on BOB Acute waiting list were treated within the year which does mean 4,557 patients are still to be treated. This time last year there were over 6,500 patients waiting over 52 weeks. (*latest unvalidated weekly figures as at 3 April 2025*)

Performance is affected by physical capacity constraints and workforce shortages, and the ICB is working alongside its partner colleagues to look at improved ways of working e.g. Royal Berkshire Foundation Trust providing mutual aid to Oxford University Hospital Foundation Trust to support in specialties where demand is outstripping capacity.

Ambulance handover times have, on average, reduced over the past year and Category 2 response times have consistency been under 30 mins since January 2025. The System and South Central Ambulance Service have committed to delivering sub 30 min response times in 2025/2026 continuing to reduce handover delays through the provision of queue nurses and instigation of Hospital Ambulance Liaison Officers where required, opening of additional capacity, and ensuring senior decision making is available. Trusts are continuing to support each other with their requests for mutual aid where appropriate, through the elective care programme and speciality level task and finish groups. The ICB has continued its focus on access this year delivering against our Primary Care Access and Recovery Plan and working with system partners and the public to build and engage on a primary care strategy to further develop our primary care services.

More detail around our financial position can be found in the accounts section of this report on page 52 and also on page 107 (Annual Accounts 2024/25).

Review of economy, efficiency & effectiveness of the use of resources

The ICB has established systems and processes for managing its resources effectively, efficiently, and economically. The Board has an overarching responsibility for ensuring the ICB has appropriate arrangements in place, and delegates responsibilities to its Committees. The Chief Finance Officer - interim (CFO) has delegated responsibility to determine arrangements to ensure a sound system of financial control. An audit programme is followed to ensure that resources are used economically, efficiently, and effectively. The Audit and Risk Committee reviews and monitors the ICB's financial reporting and internal control principles; to ensure the ICB's activities are managed in accordance with legislation and regulations governing the NHS; and to ensure that appropriate relationships are maintained with internal and external auditors. The System Productivity Committee monitors contract and financial performance, savings plans and overall use of resources; it provides assurance to the Board in relation to the financial sustainability of the system and its partners, and the achievement of system financial and productivity goals. The ICB has a process in place to secure economy, efficiency and effectiveness through its procurement, contract negotiation and contract

management processes. Effectiveness is monitored specifically through the quality processes. The Chief Finance Officer - interim meets regularly with the ICB's finance teams and holds monthly meetings with the finance leads to review month-end reporting. Regular meetings are also held with system partners' finance leads (CFOs and Deputy CFOs). The ICB informs its control framework by the work of Internal and External Audit. The ICB's external auditors are required to satisfy themselves that the ICB has made proper arrangements for securing economy, efficiency, and effectiveness in the use of its resources. Their audit work is made available to and reviewed by the Audit and Risk Committee and the Board.

Commissioning of delegated specialised services

NHS Buckinghamshire, Oxfordshire and Berkshire West ICB signed a Delegation Agreement (DA) and Collaboration Agreement (CA) with NHS England and held full commissioning responsibilities for delegated services during the 2024/2025 reporting period. This was at our March 2025 Board in public.

To the best of ICB leadership's knowledge, the commissioning of all delegated services has been compliant with the 10 core commissioning requirements – as set out in the 2024/2025 Delegated Commissioning Assurance Guidance, published by NHS England – including the requirement that all conditions set out in the DA are being met.

Where there were known compliance issues, the ICB leadership either directly as an individual ICB, or collectively with other ICBs (e.g. through multi-ICB working arrangements, where relevant) has engaged with NHS England's regional leadership to notify and address such issues in a timely manner.

The ICB leadership is able to provide the necessary evidence of core commissioning requirements compliance should NHS England or a third party (e.g. external auditors) ask for such evidence.

Delegation of ICB functions

The ICB's [SoRD](#) outlines the control mechanisms in place for delegation of functions and is found in the [Governance Handbook](#). The Board receives reports from each of its committees detailing the delivery of work, and associated risks, within their specific remit. Additionally, the Board maintains a high-level overview of the organisation's business and identifies and assesses risks and issues straddling committees. These risks are owned and overseen at Board level and scrutinised at each meeting in public to ensure appropriate management and reporting is in place. Internal Audit is used to provide an in-depth examination of any areas of concern and/or to highlight any gaps in systems of internal control.

Counter fraud arrangements

Our counter fraud provision is provided by TIAA, who are our independent accredited counter fraud specialists, for Buckinghamshire, Oxfordshire and Berkshire West. These arrangements are aligned with the following NHS required standards for counter fraud provision which can be found [here](#).

The counter fraud service has assisted with several areas of fraudulent activity, and these have been investigated appropriately. There have been two investigations from previous financial years which have continued during 2024/2025.

Counter fraud arrangements: The ICB is committed to reducing the risk from fraud and corruption and discharges its counter fraud responsibilities locally through its appointed Local Counter Fraud Specialist (LCFS) provided by TIAA who acts as the "first line of defence" against fraud, bribery, and corruption, working closely with the ICB and the NHS Counter Fraud Authority (CFA). The Chief Finance Officer is the Executive Lead for counter fraud. The ICB has a Local Anti-Fraud, Bribery and Corruption Policy.

The ICB has a range of policies and procedures in place to identify and respond to risks of fraud, bribery and corruption, including an “Anti-fraud, bribery and corruption policy and procedure”; “Conflicts of interest policy and procedure”; “Standing Financial Instructions”, “Risk management policy and procedure”, and “Freedom to speak up: raising concerns” as well as policies relating to, for example, employee verification checks etc. Such policies are available to all staff via the Trust’s Intranet system.

Fraud awareness material, including fraud alerts and information on bribery, is regularly circulated to ICB staff. Fraud referrals are investigated by the LCFS, and the progress and results of investigations are reported to the Chief Finance Officer and the Audit Committee. The Audit Committee receives an anti-crime progress report at four meetings.

In addition, the ACS undertakes a programme of work for the organisation which aims to prevent, deter, and detect fraudulent activity in accordance with the Government Functional Standard – Counter Fraud (GFS) as set out by the NHS Counter Fraud Authority (NHSCFA) 12 NHS Requirements. The outcomes of the work are reported to the Audit Committee, no less than annually, which in turn provides a summary report on its own activity to the ICB Board to maintain and improve compliance and performance against each of the standards which is assessed on an annual basis. The ICB also participates in the National Fraud Initiative Exercise now run by the Cabinet Office which is a mandatory exercise that matches electronic data within and between public and private sector bodies to prevent and detect fraud. The exercise has been run every two years since 1996.

Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1 April 2024 to 31 March 2025 for the ICB, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB’s system of risk management, governance and internal control.

The purpose of our HoIA Opinion is to contribute to assurances available to the Accountable Officer and the Board which underpin the Board’s own assessment of the effectiveness of the system of internal control. This Opinion will in turn assist the Board in the completion of its AGS and may be taken into account by regulators to inform their conclusions.

The opinion does not imply that the HoIA has covered all risks and assurances relating to the Trust. The opinion is derived from the conduct of risk-based plans generated from a robust and Management-led Assurance Framework. As such it is one component that the Board takes into account in making its AGS.

The Head of Internal Audit concluded that:

Opinion

Our opinion is set out as follows: Basis for the opinion; Overall opinion; and Commentary.

Basis for the opinion

The basis for forming our opinion is as follows:

- An assessment of the range of individual assurances arising from contemporary core reviews of financial systems, governance, risk management and data quality;

- An assessment of the range of individual assurances arising from our risk-based internal audit assignments that have been reported throughout the period. This assessment has taken account of the relative materiality of these areas; and
- An assessment of the implementation status of prior year actions raised from internal audit assignments. This assessment has taken account of the severity and nature of actions raised.

Overall opinion:

- Our overall opinion for the period 1 April 2024 to 31 March 2025 is that:
- **‘Significant assurance with minor improvement opportunities’** can be given on the overall adequacy and effectiveness of the organisation’s framework of governance, risk management and control.

Commentary:

On the basis of our work outlined below, we have concluded that our overall opinion for the period 1 April 2024 to 31 March 2025 is that ‘Significant assurance with minor improvement opportunities’ can be given on the overall adequacy and effectiveness of the organisation’s framework of governance, risk management and control.

The range of individual assurances arising from contemporary core reviews of financial systems, governance, risk management and data quality

Of the core reviews that influence the overall Head of Internal Audit Opinion we issued a ‘significant assurance’ report in relation to our core review of governance (Primary Care Commissioning) and ‘significant assurance with minor improvement opportunities’ in relation to our core reviews of Risk Management and Core Financial Controls. There has been one ‘partial’ report in relation to Data Security and Protection Toolkit 2024/25, and ‘no assurance’ opinions issued in 2024/25 in relation to our core reviews.

The range of individual opinions arising from risk-based audit assignments, contained within our risk-based plan that have been reported throughout the year

To date for risk-based reviews one ‘partial’ assurance report has been issued. There have been no ‘no assurance’ opinions issued in 2024/25 in relation to risk-based audit assignments. Two risk-based reports were advisory in nature and not rated. The partial assurance report relates to Fit & Proper Person Tests.

The implementation status of prior year actions raised from internal audit assignments

The ICB has implemented all eight recommendations raised in the period 2024/25.

No actions from the prior year remain outstanding.

We have therefore issued a **‘Significant assurance with minor improvement opportunities’** opinion overall.

Please note: We are yet to conclude the risk-based reviews of Continuing Healthcare; and Prescribing.

During the period, Internal Audit issued the following audit reports:

Area of Audit	Level of Assurance Given
01/24: Data Security and Protection Toolkit (DSPT)	Significant assurance with minor improvements
02/24: Independent Sector Controls	Review not rated
03/24: Annual Contracting	Review not rated
04/24: Core Financial Controls	Significant assurance with minor improvements
05/24: Risk Management	Significant assurance with minor improvements
06/24: Primary Care Commissioning (Governance)	Significant assurance
07/24: Fit and Proper Persons Test (FPPT)	Partial assurance with improvements required
08/24: Prescribing	Not due
09/24: Continuing Healthcare	Not due
10/24: Cyber Assurance Framework 2024/25	Partial assurance with improvements required

Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the ICB who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the ICB achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of this review by:

- The Board
- The audit committee
- If relevant, the risk / clinical governance / quality committee
- Internal audit
- Other explicit review/assurance mechanisms.

The role and conclusions of each were as outlined in this annual governance statement as part of the Head of internal audit opinion.

Conclusion

No significant internal control issues have been identified

Dr Nick Broughton
Accountable Officer
20 June 2025

Remuneration Report

Remuneration Committee

Each Integrated Care Board has a Remuneration Committee, the role of the committee is to set executive pay policy and frameworks; approve executive remuneration and terms of employment. Details of memberships and terms of reference of the committee are available in the ICB's Governance Handbook, for ease the link to the Remuneration Committee Terms of Reference is available [here](#).

Policy on the remuneration of senior managers

Senior managers' remuneration is set through a process that is based on a consistent framework and independent decision-making based on accurate assessments of the weight of roles and individuals' performance in them. This ensures a fair and transparent process via bodies that are independent of the senior managers whose pay is being set. No individual is involved in deciding his or her own remuneration. Executive senior managers are ordinarily on permanent NHS contracts. The length of contract, notice period and compensation for early termination are set out in the Agenda for Change, NHS terms and conditions of service handbook.

Policy on the remuneration of very senior managers

All very senior manager remuneration (VSM) is determined by the ICB's Remuneration Committee based on available national guidance, benchmarking data against other ICBs and with due regard for national pay negotiations/awards for NHS staff on national terms and conditions. The Remuneration Committee is also cognisant of public sector pay restraint and its responsibility to ensure that executive pay remains publicly justifiable. The Remuneration Committee acknowledges and commits to complying with the requirement to seek pre-approval from NHS England for salaries in excess of £150,000.

Percentage change in remuneration of highest paid director

Percentage Changes	24/25	23/24	Change	% Change
Highest paid director				
Salary and Allowances	262,500	247,500	15,000	6.06%
Performances and bonuses	0	0	0	N/A
Employees of the entity taken as a whole (Average)				
Salary and Allowances	63,920	61,840	2,080	3.36%
Performances and bonuses	0	0	0	N/A

Pay ratio information

The banded remuneration of the highest paid director / member in the BOB ICB in the reporting period 1 April 2024 to 31 March 2025 was £260,000 - £265,000 on an annualised basis.

The relationship to the remuneration of the organisation's workforce is disclosed in the table below.

2024/25	25 th percentile	Median pay ratio	75 th percentile pay ratio
Total remuneration (£)	44,962	55,200	72,538
Salary component of total remuneration (£)	44,962	55,200	72,538
Pay ratio information	5.84	4.76	3.62

2023/24	25 th percentile	Median pay ratio	75 th percentile pay ratio
Total remuneration (£)	42,618	52,359	71,280
Salary component of total remuneration (£)	42,618	52,359	71,280
Pay ratio information	5.81	4.73	3.47

During the reporting period 1 April 2024 to 31 March 2025 no employees received remuneration in excess of the highest-paid director/member. Remuneration ranged from £8,000 to £265,000. Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. The ICB Year-on-Year ratio variance is below.

Year on Year Pay ratio variance %	0%	1%	4%
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Senior manager remuneration (including salary and pension entitlements) 2024/25

Name	Title	BOB ICB Salary (Bands of £5,000) £000	Expense payments (taxable) (Rounded to the nearest £100) * £00	Performance Pay and bonuses (Bands of £5,000) £000	Long Term performance pay and bonuses (Bands of £5,000) £000	All Pension related benefits (bands of £2,500) † £000	Total (Bands of £5,000) £000
Nick Broughton (**)	Chief Executive 01-10-2024 (interim Chief Exec to 30-09-2024)	255-260	10	0-5	0-5	0-2.5	255-260
Alastair Groom (**)	Turnaround/Finance Improvement Officer/Interim Chief Financial Officer (from 17-02-2025)	175-180	0	0-5	0-5	0-2.5	175-180
Matthew Metcalfe (**)	Chief Financial Officer	165-170	0	0-5	0-5	55-57.5	220-225
Abid Irfan (**)	Interim Chief Medical Officer and Director of Primary Care	35-40	0	0-5	0-5	0-2.5	35-40
Priya Singh (**)	NED – Chair	25-30	0	0-5	0-5	0-2.5	25-30
Rachael DeCaux (**)	Deputy CEO & Chief Medical Officer	125-130	0	0-5	0-5	0-2.5	125-130
Rachael Corser	Chief Nursing Officer	160-165	11	0-5	0-5	10-12.5	175-180
Catherine Mountford (**)	Director of Governance	40-45	0	0-5	0-5	0-2.5	40-45
Clare Doble (**)	Director of Governance	70-75	0	0-5	0-5	30-32.5	105-110
Minoo Irani (**) (***)	Member for Mental Health	0-5	0	0-5	0-5	0-2.5	0-5
Ben Riley (**)	Chief Medical Officer	10-15	0	0-5	0-5	55-57.5	70-75
Rachael Shimmin (***)	Partner member – Local Authorities	0-5	0	0-5	0-5	0-2.5	0-5
Grant MacDonald (**) (***)	Member for Mental Health	0-5	0	0-5	0-5	0-2.5	0-5
George Gavriel	Partner member – Primary medical services	20-25	0	0-5	0-5	0-2.5	20-25
Steve McManus (***)	Partner member – NHS and Foundation Trusts	0-5	0	0-5	0-5	0-2.5	0-5
Susan Parsonage (**) (***)	Partner member – Local Authorities	0-5	0	0-5	0-5	0-2.5	0-5
Matthew Tait	Chief Delivery Officer	160-165	14	0-5	0-5	25-27.5	190-195
Caroline Corrigan (seconded from Frimley ICB) (**)	Interim Chief People Officer	50-55	3	0-5	0-5	67.5-70	120-125
Victoria Otley-Groom (**)	Chief Digital and Information Officer	100-105	0	0-5	0-5	55-57.5	160-165
Hannah Iqbal	Chief Strategy Officer	140-145	3	0-5	0-5	37.5-40	180-185
Sandra Grant (**)	Chief People Officer	40-45	0	0-5	0-5	10-12.5	50-55
Tim Nolan	NED	15-20	2	0-5	0-5	0-2.5	15-20
Aidan Rave	NED - Acting Deputy Chair	15-20	0	0-5	0-5	0-2.5	15-20
Margaret Batty (Aston)	NED	15-20	0	0-5	0-5	0-2.5	15-20
Saqhib Ali	NED	15-20	2	0-5	0-5	0-2.5	15-20
Sim Scavazza (**)	NED from 01-10-2024 (previously acting Chair to 30-09-2024)	45-50	1	0-5	0-5	0-2.5	45-50

Note:

*Taxable expenses and benefits in kind are expressed to the nearest £100. The values and bands used to disclose sums in this table are prescribed by the Cabinet Office through Employer Pension Notices and replicated in the HM Treasury Financial Reporting Manual.

**

- Nick Broughton held the role as Interim Chief Executive Officer up to 30 September 2024 and a substantive CEO from October 2024
- Alastair Groom joined the ICB as Turnaround Director in April 2024 and Interim Finance Chief Officer from 17 February 2025
- Matthew Metcalfe stepped down as Chief Finance Officer on 16 February 2025
- Rachael DeCaux left the ICB as Chief Medical Officer in November 2024
- Abid Irfan Interim Chief Medical Officer from 1 Dec 2024 to 2 March 2025
- Ben Riley joined the ICB as Chief Medical Officer in March 2025
- Catherine Mountford left the ICB as Director of Governance in July 2024
- Clare Doble joined the ICB as Director of Governance in August 2024
- Minoo Irani left the ICB as Member for Mental Health in December 2024
- Grant MacDonald join the ICB as Member for Mental Health in January 2025
- Rachael Shimmin left the ICB as partner Member – Local Authority in January 2025
- Susan Parsonage joined the ICB as Partner Member – Local Authority in February 2025
- Caroline Corrigan left the ICB as Interim Chief People Officer in December 2024
- Sandra Grant joined the ICB as Chief People Office in January 2025
- Victoria Otley-Groom stepped down as Chief Digital and Information Office in November 2024
- Priya Singh joined the ICB as NED Chair in October 2024
- Sim Scavazza interim NED Chair to 30 September 2024

Minoo Irani, Rachael Shimmin, Grant MacDonald, Steve McManus and Susan Parsonage receive no remuneration from BOB ICB.

† During the reporting period, the following members held the role part year and proportioning the real increase pension for the part year role, the disclosure of the Pension related benefit will be as follows:

- Matthew Metcalfe - 45-47.5
- Clare Doble - 17.5-20
- Ben Riley - 2.5-5
- Caroline Corrigan (seconded from Frimley ICB) - 15-17.5
- Victoria Otley-Groom -32.5-35
- Sandra Grant - 0-2.5

The ICB had no interim roles held by more than one person.

Senior manager remuneration (including salary and pension entitlements) 2023/24

Name	Title	BOB ICB Salary (Bands of £5,000) £000	Expense payments (taxable) (Rounded to the nearest £100) * £00	Performance Pay and bonuses (Bands of £5,000) £000	performance pay and bonuses (Bands of £5,000) £000	All Pension related benefits (bands of £2,500) £000	Total (Bands of £5,000) £000
Steve McManus (**)	Chief Executive (Interim)	55-60	0	0-5	0-5	0-2.5	55-60
Steve McManus (***)	Partner member – NHS and Foundation Trusts	0-5	0	0-5	0-5	0-2.5	0-5
Nick Broughton	Member for Mental Health	0-5	0	0-5	0-5	0-2.5	0-5
Nick Broughton (**)	Chief Executive (Interim)	180-185	0	0-5	0-5	0-2.5	180-185
Matthew Metcalfe (**)	Chief Financial Officer	180-185	0	0-5	0-5	45-47.5	225-230
Javed Khan (**)	NED – Chair (extended leave)	65-70	0	0-5	0-5	0-2.5	65-70
Sim Scavazza	NED – Acting Chair	70-75	1	0-5	0-5	0-2.5	70-75
Rachael DeCaux	Deputy CEO & Chief Medical Officer	180-185	1	0-5	0-5	282.5-285	465-470
Rachael Corser	Chief Nurse	155-160	11	0-5	0-5	25-27.5	185-190
Catherine Mountford	Director of Governance	120-125	1	0-5	0-5	0-2.5	125-130
Minoo Irani (***)	Member for Mental Health	0-5	0	0-5	0-5	0-2.5	0-5
Neil McDonald (**)	Partner member – NHS and Foundation Trusts	0-5	0	0-5	0-5	0-2.5	0-5
Rachael Shimmin (***)	Partner member – Local Authorities	0-5	0	0-5	0-5	0-2.5	0-5
Stephen Chandler (**)	Partner member – Local Authorities	0-5	0	0-5	0-5	0-2.5	0-5
George Gavriel (**)	Partner member – Primary medical services	10-15	0	0-5	0-5	0-2.5	10-15
Shaheen Jinah (**)	Partner member – Primary medical services	0-5	0	0-5	0-5	0-2.5	0-5
Karen Beech (**)	Acting Chief People Officer	50-55	0	0-5	0-5	0-2.5	50-55
Matthew Tait	Chief Delivery Officer	155-160	13	0-5	0-5	0-2.5	155-160
Ross Fullerton (**)	Interim Chief Digital & Information Officer	90-95	0	0-5	0-5	0-2.5	90-95
Nick Samuels (**)	Interim Director of Communications and Engagement	60-65	0	0-5	0-5	0-2.5	60-65
Raj Bhamber (seconded from NHSE) (**)	Interim Chief People Officer	0-5	0	0-5	0-5	0-2.5	0-5
Caroline Corrigan (seconded from Frimley ICB) (**)	Interim Chief People Officer	20-25	0	0-5	0-5	37.5-40	60-65
Victoria Otley-Groom (**)	Chief Digital and Information Officer	60-65	0	0-5	0-5	0-2.5	60-65
Hannah Iqbal (**)	Chief Strategy Officer	70-75	0	0-5	0-5	40-42.5	110-115
Rob Bowen (**)	Acting Director of Strategy and Partnerships	60-65	0	0-5	0-5	42.5-45	105-110
Tim Nolan	NED	15-20	1	0-5	0-5	0-2.5	15-20
Aidan Rave	NED - Acting Deputy Chair	15-20	0	0-5	0-5	0-2.5	15-20
Margaret Batty (Aston)	NED	15-20	0	0-5	0-5	0-2.5	15-20
Saqhib Ali	NED	15-20	2	0-5	0-5	0-2.5	15-20

Note:

*Taxable expenses and benefits in kind are expressed to the nearest £100. The values and bands used to disclose sums in this table are prescribed by the Cabinet Office through Employer Pension Notices and replicated in the HM Treasury Financial Reporting Manual.

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- Haider Hussain stopped being Associate NED in March 2023

- Nick Broughton joined the ICB as Interim Chief Executive Officer in July 2023
- Matthew Metcalfe joined the ICB in April 2023
- Victoria Otley-Groom joined the ICB in October 2023
- Hannah Iqbal joined the ICB in September 2023
- Steve McManus was Interim Chief Executive Officer from April 2023 to June 2023
- Steve McManus joined the ICB as Partner member in July 2023
- Raj Bhambher joined the ICB on secondment from NHSE from August 2023 to October 2023
- Caroline Corrigan joined the ICB on secondment in November 2023
- Shaheen Jinah left the ICB as Partner member in June 2023
- Neil McDonald left the ICB as Partner member in June 2023
- Stephen Chandler left the ICB as partner member in June 2023
- Rob Bowen stepped down from the Board in September 2023
- Minoo Irani joined the ICB in July 2023
- Rachael Shimmin joined the ICB as Partner member in July 2023
- George Gavriel joined the ICB as Partner member in July 2023
- Nick Samuels left the ICB in August 2023
- Ross Fullerton left the ICB in November 2023
- Karen Beech left the ICB in August 2023

*** Steve McManus, Minoo Irani and Rachael Shimmin receives no remuneration from BOB

ICB Interim Roles held by more than one person.

1. Interim Chief People Officer on secondment handled by Raj Bhambher (NHSE) and Caroline Corrigan (Frimley ICB)

Pension benefits 2024/25

Name	Title	Real increase in pension at pension age (bands of £2,500) £'000	Real increase in pension lump sum at pension age (bands of £2,500) £'000	Total accrued pension at pension age at 31 March 2025 (bands of £5,000) £'000	Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1st April 2024 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2025 £'000	Employer's contribution to stakeholder pension £'000
Nick Broughton (**)	Chief Executive 01-10-2024 (interim Chief Exec to 30-09-2024)	0-2.5	0-2.5	75-80	225-230	1,950	0	1,983	0
Matthew Metcalfe (**)	Chief Financial Officer	2.5-5	0-2.5	25-30	0-5	340	41	432	0
Rachael DeCaux (**)	Deputy CEO & Chief Medical Officer	0-2.5	0-2.5	50-55	130-135	1,001	0	1,078	0
Rachael Corser	Chief Nursing Officer	0-2.5	0-2.5	50-55	120-125	944	10	1,038	0
Catherine Mountford (**)	Director of Governance	0-2.5	0-2.5	55-60	150-155	80	0	0	0
Clare Doble (**)	Director of Governance	0-2.5	0-2.5	40-45	105-110	818	21	918	0
Ben Riley (**)	Chief Medical Officer	0-2.5	0-2.5	20-25	20-25	271	2	335	0
Matthew Tait	Chief Delivery Officer	0-2.5	0-2.5	60-65	150-155	1,279	33	1,418	0
Caroline Corrigan (seconded from Frimley ICB) (**)	Interim Chief People Officer	0-2.5	0-2.5	35-40	0-5	512	15	618	0
Victoria Otley-Groom (**)	Chief Digital and Information Officer	0-2.5	0-2.5	30-35	20-25	523	120	756	0
Hannah Iqbal	Chief Strategy Officer	2.5-5	0-2.5	15-20	0-5	167	16	212	0
Sandra Grant (**)	Chief People Officer	0-2.5	0-2.5	0-2.5	0-5	0	0	13	0

Pension benefits 2023/24

Name	Title	Real increase in pension at pension age (bands of £2,500) £'000	Real increase in pension lump sum at pension age (bands of £2,500) £'000	Total accrued pension at pension age at 31 March 2024 (bands of £5,000) £'000	Lump sum at pension age related to accrued pension at 31 March 2024 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1st April 2023 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2024 £'000	Employer's contribution to stakeholder pension £'000
Matthew Metcalfe (**)	Chief Financial Officer	2.5-5	0-2.5	20-25	0-5	229	63	340	0
Rachael DeCaux	Deputy CEO & Chief Medical Officer	10-12.5	75-77.5	45-50	130-135	487	441	1,001	0
Rachael Corser	Chief Nurse	0-2.5	45-47.5	45-50	115-120	632	228	944	0
Catherine Mountford	Director of Governance	0-2.5	2.5-5	55-60	150-155	94	0	80	0
Karen Beech (**)	Acting Chief People Officer	0-2.5	0-2.5	10-15	0-5	179	0	222	0
Matthew Tait	Chief Delivery Officer	0-2.5	35-37.5	50-55	145-150	1,043	110	1,279	0
Caroline Corrigan (seconded from Frimley ICB) (**)	Interim Chief People Officer	0-2.5	0-2.5	30-35	0-5	378	19	512	0
Victoria Otley-Groom (**)	Chief Digital and Information Officer	0-2.5	0-2.5	25-30	20-25	503	0	523	0
Hannah Iqbal (**)	Chief Strategy Officer	0-2.5	0-2.5	15-20	0-5	125	6	167	0
Rob Bowen (**)	Acting Director of Strategy and Partnerships	0-2.5	0-2.5	10-15	10-15	122	15	201	0

Notes: CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2024- 25 CETV figures.

During the year the NHS made an adjustment to the pension and lump sum data to consider the impact of the McCloud judgement (a legal case in relation to age discrimination benefits). HM Treasury released a response in February 2021 to the October 2020 McCloud remedy consultation which confirmed that some members will have NHS 2015 benefits replaced with NHS 1995/2008 section benefits by 2023, with an option to switch back to NHS 2015 at their retirement date.

Following the Public Service Pensions and Judicial Offices Act 2022, which came into force 10 March 2022, the implementation of the regulation set a deadline of 1 October 2023. The regulation allows for retrospective adjustments arising due to the McCloud judgement. The adjustment will enable all eligible members to be switched to Final Salary and then providing a choice on their actual retirement date between CARE and Final Salary benefits for their service between 2015 and 2022. Where the McCloud rollback resulted in negative real increases in pension, lump sum or CETV the negative figures have not been shown and a zero has been substituted.

- As non-executive directors do not receive pensionable remuneration, there will be no entries in respect of pensions for non-executive directors.
- Pension benefit disclosed above represents the full year 2024-25 pension to 31st March 2025.
- The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.
- Factors determining the variation in the values recorded between individuals include but is not limited to: -
 - A change in role with a resulting change in pay and impact on pension benefits.
 - A change in the pension scheme itself.
 - Changes in the contribution rates.

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of

their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement or for loss of office

No payments for compensation on early retirement or for loss of office have been made by the ICB.

Payments to past directors

No payments have been made to any person who was not a director at the time the payment was made, but who had been a director of the entity previously

Staff Report

Staff numbers and gender analysis

The ICB has a workforce comprised of employees from a wide variety of professional groups. At the end of 2024/2025 the ICB employed 474 staff (headcount including bank staff), of which 359 were women and 115 were men. As of 31 March 2025, the Chief Executive Office and Board was made up of 6 women and 8 men. Below is a breakdown of gender analysis of staff.

	Female headcount	Male Headcount	Total Headcount
CEO and Board	6	8	14
Very Senior Managers	2	2	4
All other employees	351	105	456
Total employees	359	115	474

The below table shows the number of people (headcount) employed by the ICB and other numbers, either employed by other organisations or temporary staff who are working for the ICB as at 31 March 2025:

	Permanently employed number (exc bank staff)	Other numbers	Total number
Total (headcount)	463	Bank staff 11	474

The below table shows the average number of people employed (whole time equivalent – WTE)) by the ICB and other numbers either employed by other organisations or temporary staff working for the ICB from 1 April 2024 to 31 March 2025.

	Permanently employed (exc bank staff)	Other staff	Total number
Average number of WTE people	409.18	Bank staff 0	409.18
Of which: WTE people engaged on capital projects	0	0	0

Staff turnover for the ICB is 13.28% (headcount) (1 April 2024 to 31 March 2025)

Employee benefits and cost

	Permanent Employees £'000	Total Other £'000	2024-25 Total £'000
Employee Benefits			
Salaries and wages	23,645	3,583	27,228
Social security costs	2,850	-	2,850
Employer Contributions to NHS Pension scheme*	5,382	-	5,382
Apprenticeship Levy	112	-	112
Termination benefits**	848	-	848
Gross employee benefits expenditure	32,837	3,583	36,420

	Permanent Employees £'000	Total Other £'000	2023-24 Total £'000
Employee Benefits			
Salaries and wages	23,060	4,498	27,558
Social security costs	2,471	-	2,471
Employer Contributions to NHS Pension scheme	3,957	-	3,957
Apprenticeship Levy	97	-	97
Termination benefits	233	-	233
Gross employee benefits expenditure	29,818	4,498	34,316

Sickness absence data

Local electronic staff record (ESR) data shows the sickness figures for the ICB for 2024/25 are as follows.

	1 April 2024 to 31 March 2025
Average FTE of staff	409.38
Total number of Absence days (FTE)	4,108.90
Average annual sick days per FTE	10.04

Sickness absence is managed in a supportive and effective manner by ICB managers, with professional advice and targeted support from human resources (HR), occupational health, employee assistance programme and staff support services which are appropriate and responsive to the needs of our workforce. The ICB's approach to managing sickness absence is governed by a clear HR policy and this is supported by the provision of HR advice and guidance sessions for line managers on the effective management of sickness absence.

Managers ensure that the culture of sickness reporting is embedded within their teams and sickness absence is actively monitored.

Staff engagement percentages

The results of our Staff Survey were released on 13 March 2025. While we had good staff engagement with a response rate of 66.4% (284 questionnaires completed), the headline findings indicate that staff experience in BOB ICB has not significantly improved over the last 12 months. We are currently in the process of reviewing the detailed findings for the organisation and by directorate.

The findings have been presented at our All Staff Briefing, at our Staff Partnership Forum, in directorate meetings and at the ICB People Committee. The survey highlights the need for us to re-energise the existing Organisational Development and Wellbeing action plan in collaboration with managers, staff, our ED networks and the Staff Partnership Forum with the expectation that this will generate the improvements in staff experience required over the next 12 months. A central element of this approach is the adoption of the 'One Action' approach, in which each team will agree to take one action based on the results to improve staff experience. As an organisation we are committed to listening to feedback from staff and will work closely with our staff partnership forum and staff networks to identify what we can do to improve over the next year.

Trade Union Facility Time Reporting Requirements

In January 2024 the ICB and Trade Unions signed a Trade Union Recognition Agreement & Framework. The recognition Agreement is in place from 1 April 2024. BOB ICB will comply with the Trade Union and Labour Relations (Consolidation) Act 1992 and section 25 of the NHS terms and conditions of service handbook 'Time off and facilities for trades union representatives' in relation to both time off and facilities for accredited trade unions, who have been duly elected or appointed, and who represent their members on matters that are of concern to BOB ICB and/or its employees.

Other employee matters

OD Programme: The ICB has continued to develop an organisational development (OD) programme which focuses on '*Building a better BOB ICB*'. We developed core values in partnership with staff during 2023 which are:

- Respectful – we are inclusive
- Impactful – we make a difference
- Integrity – we are kind and fair
- Leadership – we encourage leadership
- Collaborative – we work together in a positive way

These values were used in the creation of the BOB ICB Operating model which was launched in November 2024. An interim OD plan was launched around the same time to support the embedding of the new operating model within the new structures. This interim OD plan weaved the outputs from the 2023 staff survey, the ongoing engagement with Staff networks and Unions, and feedback from staff as to what the organisation needed to move forward from the re-structures and to implement the new operating model.

The OD programme is underpinned by four pillars that serve as guiding principles for the programme's success, including: Wellbeing, Inclusivity, Leadership and Development which are called the 'WILD pillars'.



Interim OD plan key highlights

The interim OD plan focused on the following key elements:

Wellbeing:

- Communication of strategic objectives and the new operating model
- Ensuring Employee Assistance Programme (EAP) and Occupational Health provision are fit for purpose and staff are getting the support they needed
- HR delivering 'Managing Self Through Change Sessions' to support staff
- Review wellbeing support offers and initiatives to identify potential additional options for support with Unions and Staff Networks
- Developing and delivering Independent wellbeing support specific for staff who had gone through formal HR process
- Career Transition & Outplacement support services - specific outplacement support (e.g. using a partner such as Right Management), and NHS Elect webinars (CV writing, personal brand, interview skills) for staff who were made redundant
- Development and deployment of Mental Health First Aiders across the ICB to support staff

Inclusivity:

- Produce Actions from Gender Pay Gap and Equality Delivery System reports and findings from latest Staff Survey and develop and deliver actions plans based on this information
- Support teams and managers to deliver the new Agile Working Model
- Develop Cultural Intelligence across BOB with Cultural Intelligence Training offer to be open to all ICB staff
- Develop and deliver Inclusive recruitment training for managers in the ICB
- Set up the process so network Leads and OD Support work in a collaborative way to plan for future OD projects and plans

- Support the building of leadership and management capability in neurodiversity, sexual safety and diverse abilities
- Set up an Equality Impact Assessment processes that has links with the Staff Partnership Forum
- Development of Staff Survey actions based on the data from those with protected characteristics

Leadership:

- Complete a Leadership and Line Management resource review to understand what resources are available and how benefits are optimized
- HR delivered a 'Leading through Change Workshops' for leaders and managers on how to support their teams through the change process
- Supporting leaders to navigate and lead the change with their teams through training, peer support and coaching
- Provide NHS Elect Webinars on a range of topics for all staff to access
- Promote NHS Confederation Training across the ICB
- Promote and make available the Bucks Health & Social Care Academy courses
- Develop and deliver the executive and leadership development sessions (refreshed in the context of the new operating model), including 360-degree feedback exercises
- Develop and deliver Leaders and Managers Support Circles - creating peer support environment for managers and leaders during the change programme.
- Set up and support Senior Leadership Forum
- Support teams to create regular 'team space' to meet face to face to connect as team, discuss change and plan improvements.

Development:

- Develop a package that supports growing system leaders' skills and abilities, focused on relationship management, financial management and system development needs
- Redesign and development of appraisal approach and Scope for Growth conversations
- Set up and deliver respectful resolution development and training
- Set up the process of facilitation of team building and networking internally and externally
- Set up the process to ensure meaningful 1-2-1 conversations to include wellbeing conversations and change programme reflections
- Ensure that the ICB meets its Statutory and Mandatory training requirements

This interim plan is at the final stages of deliver and will be completed by the end of March 2024. The ICB has recruited an interim Director of OD to oversee the delivery of the interim OD plan and to develop the longer term 3 year plan as the ICB looks to grow into its new organisation.

Staff Partnership Forum:

The ICB established a Staff Partnership Forum (SPF) which had its inaugural meeting on 23 January 2024. The BOB ICB SPF has been set up to provide a regular and formal means of information, consultation and negotiation between managers, staff directorate

representatives and trade union representatives. The SPF will be the main forum for formal consultation with staff and their representatives and the management / executive of the ICB about the Change Programme and other matters, for example health, safety and welfare of staff, creating a positive organisational culture, staff engagement, training and development, recruitment and retention, policies and procedures and equal opportunities. . There are staff representatives from each directorate as well as leads from the staff networks

Staff Networks:

As part of our ongoing commitment to creating a fairer and more diverse organisation, we have continued our support for the BOB ICB staff networks to address and tackle issues faced by underrepresented groups of people within our workforce.

They also contribute to improving patient experience, as staff develop a deeper understanding of our diverse community.

At present, we have three staff networks:

- Cultural Awareness & Race Equality (CARE) Network,
- Diverse Ability Network
- LGBTQ+ Network.

All three networks have an active membership group and have welcomed speakers and discussed ways in which the whole organisation can work to ensure it is inclusive.

Commitment to become an anti-racist organisation

The ICB has made a commitment to becoming an anti-racist organisation and launched its partnership with *Race Equality Matters*, a national charity that support organizations, including provider members of the ICS. (Berkshire Healthcare and Oxford County Council) The ICB is working very closely with the CARE network to drive this change programme and a series of events and projects are planned into 2025/2026.

BOB ICB Change Programme:

We have completed the majority of the ICB Change Programme to review and redesign the ICB's operating model. This involved carefully working through the ICB functions and thinking through at what level of the system they were best delivered building on the changes we have been through already as an organisation and our learning to date. The Change Programme was undertaken for several reasons:

- to strengthen our unique role and organisational value within the system.
- to have greater clarity on what is best delivered at system level; in local place-based partnerships; or through our provider collaboratives.
- to address the ask by NHS England of all ICBs that we are operating at our optimal size to deliver our strategic function and to achieve a running cost budget reduction of 30% by 2025/2026. An additional 10% cost reduction is required to keep us within the financial envelope for future allocations.

We held workshops to equip managers to support their staff / teams through the consultation process. Following suggestions from staff representatives at the SPF we have also held drop-in sessions, for all staff, to share information and discuss certain subjects including voluntary redundancy / how it will work and the basics of TUPE - Transfer of Undertakings (Protection of Employment) Regulations.

The SPF is a key channel for feedback from staff and discussion around the change programme. In addition, regular Directorate and team briefings enabled the broadest engagement with staff, ensuring staff voice is heard throughout the change process. Staff also sent in questions and feedback about the change programme to the communications and engagement with questions being answered and posted them on the StaffZone.

The staff consultation was launched on 29 April 2024 and closed on 4 August 2024. Following review of feedback from staff and partners the final structures were locked down on 4 September. An extraordinary board took place on 25 September 2024 to sign off all outcome of consultation papers. An all-staff briefing was held on the 30 September 2024 to brief staff on outcome of consultation. Following the meeting the outcome of consultation papers were released to staff

Approximately 370 staff were slotted into posts in the new structure. Interviews for competitive slot ins ran from 14 – 31 October.

On 28 October the ICB started the identification of vacant roles as Suitable Alternative Employment (SAE) for all staff who were identified at risk of redundancy. SAE interviews took place throughout November 2024.

There are currently 9 ICB staff who are still at risk of redundancy. The ICB's Remuneration Committee approved the redundancies on 20 February 2025. A business case has been provided to NHSE for approval to make the redundancies. The ICB will continue to look for SAE for these 9 staff.

The majority of the organisation moved to its new operating model on 6 January 2025.

Staff Partnership Forum (SPF) meetings were held fortnightly to ensure that SPF members are kept informed of the consultation to date and given an update on the next stages and to provide an opportunity to feedback any issues raised by colleagues.

The VR scheme that launched at the same time as the initial consultation closed on 4 Aug 2024. The VR panel met and approved 15 applications. One colleague has subsequently withdrawn their application. NHSE have approved the applications and settlement agreements are being prepared to finalise the VR details.

In March 2024, the Government announced a restructuring of the NHS including the abolition of NHS England; this is to be integrated in the Department of Health and Social Care. [In Jim Mackey's letter](#) to all Integrated Care Boards (ICBs) and NHS Trusts, all ICBs were advised that we would have to reduce our running costs by 50%. The letter also set out the future role of ICBs:

- as strategic commissioners, central to achieving the goals of the 10 Year Health Plan
- as commissioners and developers of neighbourhood health, with delivery moving to providers over time.

Subsequently, the ICB received a letter from the Regional Director - NHS England South East, regarding the requirement to reduce the running cost of ICBs. The communication set out further detail on the target reduction for each ICB across the country and aims to assist ICBs in our thinking prior to releasing the 'Model' ICB work at the end of April. The detail set out covers:

- The running cost reduction applies to running cost allowance (RCA*) spend and programme running cost spend (classified as ICB pay and CSU spend).
- The reductions aim to move ICBs from a national average of £32.98 per head of population to £18.76 in each ICB nationally.
- These figures exclude the impact of any future transfer of staff in respect to the delegation of Specialised Services.

- The reduction of cost per head of population for ICBs across the country is different and ranges from 27% to 63%.
- The figures show that BOB ICB will need to reduce its total running costs by net 35% to align with the £18.76 per head of population.

At the time of writing this annual report, we do not know the full impact of this change. There is significant work to be undertaken both internally and with partners over the coming year. We will continue to work with our partners across the system and with other ICBs across the wider region to explore opportunities to work together, develop cross-system arrangements and pool resources or align approaches where it makes sense to do so.

Freedom to speak up

Throughout 2024/25 we have strengthened our Freedom to Speak Up (FTSU) arrangements in the ICB endorsing the three key principles of 'speaking up, acting up and following up' to ensure staff feel confident and safe to utilise the FTSU programme and embed positive culture and behaviour within the ICB. We want to ensure our staff are supported in speaking up; that barriers to speaking up are addressed; that the organisation encourages a positive culture of speaking up and that matters raised are used as opportunities for learning and improvement. To support this, we have appointed three members of staff as FTSU guardians. Staff can contact them for advice and support to speak up.

Expenditure on consultancy

Expenditure on consultancy was £1,939k (£2,979k 1 April 2024 to 31 March 2025) as per Note 5 to the Accounts page 124.

Off-payroll engagements

Table below: Length of all highly paid off-payroll engagements

For all off-payroll engagements as of 31 March 2025, for more than £245⁽¹⁾ per day:

	Number
Number of existing engagements as of 31 March 2025	29
<i>Of which, the number that have existed:</i>	
for less than one year at the time of reporting	5
for between one and two years at the time of reporting	24
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

Below table: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2024 to 31 March 2025, for more than £245⁽¹⁾ per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2024 to 31 March 2025	39
<i>Of which:</i>	
No. not subject to off-payroll legislation ⁽²⁾	37
No. subject to off-payroll legislation and determined as in-scope of IR35 ⁽²⁾	
No. subject to off-payroll legislation and determined as out of scope of IR35 ⁽²⁾	2
the number of engagements reassessed for compliance or assurance purposes during the year	
Of which: no. of engagements that saw a change to IR35 status following review	

⁽¹⁾ The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

⁽²⁾ A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Below table: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2024 to 31 March 2025.

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during reporting period ⁽¹⁾	2
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the reporting period. This figure should include both on payroll and off-payroll engagements. ⁽²⁾	21

Exit packages, including special (non-contractual) payments

Exit package cost band (inc. any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000								
£10,000 - £25,000			3	63,307	3	63,307		
£25,001 - £50,000			1	31,697	1	31,697		
£50,001 - £100,000			8	619,663	8	619,663		
£100,001 - £150,000			1	133,333	1	133,333		
£150,001 –£200,000								
>£200,000								
TOTALS			13	848,000	13	848,000		

Redundancy and other departure cost have been paid in accordance with the provisions of NHS Redundancy Scheme. Exit costs in this note are accounted for in full in the year of departure agreed. Where the ICB has agreed early retirements, the additional costs are met by the ICB and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Table 2: Analysis of Other Departures

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	12	£753
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice*	1	£95
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval**	0	0
TOTAL	13	£848

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in table 1 which will be the number of individuals.

*Any non-contractual payments in lieu of notice are disclosed under “non-contracted payments requiring HMT approval” below.

**includes any non-contractual severance payment made following judicial mediation, and none relating to non-contractual payments in lieu of notice.

Zero non-contractual payments were made to individuals where the payment value was more than 12 months’ of their annual salary. The Remuneration Report includes disclosure of exit packages payable to individuals named in that Report.

Equality and Diversity

For information on the Public Sector Equality Duty and how we give ‘due regard’ to eliminating discrimination please see [here](#).

As outlined above, the BOB ICB set up three new staff networks Cultural Awareness and Race Equality (CARE), Diverse Ability and Lesbian, Gay, Bisexual and Transgender Plus (LGBTQ+). Each is independently chaired by an employee of the organisation and has an executive sponsor. The networks have supported Black History Month, Disability History Month and LGBTQ+ History Month.

The ICB is committed to reporting annually on ethnicity pay gap, in line with the Gender Pay Gap report and Public Sector Equality Duty report. The ICB is committed to becoming an anti-racist organisation and has started a dedicated project to begin this important journey towards equality.

Disability information

BOB ICB has developed an integrated approach to delivering workforce equality, so it does not have a separate policy for disabled employees or for any other protected characteristics. Equalities issues are incorporated in policies covering all aspects of the employee lifecycle ranging from recruitment to performance.

Health and Safety

The BOB ICB recognises that the maintenance of a safe workplace and safe working environment is critical to our continued success and accordingly, we view our responsibilities for health, safety and welfare with the utmost importance. As staff mainly work from home, considerable effort had gone into supporting staff do this. This included all staff undertaking risk assessments of their 'at home' working environment and purchasing equipment (for example office chairs and monitors) to accommodate individual staff needs. Health and Safety training forms part of the suite of statutory and mandatory training which is undertaken by all employees.

Whistleblowing

The BOB ICB has a whistleblowing (Freedom to Speak Up) policy that is communicated to all staff and was available on the staff intranet.

Auditable elements

Please note that the elements of this remuneration and staff report that have been subject to audit are the tables of salaries and allowances senior managers and related narrative notes on page 78 to 81, pension benefits of senior managers and related narrative on pages 82 to 84, staff report and related narrative on pages 85 and 86, the fair pay disclosures and related narrative notes on page 76 and 77 and exit packages and any other agreed departures on page 95 and 96.

Dr Nick Broughton
Accountable Officer
20 June 2025

Parliamentary Accountability and Audit Report

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board is not required to produce an Accountability and Audit Report but has opted to include disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges in this Accountability Report. For 1 April 2024 to 31 March 2025 there were no remote contingent liabilities, losses and special payments, gifts, fees or charges.

Dr Nick Broughton
Accountable Officer
20 June 2025

Appendix 1:

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) Committee Attendance 2024/25

Key:

Y = present and attended

A = Apologies

N/A = not applicable as not in post at that time

R = Resigned

T = Term of office ended

Board meetings 1 April 2024 to 31 March 2025

Attendees	May 2024	July 2024	September 2024	November 2024	January 2025	March 2025
Members						
Sim Scavazza Acting Chair, BOB ICB (Resumed as Non-Executive Director November 2024)	Y	Y	Y	Y	Y	Y
Priya Singh Chair	N/A	N/A	N/A	Y	Y	Y
Saqhib Ali Non-Executive Director, BOB ICB	A	A	Y	Y	Y	Y
Margaret Batty Non-Executive Director, BOB ICB	Y	Y	Y	Y	Y	Y
Tim Nolan Non-Executive Director, BOB ICB	Y	Y	Y	A	Y	A
Aidan Rave Non-Executive Director, BOB ICB	Y	Y	Y	Y	A	Y

Dr Nick Broughton CEO September 2024 BOB ICB	Y	Y	Y	Y	Y	Y
Dr George Gavriel Partner Member, Primary Medical Services	Y	Y	Y	Y	A	Y
Steve McManus Partner Member, NHS Trusts/Foundation Trusts	Y	A	Y	Y	Y	Y
Rachael Shimmin Partner Member, Local Authorities	Y	Y	A	Y	R	R
Susan Parsonage Partner Member, \Local Authorties	N/A	N/A	N/A	N/A	Y	Y
Minoo Irani Member for Mental Health	Y	Y	Y	Y	T	T
Grant Macdonald Member for Mental Health	N/A	N/A	N/A	N/A	Y	Y
Rachael Corser Chief Nursing Officer, BOB ICB	Y	Y	Y	Y	Y	Y
Dr Rachael De Caux, BOB ICB Deputy Chief Executive Officer and Chief Medical Officer	Y	Y	Y	Y	R	R
Dr Abid Ifran Acting Chief Medical Officer	N/A	N/A	N/A	N/A	Y	N/A
Dr Ben Riley Chief Medical Officer	N/A	N/A	N/A	N/A	N//A	Y
Matthew Metcalfe Chief Finance Officer, BOB ICB	Y	Y	Y	Y	Y	N/A
Alastair Groom	N/A	N/A	N/A	N/A	N/A	Y

Chief Finance Officer (Interim)						
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Audit and Risk Committee Meetings 1 April 2024 to 31 March 2025

Attendees	April 2024	4 June 2024	25 June 2024	August 2024	October 2024	January 2025	February 2025
Members							
Saqhib Ali Committee Chair and Non-Executive Director, BOB ICB	Y	Y	Y	Y	Y	Y	Y
Margaret Batty Non-Executive Director, BOB ICB	Y	Y	Y	Y	Y	Y	A
Aidan Rave Non-Executive Director, BOB ICB	A	Y	Y	Y	Y	Y	Y

People Committee Meetings 1 April 2024 to 31 March 2025

Attendees	May 2024	July 2024	Sept 2024	Jan 2025	March 2025
Members					
Sim Scavazza, Committee Chair and Acting Chair, BOB ICB	Y	Y	Y	Y	Y
Dr Nick Broughton CEO September 2024 BOB ICB	A	Y	Y	Y	Y
Caroline Corrigan Interim Chief People Officer, BOB ICB	Y	A	Y	R	R
Matthew Metcalfe Chief Finance Officer, BOB ICB	A	Y	Y	A	A
Catherine Mountford Director of Governance BOB ICB	Y	Y	R	R	R
Tim, Nolan Non-Executive Director, BOB ICB	Y	Y	Y	Y	Y
Clare Doble Director of Governance	N/A	N/A	Y	A	Y
Sandra Grant Chief of People	N/A	N/A	N/A	Y	Y

Place and System Development Committee Meetings 1 April 2024 to 31 March 2025

Attendees	April 2024	June 2024	October 2024	December 2024	February 2025
Members					
Aidan Rave Committee Chair and Non-Executive Director	Y	Y	Y	Y	Y
Sim Scavazza Non-Executive Director (Acting Chair), BOB ICB	Y	Y	Y	Y	Y
Ansaf Azhar Director of Public Health and Wellbeing, Oxfordshire County Council	A	A	Y	A	A
Philippa Baker BOB ICB Place Director, Buckinghamshire	Y	Y	Y	N/A	N/A
William Butler BOB VCSE Health Alliance Chair	Y	Y	A	A	A
Stephen Barnet BOB VCSE Health Alliance – Director	N/A	N/A	M/A	A	Y
Hannah Iqbal Director of Strategy and Partnerships, BOB ICB	A	Y	A	A	A
Daniel Leveson BOB ICB Place Director – Oxfordshire	A	Y	Y	Y	A
Matthew Tait, Chief Delivery Officer, BOB ICB ICB	Y	Y	Y	Y	Y
Sara Webster BOB ICB Place Director, Berkshire West	A	Y	A	N/A	N/A

Health and Patient Experience Committee Meetings 1 April 2024 to 31 March 2025

Attendees	April 2024	June 2024	August 2024	October 2024	December 2024	February 2025
Members						
Margaret Batty Committee Chair and Non-Executive Director, BOB ICB	Y	Y	Y	Y	Y	Y
Sim Scavazza Non-Executive Director (Acting Chair) BOB ICB	Y	Y	Y	Y	Y	Y
Daniel Alton GP Twyford Surgery, Chief Clinical Information Officer, BOB ICB	Y	A	A	A	Y	A
Rachael Corser Chief Nursing Officer, BOB ICB	Y	Y	Y	Y	Y	Y
Dr Rachael DeCaux Deputy Chief Executive Officer and Chief Medical Officer, BOB ICB	Y	A	A	Y	R	R
George Gavriel ICB Board Partner Member – Primary Medical Services	Y	A	Y	Y	Y	Y
Dr Abid Irfan Deputy Chief Medical Officer and Director of Primary Care, BOB ICB	Y	Y	Y	Y	A	A
Karl Marlowe Chief Medical Officer, Oxford Health Foundation Trust	A	A	Y	Y	Y	A
Zoe McIntosh Chief Executive, Healthwatch, Buckinghamshire	Y	A	Y	Y	A	Y
David Munday Deputy Director of Public Health, Oxford County Council	A	Y	Y	A	Y	Y

Raju Reddy Clinical Lead for TVPC, BOB ICS/Consultant Paediatric Anaesthetist	Y	A	A	A	R	R
Rashmi Sawhney Clinical Lead Inequalities, BOB ICB	A	A	A	A	A	A
Matthew Tait Chief Delivery Officer, BOB ICB	Y	A	Y	Y	Y	Y

Remuneration Committee Meetings 1 April 2024 to 31 March 2025

Attendees	Apr 2024	May 2024	Sept 2024	Oct 2024	Dec 2024	Feb 2025
Members						
Aidan Rave Committee Chair and Non- Executive Director, BOB ICB	Y	Y	Y	Y	Y	Y
Saqhib Ali Non-Executive Director, BOB ICB	Y	A	Y	Y	Y	Y
Margaret Batty Non-Executive Director, BOB ICB	Y	A	Y	Y	Y	Y
Tim Nolan Non-Executive Director, BOB ICB	Y	Y	Y	Y	Y	Y
Sim Scavazza Non-Executive Director (Acting Chair), BOB ICB	Y	Y	Y	Y	Y	Y

System Productivity Committee Meetings 1 April 2024 to 31 March 2025

Attendees	May 2024	July 2024	September 2024	November 2024	January 2025	Feb 2025
Members						
Tim Nolan Committee Chair and Non-Executive Director, BOB ICB	Y	Y	Y	Y	Y	Y
Sim Scavazza Non-Executive Director (Acting Chair), BOB ICB	Y	A	A	N/A	N/A	Y
Saqhib Ali Non-Executive Director, BOB ICB	Y	Y	Y	Y	Y	Y
Victoria Otley-Groom Chief Digital and Information Officer, BOB ICB	Y	A	Y	Y	Y	A
Matthew Metcalfe Chief Finance Officer, BOB ICB	Y	Y	Y	Y	Y	Y
Matthew Tait Chief Delivery Officer, BOB ICB	Y	A	Y	Y	Y	Y

FINANCIAL ACCOUNTS

FOR THE PERIOD ENDED 31 MARCH 2025

NHS Buckinghamshire, Oxfordshire and Berkshire West

Financial Information - Accounts Year Ended 31 March 2025

These accounts for the year ended 31 March 2025 have been prepared by Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board under a Direction issued by the NHS Commissioning Board, now known as NHS England under the National Health Service Act 2006.

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INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WEST INTERGRATED CARE BOARD

Opinion

We have audited the financial statements of Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board ("the ICB") for the year ended 31 March 2025 which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 22, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by the HM Treasury's Financial Reporting Manual: 2024-25 as contained in the Department of Health and Social Care Group Accounting Manual 2024 to 2025, and the Accounts Direction issued by NHS England in accordance with the National Health Service Act 2006.

In our opinion the financial statements:

- give a true and fair view of the financial position of Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board as at 31 March 2025 and of its net expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2024 to 2025; and
- have been properly prepared in accordance with the National Health Service Act 2006, as amended by the Health and Care Act 2022.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's AGN01 and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for a period of 12 months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report. However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the ICB's ability to continue as a going concern.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements, or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- other information published together with the audited financial statements is consistent with the financial statements; and
- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2024 to 2025.

Matters on which we are required to report by exception

We are required to report to you if:

- we issue a report in the public interest under Section 24 and Schedule 7 of the Local Audit and Accountability Act 2014 (as amended); or
- we make a written recommendation to the ICB under Section 24 and Schedule 7 of the Local Audit and Accountability Act 2014 (as amended); or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 (as amended) because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we are not satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025; or
- in our opinion the governance statement does not comply with the guidance issued in the Department of Health and Social Care Group Accounting Manual 2024 to 2025.

We have nothing to report in these respects.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's Responsibilities in respect of the Accounts, set out on page 61, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is also responsible for ensuring the regularity of expenditure and income.

In preparing the financial statements, the Accountable Officer is responsible for assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accountable Officer either intends to cease operations, or has no realistic alternative but to do so.

As explained in the annual report, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the ICB's resources.

Auditor's responsibility for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect irregularities, including fraud. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below. However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the entity and management.

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the ICB and determined that the most significant are the National Health Service Act 2006, Health and Social Care Act 2012 and Health and Care Act 2022, and other legislation governing NHS ICBs, as well as relevant employment laws of the United Kingdom. In addition, the ICB has to comply with laws and regulations in the areas of anti-bribery and corruption and data protection.
- We understood how Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of management, the head of internal audit and those charged with governance and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance
- We assessed the susceptibility of the ICB's financial statements to material misstatement, including how fraud might occur by planning and executing a journal testing strategy, testing the appropriateness of relevant entries and adjustments. We have considered whether judgements made are indicative of potential bias and considered whether the ICB is engaging in any transactions outside the usual course of business. In response to the risk of fraud in expenditure recognition for year-end accruals, we reviewed and tested revenue and expenditure accounting policies, year-end accruals and expenditure cut-off at the period end date. We specifically focused on key aspects of unrecorded liabilities to provide assurance that year-end accounts were free from material mis-statement and performed substantive procedures on Department of Health balances data, investigating significant differences outside of Department of Health tolerances.
- Based on this understanding we designed our audit procedures to identify noncompliance with such laws and regulations. Our procedures involved enquiry of management and those charged with governance/other, reading and reviewing relevant meeting minutes of those charged with governance and the Governing Body and understanding the internal controls in place to mitigate risks related to fraud and non-compliance with laws and regulations. NHS Buckinghamshire, Oxfordshire and Berkshire West ICB has robust policies and procedures to mitigate the potential for override of controls, there is a culture of ethical behaviour, supported by a number of policies in respect of human resources and counter fraud, bribery and corruption.
- We addressed our fraud risks related to management override through implementation of a journal entry testing strategy, assessing accounting estimates for evidence of management bias and evaluating the business rationale for significant unusual transactions.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at <https://www.frc.org.uk/auditorsresponsibilities>. This description forms part of our auditor's report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice 2024, having regard to the guidance on the specified reporting criteria issued by the Comptroller and Auditor General in November 2024 as to whether the ICB had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the ICB put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the ICB had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 (as amended) to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 (as amended) requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Report on Other Legal and Regulatory Requirements

Regularity opinion

In our opinion, in all material respects the expenditure and income reflected in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Basis for opinion on regularity

We are responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General as required by the Local Audit and Accountability Act 2014 (as amended) (the "Code of Audit Practice").

We conducted our work in accordance with Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022) issued by the Public Audit Forum. We are required to obtain evidence sufficient to give an opinion on whether in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Certificate

We cannot formally conclude the audit and issue an audit certificate until the NAO, as group auditor, has confirmed that no further assurances will be required from us as component auditors of Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board.

Use of our report

This report is made solely to the members of the Governing Body of Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board in accordance with Part 5 of the Local Audit and Accountability Act 2014 (as amended) and for no other purpose. Our audit work has been undertaken so that we might state to the members of the Governing Body of the ICB those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the members as a body, for our audit work, for this report, or for the opinions we have formed.

Ben Lazarus (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
London
Date

**Statement of Comprehensive Net Expenditure for the year ended
31 March 2025**

	Note	2024-25 £'000	2023-24 £'000
Income from sale of goods and services	2	(49,797)	(45,898)
Other operating income	2	(145)	-
Total operating income		(49,942)	(45,898)
Staff costs	4	36,420	34,316
Purchase of goods and services	5	3,887,437	3,591,085
Depreciation and impairment charges	5	584	793
Provision expense	5	368	(801)
Other operating expenditure	5	755	1,110
Total operating expenditure		3,925,564	3,626,502
Net Operating Expenditure		3,875,622	3,580,604
Finance expense	7	10	12
Net expenditure for the Year		3,875,632	3,580,616
Total Net Expenditure for the Financial Year		3,875,632	3,580,616
Comprehensive Expenditure for the year		3,875,632	3,580,616

The notes on pages 115 to 139 form part of this statement.

**Statement of Financial Position as at
31 March 2025**

	Note	2024-25 £'000	2023-24 £'000
Non-current assets:			
Property, plant and equipment	8	240	256
Right-of-use assets	9	1,050	1,188
Intangible assets	10	304	460
Total non-current assets		1,594	1,904
Current assets:			
Trade and other receivables	11	34,743	51,215
Cash and cash equivalents	12	996	584
Total current assets		35,739	51,799
Total current assets		35,739	51,799
Total assets		37,333	53,703
Current liabilities			
Trade and other payables	13	(234,043)	(224,907)
Lease liabilities	9	(344)	(418)
Provisions	14	(2,644)	(1,049)
Total current liabilities		(237,031)	(226,373)
Non-Current Assets plus/less Net Current Assets/Liabilities		(199,698)	(172,671)
Non-current liabilities			
Lease liabilities	9	(626)	(806)
Provisions	14	(241)	(1,753)
Total non-current liabilities		(867)	(2,559)
Assets less Liabilities		(200,565)	(175,230)
Financed by Taxpayers' Equity			
General fund		(200,565)	(175,230)
Total taxpayers' equity:		(200,565)	(175,230)

The notes on pages 115 to 139 form part of this statement.

In line with authority delegated via the Audit and Risk Committee the financial statements on pages 113 to 139 were approved by the Chief Executive and the Chief Finance Officer on behalf of the Governing Body on 20 June 2025.

Nick Broughton
Chief Executive Officer

Alastair Groom
Chief Finance Officer

**Statement of Changes In Taxpayers' Equity for the year ended
31 March 2025**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2024-25		
Balance at 01 April 2024	(175,230)	(175,230)
Changes in NHS Integrated Care Board taxpayers' equity for 2024-25		
Net operating expenditure for the financial year	(3,875,632)	(3,875,632)
Net Recognised NHS Integrated Care Board Expenditure for the Financial year	(3,875,632)	(3,875,632)
Net funding	3,850,297	3,850,297
Balance at 31 March 2025	(200,565)	(200,565)

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2023-24		
Balance at 01 April 2023	(202,586)	(202,586)
Changes in NHS Integrated Care Board taxpayers' equity for 2023-24		
Net operating costs for the financial year	(3,580,616)	(3,580,616)
Net Recognised NHS Integrated Care Board Expenditure for the Financial Year	(3,580,616)	(3,580,616)
Net funding	3,607,972	3,607,972
Balance at 31 March 2024	(175,230)	(175,230)

The notes on pages 115 to 139 form part of this statement.

**Statement of Cash Flows for the year ended
31 March 2025**

	2024-25 £'000	2023-24 £'000
Cash Flows from Operating Activities		
Net operating expenditure for the financial year	(3,875,632)	(3,580,616)
Depreciation and amortisation	585	793
Interest paid / received	9	12
(Increase)/decrease in trade & other receivables	16,472	(29,178)
Increase/(decrease) in trade & other payables	9,107	4,077
Provisions utilised	(285)	(1,088)
Increase/(decrease) in provisions	367	(801)
Net Cash Inflow (Outflow) from Operating Activities	(3,849,377)	(3,606,801)
Cash Flows from Investing Activities		
(Payments) for property, plant and equipment	(23)	(103)
Net Cash Inflow (Outflow) from Investing Activities	(23)	(103)
Net Cash Inflow (Outflow) before Financing	(3,849,400)	(3,606,904)
Cash Flows from Financing Activities		
Grant in Aid Funding Received	3,850,297	3,607,972
Repayment of lease liabilities	(485)	(547)
Net Cash Inflow (Outflow) from Financing Activities	3,849,812	3,607,425
Net Increase (Decrease) in Cash & Cash Equivalents	412	520
Cash & Cash Equivalents at the Beginning of the Financial Year	584	64
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year	996	584

The notes on pages 115 to 139 form part of this statement.

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of Integrated Care Boards (ICBs) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2024-25 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis on the assumption of a continuation of funding and services for a period of at least 12 months from when the financial statements are authorised for issue. The ICB has achieved its statutory duty to breakeven and has retained a small surplus of £9k. The ICB had an original plan deficit of £13.7m, in September 2024 the ICB received £13.2m plan deficit funding from NHSE which reduced plan deficit to £0.5m. In year the ICB continued to experience and report adverse financial cost pressure position in mental health s117, high-cost drugs, continuing healthcare and overperformance from acute providers. The favourable financial position has been achieved by materialisation of Cost Improvements Plans (CIPs) and stringent financial controls imposed on non-healthcare expenditure.

On 13 March 2025 the government announced NHS England and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of ICBs is currently unchanged.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. If services will continue to be provided in the public sector the financial statements should be prepared on a going concern basis. The statement of financial position has therefore been drawn up at 31 March 2025, on a going concern basis.

The ICB has submitted an indicative £150k surplus financial plan for 2025-26 and in-system partners £150k financial deficit forcing the ICS into a breakeven financial position. The ICB will continue to work with its partners to address financial challenges and mitigate risk with comprehensive efficiency plans and transformational change. The ICB will continue to operate as a Going Concern with no changes to its funding stream, and with an approved allocation for 2025/26 of £4.4billion, ensuring healthcare service provision throughout Buckinghamshire, Oxfordshire and Berkshire West remains unaffected.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 Movement of Assets within the Department of Health and Social Care Group

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Joint arrangements

Joint operations are arrangements in which the ICB has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The ICB includes within its financial statements its share of the assets, liabilities, income and expenses.

Joint ventures are arrangements in which the ICB has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method.

1.5 Pooled Budgets

The ICB has entered into a pooled budget arrangement with Buckinghamshire County Council, Oxfordshire County Council, West Berkshire District Council, Wokingham Borough Council and Reading Borough Council which cover Integrated Care Board geographical area [in accordance with section 75 of the NHS Act 2006]. Under the arrangement, funds are pooled for the provision of health and social care services and note 19 provides details of the income and expenditure.

There are different pooled budget hosting arrangements between the ICB and respective Councils. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

1.6 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the ICB.

Notes to the financial statements

1.7 Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

- As per paragraph 121 of the Standard, the ICB will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
- The ICB is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the ICB to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the ICBs is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles. There are no significant payment terms.

The value of the benefit received when the ICB accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.80 Employee Benefits

1.8.1 Short-term Employee Benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.8.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.8.3 Local Government Pensions

One employee is a member of the Local Government Pension Scheme (Buckinghamshire Pension Fund), which is a defined benefit pension scheme, administered by Buckinghamshire Council. The ICB recognise on the Statement of Financial Position scheme liabilities arising from employee deductions and the ICB contributions which are paid to the Council.

The liabilities of the Buckinghamshire Council pension fund and valuation methodology are disclosed in the Council's Financial Statements.

1.9 Other Expenses

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.10 Property, Plant & Equipment

1.10.1 Recognition

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the ICB;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Notes to the financial statements

1.10.2 Measurement

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are re-valued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.10.3 Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.11 Intangible Assets

1.11.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the ICB's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the ICB;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.11.2 Measurement

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.11.3 Depreciation, Amortisation & Impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the ICB expects to obtain economic benefits or service potential from the asset. This is specific to the ICB and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the ICB checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Notes to the financial statements

1.12 Leases

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration. The ICB assesses whether a contract is or contains a lease, at inception of the contract.

1.12.1 The ICB as Lessee

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The HM Treasury incremental borrowing rate of 3.51% is applied for leases commencing, transitioning or being remeasured in the 2023 calendar year; and 4.72% to new leases commencing in 2024 under IFRS 16.

Lease payments included in the measurement of the lease liability comprise:

- Fixed payments;
- Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
- The amount expected to be payable under residual value guarantees;
- The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
- Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

Variable rents that do not depend on an index or rate are not included in the measurement of the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FRoM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.13 Cash & Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the ICB's cash management.

1.14 Provisions

Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A nominal short-term rate of 4.03% (2023-24: 4.26%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- A nominal medium-term rate of 4.07% (2023-24: 4.03%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
- A nominal long-term rate of 4.81% (2023-24: 4.72%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
- A nominal very long-term rate of 4.55% (2023-24: 4.40%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the ICB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

Notes to the financial statements

1.15 Clinical Negligence Costs

NHS Resolution operates a risk pooling scheme under which the ICB pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the ICB.

1.16 Non-clinical Risk Pooling

The ICB participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the ICB pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.17 Contingent liabilities and contingent assets

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.18 Financial Assets

Financial assets are recognised when the ICB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.19 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the ICB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.20 Value Added Tax

Most of the activities of the ICB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.21 Losses & Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the ICB not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.22 Critical accounting judgements and key sources of estimation uncertainty

In the application of the ICB's accounting policies, management is required to make various judgements, estimates and assumptions. These are reviewed periodically.

1.22.1 Critical accounting judgements in applying accounting policies

The following are the judgements, apart from those involving estimations, that management has made in the process of applying the ICB's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Judgements have been made by management as required by IAS 1.122, in regards to lease classification and revenue recognition.

1.22.2 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Accruals

Accruals are calculated utilising management knowledge, market intelligence and contractual arrangements. These accruals cover areas such as prescribing and contracts for healthcare and non healthcare services. For goods and/or services that have been delivered but for which no invoice has been received/sent, the Integrated Care Board has made an accrual based upon known commitments, contractual arrangements that are in place and legal obligation.

Prescribing liabilities

NHS England actions monthly cash charges to the Integrated Care Board for prescribing drug costs. These are issued approximately 8 weeks in arrears. The Integrated Care Board uses data from the NHS Business Service Authority on prescribing costs incurred to date, which at year end would be actuals up to January, and would then base a year end prediction on the remaining months using growth patterns incurred from previous years factoring in any other cost pressures such as NCSOs (no cheaper stock obtainable) etc.

Notes to the financial statements

1.23 Continuing Care Provisions

Sources of estimation uncertainty - CHC provisions

The ICB generates provisions to cover future liabilities with an element of uncertainty over their value and/or resolution trajectory. These provisions are estimated by management based on knowledge of the business, assumptions of probability and resolution delays. These assumptions are reviewed annually.

Provision is made in the ICB books for challenges and other backdated claims for funding under Continuing Healthcare (CHC) or Children's Continuing Care (CCC). These include:

- Assessment of previously unassessed periods of care (PUPoC).
- Local Authority disputes and Responsible Commissioner disputes, where it has not been definitively determined that BOB ICB is financially responsible commissioner.
- Appeals, where a negative eligibility decision has been challenged and is to be resolved, in the first instance, locally.
- Independent review panel cases, where a negative eligibility decision has been challenged and is to be resolved by an independent review
- Retrospective cases, where an eligibility decision has not been made previously.

Each case has an estimated potential liability, calculated on the length of time for which the claim relates and an estimated cost for that period of time, up to the accounting period end.

A "risk" percentage is applied to the cases by category, based on local past experience of the success of such cases to fairly reflect the potential liability of the ICB. Where a case outcome is known to be positive but a settlement value has not yet been finally agreed, the risk percentage is 100%.

1.24 New and revised IFRS Standards in issue but not yet effective

- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2025: early adoption is not therefore permitted.
- IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted
- IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

2. Other Operating Revenue

	2024-25	2023-24
	Total	Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Education, training and research	-	1
Non-patient care services to other bodies	4,312	3,486
Prescription fees and charges	16,935	15,989
Dental fees and charges	23,424	21,688
Other Contract income	5,126	4,733
Total Income from sale of goods and services	49,797	45,898
Other operating income		
Charitable and other contributions to revenue expenditure: non-NHS	25	-
Other non contract revenue	120	-
Total Other operating income	145	-
Total Operating Income	49,942	45,898

3. Disaggregation of Income - Income from sale of good and services (contracts)

	2024-25				
	Education, training and research	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income
	£'000	£'000	£'000	£'000	£'000
Source of Revenue					
NHS	-	274	-	-	237
Non NHS	-	4,038	16,935	23,424	4,889
Total	-	4,312	16,935	23,424	5,126
	Non-patient care services to other bodies	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income
	£'000	£'000	£'000	£'000	£'000
Timing of Revenue					
Point in time	-	274	-	-	237
Over time	-	4,038	16,935	23,424	4,889
Total	-	4,312	16,935	23,424	5,126
	2023-24				
	Education, training and research	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income
	£'000	£'000	£'000	£'000	£'000
Source of Revenue					
NHS	-	630	-	-	2,626
Non NHS	1	2,856	15,989	21,688	2,107
Total	1	3,486	15,989	21,688	4,733
	Education, training and research	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income
	£'000	£'000	£'000	£'000	£'000
Timing of Revenue					
Point in time	1	3,486	15,989	21,688	4,733
Total	1	3,486	15,989	21,688	4,733

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	Total		2024-25
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	23,645	3,583	27,228
Social security costs	2,850	-	2,850
Employer Contributions to NHS Pension scheme*	5,382	-	5,382
Apprenticeship Levy	112	-	112
Termination benefits**	848	-	848
Gross employee benefits expenditure	32,837	3,583	36,420
Total - Net admin employee benefits including capitalised costs	32,837	3,583	36,420
Net employee benefits excluding capitalised costs	32,837	3,583	36,420

* Included is £13.8k contribution to the Buckinghamshire Pension Fund

** Termination benefits are those that have been formally agreed in year regardless of payment status.

4.1.1 Employee benefits

	Total		2023-24
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	23,060	4,498	27,558
Social security costs	2,471	-	2,471
Employer Contributions to NHS Pension scheme	3,957	-	3,957
Apprenticeship Levy	97	-	97
Termination benefits	233	-	233
Gross employee benefits expenditure	29,818	4,498	34,316
Total - Net admin employee benefits including capitalised costs	29,818	4,498	34,316
Net employee benefits excluding capitalised costs	29,818	4,498	34,316

4.2 Average number of people employed

	2024-25			2023-24		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	402	34	436	332	84	415

4.3 Exit packages agreed in the financial year

	2024-25	
	Other agreed departures Number	£
Less than £10,000	-	-
£10,001 to £25,000	3	63,307
£25,001 to £50,000	1	31,697
£50,001 to £100,000	8	619,663
£100,001 to £150,000	1	133,333
Total	13	848,000

4.4 Analysis of Other Agreed Departures

	2024-25	
	Other agreed departures Number	£
Voluntary redundancies including early retirement contractual costs	12	752,635
Contractual payments in lieu of notice	1	95,366
Total	13	848,000

There are no special payments made due to departure.

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in full.

Redundancy and other departure cost have been paid in accordance with the provisions of NHS Redundancy Scheme. Exit costs in this note are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

4.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years".

An outline of these follows:

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.5.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

5. Operating expenses

	2024-25	2023-24
	Total	Total
	£'000	£'000
Purchase of goods and services		
Services from other ICBs and NHS England	14,339	15,079
Services from foundation trusts	2,004,724	1,879,958
Services from other NHS trusts	495,914	472,932
Purchase of healthcare from non-NHS bodies	521,620	428,140
Purchase of social care	16,870	8,230
General Dental services and personal dental services	100,390	87,532
Prescribing costs	284,863	275,280
Pharmaceutical services	48,027	46,473
General Ophthalmic services	14,391	13,756
GPMS/APMS and PCTMS	360,199	341,681
Supplies and services – clinical	1,514	1,470
Supplies and services – general	6,729	1,723
Consultancy services	1,939	2,979
Establishment	8,854	7,447
Transport	4	4
Premises	3,554	5,423
Audit fees	300	321
Other non statutory audit expenditure		
· Internal audit services	104	141
· Other services	-	77
Other professional fees	2,524	1,928
Legal fees	382	403
Education, training and conferences	196	110
Total Purchase of goods and services	3,887,437	3,591,085
Depreciation and impairment charges		
Depreciation	428	637
Amortisation	156	156
Total Depreciation and impairment charges	584	793
Provision expense		
Provisions	368	(801)
Total Provision expense	368	(801)
Other Operating Expenditure		
Chair and Non Executive Members	199	243
Research and development (excluding staff costs)	73	421
Expected credit loss on receivables	(7)	-
Other expenditure	490	446
Total Other Operating Expenditure	755	1,110
Total operating expenditure	3,889,144	3,592,186

6. Payment Compliance Reporting**6.1 Better Payment Practice Code**

Measure of compliance	2024-25 Number	2024-25 £'000	2023-24 Number	2023-24 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	51,630	449,765	43,406	455,942
Total Non-NHS Trade Invoices paid within target	50,049	434,353	41,361	440,706
Percentage of Non-NHS Trade invoices paid within target	96.9%	96.6%	95.3%	96.7%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	963	46,009	972	49,484
Total NHS Trade Invoices Paid within target	901	39,094	898	45,579
Percentage of NHS Trade Invoices paid within target	93.6%	85.0%	92.4%	92.1%

The Better Payment Practice Code requires the ICB to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The target for achievement is greater than 95%. The ICB achieved the target in paying non-NHS invoices and was under target in paying NHS invoices.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2024-25 £'000	2023-24 £'000
Amounts included in finance costs from claims made under this legislation	1	-
Total	1	-

7. Finance costs

	2024-25 £'000	2023-24 £'000
Interest		
Interest on lease liabilities	9	12
Interest on late payment of commercial debt	1	-
Total interest	10	12
Total finance costs	10	12

8. Property, plant and equipment

	Information technology £'000	Furniture & fittings £'000	Total £'000
2024-25			
Cost or valuation at 01 April 2024	1,445	573	2,018
Additions purchased	53	-	53
Disposals other than by sale	-	(573)	(573)
Cost/Valuation at 31 March 2025	1,498	-	1,498
Depreciation 01 April 2024	1,189	573	1,762
Disposals other than by sale	-	(573)	(573)
Charged during the year	69	-	69
Depreciation at 31 March 2025	1,258	-	1,258
Net Book Value at 31 March 2025	240	-	240
Purchased	240	-	240
Total at 31 March 2025	240	-	240
Asset financing:			
Owned	240	-	240
Total at 31 March 2025	240	-	240
Net Book Value at 31 March 2024	256	-	256

	Information technology £'000	Furniture & fittings £'000	Total £'000
2023-24			
Cost or valuation at 01 April 2023	1,422	573	1,995
Additions purchased	23	-	23
Cost/Valuation at 31 March 2024	1,445	573	2,018
Depreciation 01 April 2023	1,118	573	1,691
Charged during the year	71	-	71
Depreciation at 31 March 2024	1,189	573	1,762
Net Book Value at 31 March 2024	256	-	256
Purchased	256	-	256
Total at 31 March 2024	256	-	256
Asset financing:			
Owned	256	-	256
Total at 31 March 2024	256	-	256
Net Book Value at 31 March 2023	304	-	304

8.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Information technology	3	5
Furniture & fittings	5	10

9. Leases**9.1 Right-of-use assets**

	Buildings excluding dwellings £'000	Total £'000	Of which: leased from DHSC group bodies £000
2024-25			
Cost or valuation at 01 April 2024	2,008	2,008	1,421
Additions	185	185	185
Lease remeasurement	65	65	89
Derecognition for early terminations	(427)	(427)	-
Cost/Valuation at 31 March 2025	1,831	1,831	1,695
Depreciation 01 April 2024	819	819	-
Charged during the year	360	360	256
Derecognition for early terminations	(398)	(398)	-
Depreciation at 31 March 2025	781	781	256
Net Book Value at 31 March 2025	1,050	1,050	1,439
NBV by counterparty*			
Leased from DHSC			417
Leased from NHS Providers			548
Leased from Non-Departmental Public Bodies			85
Net Book Value at 31 March 2025			1,050

* New in year disclosure.

	Buildings excluding dwellings £'000	Total £'000	Of which: leased from DHSC group bodies £000
2023-24			
Cost or valuation at 01 April 2023	1,644	1,644	593
Additions	363	363	-
Cost/Valuation at 31 March 2024	2,008	2,008	593
Depreciation 01 April 2023	254	254	99
Charged during the year	565	565	99
Depreciation at 31 March 2024	819	819	198
Net Book Value at 31 March 2024	1,188	1,188	395
Net Book Value at 31 March 2023	1,391	1,391	494

9 Leases cont'd

9.2 Lease liabilities

2024-25	2024-25	2023-24
	£'000	£'000
Lease liabilities at 01 April 2024	(1,224)	(1,396)
Additions purchased	(185)	(363)
Interest expense relating to lease liabilities	(9)	(12)
Repayment of lease liabilities (including interest)	485	547
Lease remeasurement	(65)	-
Disposals on expiry of lease term	28	-
Lease liabilities at 31 March 2025	(970)	(1,224)

9.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2024-25	Of which: leased from DHSC group bodies	2023-24	Of which: leased from DHSC group bodies
	£'000	£'000	£'000	£'000
Within one year	(344)	(327)	(418)	(236)
Between one and five years	(626)	(557)	(789)	(720)
After five years	-	-	(18)	-
Balance at 31 March 2025	(970)	(884)	(1,224)	(956)

Balance by counterparty

Leased from DHSC	(420)	(558)
Leased from NHS Providers	(464)	(398)
Leased from Non-Departmental Public Bodies	(86)	(268)
Balance as at 31 March 2025	(970)	(1,224)

9.4 Amounts recognised in Statement of Comprehensive Net Expenditure

2024-25	2024-25	2023-24
	£'000	£'000
Depreciation expense on right-of-use assets	360	565
Interest expense on lease liabilities	9	12
Expense relating to variable lease payments not included in the measurement of the lease liability	54	699

9.5 Amounts recognised in Statement of Cash Flows

2024-25	2024-25	2023-24
	£'000	£'000
Total cash outflow on leases under IFRS 16	485	547
Total cash outflow for lease payments not included within the measurement of lease liabilities	54	699

10. Intangible non-current assets

	Computer Software: Purchased £'000	Total £'000
2024-25		
Cost or valuation at 01 April 2024	780	780
Cost / Valuation At 31 March 2025	780	780
Amortisation 01 April 2024	320	320
Charged during the year	156	156
Amortisation At 31 March 2025	476	476
Net Book Value at 31 March 2025	304	304
Net Book Value at 31 March 2024	460	460

	Computer Software: Purchased £'000	Total £'000
2023-24		
Cost or valuation at 01 April 2023	780	780
Cost / Valuation At 31 March 2024	780	780
Amortisation 01 April 2023	164	164
Charged during the year	156	156
Amortisation At 31 March 2024	320	320
Purchased	460	460
Net Book Value at 31 March 2024	460	460
Net Book Value at 31 March 2023	616	616

10.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Computer software: purchased	3	5

11. Trade and other receivables**11.1 Trade and other receivables**

	Current 2024-25 £'000	Current 2023-24 £'000
NHS receivables: Revenue	1,215	3,429
NHS prepayments	54	-
NHS accrued income	1,608	691
NHS Non Contract trade receivable (i.e pass through funding)	3,632	5,100
Non-NHS and Other WGA receivables: Revenue	2,064	556
Non-NHS and Other WGA prepayments	1,557	4,609
Non-NHS and Other WGA accrued income	2,308	4,251
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice funding)	-	4,676
Expected credit loss allowance-receivables	2,878	2,260
VAT	(14)	(21)
Other receivables and accruals	453	647
	18,988	25,017
Total Trade & other receivables	34,743	51,215
Total current and non current	34,743	51,215

11.2 Receivables past their due date but not impaired

	2024-25 DHSC Group Bodies £'000	2024-25 Non DHSC Group Bodies £'000	2023-24 DHSC Group Bodies £'000	2023-24 Non DHSC Group Bodies £'000
By up to three months	3,259	22	4,041	166
By three to six months	-	4	639	-
By more than six months	-	110	-	1
Total	3,259	136	4,680	167

11.3 Loss allowance on asset classes

Balance at 01 April 2022	(21)	(21)
Lifetime expected credit losses on trade and other receivables-Stage 3	7	7
Total	(14)	(14)

Trade and other receivables - Non DHSC Group Bodies £'000	Total £'000
(21)	(21)
7	7
(14)	(14)

11.4 Provision Matrix on lifetime credit loss

	2024-25 £'000 Gross Carrying Amount	2023-24 £'000 Gross Carrying Amount
Current	47	124
1 - 30 days	22	-
61 - 90 days	-	166
Greater than 90 days	114	1
Total expected credit loss	183	291

12. Cash and cash equivalents

	2024-25 £'000	2023-24 £'000
Balance at 01 April 2024	584	64
Net change in year	412	520
Balance at 31 March 2025	996	584
Made up of:		
Cash with the Government Banking Service	996	584
Cash and cash equivalents as in statement of financial position	996	584
Balance at 31 March 2025	996	584

NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (NHS BOB ICB) does not hold any patients' money neither held money on behalf of the ICB Group by the 31 March 2025.

13. Trade and other payables

	Current 2024-25 £'000	Current 2023-24 £'000
NHS payables: Revenue	11,892	16,695
NHS accruals	28,947	24,928
NHS deferred income	664	-
Non-NHS and Other WGA payables: Revenue	33,512	33,894
Non-NHS and Other WGA payables: Capital	53	23
Non-NHS and Other WGA accruals	103,762	89,701
Non-NHS and Other WGA deferred income	44	107
Social security costs	355	355
Tax	425	365
Other payables and accruals	54,389	58,839
Total Trade & Other Payables	234,043	224,907
Total current and non-current	234,043	224,907

Other payables include £2,745k outstanding pension contributions at 31 March 2025 (2024: £2,702k)

14. Provisions

	Current 2024-25 £'000	Non-current 2024-25 £'000	Current 2023-24 £'000	Non-current 2023-24 £'000
Continuing care	2,644	241	1,049	1,752
Total	2,644	241	1,049	1,752
Total current and non-current	2,884		2,802	
	Continuing Care £'000	Total £'000		
Balance at 01 April 2024	2,802	2,802		
Arising during the year	1,879	1,879		
Utilised during the year	(285)	(285)		
Reversed unused	(1,512)	(1,512)		
Balance at 31 March 2025	2,884	2,884		
Expected timing of cash flows:				
Within one year	2,644	2,644		
Between one and five years	241	241		
Balance at 31 March 2025	2,884	2,884		

Legal claims are calculated from the number of claims currently lodged with NHS Resolution and the probabilities provided by them.

There were no legal claims outstanding at 31 March 2025.

The provision for Continuing Care is the Integrated Care Board's estimated liability to pay claims in respect of continuing care assessments.

The reversal of the provision is related to cases which were evaluated and assessed to be ineligible.

15. Contingencies

	2024-25 £'000	2023-24 £'000
Contingent liabilities		
Net value of contingent liabilities	-	48

No contingent liabilities were disclosed by the NHS Litigation Authority as at 31 March 2025 (31 March 2024: £48k) in respect of Clinical Negligence liabilities of the Integrated Care Board.

15.1 Waste procurement legal dispute

During 2024 a joint procurement [the Procurement] was undertaken with 23 other ICBs for a Primary Care Clinical Waste Collection and Disposal contract, for a period of 5 years with the option to extend for a further 4 years. Each ICB procured an individual Lot. In December 2024, 9 of the ICBs, published standstill letters with an intention to award a contract. During the subsequent standstill period, in December 2024 legal proceedings [the Claim] challenging the contract award decisions were commenced by one of the unsuccessful bidders [the Claimant], naming all 22 of the ICBs which remained involved in the Procurement (2 ICBs having decided not to proceed) as Defendants. At this early stage of the Claim, it is not possible to sensibly nor accurately determine the probability of success by the Claimant, nor is it possible to estimate the financial impact of a successful Claim with any level of certainty. Given this uncertainty of both of these key components, the ICB is therefore classifying this challenge as a contingent liability.

16. Other Financial Commitments

	Total 2024-25 £'000	Total 2023-24 £'000
In not more than one year	18,800	-
In more than one year but not more than five years	2,559	-
Total at 31 March 2025	21,359	-

16.1 Other Financial Commitments whose full cost exceeds £1m

Description	Total 2024-25 £'000	Total 2023-24 £'000
HSCN Access Services	1,852	-
Patient Transport Service	18,117	-
	19,969	-

The ICB in year implemented a No Po No Pay policy, disclosure of other financial commitments relates to purchase orders issued to Suppliers that cover more than one financial year.

17. Financial instruments**17.1 Financial risk management**

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board and internal auditors.

17.1.1 Currency risk

The Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board has no overseas operations and therefore has low exposure to currency rate fluctuations.

17.1.2 Interest rate risk

The Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board therefore has low exposure to interest rate fluctuations.

17.1.3 Credit risk

Because the majority of the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board revenue comes parliamentary funding, NHS integrated care board has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

17.1.4 Liquidity risk

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board draws down cash to cover expenditure, as the need arises. The Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board is not, therefore, exposed to significant liquidity risks.

17.1.5 Financial Instruments

As the cash requirements of Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board's expected purchase and usage requirements and Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board is therefore exposed to little credit, liquidity or market risk.

17. Financial instruments cont'd

17.2 Financial assets

	Financial Assets measured at amortised cost	Total	Total
	2024-25	2024-25	2023-24
	£'000	£'000	£'000
Trade and other receivables with NHSE bodies	477	477	643
Trade and other receivables with other DHSC group bodies	6,074	6,074	10,224
Trade and other receivables with external bodies	26,142	26,142	35,113
Cash and cash equivalents	996	996	584
Total at 31 March 2025	33,689	33,689	46,564

17.3 Financial liabilities

	Financial Liabilities measured at amortised cost	Total	Total
	2024-25	2024-25	2023-24
	£'000	£'000	£'000
Trade and other payables with NHSE bodies	2,212	2,212	828
Trade and other payables with other DHSC group bodies	38,696	38,696	43,801
Trade and other payables with external bodies	191,649	191,649	180,675
Private Finance Initiative and finance lease obligations	970	970	-
Total at 31 March 2025	233,526	233,526	225,304

18. Operating segments

The Integrated Care Board and consolidated group consider they have only one segment that being Commissioning of Healthcare Services.

19. Joint arrangements - interests in joint operations

Buckinghamshire, Oxfordshire and Berkshire West ICB (BOB ICB) should disclose information in relation to joint arrangements in line with the requirements in IFRS 12 - Disclosure of interests in other entities.

The NHS Integrated Care Board shares of the income and expenditure handled by the pooled budgets in the financial year were:

Pooled Budget Total

Arrangement schemes	2024-25				2023-24			
	Assets £000	Liabilities £000	Income £000	Expenditure £000	Assets £000	Liabilities £000	Income £000	Expenditure £000
Adults with Care and Social Needs (ACSN)	6,000	6,000	184,403	184,403	10,403	10,403	162,448	162,448
Better Care Fund	12,985	12,985	168,764	168,764	11,765	11,765	167,524	167,524
Child And Adolescent Mental Health	-	-	-	-	-	-	8,478	8,478
Community Equipment Stores	-	-	4,816	4,816	-	-	5,240	5,240
Integrated Community Equipment Service (Management)	-	-	57	57	-	-	57	57
Integrated Community Equipment Service	-	-	9,234	9,234	-	-	8,755	8,755
Respite Residential Short Breaks, Occupational Therapy, Physiotherapy	-	-	529	529	-	-	529	529
Speech And Language Therapy, Occupational Therapy & Physiotherapy	-	-	2,062	2,062	-	-	2,060	2,060
Section 117	-	-	15,249	15,249	-	-	13,315	13,315
Written Statement Of Action (WSOA)	-	-	1,024	1,024	-	-	1,027	1,027
BOB ICB and Buckinghamshire County Council - Respite Residential Short Breaks	-	-	10	10	-	-	10	10
SpeechLink	-	-	46	46	-	-	29	29
Hospital Discharge Programme	-	-	4,038	4,038	-	-	2,285	2,285
UEC	-	-	-	-	-	-	681	681
Integrated Community Services	-	-	25,340	25,340	-	-	-	-
Annual Health Checks for people with severe mental illness (SMI)	-	-	88	88	-	-	-	-
DOLS (ICB)	-	-	654	654	-	-	-	-
Total	18,985	18,985	416,314	416,314	22,168	22,168	372,438	372,438

19. Joint arrangements - interests in joint operations cont'd

Buckinghamshire		Amounts recognised in Entities books ONLY		Amounts recognised in Entities books ONLY	
		2024-25		2023-24	
		Income £'000	Expenditure £'000	Income £'000	Expenditure £'000
Name of arrangement	Description of principal activities				
BOB ICB and Buckinghamshire County Council - Integrated Community Equipment Service	The Pool Budget between BOB ICB and Buckinghamshire Council covers the provision of the Integrated Community Equipment Service (including Adult Social Care, Telecare and Children and Young People's Services) for the period. Buckinghamshire Council is the host and lead authority for this pooled fund arrangement. The Joint Pooled Fund supports procurement, storage, delivery, installation and technical demonstration as well as subsequent collection, cleaning, recycling, maintenance and repair of equipment, for use by eligible clients.	9,234	9,234	8,755	8,755
BOB ICB and Buckinghamshire County Council - Integrated Community Equipment Service (Management)	The Pool Budget between BOB ICB and Buckinghamshire Council for the provision of the Integrated Community Equipment Service Contract Management. The agreement covers the period in question. Buckinghamshire Council is the host and lead authority for this pooled fund arrangement.	57	57	57	57
BOB ICB and Buckinghamshire County Council - Section 117	The Pool Budget between BOB ICB and Buckinghamshire Council covers the provision of Section 117 aftercare, to cover the period, providing care packages that are suitable for the clients requirements. Buckinghamshire Council is the host and lead authority for this pooled fund arrangement.	15,249	15,249	13,315	13,315
BOB ICB and Buckinghamshire County Council - Better Care Fund	The Pool Budget between BOB ICB and Buckinghamshire Council for the provision of the Better Care Fund, for health and social care, to cover the period. The Joint Pooled Fund supports the provision of community health teams and social care activities for the population of Buckinghamshire. Buckinghamshire Council is the host and lead authority for this pooled fund arrangement.	13,255	13,255	12,545	12,545
BOB ICB and Buckinghamshire County Council - Child And Adolescent Mental Health	This is a Pool Budget with BOB ICB and Buckinghamshire Council for the provision of a Child and Adolescent Mental Health Service to cover the period. Buckinghamshire Council is the host and lead authority for this pooled fund arrangement.	-	-	8,478	8,478
BOB ICB and Buckinghamshire County Council - Speech And Language Therapy, Occupational Therapy & Physiotherapy	The Pool Budget is between BOB ICB and Buckinghamshire Council for the provision of Speech & Language Therapies, Occupational Therapy and Physiotherapy to cover the period. Buckinghamshire Council is the host and lead authority for this pooled fund arrangement.	2,062	2,062	2,060	2,060
BOB ICB and Buckinghamshire County Council - Respite Residential Short Breaks	The Pool Budget is between BOB ICB and Buckinghamshire Council for the provision of Residential Respite Short Breaks and covers the period. Buckinghamshire Council is the host and lead authority for this pooled fund arrangement.	529	529	529	529
BOB ICB and Buckinghamshire County Council - Written Statement Of Action (WSOA)	To support an action plan put in place following a SEND inspection in early 2022 which addressed areas of weakness in therapies, community paediatrics and the neuro developmental pathway for children and young people with ADHD and ASD.	1,024	1,024	1,027	1,027
BOB ICB and Buckinghamshire County Council - Children's Specific Training S.75 and other budgets (Respite)	To support training relating to Children and Young People.	10	10	10	10
BOB ICB and Buckinghamshire County Council - SpeechLink	To support the identification and intervention of language and speech needs.	46	46	29	29
BOB ICB and Buckinghamshire County Council - Integrated Community Services	The ICB commission a range of integrated community services from Buckinghamshire Healthcare Trust designed to prevent admission to acute care and, when admitted, to support timely discharge. These services include 24/7 Adult Community Health Teams (ACHTs) across 7 localities in Buckinghamshire; a home intravenous antibiotics service, and the Community Assessment and Treatment Service (CATS) for Buckinghamshire residents.	25,340	25,340	-	-
BOB ICB and Buckinghamshire County Council - Annual Health Checks for people with severe mental illness (SMI)	Supports delivery of the Care Act requirements	88	88	-	-
BOB ICB and Buckinghamshire County Council - DOLS (ICB)	24/7 Clinical support via video link to support care homes.	654	654	-	-

19. Joint arrangements - interests in joint operations cont'd

Oxfordshire

Parties to the arrangement and schemes	Description of principal activities	Amounts recognised in Entities books ONLY				Amounts recognised in Entities books ONLY			
		2024-25				2023-24			
		Assets £'000	Liabilities £'000	Income £'000	Expenditure £'000	Assets £'000	Liabilities £'000	Income £'000	Expenditure £'000
BOB ICB and Oxfordshire County Council (OCC) - Better Care Fund (BCF) Pool	The Age Well pool provides health and social care services to adults of working age and older adults. Services include those covering care home provision as well as services designed to promote hospital avoidance and prevention of admission to hospital.	12,985	12,985	119,154	119,154	11,765	11,765	118,046	118,046
BOB ICB and Oxfordshire County Council (OCC) - Adults with Care and Social Needs (ACSN)	The Live Well pool provides health and social care services to children and adults of working age. Services include those covering care home provision for physical disability as well as services covering mental health, acquired brain injury and learning disability.	6,000	6,000	184,403	184,403	10,403	10,403	162,448	162,448

Berkshire West

Parties to the arrangement and schemes	Description of principal activities	Amounts recognised in Entities books ONLY		Amounts recognised in Entities books ONLY	
		2024-25		2023-24	
		Income £'000	Expenditure £'000	Income £'000	Expenditure £'000
Pooled Budget with West Berkshire Council (consortium lead), Reading Borough Council, Wokingham Borough Council, Bracknell Forest Borough Council, Slough Borough Council, Royal Borough of Windsor and Maidenhead, NHS Frimley ICB, Royal Berkshire Fire and Rescue Service and BOB ICB. - Community Equipment Stores	West Berkshire Council acts as the consortium lead hosting the contract with NRS Healthcare Ltd to provide community equipment (also known as home loans) for Berkshire residents and patients. The equipment items are prescribed by social services, health and fire professionals from the partner organisations. The provision of this community equipment is intended to facilitate timely discharges of patients from hospital to home, prevent unnecessary hospital admissions, and promote health and independence in enabling people to continue living safely in their own homes.	4,816	4,816	5,240	5,240
Wokingham Borough Council and BOB ICB - Better Care Fund	Short term integrated health and social care, Step up beds at Wokingham Hospital, Community health and social care, Preventative services and Protection of adult social care	7,521	7,521	7,615	7,615
BOB ICB and Wokingham Borough Council - Better Care Fund	Reablement, Out of hospital services include speech & language therapy, care homes in reach, community geriatrician, intermediate care and health hub, connected care and street triage	3,262	3,262	3,564	3,564
West Berkshire Council and BOB ICB - Better Care Fund	Step down beds in West Berkshire Care Home, adult social care, 7 day week service, protecting social care services and delayed transfer of care projects	8,299	8,299	7,634	7,634
BOB ICB & West Berkshire Council - Better Care Fund	Reablement, Out of hospital services including speech & language therapy, care homes in reach, community geriatrician, intermediate care and health hub, connected care and street triage	4,155	4,155	4,356	4,356
Reading Borough Council and BOB ICB - Better Care Fund	Protection of social care, time to decide beds, Care Act costs, carers funding and delayed transfer of care projects	8,956	8,956	9,273	9,273
BOB ICB & Reading Borough Council - Better Care Fund	Reablement, Out of hospital services include speech & language therapy, care homes in reach, community geriatrician, intermediate care and health hub, connected care and street triage	4,162	4,162	4,491	4,491
BOB ICB & West Berkshire Council, Reading Borough Council and Wokingham Borough Council - Hospital Discharge Programme	Costs of care such as nursing and residential home beds, homecare packages, equipment costs etc for the discharged patients were met directly by the local authorities via a Pooled Budget under Section 35.	4,038	4,038	2,285	2,285
BOB ICB & West Berkshire Council, Reading Borough Council and Wokingham Borough Council - UEC	Urgent and Emergency Care	-	-	681	681

20. Related party transactions

Details of related party transactions with individuals are as follows:

Member	Related Party	2024-25				2023-24
		Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000	Net Payments £'000
Saqhib ALI - Non Exec Dir & Chair of the Audit & Risk Committee	Non Exec Dir and Audit Chair -Northamptonshire Healthcare NHSFT	136	-	2	-	130
Nick BROUGHTON BOB ICB Chief Executive Officer (from 04.09.2024); Interim BOB ICB Chief Executive Officer (01.07.2023 to 03.09.2024)	Chief Exec - Oxford Health NHS Foundation Trust	346,138	10	225	-	352,071
	Member Department of Psychiatry - University of Oxford	962	-	140	-	959
Rachael de CAUX - Chief Medical Officer (01.04.2 to 30.11.2024)	Consultant - Royal Berkshire NHS Foundation Trust	457,014	48	285	-	436,489
	Spouse - Director of Performance - NHS England South East Regional Office	552	2,737	-	3,444	(9,733)
Rachael CORSER - Chief Nursing Officer	Step sister - Director Children's services - Wokingham Borough Council	8,951	-	589	22	-
Alastair GROOM - Interim Chief Financial Officer (from 17.02.2025) previously Turnaround/Finance Improvement Officer	Director & Shareholder - Afsang Advisory Associates 1 Ltd	195	-	-	-	-
	Professional relationships with individuals (former partner) - KPMG	125	-	-	-	-
	Professional relationships with individuals (former partner) - PWC	340	-	-	-	-
	Professional relationships with individuals (former partner) - NHS England	552	2,737	-	3,444	-
	Personal relationship with Consultant Clinical Psychologist - Newcastle upon Tyne NHSFT	101	-	-	-	-
Hannah IQBAL - Chief Strategy, Digital and Transformation Officer	Spouse senior registrar - John Radcliffe Hospital / Oxford Universities Hospital	666,385	8	486	48	-
Priya SINGH - Chair BOB ICB (started 01.10.2024)	Chair - NHS Frimley ICB	1,910	439	51	57	-
Ben RILEY - Chief Medical Officer (started 03.03.2025)	Former Board Director & Chief Operating Officer for Community Health Services, Primary Care and Dentistry - Oxford Health NHSFT	346,138	10	225	-	-
Abid IRFAN - Interim Chief Medical Officer (01.12.2024 to 02.03.2025) and Director of Primary Care	GP partner - Strawberry Hill Medical Centre	3,320	0	-	-	-
Grant MACDONALD - Partner member Mental Health (started 06.01.2025)	Chief Executive - Oxford Health NHS Foundation Trust	346,138	10	225	-	-
Steve MCMANUS - Partner member NHS Trusts/Foundation Trusts	Chief Executive - Royal Berkshire NHS Foundation Trust (RBFT)	457,014	48	285	-	436,489
	Vice President - League of Friends (RBFT)	457,014	48	285	-	436,489
Tim NOLAN - Non Executive Director Chair of the System Productivity Committee	Governor - Royal Marsden NHS Foundation Trust	1,374	-	-	-	2,547
Aidan RAVE - Non Executive Director & Senior Independent Director and Chair of the Place and Organisational Development Committee	Consultant - Ernst & Young	303	-	-	-	927
Sim SCAVAZZA - Non Executive Director and Deputy Chair of ICB and Chair of the People & ICB Freedom to Speak Up (FTSU) Guardian	Non-Executive Director and Chair of People Committee - Imperial College Healthcare Trust	7,702	-	-	-	7,910
	Advisor on Race - NHS Providers	0	-	-	-	1
Minoo IRANI - Partner member Mental Health (left 31.12.2024)	Medical Director - Berkshire Healthcare NHSFT	196,509	110	18	-	180,415
	Non Exec Director -Royal Berkshire NHSFT	457,014	48	285	-	-
	Spouse employed by NHS England	552	2,737	0	3,444	(9,733)
Rachael SHIMMIN - Partner member local Government (from 07.07.2023 to 31.01.2025)	CEO - Buckinghamshire Council	48,255	3,235	3,634	446	51,074
Caroline CORRIGAN - Interim Chief People Officer (from 13.11.2023 to 31.12.2024)	Chief People Officer - NHS Frimley ICB	1,910	439	51	57	(523)
Victoria OTLEY-GROOM - Chief Digital & Information Officer (CDIO) (from 30.10.2023 to 30.11.2024)	Sister - Director Enst & Young	303	-	-	-	927
Dr George GAVRIEL - Partner member Primary Medical Services	GP Partner - The Swan Practice, Bucks	5,485	-	-	-	29
	Accountable Clinical Director - The Swan Network	1,385	-	-	-	808
	Shareholder - Fedbucks	2,800	-	185	109	-
	Director - Gavriel Professional Services Ltd	34	-	-	-	11

20. Related party transactions

GP practices within the area have joined primary care networks (PCNs), a group of practices usually within the same geographical area that work together under the PCN DES contract to gain some of the benefits of working at scale and access to additional funding. These partnerships are collaborative arrangements between health and care organisations to design and deliver services to meet local needs within a geographical area, which is supported by Integrated Care Boards. This involves paying GP practices for the delivery of these services, using an ICB placed-based allocations tool which allows the user to aggregate GP practices into defined areas i.e. "places" of interest and calculates the weighted populations and relative need indices for these defined areas. The tool is designed to provide insight into the lower area level data that informs the overall allocations to ICBs by providing information on the variation in need between different areas within ICBs. Using the statistical formula in the allocation process, make geographic distribution fair and objective, so that it more clearly reflects local healthcare need and helps to reduce health inequalities.

The amounts in the table above represent the amounts paid to organisations named rather than the individual. Where an organisation appears several times, it is a duplicate of the previous entry but related to a different Governing Body member.

The Department of Health is regarded as a related party. During the year the Integrated Commissioning Board (ICB) has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. These entities are:

- Integrated Care Board
- NHS England;
- NHS Foundation Trusts;
- NHS Trusts;
- NHS Litigation Authority; and,
- NHS Business Services Authority.

In addition, the Integrated Commissioning Board has had a number of material transactions with other government departments and other central and local government bodies. Most of these

20.1 Related party transactions

Department of Health and Social Care (DHSC) related party information for group bodies 2024-25

The individuals and entities that the Department of Health and Social Care identifies as meeting the definition of Related Parties set out in IAS 24 (Related Party Transactions) are also deemed to be related parties of entities within the Departmental Group.

This note therefore sets out the individuals and entities which we have assessed as meeting the IAS 24 definition of Related Parties for the year ending 31 March 2025 to assist group bodies in preparing disclosures compliant with IAS 24.

Ministers

The Rt Hon Victoria Atkins MP
Andrew Stephenson CBE MP
Andrea Leadsom MP
Helen Whately MP
Maria Caulfield MP
The Lord Markham CBE

The Rt Hon Wes Streeting MP
Karin Smyth MP
Stephen Kinnock MP
Ashley Dalton MP
Andrew Gwynne
Baroness Gillian Merron

Senior Officials

Sir Chris Wormald KCB
Professor Sir Christopher Whitty KCB
Shona Dunn
Clara Swinson CB
Jonathan Marron CB
Matthew Style
Michelle Dyson
Andrew Brittain
Professor Lucy Chappell
Jenny Richardson
Zoe Bishop
Hugh Harris
Lorraine Jackson
Sally Warren
Catherine Frances CB
Tom Riordan
Paul Macnaught

Non-executive Directors

Gerry Murphy
Doug Gurr
Steve Rowe
Samantha Jones
Sir Roy Stone
Will Harris
The Rt Hon Alan Milburn
Richard Douglas
Naomi Eisenstadt CB
Baroness Camilla Cavendish
Phil Jordan

Related party		2024-25			
		Payments to Related Party	Amounts Owed to Related Party	Receipts from Related party	Amounts due from Related Party
		£'000	£'000	£'000	£'000
Entity linked to the individuals above	Accurx Ltd	1,255	-	-	-
Entity linked to the individuals above	Alzheimer's Society	67	-	-	-
Entity linked to the individuals above	NHS Confederation	35	-	-	-

21. Events after the end of the reporting period

On 13 March 2025 the government announced NHS England and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of ICBs is currently unchanged but they have been tasked with significant reductions in their cost base. Discussions are ongoing on the impact of these and the impact of staffing reductions, together with the costs and approvals of any exit arrangements. ICBs are currently being asked to implement any plans during quarter 3 of the 2025/26 financial year.

The ICB is considering the implications of this and as at this date no definitive decisions have been made on how to reduce costs or to change the organisational form.

22. Losses & Special Payments

The ICB has written off £1.2k salary overpayment to a former employee (2023-24: nil).

22. Financial performance targets

NHS Integrated Care Board have a number of financial duties under the NHS Act 2006 (as amended).

NHS Integrated Care Board performance against those duties was as follows:

	2024-25			2023-24		
	Target	Performance	Achieved Yes/No	Target	Performance	Achieved Yes/No
Expenditure not to exceed income	3,925,904	3,925,877	Yes	3,588,831	3,626,900	No
Capital resource use does not exceed the amount specified in Directions	322	303	Yes	386	386	Yes
Revenue resource use does not exceed the amount specified in Directions	3,875,640	3,875,631	Yes	3,542,547	3,580,617	No
Revenue administration resource use does not exceed the amount specified in Directions	30,781	30,257	Yes	34,988	33,582	Yes