Supplemental Items for Health and Wellbeing Board

Thursday, 13 July 2023 at 9.30am

in Council Chamber Council Offices
Market Street Newbury

Part I

Page No.

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Further information and Minutes are also available on the Council's website at www.westberks.gov.uk

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NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

NHS Buckinghamshire, Oxfordshire & Berkshire West Integrated Care Board Annual Report July 2022 / March 2023

Contents

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 from its establishment 1 July 2022 until the end of March 2023, how the organisation has performed and outlines the risks it faces.

Performance Overview

What do we do?

The BOB ICB was formally established as a new statutory body on 1 July 2022, replacing the three clinical commissioning groups across the area. The ICB has the statutory responsibility to plan, buy and oversee health services for nearly 2 million people from a range of NHS, voluntary, charitable, community and private sector providers.

The ICB is supporting the development of an Integrated Care System (ICS) which includes local NHS organisations and primary care providers (GPs, dentists, pharmacists and optometrists), local authorities, public health, Healthwatch, care providers, voluntary and community groups, as well as academic and research partners. This collaboration is called the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Partnership (BOB ICP); the group work together to plan and provide health and care services for the people who live and work in the local authority areas of Buckinghamshire, Oxfordshire and Berkshire's three westerly local authority areas of West Berkshire, Reading and Wokingham (known as 'Berkshire West'). The ICP is a joint committee between the local authorities and ICB across BOB and has members from other partners as outlined above.

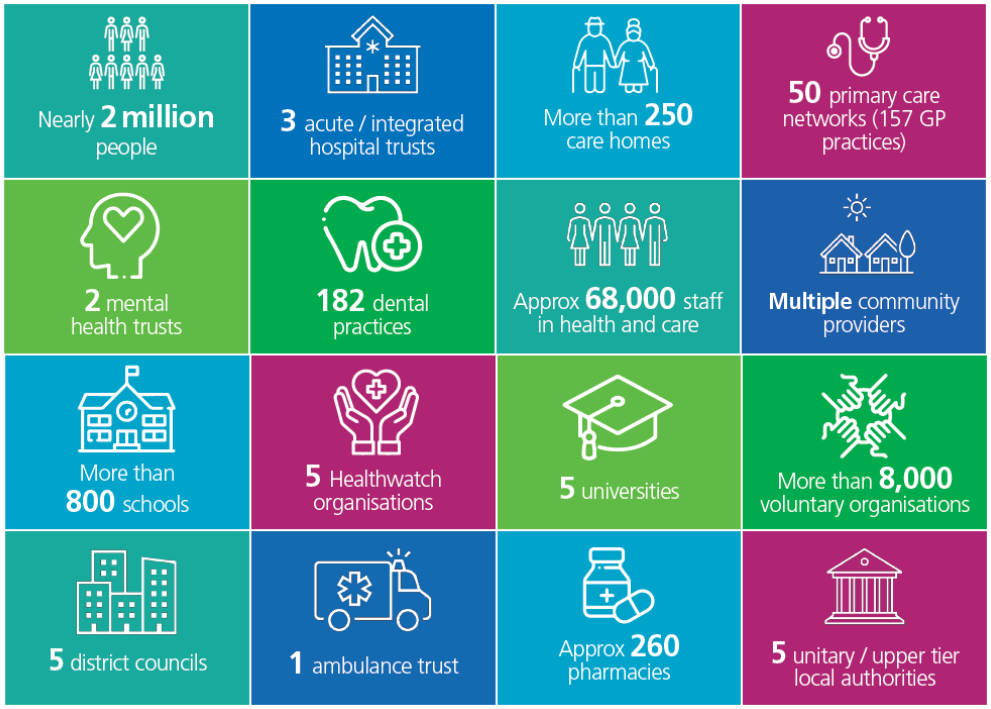
Our integrated care system is situated in the heart of the Thames Valley, much of our area is rural with more densely populated areas around our towns and cities including, High Wycombe, Oxford and Reading.

Our health and care system is made up of many organisations who all play a part in helping people to be as healthy as possible, for as much of their lives as possible. These include local councils, social care support, hospitals, emergency services, GP practices, dentists, pharmacists, optometrists, mental health providers, care homes, and many voluntary, community and social enterprise organisations.

Our partner NHS provider Trusts include:

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

In addition to these organisations who directly provide health and care services, we have links with schools, universities, businesses and research partners working in health or care in our area. There are well over 8,000 registered charities in our geography and there may be as many as 5,000 more informal community groups.



Most of the registered charities are very small and volunteer-run. As well as making a difference to the health and wellbeing of our population, these voluntary and community groups provide us with a strong link into our communities and a valuable insight into local needs. Some of the people and organisations playing a part in the health and wellbeing of our population include:

Population

The overall age profile of people living in our area is similar to the national average, with a slightly higher proportion of people aged under 18 and a slightly lower proportion of people aged over 65 years. Just over 1 in 5 people are under 18 years and just under 1 in 5 people are over 65 years of age.

This profile is likely to change over time. We anticipate a 5% growth in the overall size of the population by 2042 (an extra 89,000 people). This figure, however, masks significant changes for different age groups. The number of people aged over 65 is predicted to increase by 37% (increasing by 122,000 people) while the number of children and young people (those aged under 18 years) will reduce by 7% (26,000 people) over the same 20-year period.

According to the 2021 census, the ethnic profile for our combined area is very similar to the national average. This masks individual differences at local authority level. People who responded that they were White British make up 73% of residents overall which is similar to 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.

Other key facts include:

- People living in our area are generally healthier and live longer lives in good health than the national average. This is true for all our local authorities except for Reading where women do not live as long as the national average and men live as long as the national average. Within each local authority, how long people live varies between wards by up to 10 years, with people living shorter lives in more deprived wards.
- The proportion of babies born at term who were a low birthweight was similar to the national average of 2.9% except in Oxfordshire where 2.3% of babies born at term were low birthweight.
- A higher percentage of children in our area achieve a good level of development compared to the national average, except in Reading which is slightly lower. However, this average overlooks the experience of some of our most vulnerable children. Children in receipt of free school meals have lower levels of good development, especially in Oxfordshire and West Berkshire
- Young people aged 16-17 who are not in education, employment or training (NEET) are at increased risk of poor physical and mental health. In 2020, Buckinghamshire had a higher proportion of 16-17 years who were NEET than the national average, Reading had a similar percentage to the national average, while rates were lower in other parts of our area.
- 13% of residents in our area smoke according to GP data but this varies significantly between our least and most deprived areas.
- 1 in 4 residents in Buckinghamshire and Oxfordshire and 1 in 5 residents in Berkshire West (Wokingham, Reading and West Berkshire) are estimated to drink alcohol at levels that increase their risk of health problems.
- Around 3 in 10 children aged 10-11 years across our area are overweight or obese and around 6 in 10 adults are overweight or obese.
- Around 1 in 5 adults do less than 30 minutes moderate intensity activity a week
- Levels of long-term conditions such as heart disease or diabetes are generally lower than the national average. Long term conditions tend to increase with age and it is estimated that 3 in 5 people over 60 years have a long-term condition. However, many long-term conditions 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. Smoking causes 15% of all cancers and obesity and being overweight is the second most common cause of cancer in the UK.
- People living in deprived areas develop more long-term conditions and at an earlier age than people living in less deprived areas
- Approximately 12% of adults across Buckinghamshire, Oxfordshire and Berkshire West have a recorded diagnosis of depression which is similar to the national average and 0.8% have a severe mental illness such as schizophrenia.

Overview from Steve McManus, Interim Chief Executive

The establishment of the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) on 1 July 2022 marked a new chapter in the story of the NHS.

As one of 42 new ICBs in England, replacing the dissolved clinical commissioning groups (CCG), we took on responsibility for meeting the health needs of the 1.8 million people across our Integrated Care System geography; managing the NHS budget with the aim of making it easier for people to get the care and support they need, joined up across the health service, local councils, the voluntary and charity sector and other partners.

Dr James Kent, Chief Executive of BOB ICB, oversaw the coming together of three diverse CCGs, which had already strengthened their collaboration over the previous two years in response to the demands of the pandemic. It has been my privilege to carry on James' work since November 2022 as interim chief executive, following his move into the senior strategy team at NHS England.

When I joined the ICB we had already put in place our governance structures, begun recruiting a permanent leadership team and had started developing plans for the internal structure of the organisation. All this has been set against establishing ourselves in the wider BOB system as a key part of the Integrated Care Partnership which formally brings together our local authorities, our acute and community Trusts, our ambulance service, GPs and other primary care services such as dentists, pharmacies and optometrists, the voluntary sector and academic networks.

To date we have agreed our system priorities for the Integrated Care Partnership Strategy; established place-based leadership and partnerships in Buckinghamshire, Oxfordshire and Berkshire West; reinforced our relationship with our Voluntary, Community and Social Enterprise partners; and developed our Joint Forward View to improve the care and lives of the people and communities we serve across our geography over the next five years.

There have been many challenges, not least that that all this work has been done against the backdrop of a difficult winter period which put enormous pressure on all aspects of health and care services, the cost-of-living crisis and industrial action by NHS staff. I have been hugely impressed by the resilience and work of the team at the ICB and our wider system partners, so that, despite the many challenges, we are looking ahead to what we can achieve in the future.

The ICB came into being with four keys aims:

- To improve the health and wellbeing of people in our area
- To tackle health inequalities
- To improve how we better use our collective resources
- To support broader social and economic development.

We have made progress in all these areas over our first nine months, although much work needs to be done.

Our efforts to recover from the effects of the pandemic on waiting times for people needing planned treatment and operations (elective care) have eliminated all waits of two years. We are steadily bringing down the numbers of people waiting up to 78 weeks for treatment across our three acute Trusts – Buckinghamshire Healthcare, Oxford University Hospitals FT and Royal Berkshire FT. We have achieved this by careful

prioritising patients and through our hospitals offering mutual aid to treat people from other areas where waits in particular specialties are longest.

We continue to work with our community and mental health Trusts - BHT, BHFT and OHFT - to improve access to adult and children's mental health services and tackle inequalities. Our performance for the percentage of referrals to NHS Talking Therapies receiving an appointment has been positive and we have exceeded the six and 18-week national targets of 75% and 95% respectively. There are many examples of innovative partnership working in the mental health services section services section of this report.

Across our GP practices, more than half of patients are getting same day appointments and eight out of 10 people are being seen within two weeks of asking for a routine appointment. These encouraging numbers have been achieved through more online and telephone access to GPs and other clinical professionals in practices, and triaging those patients who need in person appointments. More than six out of ten patients are being seen face to face on average.

Our COVID vaccination programme across BOB has been hugely successful and has put more than four million doses in arms since it started in December 2020. This spring the most vulnerable members of our communities – those in care homes, people aged 75 and over and people and children with weak immune systems – have been offered a further booster, with another round planned for the autumn.

We are working to bring down the numbers of patients waiting two months or more from diagnosis to begin cancer treatment, and there has been good progress over recent months, while recognising we are still some way behind the 85% target.

Our aims in tackling health inequalities are urgent and we as the ICB have a significant contribution to make to ensure the structures and funding are in place for the wide variety of prevention and inequalities work being undertaken now and in the future.

Our BOB ICB geography and its population is perceived as being among the wealthiest areas of the UK, but the reality is that around 60,000 people living here are among the 20 per cent poorest people in the UK. Their socio-economic circumstances have profound effects on their health, life expectancy and access to services.

Our presence in this inequalities space is highlighted in our work with public health partners and Trusts around prevention of heart attack and strokes.

The risk for these life-changing and potentially fatal events is being reduced by the success of BP@Home Trailblazer Project which has led to BOB embracing home monitoring as part of the overall approach to support people diagnosed with hypertension. 7,000 monitors were given out during the pandemic to clinically vulnerable people and those living in deprived areas, when access to blood pressure monitoring was difficult. Patients continue to share their results with their GPs and we have made positive progress around the number of people with hypertension being treated, with local data suggesting we have recovered to pre-pandemic levels. Joint working continues with our partners on Cardiovascular Disease (CVD) prevention to reduce the number of strokes and heart attacks, further addressing health inequalities and building on experience.

Prevention services are also going out to where people live, work and worship. These include health pop-ups at mosques in Banbury, our Health on the Move van visiting specific sites in Bucks or the Meet Peet initiative where NHS volunteers set up shop in community centres in

parts of Reading to break down barriers by offering free health checks and medical advice. The numbers of people reached may be relatively small at individual venues and events, but these ‘tailored’ approaches work and must expand to reflect our priorities as a system.

We have worked closely with our local authority colleagues across BOB to ensure there is health provision for refugees and asylum seekers; this has included health assessments, vaccinations and ensuring they have access to primary and mental health care. We also commissioned a dental outreach team to attend those hotels accommodating families to do dental assessment and oral health support.

The pandemic enabled the NHS as a whole to accelerate its digital services and improve the way we work as a system for the benefit of patients. Our people resources are stretched, however, remote monitoring of long-term conditions, sharing of records across services, ‘virtual wards’ which allow patients to get acute hospital care at home and regular medicines reviews are just some of the ways we are improving our use of technology to support the outstanding work of our people.

The economic activity of our local area, and how productive our local towns and cities are, is heavily influenced by the area’s health status. Reducing Emergency Department attendances by providing alternative services, reducing the proportion of workers off with long-term sickness by better prevention and management of long-term conditions increases the health of the working population and provides a significant boost to the local economy. Of course, the NHS and more specifically the BOB ICB cannot do this in isolation, so our Integrated Care Partnership work with local authorities, voluntary organisations and other stakeholders will be a key driver.

We have increasingly seen the unique contribution that the ICB team can make in convening and supporting partners to come together and take a system approach across a range of areas such as the health and care workforce, a system approach to quality improvement, urgent and emergency care services, digital transformation, all in the context of our agreed ambitions set out in our new Integrated Care Strategy. Harnessing the skills and capabilities across our system is a key role of the ICB that includes how we have strengthened and formalised our relationship with the Oxford Academic Health Science Network (AHSN) regarding our collective work with the life sciences industry, academic partners and with the Patient Safety Collaborative.

I sincerely thank my ICB colleagues for their efforts in establishing our new organisation over the last nine months. I hope this brief overview has highlighted the breadth of work they contribute to as commissioners of services, supporting system partners with capacity and expertise or convening system partners to come up with innovative ways to improve quality and patient safety, bold ideas for access to urgent and emergency care and planning how to recruit and retain NHS staff. There are many more examples throughout the pages of this report of the work done and the work being planned.

We have laid solid foundations and we look forward to building on them in the year ahead.

Performance Analysis

The following performance analysis report looks at the work of ICB from its establishment 1 July 2022 until the end of March 2023, 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 has a vision '*for everyone who lives in Buckinghamshire, Oxfordshire and the Berkshire West area, to have the best possible start in life, to live happier, healthier lives for longer, and to get the right support when they need it.'*

The ICP recognises the places and circumstances in which people live and work influence their health – housing, the local environment, the cost of living, employment and communities - which is why we are working together to address this. To achieve the vision of the ICP for our population, the partnership has developed a strategy, with clear priorities to deliver over the coming years. The strategy builds on the three current joint local health and wellbeing strategies across Buckinghamshire, Oxfordshire and Berkshire West. The strategy has been developed through local engagement (for more information about the engagement go to page 40) and sets the direction for our health and care system, linking with local plans, to meet the health and wellbeing needs of people who live in the BOB area. It is also based on a commitment from our partner organisations to work together to improve people's health and wellbeing and reduce the inequalities in health experienced by people across our populations. The strategy has five identified priorities outlined below.

While these priorities will be the central focus of our work, we recognise that the success of this strategy will depend on:

- The **people** who work across our health and care system. This includes people in paid employment and the large number of volunteers and informal carers across Buckinghamshire, Oxfordshire and Berkshire West.
- **The digital solutions, data and insights** available to those who work or volunteer in our area and how we use digital technology to move care closer to people's homes and to support people to self-manage their health conditions.
- Our ability to **respond to change and learn from best practice** to embrace new and innovative ways of working.

Read more about the strategy which is available on our website.

Delivering the Joint Local Health and Wellbeing Strategies (JHLWS) across our three 'places' Buckinghamshire, Oxfordshire and Berkshire West (which covers the local authority areas of Berkshire West, Reading and Wokingham) is a priority for the ICB. During the transition from three CCGs to the ICB there have clearly been challenges identified by our Health and Wellbeing Boards in the involvement of the ICB taking forward work to deliver the JHLWS. Whilst some engagement has been noted by our Health and Wellbeing Boards it is clear this needs to be improved over the coming year. The three ICB Place Directors are working with their HWBs to ensure that priorities and delivery plans show a clear link to the JHLWS priorities.

How we continue to deliver the COVID-19 Vaccination Programme

The establishment of the BOB ICB in July 2022 coincided with the last stages of the year's Spring Booster mass campaign for COVID vaccinations.

The hugely successful vaccination programme started in December 2020 - the largest and fastest vaccine drive in health service history - and the 2022 Spring Booster offered jabs to people aged 75 and over, those aged 12 years and over with a weakened immune system, and residents in older adult care homes. By the time the three clinical commissioning groups were dissolved at the end of June 2022, more than four million jabs had been given across the BOB geography in just over 18 months.

During 2022/23 the vaccination programme has continued across the BOB area via a network of centres comprising GP-practices, community pharmacies, large vaccination centres, hospital sites, pop-up clinics, a mobile service (Health on the Move), and a schools' programme for children. As a result of hard work and commitment from NHS professionals and an army of volunteers, our area has consistently been among the highest performers across England in terms of vaccination uptake and outreach.

During the period 1 July 2022 – 31 March 2023, around 670,000 vaccinations have been given across the BOB area, which includes the completion of the Spring booster rollout and the autumn campaign which offered a top-up jab to people aged 50 years and older, residents in care homes for older people, those aged five years and over in a clinical risk group and health and social care staff.

The COVID-19 vaccination programme has been overseen by the BOB Vaccination Programme Operational Executive, whose members include representatives from the NHS and local authorities across the geography.

Throughout the success of the mass vaccination programme, our BOB ICS has worked hard on its inequalities outreach programme to bring vaccinations to those members of our communities who are more hesitant for many reasons: historical; cultural; rurality; transport etc.

The Vaccine Inequalities Group developed a plan to identify communities at risk of health inequalities and of lower levels of vaccine uptake. It also designed engagement-led approaches to working with community leaders to address underlying causes of low vaccine confidence and provided opportunities to localise vaccine delivery through outreach clinics and the health on the move van. More than 50 health on the move van events were run with each relying on an integrated team including our local authorities, RBH, RBFT, OHFT, BOB colleagues and voluntary sector partners to organise and advertise events. Although the numbers coming to each venue were small, in total more than 16,700 vaccines have been given at these various outreach events and the programme will continue into 2023/24.

This work was done by extending COVID outreach work to include an ‘all vaccinations’ approach and joint working with regional public health teams. The programme has focused on booster jabs and the ‘evergreen’ offer, but more importantly has promoted a *‘Making Every Contact*

Count'(MECC) approach which has been successful among these groups and is an opportunity to talk to people about other aspects of health and wellbeing.

Since the start of the vaccination programme 4,752,157 vaccines have been delivered. Between 1st April 22 - 31st March 2023:

- 873,157 vaccines have been delivered
- 45,604 have received their first vaccine
- 53,863 have received their second vaccine
- 600,167 have received their seasonal booster

Improving access and delivery of elective care

Like the rest of the country elective care (or planned care[1]) within BOB has been severely impacted by the COVID pandemic. Patients are now waiting significant lengths of time to be seen for a hospital consultation, treatment or surgery. In 2022, NHSE published its elective recovery plan, which set out a vision for how the NHS will recover elective services over the next three years. Its central ambitions include timelines for the service to bring down long waits for elective care.

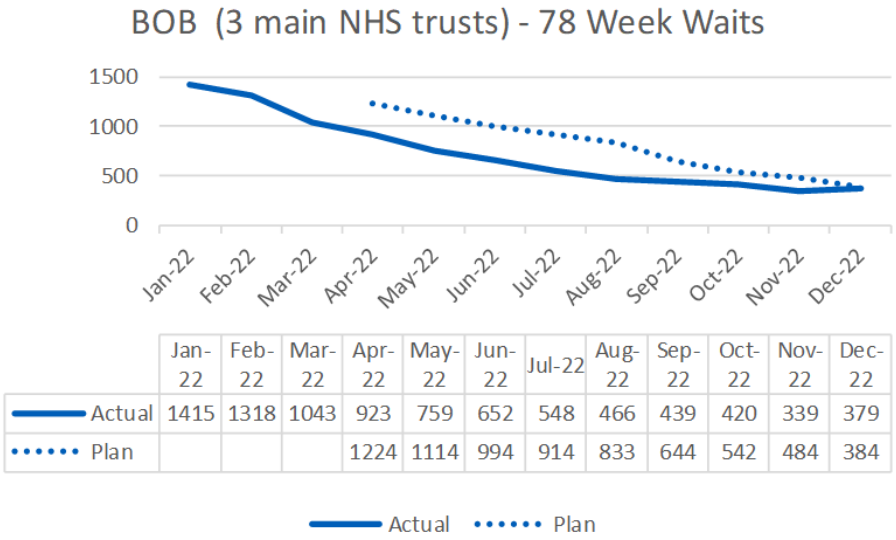
Tackling the backlog of elective care is a key priority for the ICB and our provider Trusts. Patient choice remans high on our agenda with patients being offered a variety of providers, some further away from home but with shorter waiting times. In the past year a number of initiatives have been undertaken to eradicate 104 week waits and reduce waiting times overall for our local population. These have included:

- Delivery of a theatre improvement programme to continue to build upon the significant improvements seen in 2021/22 with theatre utilisation and productivity
- Securing additional capacity with our independent sector providers
- The introduction of a referral management solution *'Rego'* starting in Ear, Nose and Throat (ENT) and Ophthalmology to provide a single point of access for clinicians in primary and secondary care to quickly and accurately triage patients to the right care
- Mutual aid support to NHS Trusts with higher volumes of long waits; ENT and musculoskeletal services for patients for a range of postcodes across BOB were offered appointments at other Trusts to improve equity of access and reduce waiting times
- Development and introduction of alternative workforce models to deliver care in ENT to make best use of a clinical specialists
- BOB ICS submitted a capital bid for £55m for development of elective capacity across the system. This consisted of an elective ophthalmology hub in Amersham Hospital; a virtual outpatients hub at Stoke Mandeville Hospital, High Wycombe; additional elective

[1] Elective or planned care refers to services for pre-arranged health appointments either in the community or in the hospital. It covers diagnostic services, outpatient services and scheduled operations.

hubs for ENT and gynecological surgery in Reading, Henley and Bracknell to support increased outpatient capacity including procedure rooms to free up theatre capacity and an elective surgical hub at the John Radcliffe Hospital in Oxford to expand theatre capacity for an additional 10 theatres

At year end, overall elective activity levels remained below planned levels. Despite activity levels remaining below plan the BOB ICS were compliant with no patients waiting over 104 weeks, with the exception of patient choice at the beginning of July 2022. And we are still achieving a steady reduction in patients waiting over 78 weeks with a trajectory to achieve 0 patients waiting over 78 weeks as per national ambition.



	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Actual	1415	1318	1043	923	759	652	548	466	439	420	339	379
Plan				1224	1114	994	914	833	644	542	484	384

Further information on waiting times is available on page 45.

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

In common with Trusts and integrated care systems across England, our urgent and emergency care providers across all care settings continue to be under significant pressure. We are seeing an increase in attendances to our Emergency Departments (EDs) and the complexity of patient cases; the average length of stay in our hospitals has also increased. The Trust in BOB delivered 71.2% (BHT), 70.6% (OUH) and 76.2% against the accident and emergency 4-hour standard (95%) at year end.

The number of ambulance handover delays also remains challenging and is an area of priority for the system. At year end >30mins handover delays were reported as 13.9% (BHT), 5.1% (OUH) and 11.9%. The handover delays directly affected SCAS's ambitions to improve waiting times for category 2 calls - 999 calls for a serious condition such as stroke or chest pain that may need rapid assessment and/or urgent transport. These calls should be responded to in under 40 minutes.

Across the BOB ICS, teams from hospital and community Trusts, the ICB and local authorities work together to ensure people who need urgent and emergency medical treatment can access services. Extensive work has been done during 2022/23 to help alleviate pressures and improve patient flow through the hospitals across BOB. Below outlines some of these initiatives:

Virtual Wards

Virtual Wards and Hospital at Home services aim to provide safe, efficient hospital care and treatment in their own home. These services either avoid and admission to hospital or provide support for early discharge. A formal programme to develop and expand our virtual ward offer has been in place throughout 2022/23.

By March 2023, BOB ICS had more than 290 virtual ward/hospital at home beds in place, delivered by six provider organisations. 73%-90% of these beds were in use between January to March 2023. There have been more than 6,000 admissions into these services, which have either prevented an admission or supported a discharge since July 2022.

As part of our standard offer virtual ward/hospital at home services to support frail people and those suffering problems with their respiratory system, which are the organs and tissues that help people breathe, are available in each place across the BOB ICS with additional pathways available in some areas including children's virtual wards, palliative end of life, alcohol withdrawal and those suffering heart disorders. Expansion of our virtual ward offer will continue throughout 2023/24.

Urgent Community Response

Urgent Community Response (UCR) services have been available across the BOB ICS since April 2021. These services aim to provide a multi-disciplinary team response to people are likely to be admitted to hospital in the next 24 hours unless they receive an urgent assessment and treatment / support. Patients are triaged and put into two categories – those needing treatment / support within 2 hours or a same day response. Our aim is to ensure that at least 70% of patients identified as needing a two-hour response should receive it within this time frame. Services are expected to respond to people with at least one of nine clinical conditions including falls, delirium/confusion, blocked catheters, unpaid carer breakdown and those vulnerable frail patients whose condition is deteriorating.

In BOB ICS at least 2,000 referrals are received each month into our Urgent Community Response services. 1,200 people are triaged as requiring a two-hour response and through the intervention provided, their imminent admission to hospital is avoided. The majority of patients seen are over 80 years of age. UCR services are available 8am-8pm, 7 days per week. Through 2023/24 we aim to continue to increase referrals into these service from key referral sources such as GPs, Community Nursing, NHS 111 and SCAS.

The Oxfordshire health and care system worked together to implement an initiative to support paramedic crews and help reduce the number of people being taken to hospital with complicated care needs. For many patients who had called 999, instead of being taken directly to ED, they are now being assessed and treated in their own home. Following the initial 999 call, a clinician is available to facilitate each call with support

from an Urgent Community Response specialist, and other medical colleagues as appropriate. A decision is then made to confirm whether the patient needs to be assessed at home or attend ED. A suitable assessor was asked to visit the patient at home within two hours for those who were well enough to be assessed in their home and appropriate care and treatment arranged to be delivered at home. The Oxfordshire health and care system has adopted the 'Call before Convey' principle to help deal with the pressures facing urgent care services. Data from July 2022 to February 2023 show the average number of falls being conveyed to ED has reduced by 10%.

Supporting patients home from ED

In Berkshire West, the ICB continued its partnership arrangement with the British Red Cross to identify patients attending ED at the RBH who could be safely transported home and supported with shopping, medications and signposting to other voluntary sector support to avoid a hospital admission. We have also worked alongside our paramedic colleagues to staff a dedicated area in ED for patients arriving by ambulances to minimise handover delays.

Urgent Care Centre

Across the BOB ICS we have two new Urgent Care Centres (UCC)[2], one in Reading and another located in Oxford. The Reading UCC opened in December 2022 to improve on-the-day-care for people with non-emergency illness. It is open seven days a week from 8am-8pm. The centre complements the range of healthcare support available to local people and provides an easy to access service for urgent, but not life-threatening illness, and eases pressure on the ED at the RBH and GP practices. It has the capacity to offer 100 appointments per day (combination of walk-ins and patients referred from primary care and ED). The UCC has been developed collaboratively with representatives from the ICB, BHFT, RBH, Reading Borough Council and Healthwatch Reading. It will run for an 18-month pilot period. The Oxford UCC is on the John Radcliffe Hospital (JR) site. The centre is run by the Oxford City Primary Care Network (PCN) and is there to support the day-to-day pressures on GP surgeries, NHS 111, and is working towards taking redirections from the JR ED. It provides an extra 300 appointments per day. Walk-in appointments are not accepted.

The ICB also commissioned additional clinical appointments in general practice to support to winter pressures on UEC; there were approximately 20,000 more appointments provided over the winter period.

Alongside these initiatives, communications teams from the ICB and system partners have worked together to deliver campaigns to local people encouraging them to look after themselves and stay healthy, and to use healthcare services in the most appropriate way. Key messages over the past year have continued to be:

- Emergency Departments (EDs) are for genuinely life-threatening conditions; for non-life-threatening conditions please use alternative services such as local pharmacies, minor injuries units, your GP and NHS 111 who can advise and direct patients to the best place for care.

[2] We have an existing urgent treatment centre operating in High Wycombe and an UCC in Banbury.

- Our EDs and hospitals remain very busy. If you can help your family member or friend home from hospital, please talk to us. We will always support people to get home with the appropriate care packages

The BOB ICB launched a new website www.staywell-bob.nhs.uk this year which signposts the public to key services across BOB and supports wellbeing. It underpins our communication activities by providing a vehicle to educate where to go the get the right care across BOB; inform people where to seek help including links to local services that will help you live independently such as home care agencies; signposts where to go to get a flu and COVID vaccine and provides access to key resources for healthcare advice and local services.

Developing services across primary care

General Practice

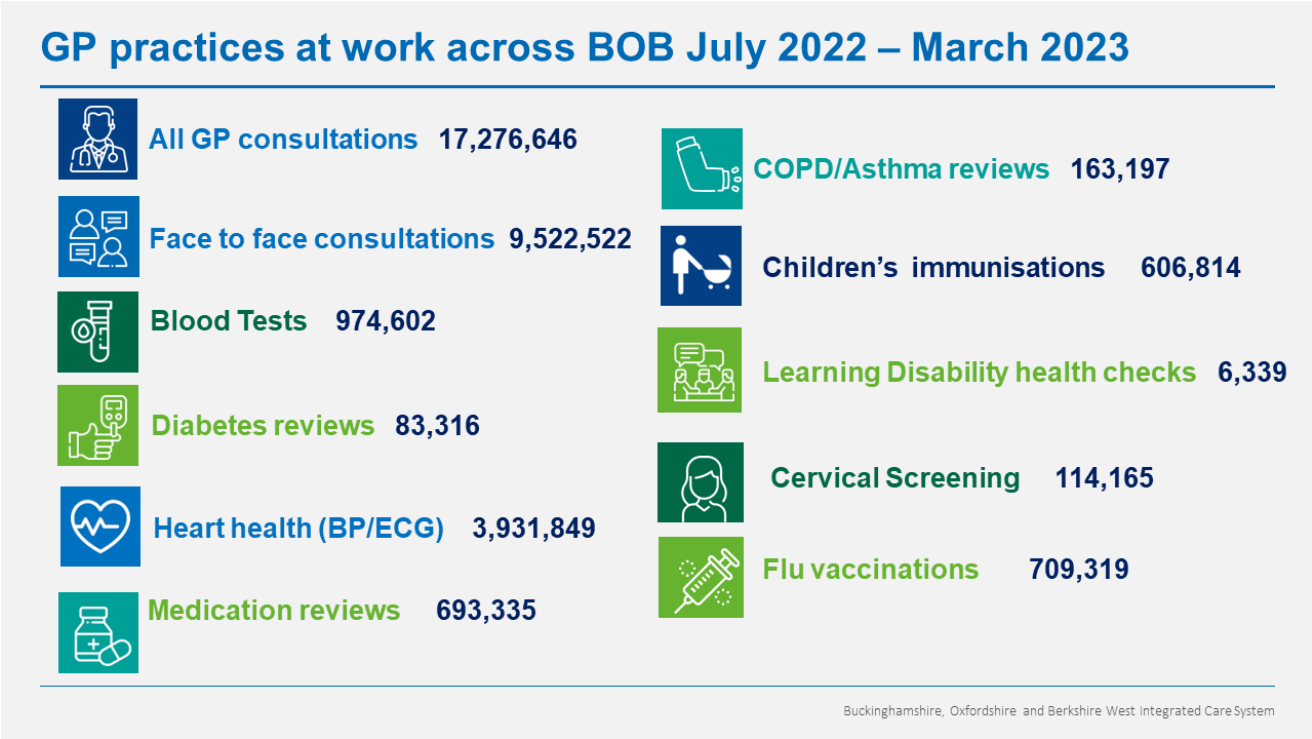
The last three years, initially in response to the COVID-19 pandemic then in response to the ongoing pandemic and roll out of the COVID-19 vaccination programme, has been unprecedented in the delivery of all public services and general practice is no exception.

General practice across BOB responded to these challenges with excellent public sector coordination and joined up response and delivery. General practice worked with local statutory organisations and community and voluntary sector partners to ensure that the needs of our populations were met in respect of both the pandemic response and ongoing service delivery.

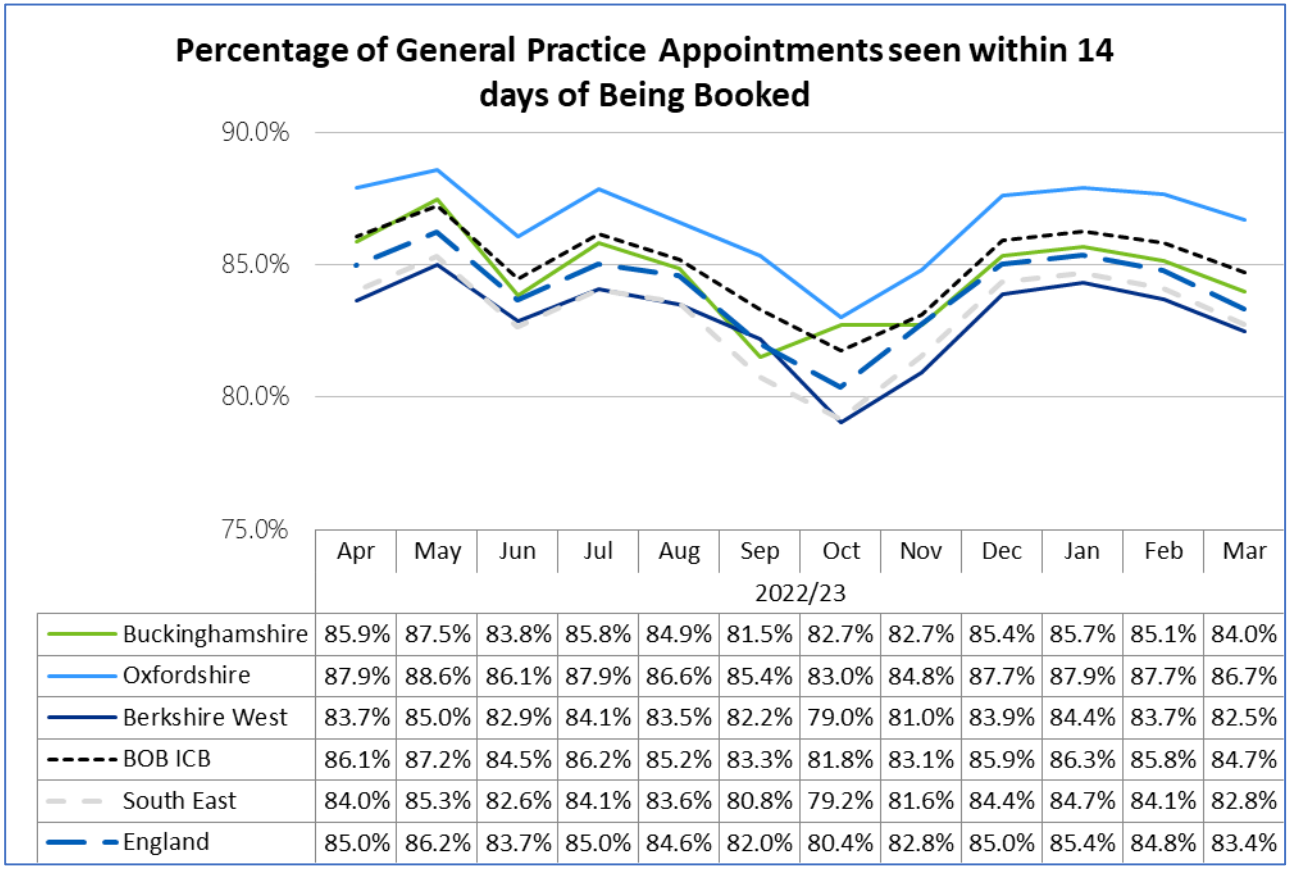
Like other NHS organisations general practice and patients had to adapt to new ways of working. The use of total triage and increased use of virtual access were two of the most significant changes in general practice. As a clear step to reduce the spread of COVID-19, patients were assessed by a GP over the phone or online first, allowing many people to be offered advice, prescriptions or referral without the need for a face-

to-face appointment. For patients with the relevant technology, appointments have been available using video conferencing with healthcare professionals.

While this has proved very successful and popular with many of our population, we recognise that we need to help patients understand how services have changed and the varied work they deliver.



Appointments in general practice are collected and reported nationally each month. The graph below sets out the appointments since April 2020 until March 2023:



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2022/23											
Buckinghamshire	85.9%	87.5%	83.8%	85.8%	84.9%	81.5%	82.7%	82.7%	85.4%	85.7%	85.1%	84.0%
Oxfordshire	87.9%	88.6%	86.1%	87.9%	86.6%	85.4%	83.0%	84.8%	87.7%	87.9%	87.7%	86.7%
Berkshire West	83.7%	85.0%	82.9%	84.1%	83.5%	82.2%	79.0%	81.0%	83.9%	84.4%	83.7%	82.5%
BOB ICB	86.1%	87.2%	84.5%	86.2%	85.2%	83.3%	81.8%	83.1%	85.9%	86.3%	85.8%	84.7%
South East	84.0%	85.3%	82.6%	84.1%	83.6%	80.8%	79.2%	81.6%	84.4%	84.7%	84.1%	82.8%
England	85.0%	86.2%	83.7%	85.0%	84.6%	82.0%	80.4%	82.8%	85.0%	85.4%	84.8%	83.4%

Primary Care Networks (PCNs) as groups of GP practices played a significant delivery role from the outset of the COVID vaccination programme. This work has continued with booster vaccinations throughout 2022/23 and work is underway to deliver a spring vaccination via GP practices and pharmacies to the 75 and over age group, people in care homes and those who are immunosuppressed.

PCNs across BOB continue to recruit roles supported through the Additional Roles Reimbursement Scheme (ARRS), which provides funding for additional roles to create bespoke multi-disciplinary teams in general practice. Two new roles were introduced in October 2022; General Practice Assistants and Digital and Transformation Leads. 705 whole time equivalent posts have now been recruited to across BOB utilising

over 90% of available funding through the scheme. These roles have been instrumental in bringing specialist skills and general clinical skills into practices enabling GPs to focus on patients with more complex needs.

Below are some examples of new initiatives across BOB PCNs

- **Neighbourhood and subplace integration for older people, frail elderly and medical management at home**: Bicester PCN, Manor Surgery in Headington and, Oxford City Primary Care (PCN) have worked together to pilot an enhanced primary care virtual wards initiative. This includes multi-disciplinary (MDT) ward rounds, home visits, MDT assessment and anticipatory care for older people post admission, admission avoidance and anticipatory. This pilot is bringing together primary care, community care, and the voluntary sector working closely with acute care and acute virtual wards.
- **Multidisciplinary Team Working:** Caversham PCN have monthly meetings organised by a Care Coordinator from the Community Trust BHFT, chaired by a Community Matron, attended by various clinicians from the Community trust BHFT, the Acute trust RBH, Reading Borough Council Adult Social Services, SCAS Ambulance Service, Social Prescribing Link Workers and GP's. Patients are selected for discussion using Risk Stratification tools. Complex patients with contact with various services are discussed, their conditions and needs better understood and actions taken to improve their care. Examples include poorly controlled diabetics with depression, young adults with learning disabilities, severely frail, patients with high attendance rates at GP practice.
- **Digital Triage**: Earley PCN developed digital triage and patient RAG segmentation (working with Connected Care, our digital integration partner within BOB and Frimley ICS) to enable prioritisation of patient's conditions. This ensures that the triage teams can stratify patients to the correct clinician and has increased the capability of different allied health professionals to see different presentations, reserving GPs for more complex cases. This work is being further enhanced by developing our digital triage offering utilising AI and integrating this with the RAG rating to increase the accuracy with which patients can be prioritised. The PCN is also developing continuity teams across its 4 sites (31000 patients) to manage red and amber patients. It hopes to be part of a place-based solution to further enhance the urgent care offering particularly for green patients.
- **One stop shop for chronic disease conditions**: Whitley PCN developed a one stop shop was developed, where all chronic disease conditions were managed in one sitting to help ensure patients attended reviews, given the PCN's relatively high levels of social deprivation and communities with health inequalities. They have also developed a GP assistant programme to help GPs manage their patient lists who support the clinicians within the consultation.
- **Social Prescribing** : Shared Decision Making has enabled personalised care across the ICS. Through the BOB ICB Personalised Care training team are accredited to deliver 'Year of Care' Shared Decision-Making Training to our workforce. By adopting this personalised approach of involving people in decisions about their health and care we hope to improve patient health and wellbeing, improve the quality of care and ensure people make informed use of available healthcare resources. Involving people in their own health and care not only adds value to people's lives, it creates value for the health and care system.

BOB ICB took delegated responsibility from NHSE for Pharmacy, Optometry and Dental (POD) services in July 2022. This delegation will allow the ICB to integrate services to enable decisions to be taken as close as possible to their residents, to ensure our population can experience joined up care, with an increased focus on prevention, addressing inequalities and improve access to care.

During the last eight months the system has increased its local knowledge and expertise of the services. This has been enhanced by increasing engagement and dialogue with key stakeholders such as Healthwatch, Health Overview and Scrutiny Committees, and system partners.

This has resulted in increasing an understanding of professional and local issues with an aim to influencing service reform to increase opportunities to develop local solutions to key services problems.

The ICB has prioritised the integration of clinical services and clinicians within the system, providing a seat at relevant partnership forums, access at practice level to wellbeing training and for professional clinical leadership.

As part of the development of the 5 year Forward View Plan, the intent to integrate and optimise POD services to enhance the primary care offer to the population is being developed.

Community Pharmacy

The ICB has approximately 265 Community Pharmacies (CP) providing pharmaceutical services to the system population. BOB Community Pharmacies are represented by Thames Valley Local Pharmacy Committee (LPC) and Buckinghamshire LPC.

Community Pharmacies are well placed within our local communities to support people to live longer, heathier lives, make healthier lifestyle choices and support care closer to home. With a culturally diverse workforce which represents the population they serve, they provide a direct route to accessing our black, Asian and ethnic minority and health inclusive groups.

In collaboration with system partners, the ICB, is working towards implementation and delivery of the NHS E Pharmacy Integration Plan Community Pharmacy Clinical services including:

- Discharge Medicine Service to reduce drug related hospital re admissions.
- Community Pharmacy Consultation Service – NHS 111, GP CPCS and upcoming UEC referrals to reduce GP appointments within the PCN for minor illnesses and reduce A&E appointments.
- Hypertension Case Finding Service to support the identification of undiagnosed Hypertensive patients and reduce the GP Practice workload.
- Smoking Cessation Transfer of Care to improve the prevention of avoidable illnesses.
- Early Diagnosis of Cancer (NHS E Pilot in Thames Valley)
- Oral Contraceptive Service – expected April 2023
- Formal agreement to develop and implementation a BOB ICB Community Pharmacy PCN Lead Programme, which aims to provide a single point of contact for engagement, strengthen Community Pharmacy and General Practice collaboration, system partnership working, optimise delivery of the Pharmacy Integration CP Clinical Services, address health inequalities and promote shared learning.

Optometry

BOB ICB has approximately 195 optical practices. Optometry services deliver NHS funded sight tests across the system, within both high street and domiciliary settings.

The ICB recognise the opportunity for increased integration of these services as part of ensuring maintaining eye health across the system. Work to date has focussed on:

- Increased clinical engagement with optometry practices to identify opportunities for integration
- Phase one development of an Integrated Eye Health Network across the system, that brings representatives from the eye care pathway together, to develop and deliver our identified integration priorities.

Dentistry

BOB ICB now has responsibility for NHS dental services, that includes:

- High street services
- Unscheduled Care-out of normal working hours
- Community Dental services- Specialised Care and Paediatric dentistry
- Orthodontic services
- Hospital services
- Level 2 Oral surgery and restorative dentistry

Good oral health is a key priority for our system population, as the ICB now has responsibility for range of dental services, this will provide an opportunity to work with system partners to collectively align resource and capacity to focus on optimising oral health prevention and early intervention. The system acknowledges the public challenge to accessing NHS high street dental services and has been working collaboratively to both understand and address access issues.

The ICB has implemented and extended an Additional Access Scheme which provides additional capacity for urgent need, with a focus on access for our most vulnerable populations across the system.

Through the flexible Commissioning Scheme, we have worked with our Local Dental Network to refocus NHS dental capacity to meet the needs of our population that have found it the most difficult to access services. The scheme is due to be implemented during the first half of 2023/24.

We have published a patient leaflet on our website to support our public in understanding dental services, supported with access information and frequently asked questions.

Community Dental services have benefited from additional financial resources in year to improve capacity. Our three community providers have increased collaborative working arrangements, sharing experience, best practice and capacity, with an intent to establish a formal Provider Collaborative arrangement.

How we are managing long term conditions

The Long Term Plan (LTP) sets out clear improvement priorities for the biggest killers and disablers of our population including Long Term Conditions (LTCs). The Global Burden of Disease study included as part of the LTP shows 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.

Our ambition for the prevention and management of LTCs is to:

- Improve outcomes in population health and healthcare with a specific focus on health inequalities.
- Acting sooner to help those with preventable LTCs.
- Detecting LTCs earlier.
- Supporting people with LTCs to stay well and independent.
- Caring for those with multiple needs as the population ages.
- Integrating care pathways to provide joined up services.

In the past year we have established LTCs Integrated Delivery Networks across BOB for cardiovascular (inc stroke), respiratory and diabetes to bring together our providers with clinical leadership to drive forward the LTP priorities including prevention, improving health, reducing inequalities, reducing variation and co-designing integrated pathways.

The areas of focus (prioritising areas of health inequalities) over the last year through the LTCs Integrated Delivery Networks have been:

1. Prevention of LTCs through earlier detection by increasing NHS Health Checks, referrals to Diabetes Prevention and smoking cessation
2. Improving the diagnosis of people with Chronic Obstructive Pulmonary Disease (COPD) symptoms
3. Increasing the detection of people with Hypertension, Atrial Fibrillation (AF) and Heart Failure to enable earlier management of the conditions.
4. Better management of people with LTCs with restoration to pre-pandemic levels:
    - Hypertension (to target blood pressure)
    - Diabetes (to treatment targets)
    - AF (optimisation of treatment)
    - COPD (decrease length of stay and readmission to hospital)
    - Stroke, Cardiac and Pulmonary rehabilitation

Some examples of the work are outlined below:

BP@Home Work was undertaken to identify people with hypertension, as part of the blood pressure at home project with BOB identified as a trail blazer. This focused on clinically vulnerable patients in the more deprived areas over the age of 65. Seven thousand blood pressure monitors were distributed across BOB. This programme of work promoted better blood pressure monitoring, increasing patient understanding and thereafter additional support for practices for BP monitoring across all age groups. Work has also been ongoing with community pharmacy

across BOB to support case finding with a focus on areas of higher deprivation. Work continues to achieve the number of people with hypertension treated to target with positive progress being made at each place.

Primary care were supported to find and optimise treatment for people living with Heart Failure, provide spirometry (which was suspended during the pandemic as this is an aerosol generating procedure) to diagnose people with breathlessness and increase referrals to the Diabetes Prevention Programme.

Rehabilitation: We worked with our providers to understand current rehabilitation services and ensure these are available consistently across the BOB area.

Personalised Care and Support Planning

Across BOB over 2000 health professionals have been trained in personalised care skills during 2022/23. The ICB continues to work to ensure that all staff are equipped with the skills to offer personalised care including personal health budgets, social prescribing, personalised care and support planning and shared decision making. Personalised Care simply means that patients have more control and choice when it comes to the way their care is planned and delivered, taking into account individual needs, preferences and circumstances.

Personalised Care and Support Planning recognises the patient's skills and strengths, as well as their experiences and the things that matter the most to them. Professionals and patients have a shared discussion to identify outcomes, goals and actions which will support the patient and lead to better outcomes. A care plan is an essential tool to integrate the person's experience of all the services they access so they have.

Over the last year over 70,000 care plans have been developed in partnership with patients within our maternity, palliative and End of Life Care, Dementia and long-term condition pathways.

Over the past year the BOB Local Maternity and Neonatal System (BOB LMNS) team have undertaken a project to develop a clear and robust personalised care and support pathway (PSCP) for all services users, that is sensitive to the diversity in our population, social determinants of health and the principles of the Core 20+5.

BOB LMNS co-produced this pathway with local maternity voice partnerships (service user voices), transformation midwives, perinatal mental health services, and input form Neonatal and Obstetric leads. Co-production promotes equality, inclusivity, accessibility and reciprocity and gave everyone a seat at the table, and the benefits were enormous. The PCSP has considered accessibility issues such as health literacy, digital poverty and literacy and health inclusion so has been developed with that in mind, so there are free text sections, visual aids and prompts to help people when they are completing it and the initial roll out will be paper versions, with digitisation coming later. The PCSP will also be translated in the top ten languages spoken in BOB initially and then more as required.

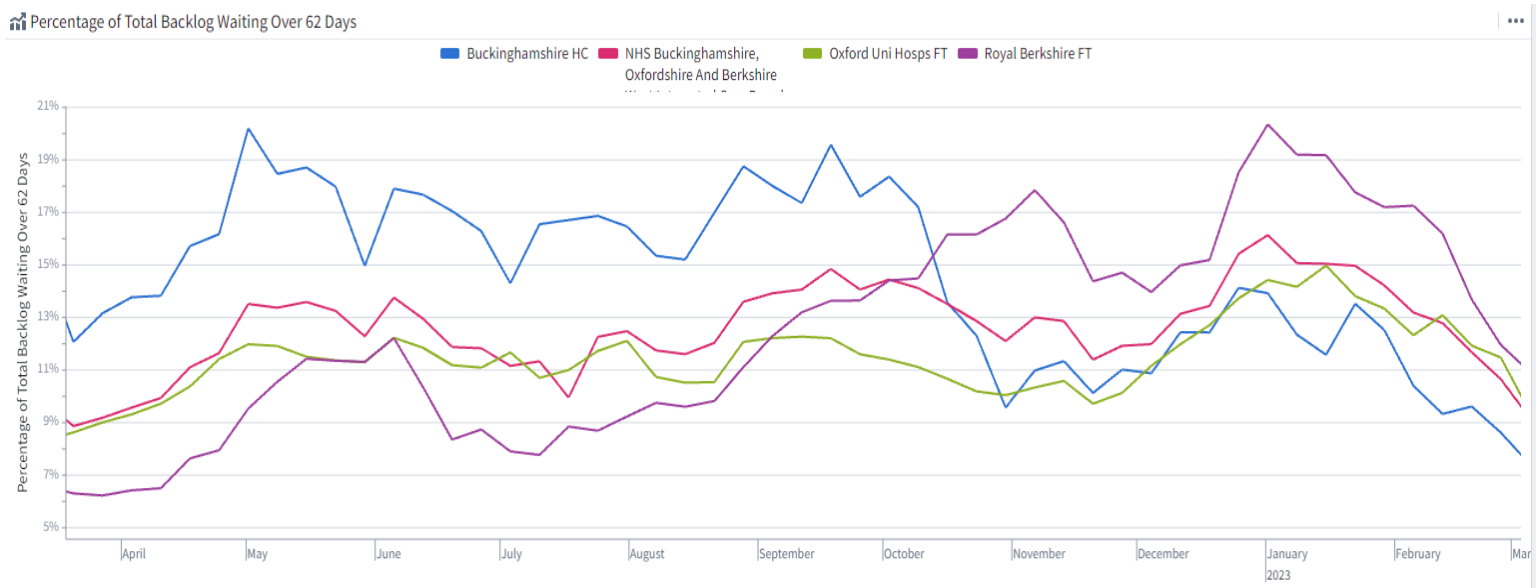
The new PCSP will provide pregnant mothers with one joined-up plan that covers their health and wellbeing needs which can be shared across all health services, meaning that patients do not have to repeat their story.

Improving diagnosis and treatment of cancer

Like other health service areas, cancer services across the country have continued to have been under significant pressure to deliver treatment for all patients following the COVID-19 pandemic. This is no different for the BOB ICS, which works with the Thames Valley Cancer Alliance (TVCA) to ensure delivery of cancer services across the area.

A key priority is for the BOB system is to achieve the target set out of returning the number of people waiting 62 days or more for cancer treatment to the pre-pandemic February 2020 level. The number of patients waiting over 62 days on the cancer patient tracking list as a percentage of the total waiting continued to fall through March 2023 with under 9% of patients waiting over 62 days, the lowest percentage in the 2022/23.

The overall >62 day waiting list has reduced from over 1,000 in December to under 600 by the end of March, lower than the same period last year. Below outlines our Trusts performance for 62 day standard:



The areas of greatest challenge across the Thames Valley over the past year are the cancer pathways of lower gastrointestinal (GI) tract, skin, urology, gynaecological and head and neck. TVCA has led the improvement plan for cancer in 2022/23 with initiatives outlined below:

- Implementation of training programmes for of staff to support improvements to pathway management across the whole cancer pathway
- Working with both primary and secondary care to support increase of faecal immunochemical test (FIT) uptake.

- Increased access to diagnostics
- Reducing pathology turnaround times to support progression on pathways.
- Reviewing pathway baselines against best practice pathways to further understand issues and to support the reduction of delays
- Embedding tele dermatology-led skin cancer pathway to support faster diagnosis and onward treatment
- Embedding patient navigators in cancer pathways to improve patient experience and engagement

Delivering improvements in mental health services

Throughout the past year work has continued to develop mental health services to support mental wellbeing and improve outcomes for people suffering from mental health conditions. As part of the NHS Long Term Plan, the Community Mental Health Framework is a new way of working that aims to improve joining up mental health services so that GPs, mental health teams and other support organisations in the community work better together and improve the experience of people with significant mental health conditions using services.

Across BOB work has progressed to improve access to NHS Talking Therapies for Anxiety and Depression. A transformation programme is underway and included a marketing campaign to promote referrals for people from BAME communities and older people. While further work will be needed to achieve the minimum access trajectory for 23/24. Our performance for the percentage of referrals receiving an appointment has been more positive and we have exceeded the 6-and 18-week national targets of 75% and 95% respectively.

Two ‘Keystone’ Mental health and Wellbeing hubs have been opened in Oxfordshire; these hubs will help these patients by providing them with access to a team of dedicated mental health professionals in their communities. This new NHS service will also enable GPs to work very closely with health staff in the hubs to ensure their patients receive care and treatment closer to their homes making it easier to get the support they require.

Work has continued through the year to achieve the national target of 60% of people with serious mental illness (SMI) to have a health check. This has included the introduction of Point of Care (PoC) machines, which offer immediate, convenient and easy to use diagnostic testing close to the patient’s home. There is a focus on equality with support given to people in deprived areas and those groups who may be hard to reach. In addition, caseloads are being reviewed to identify those people with an SMI who have not had health checks, so these can be offered. A project is being piloted in Wokingham until September 2023 which aims to boost and support physical health checks for people with serious mental illness in line with the 60% national target. Two physical health support workers are employed by Oxfordshire Mind to work with primary care networks to engage people on the SMI register who have either declined or not attended their health check appointment and those who are reluctant to go to clinics or to their GP. To date nearly 100 health checks have been done since September 2022 and it is hoped that by September this year more than 400 will have been carried out.

Despite efforts to improve the diagnosis of dementia, the dementia diagnosis rate in BOB has consistently remained around 59% which is below the standard of 67%, albeit this has slightly improved to 59.7% towards the end of the financial year. The ICB will work with the regional NHSE mental health team to review and improve pathways to diagnosis. In addition, a clinical lead has been appointed and a plan has been developed for improving diagnosis in care homes.

Supporting and treating children and young people with eating disorders is a key part of our work in the provision of mental health services for our younger population. Our targets are to 95% for both urgent referrals - one week, and four weeks for routine referrals. Unfortunately, we have fallen short of the standard over the past year, however, during some months at Place we have achieved 100% compliance for urgent referrals.

Staff turnover, vacancies and quality of referral information all affect our ability to meet these standards, and this is mirrored nationally. We have many initiatives underway to improve access, including the Referral Project which aims to improve referral information and triage. Progress is also being made to address recruitment challenges in the workforce teams for eating disorders and we expect to see an improvement in performance in this area.

Progress continues with the Pathway for Eating disorders and Autism, developed from Clinical Experience (PEACE) programme to support young people with eating disorders and neuro-diverse presentations. The ICS has a working group supporting shared practice and joint work, for example with the Avoidant and Restrictive Food Intake Disorder (ARFID) pilot.

Partnership working is key to supporting children and young people with their mental wellbeing. In February 2023 Berkshire West Children's and Young People's Mental Health Network Event brought together all partners who work with children, young people, and families, to support the development of the Mental Health and Emotional Wellbeing Services. Presentations from the ICB, providers, local authorities and volunteers shared the strategic direction and development of services in the ICB and those attending heard about existing innovations and successes from VCSE partners. Excellent feedback was received with requests for more face-to-face events. The Berkshire Health's Children and Adolescent Mental Health Services (CAMHS) has worked with volunteer organisation Berkshire Youth to support young people waiting mental health treatment. A pilot project was established in Newbury for youth workers, alongside SCT, to offer engagement to young people, make social connections and feel valued through positive activities.

The ICB reported spend of £263,588k on the mental health investment standard (MHIS) 2022/23. This is an increase of 5.81% on the outturn for 2021/22 against a target to increase by 5.54%. The ICB therefore more than achieved its MHIS target.

Learning disability and Autism

The ICB has a Learning Disability and Autism (LDA) programme shaped by the national programme. Part of the programme is to implement the BOB Learning Disabilities and Autism 3-year transformation delivery plan and to meet national performance targets. These include reducing health inequalities, improving support for autistic people and autism pathways, reducing reliance on mental health inpatient care and making this care more appropriate for people with a learning disability and/or autistic people.

Areas of focus over the past year include:

- Reducing the number of out of area placements which will ensure better patient and family experienced as well as reducing costs
- Collaborating with local authorities to support pathways associated with Special Educational Needs and Disabilities to reduce waiting times during 2023/24 and developing services to address the growing demand and backlogs

- Unblocking barriers to physical health care and addressing gaps in provision for people with Learning Disabilities and Autism in mental health inpatient settings. We will aim to incorporate mental health care into discharge planning to ensure safe discharge and ongoing physical health monitoring in the community.
- Continuing to increase the number of autistic people and / or those with a learning disability and getting an annual health check

During 2022/23 the ICB completed extensive research into specific groups including autistic people and / or those with a learning disability (it also included ethnically diverse communities, LGBTQ+ communities) to understand possible barrier in accessing services. It also looked at what we could do to make them more accessible. Recommendations are being developed to address the findings with two immediate actions taken have been to commission a dedicated mental health service for people with learning disabilities and to develop the ChAMHS Children in Care service.

Neonatal and maternity care

Like other areas, the BOB ICS has a Local Maternity and Neonatal System (LMNS). The LMNS was originally formed to be the maternity transformation arm of the ICS. However, since the independent inquiries into serious failings in maternity services in Telford and Shrewsbury (Ockenden), East Kent (Kirkup), and the MBRRACE report into maternal and neonatal morbidity/mortality, the functions and responsibilities of LMNS's have increased significantly. The BOB LMNS works as a close team, in full collaboration with the three maternity and neonatal services, as well as Maternity Voices Partnerships (service user groups) around transformation. Now in addition, the LMNS also has the task of working to seek assurance on compliance in regards key performance indicators, such as safety and service delivery.

The recently published Single Delivery Plan set the drivers for maternity and neonatal services for the next three years, and the LMNS are using this to underpin their own strategic themes, which are fully aligned and include comprehensive workforce and equity strategies, which have been commended by NHSE. They are also developing system-wide working, collaborating with ICB teams as well as the wider ICS, around workforce, the equity agenda and soon to include the women's health strategy.

The team leading this work are fully focused on promoting safe and compassionate care of women, birthing people and their babies, as well as the wellbeing of staff, and have commissioned training on Human Factors for both front line and executive leads in the trusts, as they recognise that our workforce are our greatest asset.

The BOB ICB has implemented the perinatal quality surveillance model as set out in the NHSE guidance for all system levels. The aim of this is to ensure there is system wide oversight of the quality of maternity and neonatal services across the BOB patch. Trusts submit a PQSM report quarterly, which is then sent to the LMNS board presenting key themes of good practice and items of escalation which are then sent to the NHSE regional maternity and safety concerns group on a quarterly basis. Themes are extracted from this data to identify emerging trends or common issues and risks and to then address them via quality and safety improvement projects. This allows the system to learn from serious incidents and the addressing key quality issues in order to improve the quality and safety of our services on an iterative basis.

The saving babies lives care bundle v2 (SBLCBv2) has been implemented as part of the maternity transformation programme but also as part of the immediate and essential actions from the Ockenden report. All trusts have either declared compliance or are close to full compliance. Trusts will now be working towards v3 which was released in May 2023.

As part of the preterm birth optimisation work led by the maternity and neonatal safety improvement programme (MATNEO SIP), led by the Oxford Academic Health Science Network, systems across the patch are aiming to ensure that all babies born before 27 weeks are born in the right place. This is their closest L3 NICU tertiary unit. The Neonatal Intensive Care Unit (NICU) looks after babies from extremely premature neonates, term neonates who have had difficult deliveries and babies with antenatally diagnosed conditions. For the BOB ICB this is the John Radcliffe at the Oxford University Hospitals.

The work of ensuring babies are born in the right place contributes towards the existing safety ambition: maternal mortality, stillbirths, neonatal mortality, brain injury during or soon after birth, and preterm births. In the last quarter for 2022 /2023, 100% were born in the right place and the BOB LMNS trusts continue to surpass the target for this deliverable. This is overseen by the Thames Valley Operational Development Network

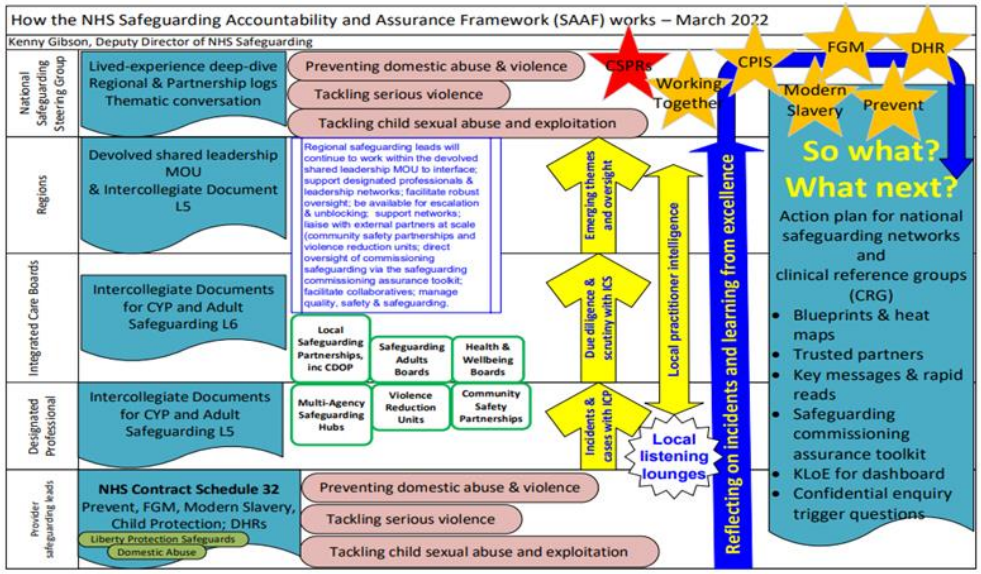
The Midwifery Continuity of Care (MCoC) is a standard of care and a way of delivering maternity care so that women received dedicated support from the same midwifery team throughout their pregnancy. The three-year delivery plan outlines that systems should consider the rollout of midwifery continuity of carer in line with the principles around safe staffing set out in September 2022.

There is one enhanced maternity continuity of carer based in the Royal Berkshire Hospital whilst Oxford University hospitals have a vulnerable women's team which are working towards continuity of carer via working on the building blocks of the model (ensure there is safe staffing). Buckinghamshire Healthcare Trust are prioritising the building blocks of the model and ensuring there is safe staffing in place before development towards the model.

Safeguarding our most vulnerable

BOB ICB has a statutory duty to put in place appropriate arrangements to safeguard children, children looked after, and adults at risk within their areas. The Safeguarding Vulnerable People in the NHS-Accountability and Assurance Framework (NHS England 2022) makes explicit the role of Integrated Care Boards in ensuring that:

- The organisations from which they commission services provide a safe system that safeguards children, young people and adults at risk of abuse or neglect
- They are fully engaged with Local Safeguarding Children and Safeguarding Adults Boards
- Robust processes are in place to learn lessons from cases where children, young people and adults die or are seriously harmed and abuse or neglect is suspected
- They work in partnership with NHS England to ensure the health commissioning system as a whole is working effectively to safeguard and improve the outcomes for children, young people and adults at risk.
- Internal ICB safeguarding governance and escalation arrangements are robust, and that safeguarding is embedded in all practice
- They secure the expertise of Designated Professionals with capability and capacity on behalf of the local health system



Overall, the quality of safeguarding and in BOB is good. Three place based safeguarding teams have established partnerships, networks, assurance systems and processes. During and since the COVID-19 pandemic there has been a significant increase in complexity and intensity of cases from a clinical, safeguarding and a psycho-social context from vulnerable groups. We have a key role in preventing and responding to harm, neglect and abuse of children and adults. Organisations within our system are facing significant challenges from capacity, workforce and population health management. System collaboration with all partner organisations is required to maintain and improve safeguarding and deliver a better outcomes for vulnerable groups.

The ICB took over the statutory responsibility for safeguarding from Buckinghamshire, Oxfordshire and Berkshire West CCGs on the 1st July 2022. The Interim Chief Nursing Officer had the Executive responsibility and accountability for Safeguarding for the ICB until they handed it over to the new substantive Chief Nursing Officer on 12th September 2022. An interim safeguarding structure has been in place to ensure robust safeguarding support and supervision to all commissioned services across the system, as well as proactive engagement in Multiagency Safeguarding arrangements for Children and Adults, across our three Place Based Partnerships. On 1st December 2022 an Interim Director Safeguarding to lead and support the development of the wider systems ICB Safeguarding structures and compliance was appointed.

Establishing a corporate ICB Safeguarding Team with the capacity and capability to provide statutory leadership and clinical safeguarding expertise across the ICS and at Place, building on the three experienced Place teams has been a priority, a new corporate team structure with increased capacity has been agreed and recruitment started. Capacity will be further reviewed during 2023/24 with a focus on Looked after Children (LAC), Child Death Overview (CDOP) and Learning from Lives and Deaths People with a Learning Disability and autistic people (LeDeR) arrangements.

The three ‘place’ based safeguarding teams, alongside our Named Leads in provider organisations, have completed audits for a programme of assurance to the locality Safeguarding Partnerships. These include self-assessments.

The ‘place’ based teams have completed both Section 11 and Care Act self-assessment audits in all three localities which overall showed that we are in a strong position. Priorities for improvement were identified around:

- Work to review and standardise our approach to allegations management for children and adults and work with Local Authority Designated Officers (LADOs) to provide assurance, standardise processes and improve information sharing, communication and reporting has started.
- Reviewing and standardising our approach to delivery of Level

There are three Child Death Overview Panels (CDOPs) in BOB each with arrangements that comply with statutory guidance and have robust reporting and learning systems at locality and nationally and publish an annual report.

- Buckinghamshire https://bscb.procedures.org.uk/tkyzqx/the-safeguarding-children-partnership-and-organisational-responsibilities/child-death-review-guideline/
- Oxfordshire https://www.oscb.org.uk/practitioners-volunteers/child-death-overview-panel/
- Pan Berkshire https://www.berkshirewestsafeguardingchildrenpartnership.org.uk/scp/about-us/child-death-overview-panel-cdop

During 2023/24 we will review and align CDOP arrangements streamlining where possible

Working Together to Safeguard Children 2018, sets out the arrangements for the three safeguarding partners (Local Authority, ICBs and CO of police) and how they will work together with other agencies to safeguard and promote the welfare of children in their local area.

In BOB the following arrangements are in place:

- Buckinghamshire https://www.buckssafeguarding.org.uk/childrenpartnership/
- Oxfordshire https://www.oscb.org.uk/
- Berkshire West https://www.berkshirewestsafeguardingchildrenpartnership.org.uk/scp

Each board publishes an annual report

Working Together to Safeguard Children 20181, states that the safeguarding partners must publish a report at least once in every 12-month period. The report must set out what they have done as a result of the arrangements, including on child safeguarding practice reviews, and how effective these arrangements have been in practice.

In BOB the following partners have published annual reports:

- https://www.ouh.nhs.uk/about/trust-board/2023/january/documents/TB2023.15-safeguarding-annual-report-2021-22.pdf
- https://www.oscb.org.uk/wp-content/uploads/2022/08/OSCB-Annual-Report-2021-22.pdf

Our ambition is to create a culture across the ICB/ICS that has at its heart the welfare of our most vulnerable citizens and ensures a strong safeguarding voice, promotes system learning, development, quality improvement and an effective early warning system to enable us to rapidly identify and address areas where safeguarding falls below expected standards.

"*Each child or adult in need of our services is supported to stay healthy, keep their independence and live their lives free from abuse and neglect*."

To deliver our ambition, we will:

- Have a better understanding of the connectivity and matrix working across BOB ICB and with ICS partners
- Embed a learning culture and continuous improvement.
- Align and standardise our safeguarding Quality Assurance Framework (QAF) and reporting, streamlining where possible
- Engage with vulnerable adults, children and young people and their representative groups to improve their experience and to develop our services.
- Ensure the patient voice is heard and acted on, making safeguarding personal and thinking family.

An inaugural BOB Health Economy Safeguarding Strategic Committee, reporting to our System Quality Group and Population Health and Patient Experience Committee took place at the end of January 2023. Chaired by the Chief Nursing Officer, membership included Associate Directors or Heads of Safeguarding for our acute, community and mental health providers, BOB Head of Prevention & Health Inequalities, SCAS Associate Director of Safeguarding, the Safeguarding Lead, NHSE SE and our Named and Designated Professionals. This meeting determined our safeguarding and LAC priorities for 2023/24:

1. **Assess demand and capacity – standardise and identify new ways of working for the following priority workstreams.**
   - Children in Care /Looked After Children (CIC/LAC) – Initial Health IHA/RHA clinical capacity
   - Multi Agency Safeguarding Hub (MASH) child and adult clinical capacity
   - Health Visitor/School Nurse capacity, working with public health commissioners
   - Quality Assurance Framework (QAF) and capacity for commissioned placements
2. **Safeguarding Processes:**
   - Effective information sharing in line with the recommendations and work of the new national Multi-Agency Safeguarding Partner Performance Board (MASPP)
   - Legal literacy MCA/DoLS as part of our preparedness for Liberty Protection Safeguards (LPS) and to including inherent jurisdiction – Deprivation of Liberty Orders for Children and Young People
   - Implementation of the Safeguarding Adult Boards Multiagency Risk Management (MARM) Frameworks
   - CPIS 2 – introduction of next stage Child Protection Information Sharing system
3. **Readiness for Serious Violence Duty to align with Community Safety Partnership and Thames Valley Police, this is a new statutory responsibility from the 21/01/23 work streams will include:**
   - Criminal Exploitation
   - Child Sexual Exploitation

- Contextual Safeguarding
- Vulnerable and seldom heard groups e.g. LD and Neurodivergent people, people with mental health needs, asylum seekers and the travelling community
- Domestic abuse
- Violence against women
- Modern Day Slavery
- Transition to adulthood – links to SEND

Our safeguarding priorities have been shaped by:

- The National Review of Children's Social Care following the deaths of Arthur Labinjo-Hughes and Star Hobson
- The Independent Inquiry into Child Sexual Abuse.
- Statutory guidance on the Serious Violence Duty in accordance with the Police, Crime, Sentencing and Courts Act 2022.
- Domestic Abuse Act, 2021 and new statutory guidance, July 2022.

Workstreams have been developed as a result of learning from BOB Child Safeguarding Practice Reviews (CSPR) Safeguarding Adult Reviews (SARS) and Domestic Homicide Reviews (DHRs) and identified in partnership with our NHS Commissioned providers and through the safeguarding child and adult partnerships and boards across BOB ICS.

Safe and effective use of medicines

The safe and effective use of medicines is an essential element of healthcare and the ICB Medicines Optimisation (MO) team supports clinicians, patients and carers in making decisions about which medications to use in order to obtain the best possible outcomes. The MO teams from the three CCGs had historically worked closely together but, with the formation of the ICB in July 2022, a single team was formed.

The three places had previously had their own approach to a Prescribing Incentive/Quality Scheme (PQS) and the ideas from each were combined to create a BOB-wide PQS the details of which were shared with our GP practices by well attended webinars. Practices were supported in working towards the targets set in the PQS. While medicines safety was the main focus of the scheme, there were projects to release costs savings. The Prescribing Dashboard was extended to cover BOB and continued to be updated monthly informing practices on all their prescribing targets, achievements and priorities. Regular prescribing data was also used to inform the ICB of ongoing cost pressures and reviewing national data helped to identify areas of potential savings as well as highlight where BOB performed better than other ICBs.

In 2022/23, significant work went into establishing a BOB-wide Area Prescribing Committee (APC) which is a strategic decision-making group with responsibility for promoting rational, evidence-based, high quality, cost-effective use of medicines to ensure equity of safe access to medicines for patients. The aim is to make decisions that are clear, consistent and evidenced and take account of regional and national recommendations. The new committee has an extensive work plan which will result in new formulary decisions, the implementation of new guidelines and the introduction of new pathways.

Collaborative working with PCN Pharmacy colleagues continued to be a priority with each place having a Lead PCN Pharmacist working in the ICB MO team and regular meetings bringing together colleagues from across the ICS to share ideas and learning. The strong links with colleagues working in PCNs supported further joint projects including the drafting of an Induction Pack for practice-based pharmacy staff and the review of possible joint posts across PCNs and secondary care. In addition, continued close working with the Local Pharmaceutical Committees (LPCs) ensured that schemes commissioned from our Community Pharmacies could become BOB-wide. The team also continued to work closely with colleagues in secondary care to ensure a consistent approach to medicines optimisation and colleagues in all sectors continue to make regular contact with the MO team with specific questions via the team's generic email addresses.

Optimising medicines use to maximise health outcomes and give the best value has never been more important and, in 2022/23, the ICB MO team continued to work with colleagues across the system to achieve this. As in previous years, there were significant cost pressures and these were managed alongside the delivery of many quality initiatives to deliver good quality, cost-effective prescribing including the review and implementation of guidelines, collaborative work with providers, the introduction of new pathways and the review of data and governance arrangements.

Digital transformation

As a newly formed ICB, we have been strengthening our partnerships with NHS and local authority organisations across the ICS to develop a shared vision and strategy for digital and data. The strategy acknowledges the need to change our ways of working to realise the benefits of being unified as a system, by exploiting and building upon collaboration opportunities which already exist within the ICS.

Our digital transformation programme has been extensive for 2022/23 and has delivered a whole wealth of outcomes which have improved the way care is provided and accessed across BOB. Below are a few examples:

Enhanced access to primary care services: Primary Care Networks (PCNs) will be required to provide 'enhanced access' with multidisciplinary teams working collaboratively to facilitate additional appointments. We have implemented digital capabilities which enable each practice to 'interoperate' so patients can access routine appointments, and more, beyond their own registered home practice. The benefit will be that practices working with each other as PCNs can offer a better understood service for their patients' needs while facilitating convenience of appointments for patients.

Digital Exclusion Inclusion and Literacy: We are working with health and local authority partners across BOB to help citizens manage their health digitally where appropriate, for example electronic prescription requests or find trusted health information via the NHS App or view their records digitally. Currently 61% of the BOB population have the NHS App compared to 54% nationally.

Our focus is:

- Ensuring practice staff are all familiar with NHS App and other relevant tools to help citizens to manage their routine health care digitally.

- Working with all voluntary organisations in BOB who provide digital support to citizens to ensure they have the knowledge and confidence to discuss or demonstrate NHS app usage with citizens.
- Ensure all involved with patient care in BOB are aware of the digital tools being used across the ICB and encourage citizens to access digital health care/advice if appropriate.

Digitising Adult Social Care Programme: The ICB has been successful in securing funding and is now leading a programme to support the digitisation of CQC registered adult social care providers with adopting a Digital Social Care Record (DSCR), often also known as electronic care plans. DSCR allows the digital recording of care information and care received by an individual, within a social care setting, replacing traditional paper records. DSCRs are person-centred and enable information to be shared securely and in real-time with authorised individuals across the health and care sector. And for care homes only, adoption of sensor-based falls prevention and detection technologies, such as acoustic monitoring, to support those residents most at risk of falls. These technologies generate data to those providing care to prevent and/or detect a fall. The benefits include:

- **DSCR** gives staff the information they need about the people they care for helps them to provide the right care at the right time and reducing the administration of care records and plans could release a day a week of carer time in an average sized care home
- **Acoustic monitoring** in care homes can reduce falls among over 65s by 40-55% and subsequent hospital admissions by 20%

Community Pharmacy Consultation Service (CPCS): CPCS enables practice teams to channel defined minor illness patients directly to a community pharmacist for their first contact, where the patient will receive clinical assessment and advice in a more timely manner. We have invested in the technology and rolled this out across GP practices and community pharmacies across BOB as follows:

- 109 (68%) BOB practices are 'Live' and referring their patients to community pharmacists via CPCS, with a further 38 (24%) 'Engaged' with the service and preparing to 'Go Live'
- Across BOB 10,828 referrals have been made since April 2022, which equates to approximately 1,805 hours of saved practice appointment time, with potential cost savings of around £80K (based on GP average)
- BOB (as of December 2022) had the highest number of completed referrals across the South East Region, achieving the second highest number of referrals per capita

Going forward the role of the ICB will be to bring together our collective strengths across the BOB ICS and facilitate delivery of a strategy aligned to the ICS development aims. Our digital strategy over the next three years will:

- Digitise our providers to reach the Minimum Digital Foundations to reach a core level of digitisation across our system
- Connect our care settings using digital, data and technology and improve citizen experience
- Transform our data foundations to provide the insights required to transform our system and better meet the needs of our population

Improving quality

The ICB is responsible for ensuring continuous improvement in the quality of services it commissions in connection with the prevention, diagnosis or treatment of illness. Quality is defined in the NHS as safe and effective care alongside outstanding patient experience. Improving the quality of healthcare provided to people across BOC is central to the work we do.

NHS Trusts within our system are facing significant challenges relating to capacity, workforce and population health management. System collaboration with all partner organisations is required to maintain and improve quality and safety and deliver a better patient experience.

Below gives a quality summary of the provider Trusts and GP practices across BOB including the Care Quality Commission rating and the system oversight framework rating for quality.

Provider Trust	Overall CQC Rating	SOF Rating
Berkshire Healthcare Foundation Trust	Outstanding	1
Royal Berkshire Foundation Trust	Good	2
South Central Ambulance Service	Inadequate	4
Buckinghamshire Healthcare Trust	Good	3
Oxford Health Foundation Trust	Good	2
Oxford University Hospitals Foundation Trust	Requires Improvement	2
BOB Primary Care: 157 GP Practices	**Overall CQC Rating**	
153 Practices (97%)	Outstanding or Good	
4 Practices (3%)	Inadequate or Requires Improvement	

*SOF = System Oversight Framework

1

Our ambition is to build a system in which we deliver continuous quality improvement and an effective early warning system to enable us to rapidly identify and address areas where quality fall below expected standards with a particular focus on pathways and links within systems.

Work has continued with our partners to improve patient experience, improve the quality of services and learn from incidents to reduce the risk of them happening again. To ensure we are continuously improving the quality of services across BOB we are developing a system-wide quality assurance framework. This framework will outline the principles, expectations, behaviours and governance for quality assurance and includes

quality assurance methodology which includes use of data, patient feedback and peer reviews. We are using NHSE draft early warning systems dataset including the System Oversight Framework and CQC ratings. This will enable the timely identification of quality concerns which will mean the system can focus on improvements.

The new structure and governance arrangements have been designed to maximise skills and integration with defined portfolio areas which will take system wide responsibility for key service lines such as care homes, end of life, primary care, mental health and urgent and emergency care.

The ICB ensures that quality improvements are made as a result of patient safety incidents. Examples of this are outlined below:

- The RBH has undertaken work on identifying and rapidly responding to deteriorating patients. This came about as a result of a theme being picked up in Serious Incidents and was subsequently made a quality priority by the Trust. The Trust undertook surveys to better understand barriers and to raise awareness of the deteriorating patient. They audited the use of both the NEWS2 tool[1] and the escalations which followed when a deteriorating patient was identified. Following the programme of quality improvement, the Trust undertook an audit which demonstrated clear improvement in outcomes from patients.
- In OUH healthcare professional feedback to the ICB and patient safety incidents had demonstrated that patients with incidental findings of cancer in ED experience disjointed and sometimes delayed pathways which resulted in a poor experience and psychological distress. A new pathway was designed in response to ensure this cohort of patients are picked up immediately on diagnosis (or suspicion of diagnosis) in ED. They are immediately put in touch with nursing and medical support and are discussed by the acute oncology multidisciplinary team. This means that the pathway is much more efficient, and patients receive the support they need immediately.

We are currently working on our priorities for the coming year which include:

- Publish a Quality Strategy to support improvement which will incorporate the National Patient Safety Strategy
- Develop a system-wide quality assurance framework to underpin our improvement work
- Ensure patient experience and co-design is fully embedded in our quality assurance/improvement work and our quality strategy

The ICB will also be responsible for quality assurance for a wider range of services than the predecessor CCGs. This is because of the planned delegation of pharmacy, optometry and dentistry. These services were previously commissioned, and quality assured centrally by NHSE.

[1] NEWS2 is the latest version of the National Early Warning Score (NEWS), first produced in 2012 and updated in December 2017, which advocates a system to standardise the assessment and response to acute illness.

Addressing health inequalities

Work continues across BOB to reduce health inequalities and enhance preventative interventions.

Ongoing work throughout 2022/23 has focused largely on the recovery and delivery of services following the COVID 19 pandemic ensuring health care provision is accessible and experience and outcomes are equitable.

The Adult and children and young people's (CYP) Core20Plus5 programme continues to be developed with significant work taking place across the ICB:

- In maternity teams across BOB were established to support the continuity of care for pregnant women from black and minority ethnic communities as well as those from most deprived populations in BOB.
- Targeted communications were developed and outreach work undertaken to increase the uptake of annual health checks for people with serious mental illness and those with learning disabilities.
- To support people with chronic respiratory conditions work has been undertaken to increase access to pulmonary rehabilitation and looking at equity of access and levelling up capacity with demand across BOB. We have also improved access to spirometry by restarting services and supporting recovery. Alongside this work, there has been targeted communication to highlight the importance of vaccinations for people in chronic respiratory groups. This includes work to increase take up of COVID, Flu & pneumonia vaccines in populations of low take up.
- Work continues with Black and minority ethnic communities and health inclusion groups to support access to screening programmes; understand experience of barriers to services and co-produce solutions and interventions.
- CYP services have recruited a Clinical Lead who is developing activities and plans for the Core20Plus5 ambitions.
- Funding had been agreed for devolvement to Place to prioritise local actions and interventions for 23/24 and the Long-Term Condition Teams portfolio and CYP portfolio are also delivering activity to continue address the five clinical priorities.

Below outlines some areas of work that are on-going as key NHS priorities as we move beyond the COVID 19 pandemic.

Restoring NHS services inclusively:

- Working with our acute service providers on elective care with a focus on recovery and reducing waiting times across system whilst mitigating against inequality of access.
- Ensuring Primary Care are supported to accelerate return to pre pandemic levels of care as quickly as possible re the management of Long-Term Conditions and ongoing patient access. i.e. Targeted Diabetes Funding to support areas in areas of higher deprivation to accelerate annual health checks and return to pre pandemic levels of clinical care.
- The identification on patient registers of top 30-50 patients who would benefit most from a holistic health and wellbeing review (physical, mental and social), supported by a social prescriber.

Mitigate against digital inclusion:

- We have appointed a Digital Inclusion Lead to ensure digital inclusion is central to developments in new and existing projects such as virtual wards and remote service patient engagement.
- There is a sustained focus on work to ensure that data sets are gathered robustly and data set are complete and timely.
- Population Health Management developments

Accelerate preventative programmes:

- The COVID-19 Vaccination Programme continues to operate across BOB, identifying cohorts of concern/ low take up and targeted interventions delivered. This continues to engage with communities and their representatives through outreach, bespoke communication, engagement, and education. The Health On the Move Van providing outreach in areas if higher deprivation is also screening for hypertension.
- Smoking cessation services are being rolled out across inpatient services for acute and mental health providers as well as maternity services to ensure that all inpatients are identified who smoke and encouraged/ supported to quit.

Strengthen leadership and accountability:

- The ICB Prevention and Heath Inequalities Group has established and agreed £4million of investment for 2023/24 to target inequalities and prevention work across the area. This will be driven by placed based agreed health inequality priorities and partnerships linking with local activities to ensure added value and grease impact.

Engaging people and our communities

We aim to create an ICB built on effective engagement and partnerships to successfully serve our citizens. We know that effective communication and engagement is key to achieving these goals. The COVID-19 pandemic resulted in increased collaboration across the system. The vaccination programme strengthened partnerships with primary care, the VCSE sector and local authorities, resulting in improved vaccination rates for vulnerable communities.

Statutory partners, such as Healthwatch, have given insight into the experiences of our citizens and made recommendations which enabled corrective action where needed. Developing the links between acute settings, including private providers, aided capacity management throughout the pandemic response. The strength of these partnerships were critical to the way that the NHS, and the communities we serve, were able to adapt to rapidly changing circumstances.

As we move on with life after the pandemic, we are committed to progressing and sustaining these relationships by empowering community representatives and providing a range of public-facing engagement facilities, both in-person (face to face) and via digital channels. In this way, we will continue to develop an effective system with engaged partners and involved stakeholders.

To help us achieve our goals we will seek opportunities to engage at the most effective geographical level, whether this be system - in other words, across the whole ICS population – or at Place (local authority level), or indeed at local neighbourhood level. For example, while the direction of travel for our ICB and priorities for the years ahead may be best approached at system-level, local community engagement needs to be delivered on a smaller level such a working with a local patient participation group on a particular issue. We also recognise that different groups of people and different communities need to be supported to engage with us in different ways.

We recognise there is much to do to develop our work with communities and people within BOB. We are currently reviewing resources and our capability to ensure we have the right team in place to deliver this important work and to develop a culture of working with our citizens and patients across the organisation. Below outlines some of the work we have undertaken across BOB since the establishment of the ICB to develop our networks and shape our public engagement.

Working with People and Communities Strategy

We have developed a high-level strategy for working with people and communities, which sets out our proposed principles for engagement and our aims for engagement for the ICB. Before the initial draft was written we held a workshop involving representatives from all five Healthwatch's across BOB, the BOB Voluntary Community and Social Enterprise Alliance (VCSE) and NHS Trust lead governors. We were also invited to speak at a wider meeting of the VCSE Alliance. These discussions were focused on testing out principles and approach.

The draft strategy was also made available on our engagement site to enable partners and members of the public to submit comments. We received a range of helpful ideas and comments, and we used these to help shape the strategy.

Development of a framework to deliver our strategy: putting our principles for engagement into practice

Following the development of our working with people and communities strategy, we designed a framework that set out how we plan to put the high-level principles of the strategy into practice. The main elements of the framework were to develop a consultation platform; further develop relationships with our partners to utilise their channels to promote awareness and drive traffic toward the consultation platform; develop a representative citizens' panel, which we will develop and use for feedback and comment via surveys and to develop and work closely with our partners to reach and engage with specific groups and communities.

Launch of our new engagement portal 'Your Voice in Buckinghamshire, Oxfordshire & Berkshire West'

The ICB has invested in a new digital engagement platform to give people across BOB the opportunity to get involved and help shape the future of health and care. It 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 work of the ICB and partners. The platform was launched in December 2022 and already has 822 participants registered. Over the next year we will be developing our membership with a campaign to raise awareness of the site and get more people on board with the work of the ICB.

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 and are working closely with our five Healthwatch groups across our system. We have strong relationships with Healthwatch, who have previously supported place-based projects, provided essential access to patient voices, and given detailed analysis and recommendations.

Our Healthwatch groups already provide invaluable support: the Oxfordshire Healthwatch, for example, already facilitate and recruit members to the county's Patient Participation Groups – a model approach being adopted by other Healthwatch groups across Buckinghamshire and Berkshire West; this is funded by the ICB.

Healthwatch will continue to provide independent scrutiny and challenge where appropriate as they are the independent health and social care champions for their places. We meet with them regularly and use their insights and public feedback to inform our strategies and plans. An example of this was the suggestion of a sign language interpreter joining our online public meetings during our engagement for developing the BOB ICP strategic priorities.

Working closely with our VCSE sector is also key to successful engagement. The voluntary and community sector has a range of skills, experience, and brings a way of looking at things that often leads to quick and creative change. They are composed of people and communities who promote mutual aid and advocacy and provide professional service.

We are working closely with the voluntary and community sector to ensure it has a voice and influence at all levels. We want to work together with the sector to better understand people's and community's needs, experiences and aspirations for health, care, and wellbeing. The BOB VCSE Alliance is a very important channel for engagement. Through them we will be able to work with community leaders, reaching out to those affected by inequalities - strengthening relationships, building trust, and enabling the voice of people and communities to be heard.

We are working with the voluntary and community sector to explore ways to reach and engage with communities who have poorer experiences and outcomes. As we develop our engagement, we will work with the BOB VCSE Alliance to tailor our approach to engagement depending on the needs of the audience rather than trying to create a one-size-fits-all approach.

Developing a BOB wide Citizen's Panel

To ensure we engage as widely as possible, we are in the process of setting up a Citizens' Panel to act as a core engagement resource. There is an established panel within Buckinghamshire, and we are developing this by recruiting a wider representative pool from across Oxfordshire and Berkshire West. Our initial aim is to recruit approximately 1,500 members. The panel will be used to answer broad surveys and to segment them and create smaller focus groups to consider specific issues in more detail.

BOB ICP strategic priorities engagement

We worked with the public, local authority partners, NHS Trusts, Healthwatch and our VCSE to seek feedback on proposed principles and priorities for the BOB ICP Integrated Care Strategy. The engagement sought to get local people and communities to help refine the proposals for a common set of priorities for our health and care system. We invited people to comment on the direction (principles) of the strategy and a common set of priorities for the partnership, through which we aim to meet local needs and reduce pressure on services.

We sought feedback on the strategy from 13 December 2022 until 29 January 2023. We drafted a document that explained the rationale for the strategy, the need for change, who is involved in the work, the principles that will guide the work of the ICP and the proposed strategic priorities.

The document was made available on the new ICB engagement site and published both an easy read version and a Word version to support online translations. We also shared recordings of the public events and a Q&A session. Through a survey, we asked people if they felt the proposed principles and priorities were the right ones and to add any ideas / suggestions to the strategy.

This public feedback is being used to refine the principles and priorities for the BOB ICP strategy. We will continue to engage with stakeholders and the public as the strategy is agreed and put it into practice. We will continue to consider public views and patient experience as we develop new ways to provide care.

More information about the engagement, including the engagement report and outcomes, is available here.

Working with our local communities

There is a wide network of GP patient participation groups across BOB Berkshire. The engage with PPGs a number of ways. In Berkshire West PPGs, in addition to their practice-based meetings, meet regularly within their local authority area and attended by ICB colleagues to share best practice, receive updates on developments within their area and discuss ways of widening their engagement within their communities. Over the last year there have been keynote speakers at these sessions including the ICB directors and RBH colleagues. A monthly e-newsletter is produced jointly by the RBH and ICB and distributed to the PPGs, Practice staff and a wider audience including parish councils, Healthwatch, VSCO and other community partners.

In Buckinghamshire, PPGs are a central part of the Buckinghamshire Engagement Reference Group. The group includes the ICB, VCSE, Healthwatch and the local authority. It comes together to support collaborative working and decision making that improves health and social care outcomes in Buckinghamshire and facilitates effective partnership between health, local authority and wider partnership organisations in Buckinghamshire

The ICB also supports practices and PPGs on specific issues, an example of this in the past year includes working closely with the PPG of Botley Medical Centre. Earlier this year, the GP partners at the Botley Medical Centre and its branch surgery in Kennington gave six months' notice to the ICB that they intended to resign their contract. The primary care team at the ICB began working immediately with the PPG and other key stakeholders to find another GP team to take on the contract, with the aim of both sites continuing to offer primary care services in the long term.

The primary care team met regularly with the PPG's executive members to update them on progress and to answer questions. The PPG executive was also involved in reviewing the proposals from other Oxfordshire GP practices which expressed an interest in taking on the provision of services to the 14,000 registered patients. The PPG shared information with patients and a dedicated web page with information and frequently asked questions was set up on the BOB ICB website. The process is ongoing as this report is published.

Working with children and young people

The ICB worked with Local Authority partners in Berkshire West, BHFT and supported by our Young People and our Counselling Organisations (No5, Time2Talk, ARC Web) to procure a Digital Mental Health and Wellbeing Support service for 11–17-year-olds. The project aimed to reduce health inequalities, with a service specification which includes service standards to this effect and a procurement selection process which includes specific questions aimed at understanding how the provider will be supporting people from the most vulnerable cohorts and proactively targeting them to improve access. In developing the questions to ask bidders for the service we worked with young people via our counselling organisation to get them to propose questions they'd like to incorporate into the tender document. A group of young people involved in the project also tested the customer facing app/web service and scored the different applications on several factors. The scores then informed the selection process.

Joint Forward Plan

At the beginning of 2023, planning started on how we would engage with local people on the development of our Joint Forward Plan. The Joint Forward Plan is how we intend to deliver the BOB Integrated Care Strategy. It will also set out how we will deliver national NHS commitments and recommendations. To launch this work the ICB held a workshop, which brought together system colleagues from across BOB to explore how we will achieve our integrated care ambitions together. Over 70 representatives from our NHS Trusts, primary care, local government, the Academic Science Health Network, voluntary and community sector and Healthwatch came together to come up with bold ideas for how we meet the challenges facing health and care and improve the health and wellbeing of our local population.

Wider engagement will run through April 2023 and will include information on Your Voice inviting ideas to be included in the Joint Forward plan; we will also be running several focus groups on the priorities we aim to deliver.

Developing a sustainable environment

The Net Zero Programme Board has developed over its first year of operation. Currently, we are developing an Action Plan for both the Board itself and for the Areas of Focus in order to produce valuable data for use in funding applications, proof of concept, reporting and to move us towards the goal of Net Zero by 2040.

The annual review of our ICS Green Plan is approaching, which will be reworked in line with feedback from the Net Zero Board on our priorities and with support from our Area of Focus leads and Trust Sustainability leads to ensure we align with our goals and ambitions across the three places.

There have been successful funding applications across the ICS, notably OUH have secured funds from the Public Sector Decarbonisation Scheme (PSDS), which will aid in their efforts to move away from Carbon emitting energy sources and implement Greener Energy. There was a number of successful applications for the Healthier Futures Action Fund for smaller projects in which funds have been received and the plans are underway.

Some of the initiatives that are currently taking place are:

- High Wycombe Hospital has been undergoing major renovations to repair and modernise the buildings. The NHS Wycombe Energy Centre has been designed to allow stable, predictable, accurate forecasting for future energy expenditure and will provide a 40% reduction in energy costs for the site. The Energy Centre will enable significant de-steaming of the site and once available, can be converted into Hydrogen Power. BHT have also made strides in reducing the waste leaving the site by introducing an ‘on site’ facility that uses an aerobic digestion machine with multiple strains of bacteria to digest organic materials. This can reduce the mass of the waste by 50% mass and up to 70% volume, thereby reducing waste collections by around 2/3. The Floc that is produced by this process is currently being used by Energy from Waste (EfW), however future plans are to send the Floc to be processed as Solid Recovered Fuel (SRF) which costs 40% less than EfW and will benefit the Circular Economy.

- Oxford Health has been working towards lowering their travel and transport carbon contributions. They have currently had a review of their grey fleet completed by The Energy Saving Trust and are using this information to develop a plan towards lowering their emissions. Oxfordshire County Council have invited NHS representatives to their Climate Adaptation Group who are working at future planning to prevent possible problems that will arise from climate changes taking place. We hope to bring this learning back to the NHS and incorporate it into our future planning.
- One area we are working towards reducing our carbon emissions is with medication management. Medication is one of the biggest contributors to our carbon footprint as a healthcare provider. The anaesthetists at The Royal Berkshire Hospital in Reading have responded to this by swapping out one of their regularly used anaesthetic gases Desflurane, with the less carbon intensive Sevoflurane, which will save 413 tonnes of CO2 per year. Over the past year RBH have reduced their usage to 0%, with BHT close behind with 1.8%.

Responding to an emergency

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

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

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

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

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

- NHS England Emergency Preparedness, Resilience and Response Framework;
- NHS England Core Standards for Emergency Preparedness, Resilience and Response;
- NHS England Business Continuity Framework.
- EPRR requirements laid out in the NHS Standard Contract
- Minimum Occupational Standards for NHS Emergency Preparedness, Resilience and Response (MOS)

- ISO 22301:2019 Security and resilience – Business continuity management systems

The ICB's Accountable Emergency Officer (AEO) is responsible for executive leadership of EPRR, supported by the ICB's EPRR team. The ICB's Chief Delivery Officer holds the AEO portfolio.

Since the creation of the ICB through the Health and Care Act 2022, the ICB has worked on developing and growing the capacity and capability of the EPRR team. This includes appointment of a Head of EPRR to lead the team. The team have developed a new EPRR Policy and Strategy, supporting the implementation of a broad programme of work to ensure the ICB is discharging responsibilities, assessing risk of emergencies, and taking appropriate preparatory action such as planning, training and exercising.

The ICB has responded to a range of incidents and emergencies over the past year, including but not limited to communicable disease outbreaks; IT systems failures; adverse weather; and industrial action.

Due to the sustained response to the COVID-19 pandemic combined with a multitude of other incidents and widespread NHS pressure, the past year has seen the NHS mostly operating at an EPRR Level 3 incident, invoking regional NHS England coordination supported by ICB leadership at system and place.

As part of enhanced operating arrangements, all ICBs in England opened System Control Centres (SCCs) at the end of 2022, to provide a 24/7 hub of coordination within the ICS for system risk balancing and system leadership in times of pressure. The SCC also acts as a central node of coordination for operational assurance between NHS England, the ICB, and our NHS providers. In the event of major, critical, or business continuity incidents, the SCC can operate as the ICB's Incident Coordination Centre (ICC) through which an incident response is coordinated and supported. The Head of EPRR is responsible for the leadership and delivery of this capability.

At the same time the ICB continues to lead on NHS engagement with the Thames Valley Local Resilience Forum, the coordination network of Category 1 responders, Category 2 responders, and Voluntary, Faith and Community groups in regard to emergency preparedness. Similarly, the ICB co-chairs the Thames Valley Local Health Resilience Partnership, where all health partners come together around emergency preparedness.

As part of the annual rhythm of assurance, the ICB conducted the 2022 annual assurance process for the NHS England Core Standards for EPRR, both within the ICB and for all providers of NHS funded care within the Integrated Care System (ICS). The outcome of this process saw the ICB rated as Substantially Compliant, and all providers rated either Substantially or Fully Compliant.

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

Revenue

BOB ICB came into existence on 1 July 2022 following the disestablishment of the three constituent CCGs. The accounts presented are for nine months only (1 July 2022 to 31 March 2023) and there is no comparator data.

For the nine months of the ICB's existence, BOB ICB's total funding was £2,506m. Of this, £2,481m was allocated for healthcare programmes and £26m for the CCG's running costs as reflected in the table below which summarises our budget (plan) and actual expenditure for 2022/23. The ICB achieved a small surplus of £248k against a stretch target agreed with NHS England of breakeven.

BOB ICB by Service Line	YTD Budget Month 12 £'000	YTD Actual Month 12 £'000	YTD Variance Month 12 £'000
Acute	1,235,034	1,255,145	(20,110)
Community Health Services	245,218	231,819	13,399
Continuing Care	122,660	139,813	(17,153)
Mental Health	230,531	232,619	(2,088)
Other Programme	101,157	63,757	37,399
Other Commissioned Services	0	(12,352)	12,352
Primary Care	136,593	127,743	8,849
Prescribing, Central Drugs and Oxygen	177,504	210,753	(33,248)
Delegated Co-Commissioning	232,171	232,053	118
Total Programme Costs	**2,480,868**	**2,481,350**	**(482)**
ADMIN Costs	26,323	24,882	1,441
NET SURPLUS / (DEFICIT) before CIP and Planned Surplus	**2,507,191**	**2,506,232**	**959**
Unidentified CIP target	(16,453)	0	(16,453)
Planned surplus/(deficit) Q2 to Q4	15,741	0	15,741
NET SURPLUS / (DEFICIT)	**2,506,480**	**2,506,232**	**248**

BOB ICB brought forward a cumulative historic surplus of £1.6m from the constituent CCGs, none of which was utilised (drawn down) in the year. The small surplus achieved in 2022/23 is expected to be added to the historic surplus and will be carried forward into next year.

The ICB also achieved its other financial targets including the Mental Health Investment standard (4.67% increase in investment compared to the target 4.33%) and Better Payment Practice code (95% of invoices by value paid within 30 days).

The block payment approach for NHS providers continued into 2022/23 continuing the simplified arrangements implemented during the pandemic.

BOB ICB has formal delegated responsibility from NHS England for GP Primary Care Commissioning and received an allocation of £232m to deliver this.

BOB ICB has also taken on delegated responsibility for Pharmacy, Optometry and Dental services (POD) from 1 July 2023 and received an allocation of £98.8m to deliver this.

The ICB now takes a role in co-ordination of system finances of its five main NHS providers. The original system plan for 2022/23 was for breakeven but this included an assumption of £22m system savings target. During the year it became apparent that the system would not be able to deliver this savings target and a revised stretch target of £35.8m deficit was agreed with NHS England for the system in December 2022. The provider trusts improved their performance overall relative to the stretch target by £5.1m to £30.6m deficit as shown in the table below:

System Revenue	BHFT £m	BHT £m	OH £m	OUH £m	RBFT £m	ICB £m	Total £m
Stretch Target	1.9	-14.3	-1.5	-5.3	-16.7	0.2	-35.8
2022-23 draft outturn pre audit	2.2	-14.3	-2.1	0.1	-16.7	0.2	-30.6
Variance	0.3	0.0	-0.6	5.4	0.0	0.1	5.1

For the next financial year (2023/24), BOB ICS has been issued with a financial envelope by NHS England based on national inflation and growth assumptions. In April 2023, the ICS submitted its latest plans for the year. Final plan submission is due on 4th May 2023.

Delivering efficiency challenges in the current climate, post covid and with elective backlogs, is challenging. To improve delivery of savings targets across the system, the ICS has laid foundations for ongoing work by setting up an ICS Efficiencies Collaboration Group (IECG) which reports to the System Productivity Committee of the ICB and is chaired by the Chief Finance Officer of a Provider trust. The group will work across the system to challenge, share opportunities and to monitor delivery.

Capital

Under the Health and Care Act 2022 (the 2006 Act) there is a new 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.

The plans for the financial year 2022/3 were required at a high level only, to include a short narrative on the main categories of expenditure. This disclosure will set the baseline towards transparency for reporting for future years and is a step towards ensuring the plan is a useful document in terms of showing how capital is contributing to the ICBs' priorities and delivering benefits to patients and healthcare users.

The BOB ICB and partner Trusts published a Joint Capital Plan for 2022/23 in accordance with this new requirement. It covers the whole financial year 2022/23 not just the nine months since the ICB was established. This is available on the ICB website here.

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

Organisation	Total Charge against capital allocation							
	Plan	Actual	Variance		Plan	Forecast	Variance	
	YTD	YTD	YTD	YTD	Year Ending	Year Ending	Year Ending	Year Ending
	£'000	£'000	£'000	%	£'000	£'000	£'000	%
Buckinghamshire, Oxfordshire And Berkshire West ICB	1,146	1,146	0	0.0%				
Berkshire Healthcare NHS Foundation Trust	8,700	9,022	(322)	(3.7%)				
Buckinghamshire Healthcare NHS Trust	20,000	20,413	(413)	(2.1%)				
Oxford Health NHS Foundation Trust	9,937	9,978	(41)	(0.4%)				
Oxford University Hospitals NHS Foundation Trust	30,838	27,466	3,372	10.9%				
Royal Berkshire NHS Foundation Trust	28,000	27,780	220	0.8%				
ICS Total	**98,621**	**95,805**	**2,816**	**2.9%**				

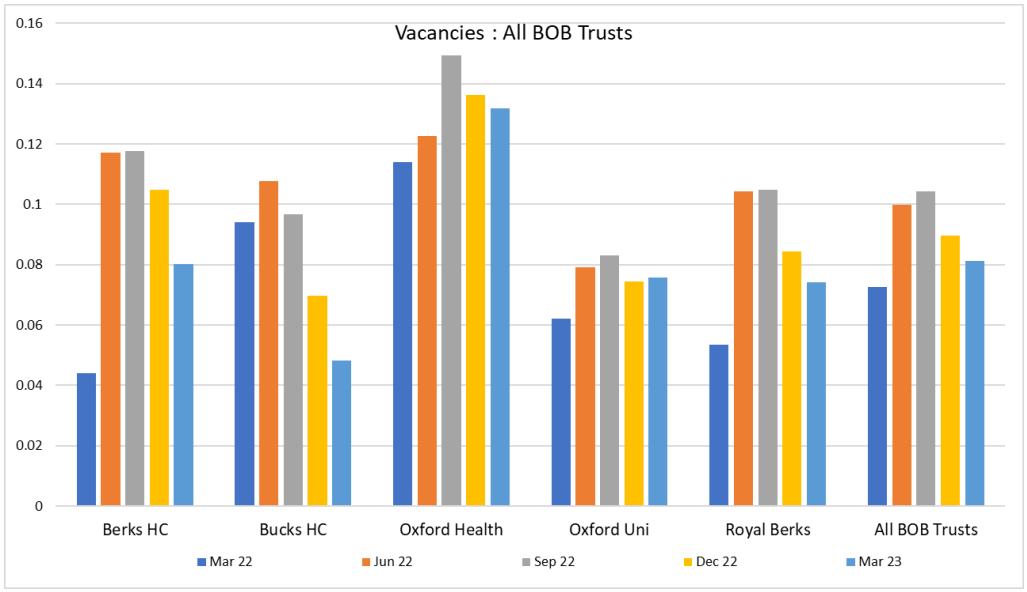
The system achieved the target of not overspending the capital allocation in year, delivering a £2.8m underspend against capital allocation.

The Joint Capital Plan for 2023/24 is also available on the website here.

BOB Integrated Care System workforce

The ICB monitors the number of vacancies across all BOB Trusts and staff turnover. The risks associated with high vacancy rates and turnover of staff include the quality and continuity of care for patients and increased cost of interim bank and agency staff to cover vacancies.

Fortunately, vacancy rates across the BOB ICS are decreasing; vacancies across all staff groups decreased from 9.1% in Jan 2023 to 8.2% in Feb 2023 and no 8.1% in March 2023. This is below the most recently published national average of 8.9% in December 2022.



For the majority of Trusts turnover rates have remained constant over the last quarter. Although we have seen a slight decrease in BHT and a steady increase in turnover for Oxford Health.

A number of initiatives are underway included targeted work on the cost of living to understand the impact of living costs and how these relate to the local health sector labour market and salary structures. This will help us to develop a geographical picture of factors underpinning living costs, how these vary and impact to inform future planned recruitment and retention interventions.

Among the initiatives supported by BOB ICB to tackle workforce shortages in the NHS is a project by Health Education England to encourage nurses, midwives and allied health professionals to come back to practice if they have had a break from their careers.

This project is being run in partnership with providers across the BOB geography:

- **Buckinghamshire Healthcare NHS Trust**
- **Oxford University Hospitals NHS Foundation Trust**
- **Oxford Health NHS Foundation Trust**
- **Berkshire Healthcare NHS Foundation Trust**
- **Royal Berkshire NHS Foundation Trust**
- **Primary Care**

All these employers have dedicated programmes to help people back into the profession through a variety of routes including university study courses with funding and job placements.

BOB ICB's has supported Return to Practice by offering information and links to employers through a dedicated webpage Return to Practice | BOB ICB. In addition, the communications an engagement team produced targeted social media advertising and messaging to publicise a recent free webinar for people to discover ways to return, the funding and resources available and meet some local employers to hear about the opportunities.

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.

NHS services in the system have faced unprecedented pressures over the course of the pandemic waves and have responded to a significant increase in demand on Primary, Community and Acute services as well as delivering the biggest vaccination programme in history.

The system continues to be under significant pressure; this has been compounded by high level of demand during the winter months which continued into spring. The table below outlines the performance in Buckinghamshire, Oxfordshire and Berkshire West from 1 June 2022 until 31 March 2023:

	Indicator	Month	Standard	BHT	OUH	RBFT
UEC	A&E Performance (All Types)	Apr 23	95%	71.2%	70.6%	76.2%
UEC	Ambulance Handover Delays (> 30 mins)	Apr 23		13.9%	5.1%	11.9%
Planned Care	Incomplete Pathways over 52 weeks at month end	Mar 23	Rated against plan	3444	2226	19
Planned Care	Incomplete Pathways over 65 weeks at month end			782	461	1
Planned Care	Incomplete Pathways over 78 weeks at month end			2	59	0
Cancer	Percentage meeting faster diagnosis standard	Mar 23	75%	70.6%	83.3%	73.9%
Cancer	Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer		93%	95.2%	79.5%	88.2%
Cancer	Percentage of patients receiving first definitive treatment within two months (62 days) of an urgent GP referral for suspected cancer		85%	60.8%	58.1%	71.9%

	Indicator	Report Period	Standard	BOB ICS (3 CCG)	Bucks	Oxon	Berks W
Mental Health	Talking Therapies - Total Accessing in Period	Rolling 3 months to Feb 23		5.2%	6.0%	5.2%	4.5%
Mental Health	Talking Therapies - Moving to Recovery	Feb 23	50%	49.2%	49.5%	50.4%	47.5%
Mental Health	Dementia Diagnosis Rate	Mar 23	67%	60.2%	56.8%	61.5%	62.5%
Mental Health	CYP Eating Disorders - Urgent (1 week)	Rolling 12 months to Dec 22	95%	68.7%	70.0%	28.6%	74.0%
Mental Health	CYP Eating Disorders - Routine (4 weeks)		95%	41.0%	33.3%	15.8%	77.9%
Mental Health	Severe Mental Illness (SMI) 6 Health Checks	2022/23 Q4	60%	54.9%	59.7%	48.9%	59.7%

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 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, People Committee, Place and System Development Committee, Population Health & Patient Experience Committee and System Productivity Committee (for more information about the committees and their purpose please see page 51).

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 . NHSE oversees the ICB through this framework through quarterly review meetings. For 2022/23 the ICB will not be formally assessed against this framework in light of the revisions to the NHSE operating model and potential implications of the Hewitt review.

How is the ICB monitored?

NHS England has a statutory duty to undertake annual assessment of ICBs. This is undertaken using the NHS Oversight Framework. The new framework is intended as a focal point for joint work, support and dialogue between NHS England, ICBs, providers and their integrated care systems.

For 2022/23 these annual assessments will not take place until quarter two.

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 ICB's ability to achieve its objectives. These risks, divided into strategic/principal, corporate and operational, are identified, assessed and managed by the organisation and reviewed at every alternate ICB Board meeting in public. They are continually reviewed at Board committee meetings including the Audit and Risk Committee, People Committee, Place and System Development Committee, Population Health & Patient Experience Committee, System Productivity Committee.

There is a regular monthly review of risk through directorates, Operational Risk Management Group and the ICB's Executive Management Committee. The ICB Board Assurance Framework and strategic risks is available here.

Steve McManus, Accountable Officer
28 June 2023

Accountability Report

Corporate Governance Report

The names of the Chair and Chief Executive for the Buckinghamshire, Oxfordshire & Berkshire West ICB are:

- Javed Khan, Chair
- Steve McManus, Chief Executive

Along with the Chair and Chief Executive the board of BOB ICB comprises non-executive directors, 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 2023 includes:

- Javed Khan, Chair
- Steve McManus, 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
- Sim Scavazza, Deputy Chair of ICB and Chair of the People Committee and the Remuneration Committee

Partner Members:

- Dr Nick Broughton, Mental Health Member
- Stephen Chandler, Partner Member - local authorities
- Dr Sheheen Jinah, Partner Member - Providers of Primary Medical Services
- Neil Macdonald, Partner Member - NHS Trusts and Foundation Trusts

Executive Directors:

- Rachael Corser, Chief Nursing Officer
- Dr Rachael de Caux, Chief Medical Officer
- Jim Hayburn, Interim Chief Finance Officer

Profiles of the board 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 51.

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

BOB ICB fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

Steve McManus
Accountable Officer
28 June 2023

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 BOB 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 Steve McManus to be the Accountable Officer of BOB 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 the BOB ICB 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 BOB 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.

Steve McManus
Accountable Officer
28 June 2023

Annual Governance Statement

Introduction and context

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

The BOB ICB's 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 July 2022 and 31 March 2023, 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 BOB 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 BOB ICB's Accountable Officer Appointment Letter.

I am responsible for ensuring that the BOB 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. The systems have been in place for the period under review and up to the date of the approval of the annual report and accounts.

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, Scheme of Reservation and Delegation (SoRD), the Standing Financial Instructions (SFIs), the BOB ICB Board and the Board assurance committees as detailed below.

The BOB ICB's 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 patients and clinicians 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).

The Board has met five times in the period of this report. The meeting was quorate in terms of executive, non-executive and partner members. A table of members attendance is included in Appendix 1. The meetings have considered establishment of the ICB, operational planning performance, financial performance, development of the joint forward plan, public engagement, development of arrangements within Place and establishment of the BOB Integrated Care Partnership Joint Committee.

The BOB 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 (except for Remuneration Committee). Each of the committees submits an annual report to the Board giving assurance they are carrying out their duties and may also undertake self-assessments of their effectiveness.

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 also to assure the Board on:

- Other assurance functions

- Counter Fraud
- Financial Reporting
- Information Governance
- Conflicts of Interest
- Emergency Planning, Resilience and Response

The Chair and Chief Executive Officer (CEO) 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 of internal audit and external audit and local counter fraud service attend each meeting. The Agenda of the Audit and Risk Committee is governed by its annual business cycle.

The Committee met five times during the period of this report. 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 members and staff

The CEO, or nominated deputy, may attend meetings. The Chair may request attendance by other individuals or subject matter experts where necessary.

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

People Committee

The purpose of the People Committee is to hold the People Board to account for achieving the intended results and benefits of the People Strategy and plans for reaching agreed milestones in supporting the Integrated Care System (ICS) to become an increasingly equitable, diverse, and inclusive health and care system. The Committee provides:

- Oversight and scrutiny of the effectiveness of the ICS People Plan
- Oversee and support the strategic approach to talent management and succession planning for the ICS

- Support opportunities to extend partnership and integrated working across the workforce agenda within the system
- Oversight of ICB people development

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.

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

Place and System Development Committee

The Place and System Development Committee provides assurance that the three Places in BOB ICB 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 can attend any meeting of the Committee and may be invited to attend to gain an understanding of the Committee's operations.

The Committee met three 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 three 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

BOB ICB has reviewed all of the statutory duties and powers conferred on 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 all of the ICB's statutory duties.

Risk management arrangements and effectiveness

The Audit and Risk Committee have approved a Risk Management Framework and overseen the development of a BOB ICB Corporate Risk Register (CRR) and a BOB ICB Board Assurance Framework (BAF. This has been supported by reports to the Board public meetings as well as Board workshop discussion on identification of its principal risks; based around the Integrated Care System (ICS) four core goals. The Board approved its principal risks at the 17 January 2023 Board meeting.

Capacity to Manage and Handle Risk

To manage its risks effectively, and in line with its risk management framework, BOB ICB put in place a Risk Management Reporting System (4Risk), enabling risk management, and reporting across the organisation. The management and evaluation of risk, including its controls and actions, are now fully embedded within BOB's core business decisions and transactions and assists in the identification, preventing and deterring of risks in relation to fraud. Risk management is overseen by a series of meetings at Directorate, Senior Management and Executive level; allowing for comprehensive discussion, risk reporting, the sharing and highlighting of areas of good practice and 'lessons learnt'; and which ultimately report into the Executive and Audit and Risk Committee. The management of 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 via individual 1:1s.

Risk Assessment and Awareness

ICB staff are responsible for their risks and for maintaining risk awareness and identifying and reporting risks as appropriate to their line manager. Staff are to ensure that they familiarise themselves with the Risk Management Framework 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 consistency of rating, review any directorate risks for escalation to the Corporate Risk Register and make recommendations to Executive Management Committee. The Group's duties, authority, accountability, and reporting is defined within its Terms of Reference (ToR). The Governance Leads will oversee the management of risk ensuring risks are being reviewed in a timely fashion and adhere to the organisational reporting cycle (Executive/Committee/Sub-Committee/Board).

The BOB ICB has no appetite for fraud/financial risk and zero tolerance for regulatory breaches. 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 Audit and Risk Committee will review the appetite statement on an annual basis and propose any changes the Board.

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 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. Embedding risk management supports achievement of the ICB's corporate objectives through managing risk to delivery.

Sustainability

In October 2020, the NHS became the world's first health service to commit to reaching carbon net zero with an ambition to provide high-quality health and care for all, both now and for future generations. As a result, the "Delivering a Net Zero Health Service" report was published which set out the NHS ambition alongside two evidence-based targets. These targets are:

- for the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032
- for the emissions we can influence (our NHS Carbon Footprint Plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

The Health and Care Act 2022 placed new duties on NHS England, and all trusts, foundation trusts, and integrated care boards to contribute towards statutory emissions and environmental targets. The Act gives NHS England power to publish statutory guidance to support the system on its path towards net zero and requires commissioners and providers of NHS services specifically to address:

- the UK net zero emissions target;

- the environmental targets within the Environment Act 2021, and;
- to adapt to any current or predicted impacts of climate change identified within the 2008 Climate Change Act.

The Open Greener NHS Dashboard provides data at Trust, ICS and Regional levels which enables ICB's to baseline, compare and track progress over time.

BOB ICS Green Plan

The ICS Green Plan was approved in March 2022 and published online https://www.bucksoxonberksw.icb.nhs.uk/media/1986/04_20220701-bob-icb-board-item-09-green-plan-annex-1.pdf. This Plan included plans to take account of climate change and, in particular, delivering a net zero national health service report under the Greener NHS Programme.

As part of the implementation of the ICS Green Plan, The ICS set up a Net Zero Board and established a working group to discuss Green Plan progress across the system. The Net Zero Board is chaired by Commercial Director of Buckinghamshire Healthcare Trust, with membership across all BOB Trusts.

Four workstreams were agreed by the Net Zero as a priority and area of focus. Each of the workstreams below has a responsible Lead from our Trusts:

- Procurement and Supply Chain
- Meds management
- Estates and Facilities
- Travel and Transport

Some examples of workstream progress are highlighted below:

- BOB ICS are working with the SE Greener NHS team and Global Action Plan to implement the ICS Clean Air Framework working collaboratively with local authorities.
- Oxford University Hospitals were successful in Phase 3b Public Sector Decarbonisation Scheme and were awarded £5.7m for 23/24 project and £24.1m for a multi-year project.
- Oxford Health have launched a community e-bike project which incorporates GPS to reduce business travel-based emissions and improve air pollution.

Discussions have now begun, so that a refreshed version of the ICS Green Plan can be presented to ICB Board in July for review, consideration, and subsequent approval.

External Review and Oversight

To manage compliance and provide assurance in risk management, the BOB ICB conducts annual risk reviews, which are part of the ICB's internal audit review process. The purpose is to ensure that the ICB has the appropriate risk management processes in place, and which conforms to its statutory duties and obligations.

As part of this process, 'Recommendations' and 'Actions' on lapses in its controls are identified and scored, with detailed findings put forward for attention. This will ensure that the ICB is compliant in all areas relating to Risk; and is meeting the expectations of a newly formed ICB.

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.

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest (published June 2016) requires commissioners to undertake an annual internal audit of conflicts of interest management. To support ICBs to undertake this task, NHS England has published a template audit framework.

The ICB's internal auditors carried out an audit for 2022/23. The conclusion of the audit was that the Board could take substantial assurance that the controls upon which the organisation relies to manage conflicts of interest are suitably designed, consistently applied and effective.

The audit identified two management actions, one low and one medium, around ensuring Conflicts of Interest forms were completed where an interest was raised and ensuring the process for new starters was formally aligned for timeliness of form submissions.

Data Quality

The sourcing of data and management of provider data quality is achieved via contracts. The data contract management processes in the ICB have been built on the well-established processes of the predecessor CCGs, and we continue to capitalise on strong relationships between NHS South Central and West Commissioning Support Unit and information governance teams within provider organisations to drive continuous improvement.

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 BOB ICB submitted its DSPT for 2022/23 before the deadline of 30 June 2023.

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.

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

Performance against constitution targets remains under pressure as the system recovers from the broader impact of the pandemic. Performance is affected by physical capacity constraints, workforce shortages and the continuing level of COVID positive cases, flu and respiratory infections.

Work is ongoing with recruitment of additional clinical and support staff, with Health Education England, across the system, especially looking at new ways of working. Trusts continue to work with South Central Ambulance Service to mitigate 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. Ways to increase capacity in general practice following the increased demand on the NHS and primary care continues and includes up to an additional 2000 sessions of clinical time in general practice and

additional capacity via the acute respiratory infection ‘hubs’. Something about sustained focus on caner services, particularly 62-day target has led to improved performance though not yet meeting constitutional standards.

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 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 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 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.

Delegation of 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 alternate meetings to ensure appropriate management and reporting is in place.

Internal Audit is used to provide an in-depth examination of any areas of concern.

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) 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 in place. This was last reviewed by the Audit and Risk Committee on 10 May 2023.

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 and Risk Committee. The Audit and Risk Committee receive an anti-crime progress report at each meeting. There is a proactive risk-based work plan aligned to the NHS CFA Standards for Commissioners 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

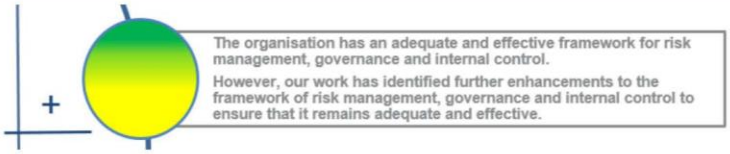
Following completion of the planned audit work for the period 1 July 2022 to 31 March 2023 for the ICB, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance and internal control.

In accordance with Public Sector Internal Audit Standards, the head of internal audit is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. The opinion should contribute to the organisation's annual governance statement.

1.1 The opinion

For the 12 months ended 31 March 2023, the head of internal audit opinion for Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board is as follows:

Head of internal audit opinion 2022/23



Please see appendix A for the full range of annual opinions available to us in preparing this report and opinion.

1.2 Scope and limitations of our work

The formation of our opinion is achieved through a risk-based plan of work, agreed with management and approved by the audit committee, our opinion is subject to inherent limitations, as detailed below:

- the opinion does not imply that internal audit has reviewed all risks and assurances relating to the organisation;
- the opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led assurance framework. As such, the assurance framework is one component that the board takes into account in making its annual governance statement (AGS);
- the opinion is based on the findings and conclusions from the work undertaken, the scope of which has been agreed with management / lead individual;
- the opinion is based on the testing we have undertaken, which was limited to the area being audited, as detailed in the agreed audit scope;
- where strong levels of control have been identified, there are still instances where these may not always be effective. This may be due to human error, incorrect management judgement, management override, controls being by-passed or a reduction in compliance;
- due to the limited scope of our audits, there may be weaknesses in the control system which we are not aware of, or which were not brought to attention; and

The Head of Internal Audit concluded that there are no issues from their work to date the ICB needed to consider as significant control issues.

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

Area of Audit	**Level of Assurance Given**
Governance (Part 2)	Substantial Assurance
Financial Feeder Systems & Payroll	Reasonable Assurance
Financial Feeder Systems including Payroll	Reasonable Assurance
Conflicts of Interest	Substantial Assurance
Primary Care Commissioning	Reasonable Assurance
Risk Management and Assurance Framework (Part 2)	Substantial Assurance

The following audits have yet to be completed:

- Commissioning and Contract Management
- Data Security and Protection Toolkit

Four advisory reviews were also undertaken in 2022/23:

- Financial Sustainability HFMA Review
- Risk Management and Assurance Framework (Part 1)
- Governance (Part 1)
- Data Security Protection Toolkit (Draft)

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.

The Board 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 guided on the effectiveness of controls through the oversight of the Board and its committees and this has also informed by review. If necessary, plans to address weaknesses and ensure continuous improvement of the system, will be put in place.

Conclusion

No significant internal control issues have been identified.

Steve McManus
Accountable Officer
28 June 2023

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 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 (1 July 2022 to March 31 2023)

Percentage Changes	22/23	21/22	Change	% Change
Highest paid director				
Salary and Allowances	226,000	0	NA	NA
Performances and bonuses	0	0	NA	NA
Employees of the entity taken as a whole (Average)				
Salary and Allowances	62,696	0	NA	NA
Performances and bonuses	0	0	NA	NA

The ICB was established on 1st July 2022 as a result there is no comparative prior year remuneration in order to establish changes.

Pay ratio information

The banded remuneration of the highest paid director / member in the BOB ICB in the reporting period 1 July 2022 to 31 March 2023 was £225,000 - £230,000 on an annualised basis.

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

2022/23	25th percentile	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	41,108	50,361	67,531
Salary component of total remuneration (£)	41,108	50,361	67,531
Pay ratio information	5.53	4.52	3.37

During the reporting period 1 July 2022 to 31 March 2023 no employees received remuneration in excess of the highest-paid director/member. Remuneration ranged from £8,000 to £227,500. 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 have no Year-on-Year ratio variance this year.

Senior manager remuneration (including salary and pension entitlements 1 July 2022 to 31 March 2023)

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
Debbie Simmons (**)	Interim Chief Nursing Officer	25-30	0	0-5	0-5	40-42.5	70-75
Dr James Kent (**)	Chief Executive	70-75	1	0-5	0-5	87.5-90	160-165
Steve McManus (**)	Chief Executive (Interim)	95-100	0	0-5	0-5	0-2.5	95-100
Richard Eley (**)	Chief Finance Officer (Interim)	70-75	0	0-5	0-5	0-2.5	70-75
Jim Hayburn (**)	Chief Financial Officer (Interim)	70-75	0	0-5	0-5	0-2.5	70-75
Javed Khan	NED – Chair	55-60	1	0-5	0-5	0-2.5	55-60
Sim Scavazza	NED – Deputy Chair	10-15	0	0-5	0-5	0-2.5	10-15
Rachael DeCaux	Chief Medical Officer	130-135	2	0-5	0-5	0-2.5	130-135
Rachael Corser (**)	Chief Nurse	80-85	9	0-5	0-5	92.5-95	175-180
Catherine Mountford	Director of Governance	85-90	1	0-5	0-5	57.5-60	145-150
Nick Broughton (***)	Member for Mental Health	0-5	0	0-5	0-5	0-2.5	0-5
Shaheen Jinah	Partner member – Primary medical services	10-15	0	0-5	0-5	0-2.5	10-15
Stephen Chandler (***)	Partner member – Local Authorities	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
Matthew Tait	Interim Chief Delivery Officer	105-110	9	0-5	0-5	20-22.5	130-135
Sonya Wallbank (**)	Chief People Officer	95-100	0	0-5	0-5	87.5-90	180-185
Karen Beech (**)	Acting Chief People Officer	80-85	0	0-5	0-5	257.5-260	340-345
Amanda Lyons (**)	Interim Director of Strategy and Partnerships	30-35	0	0-5	0-5	0-2.5	30-35
Rob Bowen (**)	Acting Director of Strategy Partnerships	80-85	0	0-5	0-5	17.5-20	95-100
Ross Fullerton	Interim Chief Information Officer	95-100	0	0-5	0-5	0-2.5	95-100
Rob Beasley (**)	Interim Director of Communications and Engagement	110-115	0	0-5	0-5	0-2.5	110-115
Nick Samuels (**)	Interim Director of Communications and Engagement	15-20	0	0-5	0-5	0-2.5	15-20
Tim Nolan	NED	10-15	1	0-5	0-5	0-2.5	10-15
Aidan Rave	NED	10-15	0	0-5	0-5	0-2.5	10-15
Margaret Batty	NED	10-15	0	0-5	0-5	0-2.5	10-15
Saqhib Ali	NED	10-15	1	0-5	0-5	0-2.5	10-15
Haider Husain	NED – Associate	5-10	0	0-5	0-5	0-2.5	5-10

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.

**

- Debbie Simmons left the ICB in September 2022
- James Kent went on secondment to NHS England in September 2022
- Steve McManus joined the ICB in October 2022
- Richard Eley left the ICB in October 2022
- Jim Hayburn joined in November 2022 and left the ICB in March 2023
- Rachel Corser joined the ICB in September 2022
- Sonya Wallbank left the ICB in February 2023
- Karen Beech was appointed Acting Chief People Officer at the ICB in March 2023
- Amanda Lyons finished her secondment to the ICB in September 2022
- Rob Bowen was appointed Acting Director of Strategy at the ICB in March 2023
- Rob Beasley joined the ICB in February 2023
- Nick Samuels joined the ICB in March 2023

*** Stephen Chandler, Neil McDonald and Nick Broughton receives no remuneration from BOB ICB

Interim Roles held by more than one person**.**

1. Interim Chief Finance Officer handled by Richard Eley and Jim Hayburn.
2. Interim Director of Communications and Engagement handled by Rob Beasley and Nick Samuels.

The BOB ICB is formally established on 1st July 2022 as a result have no prior year comparative senior manager remuneration.

Pension benefits (1 July 2022 to 31 March 2023)

Name	Title	Real increase in pension at age 60 (bands of £2,500) £'000	Real increase in pension lump sum at age 60 (bands of £2,500) £'000	Total accrued pension at age 60 at 31 March 2023 (bands of £5,000) £'000	Lump sum at age 60 related to accrued pension at 31 March 2023 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1st July 2022 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2023 £'000	Employer's contribution to stakeholder pension £'000
Debbie Simmons	Interim Chief Nursing Officer	0-2.5	0-2.5	35-40	85-90	775	7	853	0
Dr James Kent	Chief Executive	0-2.5	0-2.5	10-15	0-5	125	7	203	0
Rachael DeCaux	Chief Medical Officer	0-2.5	0-2.5	30-35	50-55	563	0	487	0
Rachael Corser	Chief Nurse	2.5-5	2.5-5	40-45	65-70	531	35	632	0
Catherine Mountford	Director of Governance	2.5-5	2.5-5	50-55	135-140	1,108	0	94	0
Matthew Tait	Interim Chief Delivery Officer	0-2.5	0-2.5	55-60	95-100	973	15	1,043	0
Sonya Wallbank	Chief People Officer	2.5-5	0-2.5	15-20	0-5	143	33	217	0
Karen Beech	Acting Chief People Officer	0-2.5	0-2.5	10-15	0-5	0	9	179	0
Rob Bowen	Acting Director of Strategy Partnerships	0-2.5	0-2.5	5-10	10-15	101	0	122	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 2023-24 CETV figures.

Given the remedy has yet to be implemented, and the uncertainty over the outcome for individual members, we believe the approach taken by NHS Pensions is appropriate at 31 March 2023. We would however expect the 31st March 2024 Greenbury calculations to take into account this remedy to the extent that any in scope member records have been processed for the McCloud remedy by that date.

- 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 2022-23 pension although the ICB reporting period is 1st July 2022 to 31st March 2023.
- The BOB ICB is formally established on 1st July 2022 as a result have no prior year comparative senior manager remuneration.
- 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.

The benefits and corresponding CETV do not allow for any potential adjustments in relation to the McCloud judgement.

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 of 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 2022/23. The ICB employed 361 staff (headcount), of which 266 were women and 95 men. As of 31 March 2023, the Chief Executive Office and Board was made up of 2 women and 4 men. Below is a breakdown of gender analysis of staff.

	Female headcount	Male Headcount	Total Headcount
CEO and Board	2	4	6
Very Senior Managers	5	5	10
All other employees	259	87	346
Total employees	266	95	361

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 2023:

	Permanently employed number	Other numbers	1 July 2022 to 31 March 2023
Total (headcount)	361	40	401

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 July 2022 until 31 March 2023.

	Permanently employed	Other staff	Total number
Average number of WTE people	256	58	314
Of which: WTE people engaged on capital projects	0	0	0

Staff turnover for the ICB is 4.25%

Employee benefits and cost

	Total Permanent Employees £'000	Other £'000	2022-23 Total £'000
Employee Benefits			
Salaries and wages	13,649	2,903	**16,552**
Social security costs	1,392	-	**1,392**
Employer Contributions to NHS Pension scheme	2,075	-	**2,075**
Apprenticeship Levy	55	-	**55**
Termination benefits	160	-	**160**
Gross employee benefits expenditure	**17,331**	**2,903**	**20,234**

Sickness absence data

Below outlines the ICB's sickness absence data from 1 July 2023 to 31 March 2023.

	1 July 2023 / 31 March 2023
Sum of full time equivalent (FTE)	915.05
Sum of FTE days available	Not available
Average annual sick days per FTE	2.44%

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 further 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

As a newly formed ICB we recognise that the staff survey results require improvement. While we had very good staff engagement in the 2022 NHS Staff Survey of 73% the results are a reflection of the current staff experiences and challenges in moving from the legacy CCGs to the newly created ICB. Due to internal reorganisation with the CCGs merging into BOB ICB this had led to staff had been uncertain about their roles over a significant period of time. Moving forward the ICB is committed to engaging with staff following the results of the survey and we are working together in collaboration with our staff to build a better BOB. An organisational transformation plan is underway that is supported by people plan that will utilise the data, feedback and insights including the staff survey results to drive the organisations staff engagement. We are committed to improving our staff engagement and will support our employees to make BOB ICB a great place to work.

Trade Union Facility Time Reporting Requirements

The ICB has 1 trade union representative for the ICB, but no trade union facilities time has been recorded for the period 1 July 2022 to 31 March 2023. We are currently in the process of agreeing our recognition agreement with the Executive and this includes our facilities agreement which will record our Trade Union facility time reporting. This should be agreed by May 2023.

Other employee matters

The covid-19 pandemic has forced ways of working to be changed. It provided an opportunity to test systems and processes to improve agile working and flexibility for staff. With a remote workforce and a reduced desk space in our new office in Sandford Gate, Oxford we encouraged teams and directorates to explore new ways of working to support staff and align to the NHS People Plan.

Our internal Project Simul programme helped us explore smarter working styles with our staff and how this could be supported by technology, reasonable adjustments and wellbeing offers. The embedding of MS Teams, and the move to a hybrid work pattern allowed for a balance between the office and home locations and this has continued during the recovery phase. We worked closely with staff throughout 2022/23, as a result we produced guidance on working in a new hybrid way. As we move forward, as part of the BOB ICB transformation programme under the wellbeing pillar, we aim to increase agile ways of working and improve flexibility in the way we work in support of our staff.

As part of the programme of transformation across the ICB, staffing structures have recently been reviewed and updated to support the newly created ICB. This has resulted in an organisational wide consultation with our staff. It is recognised that to meet the requirements of the ICB phase two of our transformation programme "Project Simul" will continue during 23/24.

Programmes are underway to develop our staff polices for the ICB and this will be supported by establishing formal staff partnership forums during 2023.

Expenditure on consultancy

Expenditure on consultancy was £1,820k 1 July 2022 to 31 March 2023 as per Note 5 to the Accounts page 109.

Off-payroll engagements

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

For all off-payroll engagements as of 31 March 2023, for more than £245[(1)] per day:

	Number
Number of existing engagements as of 31 March 2023	31
Of which, the number that have existed:	
for less than one year at the time of reporting	31
for between one and two years at the time of reporting	0
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 July 2022 to 31 March 2023, for more than £245[1] per day:

	Number
No. of temporary off-payroll workers engaged between 1 July 2022 to 31 March 2023	47
Of which:	
No. not subject to off-payroll legislation[2]	0
No. subject to off-payroll legislation and determined as in-scope of IR35[2]	47
No. subject to off-payroll legislation and determined as out of scope of IR35[2]	0
the number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: no. of engagements that saw a change to IR35 status following review	0

[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 July to 31 March 2023.

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during reporting period[1]	1

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)	8

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								
£25,001 - £50,000								
£50,001 - £100,000								
£100,001 - £150,000								
£150,001 –£200,000	1	£160,000						
>£200,000								
TOTALS	1	£160,000						

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. 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	n/a	n/a
Mutually agreed resignations (MARS) contractual costs	n/a	n/a
Early retirements in the efficiency of the service contractual costs	n/a	n/a
Contractual payments in lieu of notice*	n/a	n/a
Exit payments following Employment Tribunals or court orders	n/a	n/a
Non-contractual payments requiring HMT approval**	n/a	n/a
TOTAL		nil

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.

Disability information

The 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. However, in the past year, the majority of staff have been working from home. During this time, considerable effort had gone into supporting staff as they continue to work from home. 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 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 72 and 73, pension benefits of senior managers and related narrative on pages 73 and 74, the fair pay disclosures and related narrative notes on page 70 to 71 and exit packages and any other agreed departures on page 81 and 82.

Steve McManus
Accountable Officer
28 June 2023

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 July 2022 to 31 March 2023 there were no remote contingent liabilities, losses and special payments, gifts, fees or charges.

Steve McManus
Accountable Officer
28 June 2023

Appendix 1:

Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board (BOB ICB)
Board Meetings 1 July 2022 – 31 March 2023

Attendees	01 Jul 2022	27 Sept 2022	15 Nov 2022	17 Jan 2023	21 Mar 2023
Members					
Javed Khan	Y	Y	Y	Y	Y
Dr James Kent	Y				
Steve McManus	Y*	Y*	Y***	Y***	Y
Saqhib Ali	Y	Y	Y	Y	Y
Margaret Batty	Y	Y	Y	A	Y
Dr Nick Broughton, Chief Executive at Oxford Health NHS Foundation Trust - Partner Member NHS Trusts	Y	Y	A	Y	A
Stephen Chandler, Interim Executive Director: People, Transformation & Performance at Oxfordshire County Council - Partner Member Local Authorities	Y	Y	Y	Y	Y
Rachael Corser	Y**	Y	Y	Y	Y
Rachel De Caux	Y	Y	Y	Y	Y
Richard Eley	Y	Y			
Jim Hayburn			Y	Y	Y
Dr Shaheen Jinah, Partner Member Primary Care	A	Y	Y	A	Part
Neil McDonald, Chief Executive at Buckinghamshire Healthcare NHS Trust - Partner Member NHS Trusts			A	Y	Y
Tim Nolan	A	Y	Y	Y	Y
Aidan Rave	Y	Y	Y	Y	Y
Sim Scavazza	Y	Y	Y	A	Y
Debbie Simmons	A				
Regular Attendees					
Rob Beasley	Y	Y	Y	Y	
Rob Bowen			Y	Y	Y
Ross Fullerton	A	A	A	Y	Y
Catherine Mountford	Y	Y	Y	Y	Y
Nick Samuels					Y

Matthew Tait	Y	Y	Y	Y	

* As Partner member – NHS Trusts

** As Chief Nursing Officer Designate

*** As Chief Executive Officer

Audit and Risk Committee Meetings 1 July 2022 – 31 March 2023

Attendees	**23 Aug 2022**	**11 Oct 2022**	**06 Dec 2022 (Cancelled)**	**03 Jan 2023**	**28 Feb 2023**
Members					
Saqhib Ali	Y	Y	N/A	Y	Y
Margaret Batty	Y	A	N/A	Y	Y
Aidan Rave	A	Y	N/A	A	Y
Regular Attendees					
Rachael Corser		Y	N/A	A	Y
Rachael De Caux	Y	Y	N/A	Y	Y
Richard Eley	A	Y	N/A		
Jim Hayburn				Y	Y
Noreen Kanyangarara	Y	Y	N/A	(SG) Y	Y
Catherine Mountford	Y	Y	N/A	Y	Y
Steve McManus	N/A	N/A	N/A	N/A	Y
Debbie Simmons (DS)	Y				

People Committee Meetings 1 July 2022 – 31 March 2023

Attendees	**24 Nov 2022**	**10 Jan 2023**	**22 Feb 2023**
Members			
Tim Nolan	Y	Y	Y
Sim Scavazza	Y	Y	Y
Juliet Anderson, Director Buckinghamshire Health and Social Care Academy	Y	Y	Y
Ansaf Azhar, Corporate Director of Public Health Oxfordshire County Council	Y	A	Y

Stephen Barnet, Partnerships Manager Voluntary, Community and Social Care Enterprise Health Alliance BOB	A	Y	Y
Rachael Corser	Y	Y	Y
Tracy Daszkiewicz, Director of Public Health for West Berkshire	Y	Y	A
Rachael De'Caux	A	Y	A
Charmaine D'Souza, Chief People Officer Oxford Health NHS Foundation Trust	Y	Y	Y
Don Fairley	A	A	A
Louise Hall, Director of Workforce and OD NHS England South East	A	Y	A
Abid Ifran	A	A	A
Sarah Keyes, Human Resources Director Buckinghamshire County Council	A	Y	A
Amir Khaki, Inclusion, Education and Organisational Development Buckinghamshire Healthcare	Y	Y	Y
Ruth Monger, Health Education England Regional Director South East	Y	Y	A
Sarah Murphy-Brookman, Corporate Director Resources Buckinghamshire County Council	A	Y	A
Jane Nicholson, Director of People Berkshire West	Y	Y	Y
Jane O'Grady, Director of Public Health Buckinghamshire Council	A	A	A
Bridget O'Kelly, Chief People Officer,	Y	Y	A

Buckinghamshire Healthcare			
Terry Roberts, Chief People Officer Oxford University Hospitals NHS Foundation Trust	A	A	Y
Claire Taylor, Corporate Director Oxfordshire County Council	Y	A	A
Sonya Wallbank	Y	Y	
Regular Attendees			
Javed Khan OBE	Y	Y	Y
Steve McManus	A	Y	Y

Place and System Development Committee Meetings 1 July 2022 – 31 March 2023

Attendees	11 October 2022	13 December 2022	14 February 2023
Members			
Aidan Rave	Y	Y	Y
Ansaf Azhar, Director of Public Health and Wellbeing Oxfordshire County Council	Y	Y	Y
Philippa Baker	A	Y	Y
William Butler, BOB VCSE Health Alliance Chair	Y	Y	Y
Tracy Daszkiewicz, Director of Public Health for West Berkshire	Y	A	A
Javed Khan OBE	A	Y	Y
Daniel Leveson	Y	Y	Y
Amanda Lyons	Y	A	A
Jane O'Grady, Director of Public Health Buckinghamshire County Council	A	A	A
Gillian Quinton, Corporate Director (Adults and Health Directorate) Buckinghamshire County Council	Y	A	A
Matthew Tait	A	Y	Y

Sarah Webster	Y	Y	Y
Regular Attendees			
Robert Bowen	A	Y	Y
Katie Higginson, Chief Executive Community Impact Buckinghamshire	A	A	Y
Matt Pope, Director of Adult Services Wokingham Borough Council	A	A	A
Melissa Wise, Interim Executive Director of Adult Social Care and Health Reading Borough Council	A	A	A

Population Health and Patient Experience Committee Meetings 1 July 2022 – 31 March 2023

Attendees	**29 November 2022**	**05 January 2023**	**28 February 2023**
Members			
Daniel Alton	Y	A	A
Margaret Batty	Y	Y	Y
Shairoz Claridge	Y	Y	Y
Rachael Corser	Y	Y	Y
Rachael De Caux	Y	Y	Y
Sanjay Desai	Y	Y	Y
Ross Fullerton	A	A	A
Steve Goldensmith	Y	Y	Y
Abid Irfan	A	A	A
Vanessa Lodge		Y	Y
Karl Marlowe, Medical Director Oxford Health NHS Foundation Trust	A	A	A
Zoe McIntosh, Chief Executive Healthwatch Buckinghamshire	Y	Y	Y
Raju Reddy, Clinical Lead for TVPC, BOB ICS / Consultant Paediatric Anaesthetist	Y	Y	Y
Rashmi Sawhney	Y	Y	Y

Sim Scavazza	Y	Y	Y
Andrew Sharp, Healthwatch Buckinghamshire	Y		
Matthew Tait	Y	Y	Y

Remuneration Committee 1 July 2022 – 31 March 2023

Attendees	**27 September 2022**	**9 December 2022**	**11 January 2023**
Members			
Javed Khan OBE	Y	Y	Y
Sim Scavazza	Y	Y	Y
Margaret Batty	Y	Y	A
Aidan Rave	Y	Y	Y
Tim Nolan	Y	Y	A
Saqhib Ali	Y	Y	A
Regular Attendees			
Steve McManus	A	Y	Y
Sonya Wallbank	Y	Y	Y

System Productivity Committee Meetings 1 July 2022 – 31 March 2023

Attendees	**06 Sep 2022**	**01 Nov 2022**	**06 Dec 2022**	**06 Jan 2023**	**07 Feb 2023**	**07 Mar 2023**
Members						
Saqhib Ali	Y	Y	Y	Y	Y	Y
Haider Husain	Y	Y	Y	Y	Y	A
Tim Nolan	Y	Y	Y	Y	Y	Y
Richard Eley	Y					
Jim Hayburn		Y	Y	Y	Y	Y
Ross Fullerton	Y	Y	Y	A	Y	Y
Matthew Tait		A	A	Y	A	Y
Regular Attendees						
Rob Bowen		Y				
Rachael Corser					Y	A
Rachel De Caux			Y	A	Y	A
Jason Dorsett, Chief Finance Officer, Oxford University		Y	A	Y	A	A

Hospital NHS Foundation Trust						
Ben Gatlin			Y	A	Y	A
Javed Khan OBE	Y	Y	Y	Y	A	Y
Amanda Lyon	Y					
Steve McManus		A	A	A	Y	A
Jenny Simpson			Y	Y	Y	Y
Andrew Thomas	Y	Y				

FINANCIAL ACCOUNTS

FOR THE PERIOD ENDED 31 MARCH 2023

NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

Financial Information - Accounts Year Ended 31 March 2023

These accounts for the year ended 31st March 2023 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 NHS BUCKINGHAMSHIRE, OXFORDSHIRE & BERKSHIRE WEST INTEGRATED CARE BOARD

Opinion

We have audited the financial statements of NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board ("the ICB") for the nine-month period ended 31 March 2023 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 2022/23 HM Treasury's Financial Reporting Manual (the 2022/23 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2022 to 2023, 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 NHS Buckinghamshire, Oxfordshire and Berkshire West ICB as at 31 March 2023 and of its net expenditure for the nine-month period then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2022 to 2023; and
- have been properly prepared in accordance with the National Health Service Act 2006, as amended by the Health and Social 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, or the successor body's, ability to continue as a going concern for a period of at least 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 2022 to 2023.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the guidance issued in the Department of Health and Social Care Group Accounting Manual 2022 to 2023; 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 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 are not satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the nine-month period ended 31 March 2023.

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 55, 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 NHS Buckinghamshire, Oxfordshire and Berkshire West ICB 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 form 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, 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 risk 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 2020, having regard to the guidance on the specified reporting criteria issued by the Comptroller and Auditor General in January 2023 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 nine-month period ended 31 March 2023.

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

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 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.

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.

Certificate

We certify that we have completed the audit of the accounts of NHS Buckinghamshire, Oxfordshire and Berkshire West ICB in accordance with the requirements of the Local Audit and Accountability Act 2014 (as amended) and the Code of Audit Practice.

Use of our report

This report is made solely to the members of the Governing Body of NHS Buckinghamshire, Oxfordshire and Berkshire West ICB 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.

Maria Grindley (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Reading
5 July 2023

Statement of Comprehensive Net Expenditure for the year ended 31 March 2023

	Note	2022-23 £'000
Income from sale of goods and services	2	(36,276)
Other operating income	2	(324)
Total operating income		**(36,599)**
Staff costs	4	20,234
Purchase of goods and services	5	2,522,298
Depreciation and impairment charges	5	463
Provision expense	5	(757)
Other Operating Expenditure	5	565
Total operating expenditure		**2,542,803**
Net Operating Expenditure		**2,506,203**
Finance expense	7	29
Net expenditure for the Year		**2,506,232**
Total Net Expenditure for the Financial Year		**2,506,232**
Comprehensive Expenditure for the year		**2,506,232**

The notes on pages 100 to 122 form part of this statement.

Statement of Financial Position as at 31 March 2023

	Note	2022-23 £'000	2022-23 As at 30 Jun £'000
Non-current assets:			
Property, plant and equipment	9	304	244
Right-of-use assets	10	1,391	1,494
Intangible assets	11	616	733
Total non-current assets		**2,310**	**2,471**
Current assets:			
Trade and other receivables	12	22,037	12,871
Cash and cash equivalents	13	64	3,226
Total current assets		**22,101**	**16,097**
Total current assets		**22,101**	**16,097**
Total assets		**24,411**	**18,568**
Current liabilities			
Trade and other payables	14	(220,910)	(171,000)
Lease liabilities	10	(228)	(214)
Provisions	15	(2,851)	(4,556)
Total current liabilities		**(223,989)**	**(175,770)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(199,578)**	**(157,202)**
Non-current liabilities			
Lease liabilities	10	(1,169)	(1,281)
Provisions	15	(1,840)	(1,840)
Total non-current liabilities		**(3,009)**	**(3,121)**
Assets less Liabilities		**(202,586)**	**(160,323)**
Financed by Taxpayers' Equity			
General fund		(202,586)	(160,323)
Total taxpayers' equity:		**(202,586)**	**(160,323)**

The notes on pages 100 to 122 form part of this statement.

The financial statements on pages 100 to 122 were approved by the Governing Body on 28 June 2023 and signed on its behalf by:

Steve McManus
Chief Accountable Officer

Matthew Metcalf
Chief Finance Officer

Statement of Changes In Taxpayers Equity for the year ended 31 March 2023

	Note	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2022-23			
Balance at 01 April 2022		-	-
Changes in NHS Integrated Care Board taxpayers' equity for 2022-23			
Net operating expenditure for the financial year		(2,506,232)	**(2,506,232)**
Transfers by absorption to (from) other bodies	8	(160,323)	(160,323)
Net Recognised NHS Integrated Care Board Expenditure for the Financial year		**(2,666,555)**	**(2,666,555)**
Net funding		2,463,969	**2,463,969**
Balance at 31 March 2023		**(202,586)**	**(202,586)**

The notes on pages 100 to 122 form part of this statement.

Statement of Cash Flows for the year ended 31 March 2023

	Note	2022-23 £'000
Cash Flows from Operating Activities		
Net operating expenditure for the financial year	5	(2,506,232)
Depreciation and amortisation		463
Interest paid	10	10
(Increase)/decrease in trade & other receivables	12	(6,903)
Increase/(decrease) in trade & other payables	14	47,589
Increase CHC PUPOC transfer liability	8	83
Provisions utilised	15	(947)
Increase/(decrease) in provisions		(757)
Net Cash Inflow (Outflow) from Operating Activities		**(2,466,694)**
Cash Flows from Investing Activities		
(Payments) for property, plant and equipment		(242)
Net Cash Inflow (Outflow) from Investing Activities		**(242)**
Net Cash Inflow (Outflow) before Financing		**(2,466,936)**
Cash Flows from Financing Activities		
Grant in Aid Funding Received		2,463,969
Repayment of lease liabilities		(195)
Net Cash Inflow (Outflow) from Financing Activities		**2,463,774**
Net Increase (Decrease) in Cash & Cash Equivalents	13	**(3,162)**
Cash & Cash Equivalents at the Beginning of the Financial Year		**3,226**
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**64**

The notes on pages 100 to 122 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 (Integrated Care Boards) 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 2022-23 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 Integrated Care Board for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group 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. The Health and Social Care Act was introduced into the House of Commons on 6 July 2021. The Bill allowed for the establishment of Integrated Care Boards (ICB) across England and abolished Clinical Commissioning Groups (CCG). ICBs took on the Commissioning functions of CCGs. The CCG functions, assets and liabilities were transferred to an ICB on 1 July 2022.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

When Clinical Commissioning Group ceased to exist on 1 July 2022, the services continued to be provided by Integrated Care Boards (using the same assets, by another public sector entity). The financial statements for Integrated Care Boards are prepared on a Going Concern basis as they will continue to provide the services in the future.

The ICB has submitted a forward financial plan for 2023/24 in May 2023 to NHS England which has now been formally approved. For 2023/24 the ICB is forecasting a breakeven position. In addition, the ICB has received indicative funding allocations for the provision of services for 2024/25. (See: NHS England » Allocation of resources 2023/24 to 2024/25). Longer-term strategic plans are being developed with key local partners and stakeholders as part of the wider Integrated Care System. This supports the use for the application of the Going Concern assumption for a period of at least 12 months from the date of the authorisation of these financial statements.

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.

For transfers of assets and liabilities from Buckinghamshire CCG, Oxfordshire CCG and Berkshire West CCG that closed on 30 June 2022 a modified absorption approach has been applied. For these transactions only gains and losses are recognised in reserves rather than the Statement of Comprehensive Net Expenditure.

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**

Arrangements over which the Integrated Care Board has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the Integrated Care Board is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.

1.5 **Pooled Budgets**

The Integrated Care Board 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 a note 19 to the accounts provides details of the assets, liabilities, income and expenditure.

There are different pooled budget hosting arrangements between the ICB and respective Councils. The Integrated Care Board 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 Integrated Care Board.

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 Integrated Care Board will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

• The Integrated Care Board 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 Integrated Care Board to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the Integrated Care Boards 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 terms.

The value of the benefit received when the Integrated Care Board 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.

1.8 **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 Integrated Care Board 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.

1.9 **Other Expenses**

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.1 **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 Integrated Care Board;
- 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 but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. 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 Integrated Care Board'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 Integrated Care Board;
- 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.

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.

Notes to the financial statements

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 Integrated Care Board expects to obtain economic benefits or service potential from the asset. This is specific to the Integrated Care Board 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 Integrated Care Board 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.

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 Integrated Care Board assesses whether a contract is or contains a lease, at inception of the contract.

1.12.1 **The Integrated Care Board 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 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 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 FReM.

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 Integrated Care Board's cash management.

Notes to the financial statements

1.14 **Provisions**

Provisions are recognised when the Integrated Care Board has a present legal or constructive obligation as a result of a past event, it is probable that the Integrated Care Board 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 3.27% (2021-22: -0.47%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

• A nominal medium-term rate of 3.20% (2021-22: 0.70%) 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 3.51% (2021-22 0.95%) 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 3.00% (2021-22: 0.66%) 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 Integrated Care Board 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.

1.15 **Clinical Negligence Costs**

NHS Resolution operates a risk pooling scheme under which the Integrated Care Board 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 Integrated Care Board.

1.16 **Non-clinical Risk Pooling**

The Integrated Care Board participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Integrated Care Board pays an annual contribution to the 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 Integrated Care Board, 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 Integrated Care Board. 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 Integrated Care Board 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 Integrated Care Board 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 Integrated Care Board 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.

Notes to the financial statements

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 Integrated Care Board 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 Integrated Care Board's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

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 Integrated Care Board's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

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.

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 the 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 funder 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 panel.
- Retrospective cases, where an eligibility decision has not been made previously.

Each case has an estimated potential liability, calculate 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. This risk percentage varies by category/locality. 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 14 Regulatory Deferral Accounts – Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.

● 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.

2 Other Operating Revenue

31 March 2023	2022-23 Admin	2022-23 Programme	2022-23 Total
	£'000	£'000	£'000
Income from sale of goods and services (contracts)			
Education, training and research	-	4,633	**4,633**
Non-patient care services to other bodies	130	1,888	**2,019**
Prescription fees and charges	-	11,413	**11,413**
Dental fees and charges	-	15,877	**15,877**
Other Contract income	1,040	1,294	**2,334**
Total Income from sale of goods and services	**1,170**	**35,105**	**36,276**
Other operating income			
Other non contract revenue	-	324	**324**
Total Other operating income	**-**	**324**	**324**
Total Operating Income	**1,170**	**35,429**	**36,599**

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

	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	-	284	-	-	1,255
Non NHS	4,633	1,735	11,413	15,877	1,079
Total	**4,633**	**2,019**	**11,413**	**15,877**	**2,334**

	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	4,633	2,019	11,413	15,877	2,334
Over time	-	-	-	-	-
Total	**4,633**	**2,019**	**11,413**	**15,877**	**2,334**

4. Employee benefits and staff numbers

4.1 Employee benefits

	Total		2022-23
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	13,649	2,903	**16,552**
Social security costs	1,392	-	**1,392**
Employer Contributions to NHS Pension scheme	2,075	-	**2,075**
Apprenticeship Levy	55	-	**55**
Termination benefits	160	-	**160**
Gross employee benefits expenditure	**17,331**	**2,903**	**20,234**
Total - Net admin employee benefits including capitalised costs	**17,331**	**2,903**	**20,234**
Net employee benefits excluding capitalised costs	**17,331**	**2,903**	**20,234**

4.2 Average number of people employed

	2022-23		
	Permanently employed Number	Other Number	Total Number
Total	**256**	**58**	**314**

4.3 Exit packages agreed in the financial year

	2022-23 Compulsory redundancies		2022-23 Total	
	Number	£	Number	£
£150,001 to £200,000	1	160,000	**1**	**160,000**
Total	**1**	**160,000**	**1**	**160,000**

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 full in the year of departure.

4.4 Pension 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.

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:

4.4.1 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 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 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 report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.4.2 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 (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

5. Operating expenses

	2022-23 Admin £'000	2022-23 Programme £'000	2022-23 Total £'000
Purchase of goods and services			
Services from other ICBs, CCGs and NHS England	8,410	3,066	11,477
Services from foundation trusts	-	1,307,723	1,307,723
Services from other NHS trusts	-	312,919	312,919
Purchase of healthcare from non-NHS bodies	-	329,395	329,395
Purchase of social care	-	3,273	3,273
General Dental services and personal dental services*	-	61,617	61,617
Prescribing costs	-	206,698	206,698
Pharmaceutical services*	-	33,282	33,282
General Ophthalmic services*	-	10,497	10,497
GPMS/APMS and PCTMS	-	229,342	229,342
Supplies and services – clinical	-	1,149	1,149
Supplies and services – general	254	1,447	1,701
Consultancy services	908	912	1,820
Establishment	241	4,693	4,933
Transport	0	1	2
Premises	777	2,165	2,941
Audit fees	200	-	200
Other non statutory audit expenditure			
· Internal audit services	150	-	150
· Other services	331	-	331
Other professional fees	216	1,270	1,486
Legal fees	63	236	299
Education, training and conferences	34	1,028	1,063
Total Purchase of goods and services	**11,584**	**2,510,713**	**2,522,298**
Depreciation and impairment charges			
Depreciation	235	111	346
Amortisation	6	111	117
Total Depreciation and impairment charges	**241**	**222**	**463**
Provision expense			
Provisions	-	-	(757)
Total Provision expense	**-**	**-**	**(757)**
Other Operating Expenditure			
Chair and Non Executive Members	-	-	147
Grants to Other bodies	147	-	25
Research and development (excluding staff costs)	-	-	281
Other expenditure	-	-	112
Total Other Operating Expenditure	**147**	**306**	**565**
Total operating expenditure	**11,972**	**2,511,242**	**2,522,569**

* Pharmacy, Optometry and Dental services (POD) were delegated commissioning from 1st July 2022.

6.1 Better Payment Practice Code

Measure of compliance	2022-23 Number	2022-23 £'000
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the Year	25,894	314,600
Total Non-NHS Trade Invoices paid within target	24,929	309,196
Percentage of Non-NHS Trade invoices paid within target	**96.3%**	**98.3%**
NHS Payables		
Total NHS Trade Invoices Paid in the Year	763	25,415
Total NHS Trade Invoices Paid within target	714	24,154
Percentage of NHS Trade Invoices paid within target	**93.6%**	**95.0%**

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 within Non NHS both in volume and value however achieved target in NHS by value and not volume.

7. Finance costs

	2022-23 £'000
Interest	
Interest on lease liabilities	10
Other interest expense	19
Total interest	**29**
Total finance costs	**29**

8. Net gain/(loss) on transfer by absorption

Transfers as part of a reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. 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.

For transfers of assets and liabilities from Buckinghamshire CCG (Bucks), Oxfordshire CCG (Oxf) and Berkshire West CCG (BW) that closed on 30 June 2022 a modified absorption approach has been applied. For these transactions only gains and losses are recognised in reserves rather than the Statement of Comprehensive Net Expenditure.

In closing year end the individual legacy CCGs (Bucks, Oxford and BW) each completed a CCG_CSU template and set of statutory accounts as at 30 June that includes all their individual assets and liabilities to transfer to the new entity BOB ICB. Using numbers the closing balances at 30 June and impact on the group account is reflected below.
The group position remains the same as the group overall has taken on no new assets or liabilities as a result of the closure of the three legacy CCGs and creation of the BOB ICB.

	2022-23	2022-23 (As at 30 Jun 22)					
	BOB ICB NHS England Group Entities (non parent) £'000	Bucks CCG £'000	Oxford CCG £'000	BW CCG £'000	Total £'000	Consol adj £'000	Group account £'000
Transfer of property plant and equipment	**244**	157	42	45	**244**	-	**244**
Transfer of Right of Use assets	**1,494**	694	-	800	**1,494**	-	**1,494**
Transfer of intangibles	**733**	703	30	-	**733**	-	**733**
Transfer of cash and cash equivalents	**3,226**	215	2,822	189	**3,226**	-	**3,226**
Transfer of receivables	**12,871**	2,014	11,713	1,407	**15,134**	(2,263)	**12,871**
Transfer of payables	**(170,917)**	(61,778)	(67,404)	(43,998)	**(173,180)**	2,263	**(170,917)**
Transfer of provisions	**(6,396)**	(1,362)	(1,232)	(3,802)	**(6,396)**	-	**(6,396)**
Transfer of Right Of Use liabilities	**(1,495)**	(694)	-	(801)	**(1,495)**	-	**(1,495)**
Transfer of PUPOC liability - payables	**(83)**	-	(83)	-	**(83)**	-	**(83)**
Net loss on transfers by absorption	**(160,323)**	**(60,051)**	**(54,112)**	**(46,160)**	**(160,323)**	**-**	**(160,323)**

9. Property, plant and equipment

2022-23	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2022	-	-	-
Additions purchased	215	-	215
Transfer (to)/from other public sector body	1,207	573	1,780
Cost/Valuation at 31 March 2023	**1,422**	**573**	**1,995**
Depreciation 01 April 2022	-	-	-
Charged during the year	155	-	155
Transfer (to)/from other public sector body	962	573	1,536
Depreciation at 31 March 2023	**1,118**	**573**	**1,691**
Net Book Value at 31 March 2023	**304**	**-**	**304**
Purchased	304	-	304
Total at 31 March 2023	**304**	**-**	**304**
Asset financing:			
Owned	304	-	304
Total at 31 March 2023	**304**	**-**	**304**
Net Book Value at 30 June 2022	244	-	244

9.1 Economic lives

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

10. Leases

10.1 Right-of-use assets

2022-23	Buildings excluding dwellings £'000	Total £'000	Of which: leased from DHSC group bodies £000
Cost or valuation at 01 April 2022	-	-	
Additions	87	87	
Transfer (to) from other public sector body	1,557	1,557	593
Cost/Valuation at 31 March 2023	**1,644**	**1,644**	**593**
Depreciation 01 April 2022	-	-	
Charged during the year	190	190	74
Transfer (to) from other public sector body	63	63	25
Depreciation at 31 March 2023	**253**	**253**	**99**
Net Book Value at 31 March 2023	**1,391**	**1,391**	**494**
Net Book Value at 30 June 2022	1,494	1,494	

10.2 Lease liabilities

2022-23	2022-23 £'000
Lease liabilities at 01 April 2022	-
Additions	(87)
Interest expense relating to lease liabilities	(9)
Repayment of lease liabilities (capital and interest)	195
Transfer (to) from other public sector body	(1,495)
Lease liabilities at 31 March 2023	**(1,396)**

10.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2022-23 £'000
Within one year	(227)
Between one and five years	(1,134)
After five years	(35)
Balance at 31 March 2023	**(1,396)**
Balance by counterparty	
Leased from DHSC	(693)
Leased from NHS Providers	(496)
Leased from Non-Departmental Public Bodies	(207)
Balance as at 31 March 2023	**(1,396)**

10.4 Amounts recognised in Statement of Comprehensive Net Expenditure

2022-23	2022-23 £'000
Depreciation expense on right-of-use assets	190
Interest expense on lease liabilities	9
Expense relating to variable lease payments not included in the measurement of the lease liability	745

10.5 Amounts recognised in Statement of Cash Flows

	2022-23 £'000
Total cash outflow on leases under IFRS 16	195
Total cash outflow for lease payments not included within the measurement of lease liabilities	745

11. Intangible non-current assets

2022-23	Computer Software: Purchased £'000	Total £'000
Cost or valuation at 01 April 2022	**-**	**-**
Transfer (to)/from other public sector body	780	**780**
Cost / Valuation At 31 March 2023	**780**	**780**
Amortisation 01 April 2022	**-**	**-**
Charged during the year	117	**117**
Transfer (to) from other public sector body	47	**47**
Amortisation At 31 March 2023	**164**	**164**
Net Book Value at 31 March 2023	**616**	**616**
Purchased	616	**616**
Total at 31 March 2023	**616**	**616**
Net Book Value at 30 June 2022	733	**733**

11.1 Economic lives

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

12.1 Trade and other receivables	**Current 2022-23 £'000**	Current 2022-23 £'000 As at 30 Jun 22
NHS receivables: Revenue	1,017	375
NHS prepayments	874	699
NHS accrued income	45	2,136
NHS Non Contract trade receivable (i.e pass through funding)	1,451	397
Non-NHS and Other WGA receivables: Revenue	982	937
Non-NHS and Other WGA prepayments	225	1,942
Non-NHS and Other WGA accrued income	3,989	2,003
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	3,641	854
Non-NHS Contract Assets	27	-
Expected credit loss allowance-receivables	(21)	(21)
VAT	119	265
Other receivables and accruals	9,690	3,283
Total Trade & other receivables	**22,037**	**12,871**
Total current and non current	**22,037**	**12,871**

12.2 Receivables past their due date but not impaired

	2022-23 DHSC Group Bodies £'000	**2022-23 Non DHSC Group Bodies £'000**
By up to three months	1,538	68
By three to six months	29	14
By more than six months	40	70
Total	**1,607**	**152**

12.3 Loss allowance on asset classes	**Trade and other receivables - Non DHSC Group Bodies £'000**	**Total £'000**
Transfer by Absorption from other entity	(21)	**(21)**
Total	**(21)**	**(21)**

13. Cash and Cash Equivalents

	2022-23 £'000	2022-23 £'000 As at 30 Jun 22
Balance at 01 April 2022	3,226	336
Net change in year	(3,162)	2,890
Balance at 31 March 2023	**64**	3,226
Made up of:		
Cash with the Government Banking Service	64	3,226
Cash and cash equivalents as in statement of financial position	**64**	
Balance at 31 March 2023	**64**	3,226

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 2023.

14 Trade and other payables	**Current 2022-23 £'000**	Current 2022-23 £'000 As at 30 Jun 22
NHS payables: Revenue	19,187	7,248
NHS accruals	7,361	10,456
Non-NHS and Other WGA payables: Revenue	12,146	14,790
Non-NHS and Other WGA payables: Capital	103	130
Non-NHS and Other WGA accruals	109,104	84,389
Non-NHS and Other WGA deferred income	220	79
Social security costs	266	260
Tax	285	243
Other payables and accruals	72,238	53,323
CHC PUPOC Accruals	-	83
Total Trade & Other Payables	**220,910**	171,000
Total current and non-current	**220,910**	171,000

Other payables include £2,685k outstanding pension contributions at 31st March 2023

15. Provisions

	Current 2022-23 £'000	**Non-current 2022-23 £'000**	Current 2022-23 £'000	Non-current 2022-23 £'000
Continuing care	2,851	1,840	4,556	1,840
Total	**2,851**	**1,840**	4,556	1,840
Total current and non-current	**4,691**		6,396	

	Continuing Care £'000	**Total £'000**
Balance at 01 April 2022	**-**	**-**
Arising during the year	1,072	1,072
Utilised during the year	(947)	(947)
Reversed unused	(1,829)	(1,829)
Transfer (to) from other public sector body under absorption	6,395	6,395
Balance at 31 March 2023	**4,691**	**4,691**
Expected timing of cash flows:		
Within one year	2,851	
Between one and five years	1,840	
Balance at 31 March 2023	**4,691**	

Pension payments are made quarterly and amounts are known. The pension provision is based on life expectancy.

Legal claims are calculated from the number of claims currently lodged with the NHS Resolution and the probabilities provided by them. There were no legal claims outstanding at 31st March 2023.

The provision for Continuing Care is the Integrated Care Board's estimated liability to pay claims in respect of continuing care assessments.

16. Contingencies

	2022-23 £'000
Contingent liabilities	
Net value of contingent liabilities	53

There was a contingent liabilities of £53k provided by the NHS Litigation Authority as at 31st March 2023 in respect of Clinical Negligence liabilities of the Integrated Care Board. The timing of cash outflow is not certain as the case is still under review.

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 NHS Integrated Care Board (ICB) 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 ICB 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 ICB in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS ICB Standing Financial Instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS Integrated Care Board and internal auditors.

17.1.1 Currency risk

The NHS 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 NHS ICB has no overseas operations. The NHS ICB and therefore has low exposure to currency rate fluctuations.

17.1.2 Interest rate risk

The 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 Integrated Care Board therefore has low exposure to interest rate fluctuations.

17.1.3 Credit risk

Because the majority of the NHS Integrated care Board (ICB) and revenue comes from 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

NHS Integrated Care Board is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS Integrated Care Board draws down cash to cover expenditure, as the need arises. The NHS Integrated Care Board is not, therefore, exposed to significant liquidity risks.

17.1.5 Financial Instruments

As the cash requirements of NHS England 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 NHS England's expected purchase and usage requirements and NHS England 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 2022-23 £'000	Total 2022-23 £'000
Trade and other receivables with NHSE bodies	306	306
Trade and other receivables with other DHSC group bodies	1,971	1,971
Trade and other receivables with external bodies	18,563	18,563
Cash and cash equivalents	64	64
Total at 31 March 2023	**20,904**	**20,904**

17.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2022-23 £'000	Total 2022-23 £'000
Trade and other payables with NHSE bodies	3,890	**3,890**
Trade and other payables with other DHSC group bodies	24,127	**24,127**
Trade and other payables with external bodies	193,519	**193,519**
Total at 31 March 2023	**221,536**	**221,536**

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

	2022-23			
Arrangement schemes	**Assets £000**	**Liabilities £000**	**Income £000**	**Expenditure £000**
Adults with Care and Social Needs (ACSN)	1,287	1,287	66,361	66,361
Better Care Fund	8,398	8,398	144,913	143,805
Child And Adolescent Mental Health	-	-	7,064	7,064
Community Equipment Stores	-	-	3,266	3,266
Integrated Community Equipment Service (Management)	-	-	43	43
Integrated Community Equipment Service	-	-	5,252	5,252
Respite Residential Short Breaks, Occupational Therapy, Physiotherapy	-	-	401	401
Speech And Language Therapy, Occupational Therapy & Physiotherapy	-	-	1,536	1,536
Section 117	-	-	8,291	8,291
Total	**9,685**	**9,685**	**237,127**	**236,019**

Buckinghamshire		**Amounts recognised in Entities books ONLY**	
		2022-23	
Parties to the arrangement and schemes	**Description of principal activities**	**Income**	**Expenditure**
		£'000	**£'000**
BOB ICB and Buckinghamshire County Council - Integrated Community Equipment Service	The Pool Budget covers the provision of Integrated Community Equipment Service (including Adult Social Care, Telecare and Children and Young People's Service) 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.	5,252	5,252
BOB ICB and Buckinghamshire County Council - Integrated Community Equipment Service (Management)	The Pool Budget is for the provision of Integrated Community Equipment Service Contract Management. The agreement covers the period. Buckinghamshire Council is the host and lead authority for this pooled fund arrangement.	43	43
BOB ICB and Buckinghamshire County Council - Section 117	The Pool Budget covers the provision of Section 117 aftercare, to cover the period, providing care packages that are suitable for the clients requirements. Buckinghamshire County Council is the host and lead authority for this pooled fund arrangement.	8,291	8,291
BOB ICB and Buckinghamshire County Council - Better Care Fund	The Pool Budget is 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.	25,317	25,317
BOB ICB and Buckinghamshire County Council - Child And Adolescent Mental Health	This is a Pool Budget is for the provision of Children and Adolescence Mental Health Service to cover the cover the period. Buckinghamshire Council is the host and lead authority for this pooled fund arrangement.	7,064	7,064
BOB ICB and Buckinghamshire County Council - Speech And Language Therapy, Occupational Therapy & Physiotherapy	The Pooled budget is for the provision of Speech & Language Therapies this covers the period. Buckinghamshire County Council is the host and lead authority.	1,536	1,536
BOB ICB and Buckinghamshire County Council - Respite Residential Short Breaks	The Pooled budget is for the provision of Residential Respite Short Breaks this covers the period. Buckinghamshire County Council is the host and lead authority.	401	401

19. Joint arrangements - interests in joint operations

Oxfordshire

Parties to the arrangement and schemes	Description of principal activities	Amounts recognised in Entities books ONLY 2022-23 Assets £'000	Liabilities £'000	Income £'000	Expenditure £'000
BOB ICB and Oxfordshire County Council (OCC) - Better Care Fund (BCF) Pool	The BCF pool provides health and social care services to adults of working age and older adults. Services include those covering care homes provision as well as services designed to promote hospital avoidance and prevention of admission to hospital.	8,398	8,398	95,073	95,073
BOB ICB and Oxfordshire County Council (OCC) - Adults with Care and Social Needs (ACSN)	The ACSN pool provides health and social care services to children and adults of working age. Services include those covering mental health, acquired brain injury and learning disability.	1,287	1,287	66,361	66,361

Berkshire West

Parties to the arrangement and schemes	Description of principal activities	Amounts recognised in Entities books ONLY 2022-23 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.	3,266	3,266
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	4,324	4,324
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	2,965	2,965
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	5,004	5,004
BOB ICB & West Berkshire 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	3,373	2,266
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	5,093	5,093
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	3,763	3,763

20. Related party transactions

Details of related party transactions with individuals are as follows:

NHS BOB ICB Related Party Disclosure 2022-23

		2022-23			
Member	Related Party	Payments to Related Party	Amounts owed to Related Party	Receipts from Related Party	Amounts due from Related Party
		£'000	£'000	£'000	£'000
Saqhib ALI - Non Exec Dir & Chair of the Audit & Risk Committee	Non Exec Dir and Audit Chair - NHS BEDFORDSHIRE LUTON AND MILTON KEYNES ICB	156	2	-	-
	Non Exec Dir and Audit Chair -Northamptonshire Healthcare NHSFT	124	-	-	-
Nick BROUGHTON - Mental Health Partner member	Chief Exec - Oxford Health NHS Foundation Trust	224,700	4,760	264	-
	Honorary Fellow - University of Oxford	1,179	-	-	2
	Board member - Mental Health network, NHS Confederation	40	-	-	-
Rachael de CAUX - Chief Medical Officer	Consultant - Royal Berkshire NHS Foundation Trust	296,950	1,519	-	200
	Spouse - Director of Performance - NHS England South East Regional Office	646	211	7,064	1,390
Stephen CHANDLER - Partner member Local Authorities	Chief Executive - Oxfordshire County Council	93,806	2,586	13,607	1,688
Richard ELEY - Interim Director of Finance (left on 31/10/2022)	Member - Oxford Health NHS Foundation Trust	99,867	2,116	117	-
Haider HUSAIN - Associate Non Executive Director	Non-Executive Director - Milton Keynes University Hospital NHS Foundation Trust	12,126	-	-	-
Dr James KENT - Chief Executive (left on 26/09/2022)	Spouse is employed as a senior Pharmacist - Hall Practice and Chalfont PCN	293	-	-	-
	Friend, Porthaven Chief Executive	548	-	-	-
Javed KHAN - Chair	Non-Executive Director - Guy's and St Thomas NHS Foundation Trust	11,325	337	-	-
Neil MCDONALD - Partner member NHS Trusts	Chief Executive Officer - Buckinghamshire Healthcare NHS Trust	303,346	723	507	216
	Spouse is Managing Partner - Marlow Medical Group	2,579	-	-	-
	Spouse is Chair - FedBucks	8,234	-	66	69
	Spouse is Accountable Clinical Director - Wooburn Green Primary Care Network	1,260	-	-	-
Steve MCMANUS - Interim Chief Executive	Chief Executive - Royal Berkshire NHS Foundation Trust (RBFT)	296,950	1,519	-	200
Tim NOLAN - Non Executive Director Chair of the System Productivity Committee	Governor - Royal Marsden NHS Foundation Trust	339	-	-	-
Sim SCAVAZZA - Non Executive Director and Deputy Chair of ICB and Chair of the People & Remuneration Committee	Non-Executive Director and Chair of People Committee - Imperial College Healthcare Trust	5,796	-	-	-
Sonya Wallbank - Chief People Officer	Consultant - Kings Fund	12	-	-	-
Ross Fullerton - Interim Chief Information Officer	Director - Starlight Management Consultancy Limited	166	-	-	-

GP practices within the area have joined other professionals in the Integrated Care Board in order to plan, design and pay for services. Under these arrangements some services are designed to be delivered in a primary care setting. This involves paying GP practices for the delivery of these services. A GP is also paid by the ICB for taking a lead role on clinical services. All such arrangements are in the ordinary course of business and follow the ICBs strict governance and accountability arrangements. From 1 July 2022, the ICb had delegated commissioning responsibility for primary care GP services. This means that the ICB now makes all payments due to practices based on the Statement of Financial Entitlement and the Premises Direction and this has resulted In a significant increase in the amounts recorded against practice based Governing Body members. Material transactions are disclosed appropriately in the accounts.

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 Care Board 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 Care Board has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Local Authority in respect of joint commissioning arrangements.

20. Related party transactions - continued

Department of Health and Social Care (DHSC) related party information for group bodies 2022-23

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 2023 to assist group bodies in preparing disclosures compliant with IAS 24.

Ministers	**Senior Officials**	**Non-executive Directors**
The Rt Hon Steve Barclay MP	Sir Chris Wormald KCB	Kate Lampard
The Rt Hon Dr Thérèse Coffey MP	Professor Sir Christopher Whitty KCB	Doug Gurr
The Rt Hon Sajid Javid MP	Shona Dunn	Gerry Murphy
Edward Argar MP	Clara Swinson CB	Julian Hartley
Gillian Keegan MP	Jonathan Marron	
Dr Caroline Johnson MP	Matthew Style	
Robert Jenrick MP	Michelle Dyson	
William Quince MP	Andrew Brittain	
Helen Whately MP	Stephen Oldfield	
Maggie Throup MP	Matthew Gould	
Maria Caulfield MP	Professor Lucy Chappell	
James Morris MP	Jenny Richardson	
Neil O'Brien MP	Hugh Harris	
Lord Markham	Lorraine Jackson	
Lord Kamall		

		2022-23			
	Related party	**Payments to Related Party £'000**	**Amounts Owed to Related Party £'000**	**Receipts from Related party £'000**	**Amounts due from Related Party £'000**
Entity linked to the individuals above	Leeds Teaching Hospital NHS Trust	104	-	-	-
Entity linked to the individuals above	Macmillan Cancer Support	-	-	8	70

21. Events after the end of the reporting period

The Integrated Care Board has no events after the end of the reporting period to disclose at the point of producing these accounts.

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:

	2022-23 Target	**2022-23 Performance**	**Duty Achieved?**
Expenditure not to exceed income	2,543,382	2,543,134	Yes
Capital resource use does not exceed the amount specified in Directions	303	303	Yes
Revenue resource use does not exceed the amount specified in Directions	2,506,480	2,506,232	Yes
Revenue administration resource use does not exceed the amount specified in Directions	25,346	24,882	Yes