BOB ICB Board Meeting in Public

Responses to the public questions submitted to the 16 July 2024 Board meeting:

No. 1 (Item 08)	Can the board please tell me when there is likely to be a meeting with the current Secretary of state for health/ NHS chief executive, or senior NHS rep, at which time the subject of the Horton Hospital infrastructure/plan B vision for the Banbury Horton site may be discussed. In particular, the ongoing concerns, re events following the loss of Obstetric services on October 16th 2016. This has been highlighted by a recently published and distributed dossier, from 50 birth experience mothers, and there evidential statements with a part 2 dossier currently being compiled. *Questions submitted by Keith Strangwood, Chairman Keep The Horton General. (KTHG)*
Response	The Integrated Care Board (ICB) is in regular discussion with senior partners at NHS England in regard to commissioning and delivery strategies to ensure the best possible outcomes for Buckinghamshire, Oxfordshire and Berkshire West (BOB) residents. Residents' concerns surrounding the Horton remain a priority in these discussions, including the changes to the provision of obstetric services. Oxford University Hospitals NHS Foundation Trust (OUH) have conducted a thorough review of the 50 cases highlighted in the recently published dossier and are having ongoing discussions with the ICB about these findings and next steps. The information in the dossier will be used to inform any potential future strategic review of maternity services. We are committed to keeping the community informed of any developments and will continue to address these important issues in our ongoing work.

No. 2 (Item 08)	In Article 1,1 (b) of its Constitution, BOB ICB declares that it will: "tackle inequalities in outcomes, experience and access". Those of us that live in the north of Oxfordshire, in what is known colloquially as Banburyshire feel neglected in respect of access to medical services provided and which have over the time I have resided in Swalcliffe (OX15) I have witnessed a number of critical services diminished or eliminated, principle of these being Emergency Abdominal Surgery and particularly Consultant led Obstetrics. In addition to these critical services, many clinics have disappeared from the Horton over the past 30 years which entail many unnecessary journeys from this area to Oxford campus hospitals. According to the last Strategic plan of the OCCG, as many as 90,000 "clinically unnecessary" journeys were claimed. With the increasing versatility of technology and corresponding electronic communications, surely many more consultations could be conducted via remote connections obviating these unnecessary journeys to Oxford. Additionally, where face to face consultations is preferable or essential, surely it makes more sense for consultants to travel to the Horton than for 90,000 patient journeys in the opposite direction. I understand there are plans on hand for major improvements of the aged, uneconomic estate at the Horton and this would provide an opportunity to enhance those facilities referred to above I would appreciate it if my views were communicated to the Board Meeting on 16th July 2024. *Questions submitted by Peter McLoughlin*
Response	The Horton General Hospital (HGH) is an acute general hospital providing a wide range of services to the communities of North Oxfordshire and surrounding areas. It is one of the four main hospital sites of OUH. The hospital is supported by models of ambulatory care

	(avoiding unnecessary inpatient admission to hospital), virtual wards and works closely with local community services. The HGH already provides day case surgery and is a hub for outpatient services. The OUH Clinical Strategy 2023-2028, published in March 2023, sets out priorities for the HGH including plans to increase ambulatory care and increase surgical capacity and day case surgery across many clinical specialities. Diagnostics at the HGH have already been significantly increased with the investment and installation of a new CT scanner in 2023 which doubled the scanning capacity and will help to reduce waiting lists. The ICB and OUH remain committed to maintaining and improving the services provided at the Horton General Hospital. Additionally, the ICB has a responsibility for commissioning services across BOB. This capability continues to be strengthened and will be responsible for supporting healthcare providers across BOB to deliver financial and operationally sustainable services. This will involve working with partner NHS organisations, such as the OUH, to continue to refine and transform services for the benefit of our patients together with an ongoing drive for efficiency and value for money. This will include the ongoing rollout of services which allow people to stay at home or in their communities for longer, such as Hospital at Home, remote monitoring and virtual consultations, this system-wide approach to planning across BOB will also mean a more consistent approach to tackling inequalities in access, experience and outcomes. In the last twelve months OUH has provided 228,700 non face to face appointments which corresponds to 22% of the total number of outpatient appointments seen.

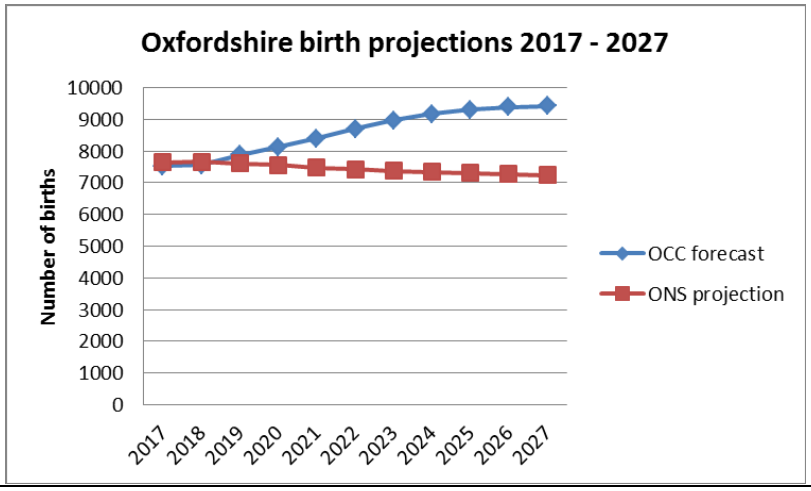
No. 3 (Item 08)	1. While volume 2 of the Birth Trauma dossier is being put together, what action have you immediately taken and do you intend to take to prevent further unnecessary deaths of babies and birth trauma to mothers and their families at the John Radcliffe? 2. In 8 years since the Horton downgrade due to staff shortages that were created by supplementing the John Radcliffe, what steps have you taken to increase the number of Obstetricians and Midwives and how do staffing levels compare between 2016 and 2024? *Questions submitted by Beth Hopper*
Response 1	Oxford University Hospitals Trust have conducted a thorough review of the 50 cases highlighted in the first dossier and are having ongoing discussions with the ICB about these findings and next steps. The information in the dossier will be used to inform any potential future strategic review of maternity services. We are committed to keeping the community informed of any developments and will continue to address these important issues in our ongoing work.
2	Oxford University Hospitals Trust have adopted national recommendations for obstetric and midwifery staffing. Assurance of this is provided to the ICB and NHS resolution through the maternity incentive scheme. Staffing level requirements for obstetricians and midwives are calculated using nationally recommended workforce tools. Between 2016 and 2024 these tools and recommended staffing ratios have varied due to changing national recommendations such as those in the Ockenden report and changing strategic direction such as Better Births therefore it is not possible to make a meaningful comparison.

No. 4 (Item 08)	1. Regarding the Chief Executive and Director's Report: Why is Item 33 headed "Horton Maternity Services" and relates to maternity services in Banbury when it is perfectly clear from reading the dossier that, although it covers the experiences from mothers in the Banbury area, the majority (more than 75%) of cases highlight the shortcomings of the John Radcliffe Hospital in Oxford?

	2. The extensive analysis conducted by Oxfordshire Clinical Commissioning Group, overseen by Catherine Mountford, in 2018 concluded that there should be a two centre (Oxford and Banbury) solution for obstetrics, but it was immediately dismissed on the grounds of shortage of obstetricians. In the intervening period the number of births at the John Radcliffe Hospital has increased significantly and now the dossier has clearly illustrated that the JR is unable to cope. Isn't it now time to revisit the preferred option and summon the will to overcome seemingly insurmountable obstacles as demonstrated by the Better Healthcare Programme in 2010? *Questions submitted by Jenny Jones for Keep the Horton General Campaign Group*
Response 1	Item 33 was headed "Horton Maternity Services" as the dossier is a collection of accounts of childbirth in Oxfordshire following the reconfiguration of the Horton General Hospital's obstetric (consultant-led) unit in 2016.
2	The information in the dossier will be used to inform any potential future strategic review of maternity services.

No. 5 (Item 08)	In the light of the new campaign by the Keep the Horton General group to ensure provision is made for a return of obstetrics to the Horton General Hospital, I would like to submit some calculations and **ask whether the ICB will commit to start planning NOW for the needs of the growing population**. We know that seeking approval for funding and future planning for growth can take several years which is why it is vital **that this is not delayed**. We understand that the ICB has the Stoke Mandeville Hospital roof and West Berkshire Hospital in its shorter term plans but this issue is going to become a very important issue. In 2017, the then-Oxfordshire Clinical Commissioning Group pledged to review the case for obstetrics to the Horton if population growth of the catchment demanded it. Indeed, the recommendation was that the optimum solution for childbirth in Oxfordshire was two obstetric centres (as there had previously been, with the Banbury centre, its theatre capacity and special care baby unit being used for JR overflow as well as the needs of the catchment). The reason given for not taking this route was staffing and again, it is encumbent on the ICB to be putting real pressure on NHS England, DoHSC and Royal College of Obstetrics and Gynaecology to increase training places to ensure sufficient medical staffing is available when needed. A large population reproduces and childbirth is a constant requirement throughout the NHS. It is not an illness or something that can be reduced through strategy. **Will the ICB use what influence it has, with hospital trusts, to put pressure on NHS England, the DoHSC and RCOG to increase training places in line with demand?** The catchment area for the Horton General Hospital in 2016 (based on the 2011 census), when obstetrics was removed from the Horton, was approximately 160,000. (The catchment area consists of Cherwell, south Northamptonshire and the Stratford on Avon districts. West Oxfordshire also comes partially into the Horton catchment via Chipping Norton and its villages.) The district figures published for projected population growth are as follows. Cherwell District Council - 161,000 in 2021 to **185,500 Cherwell 2021 - 31.** In 2040 Cherwell population will be **220,000** (**without** new Labour 'grey' settlement increases). South Northamptonshire population 2021 **126,540** growing by an average of 523 per year to 2040 (+11,572) = **139,152** Stratford on Avon district council population 135,000 adults expected to be living in the district by 2040. For the purpose of this calculation we use 25% of that figure for the south of that district looking to the Horton General Hospital - **31,635**

	West Oxfordshire prediction by 2040 **145,000.** Chipping Norton alone is predicted to grow by 39% by 2031, calculations not available for 2040**.** For the purposes of this calculation we add a conservative estimate of 10% of the 2031 number looking to Banbury for maternity/hospital care - **14,500.** The population increase in the Oxfordshire alone, according to the Oxfordshire Infrastructure Strategy by 2040 is +35% at 950,000 Cherwell is the second highest increase in the county at 44% - 220,000 South Oxfordshire is the highest increase at 45% - 210,000 West Oxfordshire - 145,000 Vale of White Horse 200,000 Oxford City - 180,000 The figures above show two obvious things: 1. That the area known as 'Banburyshire' - the catchment of the Horton that includes Cherwell and extends to South Northants, Stratford on Avon and some of West Oxfordshire - will have a population estimated at **405,287.** This does include Bicester - which currently looks to the John Radcliffe Hospital for obstetric care. However the case for returning obstetrics to Banbury involves the reality that **the John Radcliffe is not going to have capacity for the obstetric/childbirth needs for a population of 950,000**. Bicester's current population is 28,672 so even without it, the figures for the Horton catchment more than justify an obstetric unit for Banbury. 2. The John Radcliffe Hospital - as the KTHG Birth Trauma Dossier shows - is (as predicted) suffering terrible stress and overwhelm in inadequate facilities (some labouring women report being put in cupboards without windows or fresh air). The staff are overwhelmed and the situation can only get worse as staff are demoralised, exhausted and stretched to the point where some are giving up and leaving the service. The argument for a full, consultant led obstetric and gynae service in Banbury is irrefutable on the basis of the projected figures. **This must not be left until maternity is in a worse crisis than it already is**. The KTHG dossier is being followed by a second volume. Four fifths of the cases in Volume 1 are friends of the original instigator, Beth Hopper. The group knows that there must be many hundreds more and that these incidences will not stop until the JR is relieved of the unacceptable caseload. The New Hospitals Fund was abandoned by the Johnson government and the £387m requested for a Horton rebuild (clearly necessary) was lost. Plan B is being considered but relies on the ICB to find funds or funding methods for this. To reiterate, the questions are 1. **Does the ICB acknowledge the need for space for an obstetric unit in the redevelopment of the Horton, as promised?** 2. **Will the ICB commit to start planning NOW for the obstetric needs of the 'Banburyshire' area before population growth becomes a critical problem?** 3. **Will the ICB use whatever influence it has and put pressure on NHS England, the DoHSC and RCOG to increase training places in line with demand?** *Questions submitted by Roseanne Edwards, Senior Multimedia Reporter, Banbury Guardian*
Response 1	The ICB is in discussion with Oxford University Hospitals Trust following their thorough review of the cases highlighted in the dossier including obstetric capacity and next steps. The information in the dossier will be used to inform any potential future strategic review

	of maternity services. The ICB will provide any relevant updates on this review at a future Board meeting. We are committed to keeping the community informed of any developments and will continue to address these important issues in our ongoing work.
2	In the Oxfordshire CCG board paper – Responding to Secretary of State letter following referral of the permanent closure of consultant led maternity services at the Horton general hospital (September 2019) it states that predicting the number of births with any degree of certainty is particularly difficult given the many and varying factors that can affect the birth rate. The Office of National Statistics (ONS) makes population projections, including projecting the number of births, based on population data and assumed age related fertility rates. Given the historical reduction in the fertility rate nationally, the ONS projections for 2016 – 2026 are based on the assumption that women will have fewer children and therefore predicts a decrease in births in Oxfordshire during that period. 
3	The ICB regularly converses with relevant senior leaders in NHSE and arms length bodies with respect to long term workforce planning and seeks to positively influence the demand and capacity requirements.

No. 6 (Item 08)	I should like to ask a question to the ICB relating to the chief executive's report to the 16th July Board. (agenda item 8). The question is in three related parts: While acknowledging the pressures on the ICB and the benefits of promoting good morale within the ICB workforce, does the chief executive consider that paragraphs 15 and 25 of his report adequately reflect the description of an ICB which NHS England have just rated as in segment 3 of the NHSE Oversight Framework. This describes segment 3 performance as "ICB or provider and/or wider system are significantly off-track in a range of areas. We lack confidence in the capability to respond to challenges without support"? For transparency, will the ICB be publishing the NHSE assessment, as the internet shows was done by other ICBs last year? The ICB's own constitution states: "The principle of transparency will be demonstrated by: … The ICB acting in a manner that is open and honest, not concealing unflattering information....". In the light of the segment 3 rating, what concrete assurances can the ICB give that there will be demonstrable performance improvements in the coming 12 months, noting that the ICB's annual report states that NHSE's assessment feedback will be "incorporated into the BOB 2024/25 system plans"? *Questions submitted by Mike Etkind*
Response	The agreed operating plan for 2024/25 outlines clear improvements in performance, and the ICB has an agreed deficit for 2024/25 which may result in the ICB continuing to receive NHSE support given our specific challenges. We can confirm the ICB will be publishing the NHSE assessment as an appendix to the board minutes of the meeting held on 17 July 2024.

No. 7 (Item 08)	The South Oxfordshire PPG Alliance (SOPA) represents PPGs across South Oxfordshire, and is a collaboration between the former SE and SW Locality Forums, established by Oxfordshire CCG. One of SOPA's key aims is to facilitate communication and consultation processes between PPGs and key decision makers, including PCNs, GP Practices and BOB ICS/ICB. Locality Forums gained significant benefit from the input of a CCG Clinical Lead at their meetings, and this input has become a valuable element of SOPA meetings. For the past six years, Dr Capo-Bianco, Clinical Lead for Urgent and Emergency Care, has carried out this critical role. His support has been invaluable, due to his open communication style, and he has helped us to navigate the structural and policy changes and challenges within both the Oxfordshire NHS and the wider BOB landscape. His input has enabled us to make an informed contribution to discussions about NHS services, on behalf of local patients. It has also put us in a stronger position to help patients understand the ICB's aims and objectives. SOPA members are extremely concerned to learn about the proposal to abolish this post, under the proposed re-structuring. We fully understand the operational pressures on BOB ICB, but we consider it counter-productive to remove a key element of the patient/provider dialogue. We would like to know how the ICB proposes to maintain the same high level of two-way communication and engagement with SOPA and South Oxfordshire patients that Dr Capo-Bianco has brought to our deliberations. *Question submitted by Shelagh Garvey, Chair, South Oxfordshire PPG Alliance*
Response	Thank you for providing your feedback on the current proposals under consultation. As touched upon during the Board meeting, we will carefully consider your input, along with the feedback from our other external partners, as we develop the final proposal. This proposal will be presented to the Board in September for ratification.

No. 8 (Item 12)	In paper 12 from 21 May meeting on page 24 (Cancer 62 day performance) the Berkshire West graph is shown twice and Oxfordshire not at all. *Question submitted by Tom Lake, Information Officer, Reading Patient Voice Group*
Response	Thank you for pointing out this error. We have provided an amended slide for this page of the May report which is available here. A refreshed Performance and Quality report is presented at this meeting for the first time and the revised content includes performance against the 62-day cancer standard by provider**.**

No. 9 (Item 13)	With regard to the finance report as presented at each meeting: The budget line on primary care is only a small proportion of local NHS expenditure on primary care - e.g. £45M in 21 May finance report. While it is understandable that the ICB needs its own liabilities clearly set out, the report leaves the public with very little idea of what is being spent on primary care in their area. Could there be a supplementary report showing what is actually being spent on primary care within the BOB area, perhaps breaking down the total by category. *Question submitted by Tom Lake, Information Officer, Reading Patient Voice Group*
Response	Thank you for your enquiry. The finance report does contain this information for primary care, it is included over the following three lines (annual figures given relate to the 2024/25 finance report presented to July meeting): 1. Primary Care – £47.388 million. 2. The POD and delegated co-commissioning budget are ringfenced and set nationally based on population.

	3. The £332 million funds the national primary medical services contracts including the core contract payments, Primary Care Network (PCN) payments and funds for Additional Roles Reimbursement Scheme (ARRS) staff, Quality and Outcomes Framework (QOF) aspiration, premises and others. Practices use these payments to fund staff and overheads as well as providing partners drawings. Each practice contractually is required to share GP salaries on its website. The primary care budget is set locally and competes with funding for other services. The breakdown of how the £47 million in (1) is allocated: • Out of hours service – £15.4 million. • Medicines Optimisation team contribution – £1.4 million. • Primary care transformation £3.5 million which funds digital first, GP leadership group, GP fellowship programme, locum deck and a few other things. • Commissioning schemes £4.6m – historically and currently used to commission wider primary care services in Oxfordshire e.g. primary care visiting service; acute hub in The Leys. • Locally Commissioned Services – £15.3 million.

No. 10 (Item 15)	I would like the board to confirm, the cost of the ICB staff which looking at last year's figures was 272 staff members at a cost of 22 million pounds for a year? This figure is taken from the published accounts. This just seems expensive at over 80k per employee? *Question submitted by Neil Smith*
Response	The Annual Report 2023/24 contains the Remuneration report on pages 68-76. Page 69 includes the pay ratio report which indicates that the median salary for an ICB employee was £50,361. On top of this, as an employer, the ICB would pay national insurance and pension contributions in line with national requirements.

No. 11 (Not on agenda)	There are a few questions I would like to ask the Board about Transgender health care. 1. Please can you explain and give legal and justifiable reasons why Testosterone (Testogel) is not on the NHS Drugs Tariff for Transmen? This is very unfair since Transwomen are catered for with Oestradiol (Oestregon). 2. Why don't you allow NHS GP's to work with the private sector where necessary, and provide Testosterone in a primary care setting? 3. Why do you not support Transgender people and healthcare for them in Oxfordshire and the other locations covered by the Board? 4. Why don't you have any people on the LGBTQ Spectrum serving on the Board? I looked at the list of Board members fairly recently and could see that the majority of them are Cisgender. Therefore, I feel that the LGBTQ Spectrum is under-represented and the Board is only interested in Cisgender people. I offered to help the Board last year, however, this offer was not taken up by them even though they were mildly interested. Considering that I am a member of the NHS LGBTQ Sounding Board, which I pointed out to the Integrated Care Board at the time, I would have thought the Board might want my input. 5. Why do you not accept Individual Funding Requests from GP's for patients who require Testosterone? My GP refuses to apply for the funding as he claims the Board would not agree to it. At present, as a Transman, I am forced to source the Testogel privately and self medicate, which is not encouraged, yet because of the NHS and the Board's reluctance to allow my GP to prescribe it even as a Bridging Prescription, I have no option except to get it privately. I would have expected that to be covered by the Individual Funding Request as an exceptional case.

	In conclusion, I strongly believe that the current Integrated Care Board is not fit for purpose and needs to review its operating system and procedures. It must bear in mind that it should be fully compliant with the NHS Guidelines for Integrated Care Boards and the provisions of the Equalities Act of 2010, in terms of Gender, which is a Protected Characteristic. *Question submitted by Mr FM Pratt*
Response 1	Every medicine that can be prescribed by GPs is listed in the Drug Tariff for England and Wales, which is produced by the NHS Business Services Authority (NHSBSA) for the Secretary of State. It is published here. The Drug Tariff provides information on what medicines and other items are allowed to be prescribed and dispensed on the NHS outside of hospitals, i.e. prescribed by GPs and dispensed by community pharmacies. Testosterone and oestrogen products, including Testogel, are listed in the national Drug Tariff for prescribing in the NHS. The Drug Tariff does not include what therapeutic uses or indications a medicine can be prescribed for.
2	BOB ICB has a policy BOBFPC35 that clarifies the boundaries between NHS and privately funded healthcare. This supports GPs to work with private providers, e.g. shared care arrangements, in some circumstances and when the GP practice has made their own decision to do so and feels that the shared care is safe and appropriate. In addition, key national bodies have issued advice and guidance to GPs about the role of the NHS GP in transgender care: • Royal College of General Practitioners – The role of the GP in transgender care • General Medical Council – Trans healthcare • British Medical Association – Managing patients with gender dysphoria • NHS England, who are the responsible commissioner for commissioning specialised gender dysphoria services – Gender Services Clinical Programme and Specialised Services Circular: Primary Care Responsibilities In Regard To Requests by Private On-Line Medical Service Providers to Prescribe Hormone Treatments for Transgender People and Service Specification No: 1719 Gender Identity Services for Adults (Non-Surgical Interventions) Appendix J: Arrangements for prescribing endocrine treatments Key points to note are: • There is no obligation for the GP to prescribe treatment recommended by a private practitioner if it is contrary to local agreement, not supported by national guidance or outside normal clinical practice for that care setting. • The NHS will not normally fund treatments that have been recommended by a private practitioner if that treatment is not normally commissioned within the local area. • Any patient that commences care privately can request that further treatment be provided within the NHS by a GP, but the decision whether to prescribe is down to the individual GP after considering relevant guidance. Clinical needs for a patient with any identified condition should be reassessed for NHS treatment within the same regime of priorities and guidance applicable to NHS patients with the same condition, as in service specification and guidance above. • A GP will also consider whether a request to prescribe an item for a patient is within the license for that product. The therapeutic uses or indications that a medicine is allowed to be prescribed for under the terms of its license is regulated by the Medicines and Healthcare products Regulatory Agency (MHRA). At the current time, there are no oestrogen or testosterone medicinal products that are licensed for use to treat gender incongruence, whether transmen or transwomen. Prescribing unlicensed medicines in some circumstances is supported by national guidance and may be necessary in some instances such as if there is no suitably licensed medicine that will meet the patient's need. • The Oxfordshire formulary lists all testosterone gel products as available to be prescribed for their licensed indications, and are not blocked in primary care where a GP feels it is appropriate to prescribe for the clinical needs of their patient.

	• The General Medical Council (GMC) advises that GPs can work with a gender specialist service under Shared Care Agreements set up between specialist service providers and practices to provide joint care for patients. Shared care requires the agreement of all parties, including the patient. It's essential that all parties must be competent to take their share of the clinical responsibility and must be in a position to communicate effectively and work together. If a GP is uncertain about their competence to take responsibility for the patient's continuing care, for instance where a treatment is being used outside of license, the GP should explain this to the other clinician and to the patient and make appropriate arrangements for the patient's continuing care.
3	NHS BOB ICB strives to support all of our population across our services and seeks to deliver care that is personalised and supports individuals regardless of their gender. NHS must meet the Equality Act 2010 – Public Sector Equality Duty i) prevent unlawful discrimination, ii) advance equality of opportunity, and iii) foster good relations between people who share a protected characteristic and those who do not. The Health and Care Act 2022 has introduced a range of obligations for NHS bodies in relation to Health Inequalities which we also work to. BOB ICB Equality and Quality Impact Assessment process specifically lists Transgender / Gender Reassignment as one of the protected characteristics to consider in service projects, function or change.
4	Thank you for highlighting this important issue. BOB ICB values diversity and inclusion deeply and the Chair would like to emphasise the ICB is committed to encouraging a diverse range of candidates for all positions, including Board positions. We have made significant strides in ensuring diversity in terms of ethnicity and gender among our current Board members. We believe this diversity enriches our perspectives and decision-making processes, as we strive to always better-reflect the communities we serve. It is also important to note that not all Board members have declared their gender / sexuality. Therefore, the visible representation may not fully capture the diverse identities that are present within the Board. The Chair remains committed to the principles of equity and inclusion and will continue to advocate for increased diversity across all levels of BOB ICB. We recognise the importance of having voices from the LGBTQ community and other underrepresented groups in our leadership to guide our efforts in delivering inclusive healthcare. We are grateful for the valuable time you dedicate to the NHS LGBTQ Sounding Board. While your previous offer was not taken up at the time, this does not reflect a lack of interest but rather the complexities of Board appointments and the need to balance various factors, in co-ordination with NHS England. We would like to reassure you of our commitment to equality, equity, diversity and inclusion in any past, current and future appointments. Our residents feedback is valuable to us, and we remain dedicated to continually improving our processes and ensuring our Board and workforce reflect the rich diversity of the populations we serve.
5	The Individual Funding Request process may only be used in exceptional clinical circumstances, and only considers clinical information. This means that a clinician must show evidence that their patient is in a different clinical condition when compared to the typical patient population with the same condition (e.g. number of people in the local population who would give their gender identity as transman in the national census), and because of that clinical difference their patient is likely to receive material additional clinical benefit from that treatment when compared to a typical patient with that condition who is also not eligible for the same NHS treatment. Meeting the accepted indications for a treatment does not, in itself, provide a basis for an exception, nor the fact that a patient is likely to respond to the requested treatment. In this instance, the situation does not appear to be one of clinical exceptionality, but may require an individual assessment of national guidance and safe and appropriate prescribing.

	Further information about Individual Funding Requests is available on the ICB website here.

No. 12 (Not on agenda)	After a discussion with Dan Levison and Jeffrey Ng I am still concerned that there is no apparent appetite to regularly request all possible developer related funding for Primary Care. I've check to see how much of the potential maximum BOB & OCCG have requested in Cherwell and it is only a paltry percentage. This is money designed to expand primary care services through capital projects, buildings, ICT systems as described in the 2018 supplementary planning document. Could you please justify what BOB ICS is not requesting this funding on all planning applications of 10 or more dwellings and ask the officer responsible to contact me so that I can assist in making this procedure simpler and ease any issues at the Cherwell end. *Questions submitted by Cllr David Rogers, Cherwell District Council, Deddington Ward*
Response	BOB ICB very much welcomes the opportunity to work with Local Authorities to gain possible developer related funding for primary care. We have already utilised developers' contributions to reconfigure our estate in Didcot to provide more clinical space and are currently working on other projects where developers' contributions will be essential to ensure we can mitigate the impact of significant areas of housing growth in BOB. However, as BOB ICB is not a statutory consultee in planning applications we are reliant on the discretion of local planning authorities to consult with the ICB. Where informed the ICB is currently making representations on major and strategic planning applications which have more than 50 units and occasionally applications with less than 50 units where they have significant impacts to primary care. BOB ICB is keen to work closely with Cherwell District Council so that we can formally be consulted on all major planning applications. Our Senior Primary Care Estates Manager is the lead for this area with a key part of his role being coordinating and making representations to planning applications, including appeals. They will make contact with the enquirer.

No. 13 (Not on agenda)	With regards to supporting service users in Co-production throughout BOB and by encouraging their involvement and engagement, as referred to in the BOB Joint Forward Plan (June 2023) and BOB Integrated Care Strategy (Page 42). When will the Policy for public involvement and engagement (as referenced by the BOB Integrated Care Board Constitution (V1.0) for the BOB ICB Governance Handbook) be published? …and will it consider the following "statutory guidance": • NHS England - Working in Partnership with People and Communities • Together with pertinent elements of associated NHS England Policies: • Patient and Public Participation Policy • Patient and Public Voice Partners Policy • Reimbursing expenses and paying involvement payments Policy • Standards of Business Conduct Policy NOTE: The BOB Integrated Care Board Constitution V1.0 (as linked on the BOB website – not V1.1) references (in 1.7.3. (e) Key policy Documents – Page 10) the Policy for public involvement and engagement to be part of the BOB ICB Governance Handbook. *Questions submitted by Lionel Barnard, Expert by Experience Mental Health with Our Voice (Oxon) - Under the Patient Experience and Involvement Team*

Response	We apologise that our approach to public involvement and engagement has not been published with/linked to our governance documents. This is an omission we are in the process of addressing alongside an update of the Constitution and Governance Handbook.
	
	We would like to assure you that we have had an agreed approach to public involvement and engagement since the ICB was established. We have done this through development of a strategy rather than a policy and the evolution of this can be seen in our Board meeting papers below:
	
	• 1 July 2022 Establishment meeting
	  ○ 14-20220701-bob-icb-establsihment-board-item-05-engagement-strategy.pdf
	  ○ 15-20220701-bob-icb-establishment-board-item-05-engagement-strategy-annex-1.pdf
	
	• 18 July 2023
	  ○ 20230718-bob-icb-board-item-13-communications-and-engagement-strategy.pdf