NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

BOB ICB Board Meeting in Public

Responses to the public questions submitted to the 13 May 2025 Board meeting:

Ref	Questions / Comments
No.1 (Item 10)	The Board will be aware that recent research by the Centre for Health and the Public Interest (CHPI) into the use of the private sector to deliver NHS funded eye care has revealed that eye-watering amounts are leaking from the NHS into the coffers of private eye clinics. **£536 million** was paid by the NHS in England to **5 companies in one year**. [1] Figures for the **BOB ICB** show: • **Total spend in 2023/24 on 5 eye care companies: £14,007,754** • **Total profit (EBITDA) from NHS income: £4,635,805** • **Total interest payments on debt: £1,539,829** The profits and interest payments of these companies from NHS income amount is **44% of overall spend,** which means that **nearly £1 in every £2 spent** on outsourcing boosts the income of for-profit companies and does not go towards patient care in our BOB ICS area. 1. Plugging the leak would mean more money for patient eye care and for building capacity in NHS ophthalmology departments. How can the Board justify this significant loss of funding? 2. What action can the Board take to prevent further funding from being diverted from the NHS to private for-profit companies? 3. How will the Board use its powers to ensure all arrangements with for-profit providers of NHS funded eye care represent value for money? 4. As the statutory body responsible for planning and providing health and care services in our area, does the BOB ICB have effective metrics, responsibilities and accountabilities to evaluate its decisions to commission outsourced eye care services? 5. What impact is this loss of funding having on the financial sustainability, training and workforce of NHS ophthalmology departments in our area? 6. Will the BOB ICB investigate its contracts with private providers of NHS funded eye care to determine the current levels of profit being generated and lost to the NHS? 7. The government is introducing a cap on profits in the children's social care sector. Will the BOB ICB make the case for a cap on profits in NHS funded eye clinics? [1] https://www.chpi.org.uk/the-outsourcing-of-nhs-eye-care-profit-map *Question submitted by Joan Stewart, Oxfordshire Keep Our NHS Public*
Response	**Response** Thank you for taking the time to explore this matter and sharing your concerns. We have reviewed your queries and provided responses for each question. Additional context

	Firstly, we should highlight that ICB commissions services in line with NHSE choice regulation. The key feature of this is that ICBs must accredit and allow access for patients to any provider that can meet the service specification for consultant led secondary care elective services. This regulation mandates all ICBs must support providers (independent or NHS Trust) in being commissioned should the provider express an interest and then complete an accreditation process. The ICB does not outsource. This term refers to Trusts or providers that utilise other providers and solutions where they are unable to meet their demand or obligations. The ICB does not outsource, it is required by law to commission any provider regardless of whether or not they are an NHS Trust of independent provider. Responses: 1. **Plugging the leak would mean more money for patient eye care and for building capacity in NHS ophthalmology departments. How can the Board justify this significant loss of funding?** The board has a legal obligation under the NHS Choice regulation to offer a contract and commission any provider who can meet the requirements of service specifications. We have established a single point of access model for ophthalmology to ensure patient fully understand the different pathways. 2. **What action can the Board take to prevent further funding from being diverted from the NHS to private for-profit companies?** We have no legal levers to prevent or avoid this and it is the ICB role to commission services for the local population and support choice. 3. **How will the Board use its powers to ensure all arrangements with for-profit providers of NHS funded eye care represent value for money?** All providers are on the same contracts and terms. Financially, this means all providers are funded at tariff. Tariffs are nationally set and not locally. 4. **As the statutory body responsible for planning and providing health and care services in our area, does the ICB have effective metrics, responsibilities and accountabilities to evaluate its decisions to commission outsourced eye care services?** We do not outsource services. We have an established and robust accreditation process to ensure providers meet the same minimum standards for delivery, quality and safety that NHS Trusts do for services they offer. Where risk and clinical complexity increase, services and offers are limited and concentrated on Trusts to provide these, such as more specialist care like cancer. 5. **What impact is this loss of funding having on the financial sustainability, training and workforce of NHS ophthalmology departments in our area?** The ICB has heard from some Trusts and escalated upwards to NHSE of the risks to more market saturation of independent providers that focus on high volume and low complexity procedures. This has seen some training offers limited in Trusts and reduction resource availability. To aid this, the ICB has supported and encouraged Trusts and private providers to partner up to create a more sustainable and harmonious offer rather than competing. This continues to be explored to see where capacity can be shared to meet population needs of now and the future. 6. **Will BOB ICB investigate its contracts with private providers of NHS funded eye care to determine the current levels of profit being generated and lost to the NHS?** The ICB has no current plans to review and investigate profit margins by any provider. All providers are contracted and commissioned at national tariff levels.

	7. **The government is introducing a cap on profits in the children's social care sector. Will the ICB make the case for a cap on profits in NHS funded eye clinics?** No this is not the role of the ICB and is governed by national choice policy and national tariffs.

No. 2 (Item 7)	In relation to item 7 of the agenda: Given that in just three pages the new table of model ICB core functions and activities (in blueprint v1.0) references people and communities on six separate occasions in connection with convening, input, testing, co-producing, evaluation, co-design, deliberative dialogue, and fulfilling statutory duties, will future chief exec and directors' reports a) either be written in a way understandable by the generality of BOB residents or at minimum have a plain language summary, and b) include a paragraph describing public/community engagement activities undertaken in the previous two months, and c) be published on the BOB ICB website as a news item not tucked away under 'board papers'? *Questions submitted by Mike Etkind*
Response	Thank you for your suggestion. We strive to use plain language in our communications and recognise the importance of having board papers that are accessible to people. As part of our statutory responsibilities Board papers are filed in one accessible location on our website clearly marked and not under the news section. We appreciate your input and will incorporate more public involvement activities into the Chief Executive & Director's reports moving forward.

No. 3 (Item 10)	In relation to item 10 of the agenda: What is the basis for the South East England ICBs CEO Joint Committee determining that it is not subject to the Public Bodies (Admissions to Meetings) Act 1960, given that an integrated care board established under section 14Z25 of the National Health Service Act 2006 is listed in the Schedule to the 1960 Act, and the Committee's terms of reference describe it as the collective governance vehicle for joint decision-making by the ICB Partners? *Question submitted by Mike Etkind*
Response	The Joint Committee itself is not a statutory body but rather a collaborative governance mechanism formed under delegated authority from the constituent ICBs. The Committee operates as a forum for Chief Executive Officers of the six ICBs to collectively discuss and agree on strategic priorities that span across their respective systems. The Joint Committee is committed to transparency and public accountability. Decisions made within the scope of the delegated authority from the ICB Boards will be reported back to those Boards and made available through standard governance processes. This approach balances the need for effective, strategic collaboration at the executive level with the principles of openness and accountability that underpin public service governance.

No. 4 (Item 11)	In relation to item 11 of the agenda: What/where are the six neighbourhoods defined in Buckinghamshire? What engagement was undertaken with local people and communities in designating the neighbourhoods? Will details of the neighbourhoods be published on the Buckinghamshire Place page of the BOB ICB website together with their role and function? *Question submitted by Mike Etkind*
Response	In considering these questions, it's important to note that the neighbourhoods are not something that NHSE or the ICB has prescribed from the top down but are local collaborations evolving over time as their purpose and function is developed and refined. Most of the neighbourhood projects underway in BOB to date have been based around Primary Care Networks and therefore reflect general practice population boundaries, although this may evolve as the next stage of neighbourhood development increasingly includes more community and voluntary sector, local authorities and other system partners. The current neighbourhood geographies for Bucks are shown in the linked presentation: Microsoft PowerPoint - BuckinghamshireINTmodelfeb25 The Buckinghamshire Place team have advised that two discussions on neighbourhood development have been held at the Patient Participation Steering group to seek input and ideas on how to best engage with local residents, and more of these sessions are planned. A number of neighbourhood pilots were run in 24/25 and patients and members of PPGs have reflected their positive engagement in these pilots, such as a frailty neighbourhood pilot in the north of Bucks. These are early steps and a key aim of the new Neighbourhood programme will be to develop a consistent health offer for residents within their local community context and an effective approach to local engagement and co-production, for example by using community researchers, community leaders and communities of practice as examples. Healthwatch is also working with us on this important aspect of neighbourhood development and neighbourhood development is being reviewed and discussed frequently at local authority HWBBs and HOSCs.