Hertfordshire and West Essex Integrated Care Board

Annual Report 2024/25

1 April 2024 – 31 March 2025

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PERFORMANCE REPORT

Chief Executive's summary of key performance

This year our ICB has worked ever more closely and effectively with system partners to implement care that is being delivered closer to home, to launch our Medium Term Plan to help us focus on priorities for the benefit of our population and put systems in place to support people to take control of their own health and wellbeing.

We have been more proactive than ever in delivering preventative solutions to ongoing health and care challenges across the system, with teams across the system working in innovative ways to provide the best care for patients.

Our Medium Term Plan, which was agreed this year, has guided our work and enabled us to focus on our most pressing priorities which will not only transform the care people receive, but enable us to make the efficiency savings needed to reduce the overall system deficit and become financially sustainable. Our own local plans are fully aligned with the key workstream areas that will form the national NHS 10 Year Plan, and we have been hearing from local people about their ideas as part of the national NHS Change consultation.

We welcomed the Secretary of State for Health and Social Care, Wes Streeting, to Epping in August to showcase our system's work to support people to leave hospital quickly or avoid the need to be admitted in the first place, with more people recovering in the familiar surroundings of their own homes. This is a key area of focus for everyone who works in health and social care in Hertfordshire and west Essex (HWE).

In March 2025, the Government announced that NHS England would be abolished and directed ICBs across the country to reduce running costs by 50% in the upcoming financial year. At the time of writing, we are awaiting more details about the announcements, including what this means for the future of some services and staffing. We do know that:

- NHS provider organisations including our hospital trusts which deliver health services, have also been asked to make substantial reductions in roles that are not patient-facing
- we will need to reduce our running costs, like all ICBs, within the next financial year. This means we will be reviewing our plans when we have more information about the ICB's roles and functions in the future
- the Department of Health and Social Care will be reduced by half, with half of NHS England staff being brought back into the department

As a system we have worked together to design our future operating model, which seeks to further strengthen our ambition to see true integration and alignment of our services alongside a shift from treatment to prevention. We had initially planned to delegate many current responsibilities to local health and care partnerships from April 2025, however this will be paused and reviewed when more information becomes available following the Government's announcements.

With the over 65 population in Hertfordshire and west Essex expected to grow by 23-28% over the next 15 years, and over 85s by 55%, designing appropriate healthcare within the community to meet the needs of older people and keep people living independently is a key priority for our system.

We also continue to be challenged in meeting the increasing demand for mental health and wellbeing support, particularly for children, so improving access to these services and enabling young people to return home after being inpatients at hospital are just some of the changes highlighted in this report.

Our vaccination campaigns continue to promote the benefits of immunisations to protect the most vulnerable from seasonal illnesses as well as driving the uptake of routine childhood immunisations. The new respiratory syncytial virus (RSV) vaccine, added to the schedule in 2024, helps protect older people and newborn babies who are most at risk of needing hospital treatment for breathing conditions in the winter.

Our annual report and accounts have been prepared on a going concern basis. You can read more about all of these projects, as well as our successful campaign to identify people with hidden high blood pressure, later in this report.

Dr Jane Halpin

Accountable Officer

20th June 2025

Performance Overview

This section provides an outline of the performance of NHS Hertfordshire and West Essex Integrated Care Board (ICB) from 1 April 2024 to 31 March 2025. It gives an overview of how we have commissioned services and discharged our statutory functions on behalf of the population we serve.

Our strategic approach

Our Medium Term Plan, agreed in June 2024, describes the ICB's vision for Hertfordshire and west Essex for 2024-26, our key priorities and the shifts in our care model we need to make to achieve these. It sets out where we will focus our efforts and investment in the next two years, and how we will build our operating model. This is based on the principle that decisions should be taken as closely as possible to our residents.

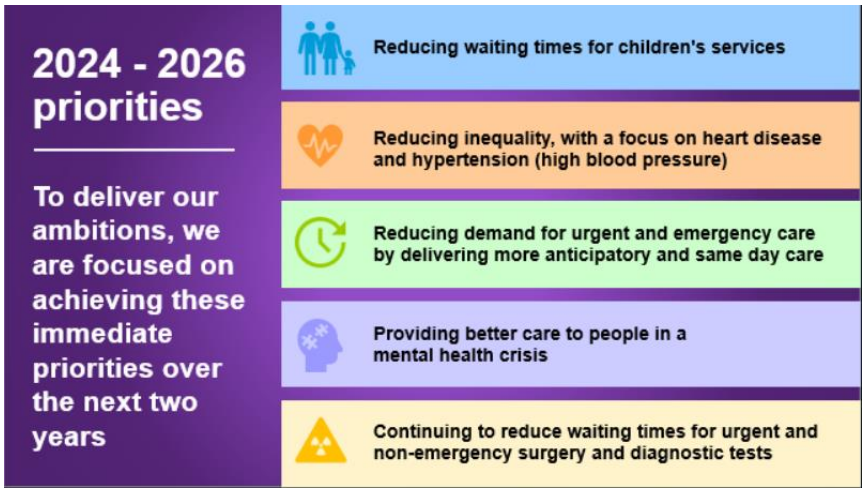
The Medium Term Plan will continue to guide the work of the organisation for the remainder of this decade. The framework sets out an ambitious set of strategic objectives for that time:

- Increase healthy life expectancy and reduce inequality
- Give every child the best start in life
- Improve access to health and care services
- Increase the number of citizens taking steps to improve their wellbeing
- Achieve a balanced position annually

Success will mean:

- Our whole system delivers high quality, fully integrated care that can be accessed easily and quickly
- No patient is treated in a hospital setting when it would have been possible for them to receive their treatment at home or in their community
- The quality of care, experience and outcomes of all Hertfordshire and west Essex residents matches the experience and outcomes of those who live in our least deprived areas, with a focus on tackling unwarranted variation across and within our Health and Care Partnership (HCP) areas
- Our system is proactive and as focused on interventions to prevent illness and reduce the risk of hospitalisation, as we are on the management of illness
- We base our strategy and decisions on evidence and what has been proven to work, with strategy designed at a system level and implemented by each HCP in a way that is tailored to the needs of residents
- We move to a sustainable financial position as a system which enables us to shift funds away from acute care and into prevention and care in home or community settings.

The Medium Term Plan also sets out the systems transformation priorities for 2024-2026:



These priorities are underpinned by a number of wider plans. Our Quality Strategy 2023- 2026 which supports the planning and delivery of the best possible joined-up and high-quality and safe services which promote equal access, positive experiences and good clinical outcomes. In addition, Integrated Care Systems (ICS) Urgent and Emergency Care Strategy (UEC) 2024-2029 sets out the approach to urgent and emergency care transformation, aligning to the national UEC recovery delivery plan and performance improvement requirements, and our local strategies and priorities are tailored to the needs of our population.

.Read more about our plans, strategies and priorities.

Review of 2024/2025

Vaccinations

The NHS vaccination programme extended in 2024 to protect more people from a common winter virus.

In addition, Vaccination teams from Hertfordshire Community NHS Trust have worked closely with maternity staff to make it as easy as possible for women to get all the maternal vaccinations.

So far, more than 29,000 eligible older people have received their respiratory syncytial virus (RSV) vaccine - a good start to a long-term programme of protection.

Our COVID vaccination programme continued during spring and autumn. While overall uptake continues to decline, our vaccination teams continue to focus on reversing this trend, particularly amongst people with pre-existing health conditions.

Flu vaccination uptake in those aged 65 and older was similar to last year at 78% which is encouraging. However, we have more work to do with patients who are clinically at-risk and those with severe learning disabilities where the uptake is lower. GP practices undertook extra vaccination reviews during our winter campaign which saw 41,200 additional winter vaccinations given.

Winter

Levels of flu, COVID, winter vomiting bugs and respiratory illnesses put an extraordinary level of pressure on our hospitals during what is already a challenging time for the NHS.

Encouragingly, collaboration between the ICB and partners has strengthened further in the last year and day-to-day management of system pressures has supported efforts to manage pinch points as smoothly and efficiently as possible. Our 'System Co-ordination Centre' continues to operate well to support trusts and provide mutual support.

NHS Change

ICB colleagues have been gathering the views of staff, patients and the public to support the government's NHS Change campaign to develop a 10 Year health Plan.

It's encouraging to see people give their time to share their views on what is working and what can be improved to feed into national plans for our healthcare system. As part of this one-in-a-generation opportunity, we held focus groups with staff, patients, our Youth Council and stakeholders. We look forward to seeing the outcome of the work later in 2025.

Cancer

While teams are working hard to keep improving cancer waiting lists and ensure people are treated as quickly as possible, we are also looking ahead in 2025 to NHS England's public consultation for the Mount Vernon Cancer Centre in Hillingdon, which serves patients across Hertfordshire, parts of north and central London, Bedfordshire, Buckinghamshire and East Berkshire.

The non-surgical specialist cancer centre has an excellent reputation, and its staff – employed by East and North Hertfordshire NHS Trust - are highly regarded. However, the extensive renovation and maintenance needed on the buildings they work from makes it challenging for them to deliver excellent care.

The consultation is expected to recommend that services are relocated to a brand new facility at the Watford General Hospital site, with satellite radiotherapy services in either Stevenage or Luton. Our teams will be supporting this consultation process to ensure patient views are taken into account.

Children and young people

There are escalating mental health issues among children and young people and reducing waiting times is one of our pressing strategic priorities

There is a significant backlog for some services, with waiting times for some community paediatric services over 150 weeks in some places. To help meet these needs we have increased children and young people's mental health access by 44% year on year, and increased support in early help by 54%.

A new Neurodiversity Support Offer for children and young people in Hertfordshire has been successfully rolled out – comprising courses and workshops to support young people with a

diagnosis of Autism and/or ADHD and their families and carers. Courses are now live with good take-up and feedback from providers and people accessing the courses being generally positive.

Mental Health Support Teams in schools have been expanded with over 40% of schools in west Essex and Hertfordshire now covered.

To support teenagers who have been mental health inpatients to return home to their families, we have opened a new residential children's home, Cherry Trees, which provides placements for 12–17-year-olds recovering from health crises. This has reduced the number of young people who have to be placed out of county, which is good for them and their families. The therapeutic environment has improved outcomes for young people, helping to prepare them for life back at home.

In the last year we have continued to build on improvements we put in place for services for children with Special Educational Needs and Disabilities in Hertfordshire after an Ofsted and CQC inspection of services carried out in 2023 found the services, offered by the NHS and Hertfordshire County Council, generally required improvement.

We have already improved the information available to support education, health and social care practitioners to help children and families. In Essex, new pathways for neurodevelopmental disorders have been developed to provide parents with information, advice, and guidance, training (pathways and referral), diagnostic pathways, pre and post assessment support and work to provide a positive experience for families.

Hypertension

In May 2024, we launched one of our biggest campaigns of the year to encourage more people to check their blood pressure, particularly those over 40, even if they feel well.
More than 200 pharmacies across Hertfordshire and west Essex provide free checks and we are pleased that currently more than 5,000 people each month are now having their blood pressure checked.

Reducing waiting times for tests and surgery

Our Community Diagnostic Centre programme (CDC) is improving the availability of diagnostic tests, cutting waiting lists and making it easier to pick up illnesses earlier, when treatment can be more effective.

We have CDCs in Welwyn Garden City, St Albans, Hemel Hempstead and Bishop's Stortford. We were awarded NHS England funding to develop a new community diagnostic centre 'hub' covering Epping, which is due to open later in 2025, and to enhance the types and numbers of tests and treatments in Bishop's Stortford.

These one-stop-shop centres offer checks, scans and tests in one place, rapidly assessing patients identified to be at risk of an illness or condition, including suspected cancer.

We anticipate the new surgical centre at St Albans City Hospital, will open later in 2025 and will cut waiting lists for elective surgery for patients.

This is a collaborative venture between our ICB and our three local NHS hospital trusts whose surgical teams will carry out operations there. Patients waiting for operations at each of these trusts will be offered the choice of having their treatment at the surgical centre.

It will provide non-complex orthopaedic, hip and knee surgery, spinal injections and ear, nose and throat (ENT) procedures for around 4,400 patients per year, from across our area and be open six days a week. We are working with patient representatives from across our area to ensure that we make the surgical centre as accessible as possible for people.

Infrastructure projects

New Hospitals Programme review outcome and new timetable

We welcomed the government's revised timetable for the New Hospitals Programme in January 2025. While it is disappointing our hospitals are not included in wave 1 of the programme, it is positive that they will be next in line to begin construction.

The Department of Health and Social Care announced that new hospitals in Watford and in Harlow can begin building work between 2032 and 2034. Our trusts will continue to develop their plans and engage with stakeholders to fit that timetable.

Hemel Health Campus

The ICB and other local NHS organisations, along with Dacorum Borough Council continues work on developing a health campus in Hemel Hempstead to provide hospital, community and primary care services to support patients in a holistic way.

Options being developed include the proposed relocation of services currently provided at Hemel Hempstead hospital to a new town centre health campus as part of a regeneration plan for the Market Square area.

A strategic outline case, which will be completed by the end of 2025, will evaluate options for the location of the health campus and which services will be provided there. These will be shared with local people as part of a public engagement process.

Risks

While our system works hard to deliver good quality services and a positive patient experience, there are some areas of challenge in which we need to improve. Some of these challenges pose risks to our service delivery and patient experience and can impact on how and when we meet our objectives.

All our risks are logged, monitored and updated on a regular basis, including any mitigating actions we can take, and the most significant are logged onto our Corporate Risk Register. These are subject to routine review by our Executive team and committees. All our risks are aligned to our organisational objectives and range from financial risks to risk of patient safety. These include:

- An ongoing risk to patient outcomes if urgent and emergency care performance does not meet national standards. Our ICB is keen to encourage our population to take proactive steps for their own health and wellbeing and to encourage people to use the right health service for their needs and delays to assessment and treatment could impact on this. We work closely with our system resilience group to ensure delays and challenges in urgent and emergency care are monitored and addressed, with daily

system calls, weekly place based meetings and fortnightly performance meetings set up to identify issues before they arise.

- We have been making significant savings for the last two years and it's vital we continue to ensure we can deliver on our ambitions for community-based care, digital infrastructure and not undermine public trust. We have put in place several measures to ensure we maintain our efficiencies where we can, particularly in light of the latest requirement to make additional savings of 50% to ICB running costs. The measures include a triple lock framework, income and expenditure reporting, reports to the Executive team and relevant ICB boards.
- 2024-25 saw a significant amount of industrial action across the NHS which impacted on our providers' plans to reduce waiting lists for planned care and on their daily operational performance. Prolonged industrial action poses a substantial risk to the continuity of care, patient safety and equitable access to services. Our partnerships with providers and the voluntary sector has allowed for some of these risks to be mitigated, including frequent SITREP arrangements, business continuity plans, incident report plans and an on call system to manage out of hours issues.
- Our GP practices are delivering more appointments than before the pandemic, however demand has significantly increased. This could limit their ability to deliver on key transformation objectives that impacts on patient experience. In addition, workforce shortages prevent patients from being able to access services in a meaningful way. Sustained pressure in general practice may limit our ability to deliver on key transformation objectives and risks suboptimal patient experience. While multiple initiatives, including the Primary Care Access Recovery Plan, have been launched, ongoing workforce shortages and increased service demand present barriers to improving population access and outcomes. Additional funding was provided to PCNs to support them during junior doctor industrial action and there was further support for the implementation of Modern General Practice.

Performance analysis

Summary of Performance 2024-25

Herts and West Essex ICB is responsible for the performance and oversight of NHS Services across the Integrated Care System. The following summarises our performance against key constitutional standards and commitments in the NHS Long Term Plan, Operational Plan and Oversight Framework. You can read about the ICB structure on page 9 of the ICB Governance Handbook.

Primary care

The national planning guidance for 2024/25 outlined the expectation that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need.

The number of attended GP appointments increased by 4.7% in 2024/25 compared to 2023/24. In 2024/25, 67.8% of appointments booked were face-to-face, which is drop of 1.9 percentage points compared to 2023/24. 88.4% of appointments were booked within 14 days of the patient contacting their surgery. This was an increase of 1.8 percentage points compared to 2023/24.

Primary Care	Q1 (000s)	Q2 (000s)	Q3 (000s)	Q4 (000s)	2023/24 (000s)	2022/23 (000s)
Number of GP appointments attended	1,968	1,957	2,202	2,128	8,256	7,886
Proportion of Face-to-Face appointments	67.6%	67.5%	69.4%	66.8%	67.8%	69.7%
Proportion of attendances which took place within 14 days of booking (IIF ACC-08 definition1)	88.1%	88.4%	88.2%	88.8%	88.4%	86.6%

1. The IIF ACC-08 definition of a GP appointment should only include appointments where the patient is hoping to get the next available appointment and excludes appointments such as planned vaccinations

Urgent 2 Hour Community Response Times

Urgent Community response services are a commitment in the NHS Long Term Plan to provide urgent care to people in their own homes if their health or wellbeing suddenly deteriorates. Services were required to reach at least 70% of patients referred to them within two hours.

In 2024/25, 82.5% of urgent community responses were reached within 2 hours. This is a 2.4 percentage point improvement compared to 2023/24. Performance has been above the 70% target for every month in 2024/25. This was despite an ongoing increase in the number of responses being provided: in 2024/25 there was a 19.4% increase in urgent community responses when compared to 2023/24

Urgent 2 Hour Community Response	Target	Q1	Q2	Q3	Q4	2024/25	2023/24
To reach patients within 2 hours	70%	84.4%	84.8%	81.4%	79.9%	82.5%	80.1%

UEC

The national requirement for 2024/25 was that 78% of patients attending A&E are treated, admitted or transferred within 4 hours of arrival. In March 2025, Hertfordshire and West Essex ICS achieved 77.1% against the 4 hour standard.

Across the whole of 2024/25, system level performance against the four-hour standard was 73.4%. This is an improvement of 6.8 percentage points compared to 2023/24. This improvement was achieved despite a 3.5% increase in ED attendances in 2024/25.

The reasons for this target not being met are multi factorial and relate to rising emergency admissions, high bed occupancy and staffing pressures. The system is working together to improve areas of challenge through focus on working together to improve flow.

A&E	Target	Q1	Q2	Q3	Q4	2024/25	2023/24
Treated / Admitted / Transferred in under 4 Hours	78%	73.8%	75.7%	70.1%	74.3%	73.4%	67.6%

Ambulance Response Times

Response times to ambulance calls are measured on the time it takes from receiving a 999 call to a vehicle arriving at the patient's location. There are four categories of call with associated required response time targets:

- **C1** People with life threatening injuries and illness (target mean response time of 7 minutes)
- **C2** Emergency calls (target mean response time of 18 minutes)
- **C3** Urgent calls (target 90% of calls to be responded to within 120 minutes)
- **C4** Less urgent calls (target 90% of calls to be responded to within 180 minutes)

All four of the response time targets were not met in 2024/25 plus the interim C2 target of 30 minutes was not met. Furthermore, over the whole of 2024/25, responses times were longer across all four categories when compared to 2023/24. However, following increases in capacity and reductions in hospital handover delays, there was a significant improvement in ambulance response times during Q4 of 2024/25 with March 2025 being the best month of the year for all four response time targets.

System working and improved handover times have contributed to improvement through each of the categories of ambulance response and there is continued focus for 2025/26 to reach the target. Further staff and resource productivity actions are also in place and within the remit of the East of England Ambulance Service.

EEAST Ambulance Response	Target	Q1	Q2	Q3	Q4	2024/25	2023/24
C1 People with life threatening injuries and illness (mean)	Mean <7 minutes	09:29	09:35	10:25	09:02	09:38	09:13

C2 Emergency calls (mean)	Mean <18 minutes	47:21	45:58	66:17	40:48	50:17	48:39
C3 Urgent calls (90th centile)	90th centile <120 minutes	399:54	421:28	653:52	315:06	429:50	348:51
C4 Less urgent calls (90th centile)	90th centile <180 minutes	662:31	629:38	775:47	489:47	656:31	670:03

Elective

Under the NHS Constitution the performance standard is that 92% of patients on an incomplete elective pathway should be seen within 18 weeks. In response to COVID-19, routine elective treatments were stood down at peak times throughout 2020/21 and 2021/22 which caused an increase to numbers on elective waiting lists and the length of time to treatment. To aid recovery during 2024/25 a performance target was set such that no patient should have been waiting longer than 65 weeks (with the exception of patient choice) by December 2024.

Referral to treatment (RTT) breaches showed improvement throughout 2024/25. One of the main focusses of 24/25 was to reduce 65 week waits to zero, hence the large shift in Q1. Focus on seeing the long wait patients plus validation helped to improve the long wait lists, with Q4 showing 43 patients breaching 65 week waits which was due to the insufficient capacity, patient choice and the complexity of cases. Although the target to eliminate those waiting longer than 65 weeks was not met, there was significant improvement. There are weekly returns to monitor the long waits and there will continue to be focus on reducing patient long waits.

Patients waiting less than 18 weeks for treatment improved in 2024/25 reaching 55.68% across the year which is an improvement of 4 percentage points compared to 2023/24. Recovery is underway with the goal in the operating plan to reach the constitutional of 92% target by 2029.

RTT Waiting Times		Target	Q1	Q2	Q3	Q4	2024/25	2023/24
65 Weeks*	Number of patients breaching 65 week wait	**0**	1307	235	95	43	43	1127
18 Weeks	Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	**92%**	55.7%	55.7%	55.3%	56.0%	55.6%	51.6%

*Data shows snapshot of each quarter and the year-end final figure.

Waiting times for cancer treatment

Following the cancer waiting times (CWT) standards modernisation in October 2023 there are three standards:

- 28-day faster diagnosis standard (FDS)
- 31-day decision to treat to treatment standard

- 62-day referral to treatment standard

All three cancer waiting times targets improved across the system in 2024/25 with the FDS performance reaching 78.3% overall which is an improvement of 3.8 percentage points on 2023/24 and above the 77% target.

The 31 day standard reached an overall 95.8% which is a 2.3 percentage point improvement on the previous year but marginally missed the 96% constitutional standard.

The 62 day standard reached 74.6% in 2024/25, which surpassed the 70% recovery target, with the constitutional target of 85% target. There is also a 5 percentage point improvement on 2023/24.

Cancer performance is monitored at the ICB Cancer Delivery Group, the Health and Care Partnership Boards, the ICB System Transformation and Quality Improvement Committee and ICB Board.

Cancer Waiting Times	Target	Q1	Q2	Q3	Q4	2024/25	2023/24
28 day Faster Diagnosis Standard (FDS)	**77%**	78.0%	79.7%	78.6%	76.8%	78.3%	74.50%
31 day Decision to treat to treatment standard	**96%**	95.0%	96.0%	96.5%	95.9%	95.8%	93.05%
62 day referral to treatment standard	**85% (70% recovery target)**	71.8%	73.5%	78.3%	75.0%	74.6%	69.58%

Diagnostics

Under the NHS Constitution there is a performance standard related to patients access to diagnostic testing with 99% of tests are undertaken less than 6 weeks from request. In response to COVID-19, routine diagnostics were stood down at peak times throughout 2020/21 and 2021/22 which caused an increase to numbers on diagnostic waiting lists and the length of time to access diagnostics. To aid recovery, the 2024-25 operational planning guidance included a target to reach 95% by March 2026.

Diagnostics has been an area of challenge in 2024/25 and performance was 4 percentage lower than 2023/24. The main area of challenge is audiology. If audiology is excluded, then DM01 performance across the system has improved from 67.3% in March 2024 to 79.5% in March 2025.

Diagnostic Waiting Times		Target	Q1	Q2	Q3	Q4	2024/25	2023/24
6 Weeks	Percentage of patients whose diagnostic test is undertaken less than 6 weeks from request	95%	67.4%	62.2%	64.9%	69.0%	65.9%	69.8%

Mental Health Services

The NHS Long Term Plan sets out a national ambition to eliminate inappropriate out of area placements for acute mental health inpatient care; an 'out of area placement' happens when a person is admitted to a unit that does not form part of the usual local network of services.

Mental Health Services		Target	Q1	Q2	Q3	Q4	2024/25	2023/24
Acute MH Inpatient Care	Number of people in an out of area inappropriate placement*	**0**	100	121	91	112	112	309

*Patients could bridge the quarter if they are an inpatient over more than one quarter

Learning Disability Services

The NHS Oversight Framework monitors two areas of Learning Disability Services:

- Number of inpatients with a learning disability or who are autistic per 1million head of population
- The proportion of people aged 14 and over with a learning disability on the GP register receiving an annual health check

Our Learning Disability programme is about making health and care services better so that more people with a learning disability, autism or both can live in the community, with the right support and close to home.

Health checks for people with learning disabilities achieved the 75% standard and showed an improvement on last year's position.

Mental Health

Demand for mental health support in our area continues to grow. There is a high demand for inpatient beds which means that some services users are admitted into out of area placements, and sometimes inpatients are not discharged as promptly as they could, because of the need for more for community-based support.

Supporting patients in Mental Health crisis is a key priority of our Medium Term Plan. One example of the impact of our focus in this area is the over 500 people who have transferred from emergency departments in the system, to our Mental Health Crisis centre since it opened in 2024.

We are proud that our end of year performance for annual health checks for people with learning disabilities shows that the ICB has exceeded the national 75% target for the second year running at 81.7%, the highest performing in the East of England region and exceeding the national average of 77.6%.

Against a background of growing demand, we are committed to improving access to services for people with Autism and attention deficit hyperactivity disorder (ADHD).

Mental Health Investment Standard

A very important requirement in the 2024/25 planning guidance related to the Mental Health Investment Standard (MHIS), under which all ICBs were required to increase their spending on mental health services by at least the percentage increase in the ICB's programme allocation growth. In 2024/25 the ICB's Mental Health Investment Standard growth target was 6.67%. Spending on Learning Disability and Dementia services is currently excluded from the Mental Health Investment Standard calculation.

Achievement of the Mental Health Investment Standard is measured by comparing expenditure in 2023/24 to that in 2024/25, after adjustment of all non-recurrent allocations received by the ICB in either of these years. These adjustments are made to ensure that changes in spending are not skewed by non-recurrent allocations and are limited to reviewing spending funded from the ICB general allocation.

ICBs are required to calculate if their spending met the Mental Health Investment Standard and to publish a formal declaration on this, i.e. whether in 2024/25 Hertfordshire and West Essex ICB spending on mental health services increased by at least 6.67%.

The table below provides the ICB's calculations demonstrating that in 2024/25 Hertfordshire and West Essex ICB did meet the requirements of the Mental Health Investment Standard.

Description	£000 unless stated otherwise
2024/25 Mental health spending	355,827
Less spending on Learning disability and dementia	(80,038)
Less spending covered by allocations received	(28,903)
2024/25 spending funded by general allocation	246,886
2023/24 spending funded by general allocation	231,098
Increase in spending	15,788
Increase in spending (%)	6.8%
Has the Mental Health Investment Standard been met?	**Yes**

Primary Care – general practice, pharmaceutical services, dental services, optometry services

During 2024/25 we've continued our work to improve patients' access to primary care services and have shared progress with the ICB Primary Care Transformation Committee.

General practice - We continue to seek to improve the access and experience of primary care for our residents.

Online access, which empowers patients to take control of their care, is an important part this. Our GP practices have fully enabled access to patient records for 730,000 (84%) patients. Numbers of patients accessing the NHS app has risen by 73%, using it for things like ordering

repeat prescriptions. Hertfordshire and west Essex also has some of the highest average online consultation rates in England with around 80 to 90 submissions per 1,000 patients – although there are big variations between practices.

GP practice websites are an important way for patients to access care and support. During 2024 we audited GP websites against national guidelines and shared the results with practices to help them improve patient experience.

It's important that patients have a good experience when they contact their practice by telephone, and all now have cloud-based telephony. 98 out of 125 practices have advanced telephone systems with call-back, call queuing and enhanced reporting so practices can staff lines more effectively during busy periods. The ICB is evaluating options for bringing all practices these advanced standards.

Multi-professional primary care teams are now part of everyday practice and staff can now support patients to see the most appropriate professional for their needs. This includes directing patients to a pharmacy or another service in the community, where appropriate.

We recognise the particular support needs of people serving in HM Armed Forces, reservists, veterans and their families. During 2024/25 we met the national target of having at least one veteran friendly accredited GP practice per Primary Care Network (PCN) in our area, ensuring trained support.

In November 2024, we held the second annual 'Celebrating Primary Care Achievements' awards were held, showcasing a wealth of different NHS primary care service across HWE. 65 nominations were received, highlighting projects, teams and individuals across nine categories.

We have continued to work with our three main acute trusts to improve the interface between primary and secondary care for our patients. All trusts have self-assessed themselves against key points in the recovery plan: onward referrals; fit notes; discharge summaries; call and recall; and clear points of contact.

Primary care teams have worked also with hospital trusts to support patients to return to their own homes as soon as possible through the Discharge to Assess (DTA) programme, helping patients get home and stay well at home.

Key risks to the ongoing achievement of our goals in improving access include the sustained high demand for primary care services and workforce pressures in general practice which can impact on the time available for transformation projects and new ways of working. The ICB is seeking to mitigate this through deployment of national and local resources to support practice to implement Modern General Practice model such as identifying those practices who will benefit from the Support Level Framework offer or local digital transformation workshops. We are also working with practices and Local Professional Committees to review our local commissioned services to reduce bureaucracy and better reflect the time and resources required to deliver high quality services. In addition, the introduction of GPs as part of the national Additional Roles Reimbursement (ARRS) scheme from October 2024 and continuing in 2025/26 has had a positive impact also with many Primary Care Networks taking up this new funding stream for additional GPs.

Pharmaceutical Services

At the end of January 2025 98% of all community pharmacies in our area had registered to provide Pharmacy First, ensuring our patients receive quick and easy care for minor ailments under the programme's seven clinical pathways. The ICB has supported the roll out of Pharmacy First with resources for clinicians and training webinars for practices. The national operating report showed that between August and December 2024 Hertfordshire and west Essex had the highest percentage of Pharmacy First referrals from GP practices in the East of England.

This endeavour will be supported by sixteen newly appointed Community Pharmacy PCN Engagement Leads who will also collaboratively work with general practice and community pharmacy to support better public awareness of pharmacy services.

Community Pharmacy has raised through national and local conversations the increasing pressures on workforce and growing costs. The ICB is working with the local professional committees and through the Community Pharmacy PCN engagement leads to mitigate this through successful implementation of the 25/26 contract framework agreement, promoting take up of the new services to improve patient access and increase revenue streams to Community Pharmacy.

Dental services

We have focused on improving access to NHS dental services by increasing appointments and working with local authority public health services to improve children and young people's oral health. This work will continue in the coming year.

Thanks to the New Patient Premium Scheme, since 1 March 2024 we have provided NHS dental appointments for 99,212 patients who had been unable to see a dentist in the last two years. We have recruited one dentist under the "Golden Hello" Dental Recruitment Incentive Scheme which requires a three-year commitment to staying in post. We continue to identify other opportunities to support dental practice recruitment processes where eligible. During 2025/26 we will work to enhance the dental skillset with the skills mix through our Primary Care Workforce training hub.

In December 2023 we launched a dental enhanced access pilot to offer patients urgent appointments seven days a week during core and out-of-hours (including bank holidays) for patients referred via NHS111. Where needed the service offers patients follow-up appointments to stabilise their oral health. Up to the end of March 2025, the enhanced service provided an additional 11,474 patient appointments. The service has had positive feedback from patients and from local Healthwatch organisations who have seen fewer concerns raised about access to urgent dental care. The pilot has been extended until March 2026.

We have also continued to develop special care dental services. This includes a dental domiciliary screening pilot across a number of care homes in Hertfordshire, commissioned by the ICB and led by Hertfordshire Community NHS Trust and the development of a nurse-led anxiety management pathway for children. This uses therapy techniques to support children with extreme anxiety to see a dentist in their family practice without the need for general anaesthetic which would require attendance at a specialist clinic.

The ICB, in conjunction with the Local Authority Public Health teams, restarted the Oral Health Alliance Group. The group is taking forward various initiatives to improve the oral health of children and young people with a particular focus on the most deprived communities. These include pop up dental clinics in children's centres, dental screening in primary schools and

supervised toothbrushing schemes for two- to-five-year-olds. During 2025/26 the group will work to implement child-focused dental practices.

Dental services also continue to see high demand from patients, while delivery of dental appointments in HWE ICB in 24/25 rose considerably, this was due in part to the New Patient Premium which does not continue in 25/26 and may present a risk to delivery at the same level this year. However, we are working to mitigate this through robust contract management, moving activity from persistently underperforming contracts to areas of high need.

Optometry Services

We have put in place the General Ophthalmic Additional Services Contract, of which there are 28 in our area, that provides mobile services for patients who cannot attend Ophthalmic Services premises. Optometry Services are stable in HWE ICB, with no known gaps in provision. The ICB has good engagement with our Local Optometry Committees and will continue to scope possible project for new services from this contractor group such as the current Hypertension pilot. There are no known risks identified.

Children and Young People (CYP) safeguarding

Safeguarding remains a fundamental part of the ICB commissioning, assurances, and the contractual process. HWEICB has robust governance and accountability arrangements in place which ensure that safeguarding is core business and that the ICB continues to meet its statutory duties and is consistent with the priorities set out in the NHS England Safeguarding and Accountability framework 2024; Care Act 2014; the Mental Capacity Act 2005; Children Act 1989/2004 and the Domestic Abuse Act 2021.

The ICB designated professionals for adult and children are part of the safeguarding regional and national networks including Children in Care (CIC) and the Child Death Overview Process (CDOP)networks which promote leadership and influence innovative change nationally, across the regions, ICS and ICBs. The functions of the safeguarding team are embedded within the ICB strategic priorities. The key activities within the safeguarding partnership arrangements include work on the following priorities.

- Babies, children, and young people are given the best start in life. This is delivered across the lifespan through the Family Safeguarding arrangements, Child Death Review process, CIC and maternity safeguarding arrangements.
- Lessons learnt from statutory and local reviews, audits and safeguarding scrutiny promoted a culture of change, practice improvement, and improve safeguarding outcomes for the population.
- Strengthening the transitioning adulthood arrangements for CIC and Care experienced and took steps to address the impact of trauma and adverse childhood experiences at all ages.
- Tackled inequalities linked to abuse, neglect, child deaths, Violence Against Women and Girls and victims of serious crimes.
- Promoted the welfare of Adults at Risk, strengthened the implementation of the Mental Capacity Act 2005 and the safeguarding arrangements for adults with complex health needs.

Safeguarding Duties and Responsibilities

The safeguarding team advised and supported the ICB executive and Board members and provided regular update and assurances through the internal governance arrangements.

Prioritising the voice and lived experiences of vulnerable children, young people and Adults at Risk and hearing their journey through health service delivery is a key element of the regular ICB commissioning and Provider engagement in all aspect of safeguarding assurance activities and was used to inform and change practice.

ICB's Health Providers' assurance submissions are used to inform commissioning arrangements. The Assurances are also part of the focus in ensuring that services are discharged having regard to the need to safeguard and promote the welfare of children and Adults at Risk of harm and abuse. The assurance framework within safeguarding acknowledges the new guidance set out in the Intercollegiate documents for adults, children and CIC and in ensuring that safeguarding supervision arrangements across all ages are robust and strengthened through the new publication of Adult Safeguarding: Role and Competencies for Health Care staff 2024. There will be further work in the coming year to ensure that the principles set out in the Mental Capacity Act 2005 are robust including the arrangements for Deprivation of Liberty Safeguards within community settings and its application to young people.

. Please see the most recent statutory safeguarding partnerships annual reports below.

Children

- ESCB: ESCB-annual-report-2023-2024.pdf
- HSCP: HSCP annual-report-2023-24.pdf

Adult.

- HSAB: HSAB-annual-report-23-24.pdf
- ESAB: ESAB annual_report_2023.pdf

Child Protection-Information Sharing

The safeguarding team led on the preparation for the launch of phase 2 of The Child Protection-Information Sharing (CP-IS) programme assists information sharing between the local authority and health. CP-IS identifies and safeguards unborn babies and children who are subject to a local authority Child Protection Plan when attending unscheduled healthcare settings across England. Throughout the reporting year NHS England progressed the delivery of phase 2 of the CP-IS, which included the expansion of the current service into the following health care settings:

• primary care: general practice
• mental health: child and adolescent mental health services
• sexual health: sexual assault referral centres
• sexual health: termination of pregnancy services
• 0-19 services: school nursing and health visitors
• community paediatrics: planned and direct access to wards
• dentistry: emergency and routine appointments

HWEICB NHS Providers alongside the guidance of NHSE are now awaiting the launch of phase 2 in March 2025. Work is underway to ensure that Standard Operational Procedures for CP-IS and the general data protection arrangements are robust. National Data Protection Impact

Assessment for local adaptation is still unavailable, delaying IG framework completion. (A DPIA (Data Protection Impact Assessment) is a structured process required under the UK GDPR (General Data Protection Regulation) for assessing and mitigating risks to personal data processing. It is essential when processing data that could result in a high risk to the rights and freedoms of individuals.

In the context of CP-IS, a DPIA ensures compliance with data protection laws while safeguarding sensitive child protection data.) NHS England Digital team continue to support the preparation for this launch in March 2025.

Child Protection-Information Sharing Service

Violence Against Women and Girls

The safeguarding team at all levels supported the multiagency arrangements for tackling health and social inequalities that are linked to Violence Against Women and Girls via the Community Safety Partnership arrangements. These include strengthening commissioning arrangements, expert advice at all levels and the strategic directions within Southend Essex and Thurrock Domestic Abuse Board (SETDAB) and Hertfordshire Violence Against Women and Girls Partnership and Executive Board.

In October 2024, a Joint Targeted Area Inspection (JTAI) on domestic abuse in Hertfordshire highlighted good practice across the systems and made key recommendations within the multiagency arrangements to strengthen areas of practice for children who are victims of domestic abuse.

Children in Care and Care Experienced

Designated Professional for Children in Care in west Essex and Hertfordshire place base, supported the planning, learning and action plans from reviews with their expert knowledge of health for CIC and Care Experienced.

Hertfordshire was successful in becoming a pathfinder for supporting Care Experienced and CIC in the Care Leavers Deed of Covenant. The Covenant is crucial in addressing health and social inequalities for this cohort of young people in accessing employment, education, and successful transition to adulthood. The designated professionals also played a critical role in supporting CIC to access timely dental care and treatment through specialist contractual arrangements with dental services.

Separated Migrant Children (SMC)

SMC are accommodated by the local authority and their health needs are addressed as part of the statutory reviews for Initial and Review health assessments.

The number of SMC remained stable when compared to the number of adult undocumented migrants to the UK. However, the age range tend to be older children and or young adults. This has implication due to their health needs and Transition to adulthood arrangements which are linked to the traumatic experience of their journey and prior experiences.

Child Death

Designated professionals supported the Child Death Review process and subsequent public health campaigns to bring about change in practice, promote greater awareness of preventable

sudden unexpected infant deaths. We have strengthened the supported arrangements for bereaved siblings and parents and raised awareness about bed poverty and implemented a new strategic Child death process in Hertfordshire.

Hertfordshire and West Essex Local Maternity and Neonatal System (LMNS)

Vision

To ensure every mother, baby, and family in Hertfordshire and West Essex receives safe, personalised, and high-quality maternity and neonatal care, fostering the best possible start in life.

National Drivers and Deliverables

Three-year delivery plan for maternity and neonatal services

The Three-Year Delivery Plan for Maternity and Neonatal Services, published in March 2023, aims to enhance the safety, personalisation, and equity of care for women, babies, and families. The plan focuses on four key themes:

1. Listening to and working with women and families, with compassion
2. Growing, retaining, and supporting the workforce
3. Developing and sustaining a culture of safety, learning, and support
4. Establishing standards and structures for safer, more personalised, and equitable care

The Hertfordshire and West Essex LMNS is actively implementing these requirements. Initially in 2023/24, we developed SMART (Specific, Measurable, Achievable,cns Relevant, Time-Bound) actions to ensure progress and identify areas needing targeted focus. This collaborative effort with providers has progressed during 2024/25 and will continue into 2025/26, aligning with the latest NHS priorities and operational planning guidance.

Neonatal

The National Neonatal Critical Care Transformation (NCCR) Review 4-year project completed in December 2024 and the neonatal workstreams now move to sustainability, still embracing and further embedding the overarching actions of NCCR, safety, quality and improvement and keeping mothers and babies together when it is clinically safe to do so.

Quality improvement and transformation has been at the forefront of the neonatal work and the engagement and stakeholder support of the work, across the three acute Trusts has made the improvements for babies and families possible.

The systems neonatal workstreams work closely with regional and national teams and drivers ensuring new and evolving actions for ongoing safe care are interfaced to our HWE services.

Working with People and Communities

The Three-year delivery plan for maternity and neonatal services recognises that listening and responding to all women and families is an essential part of safe and high-quality care. Listening to women and families with compassion improves the safety and experience of those using maternity and neonatal services and helps address health inequalities.

In conjunction with the Maternity and Neonatal Voices Partnership Guidance (NHS England 2023) the LMNS have: Transitioned from Maternity Voices Partnerships (MVPs) to Maternity & Neonatal Voices Partnerships (MNVPs). A gap analysis of current service provision was undertaken against the guidance which informed our programme of work in this area to be delivered as part of Clinical Negligence Scheme for Trusts (CNST, Maternity Incentive Scheme) compliance. To meet the deliverables contained within the MNVP guidance and CNST, the ICB successfully appointed six Maternity and Neonatal Service leads to work with service users across the system ensuring that we show clear commitment to coproduction, service user participation and reaching out to those seldomly heard from. This will support the LMNS to achieve the deliverables set out in the Three-Year plan, and in turn improve quality and safety outcomes for families as strongly evidenced. The development of our MNVP and the progression of programmes supported by them are underpinned through governance structures and the Perinatal Quality Oversight model.

Saving Babies Lives Care Bundle

The Hertfordshire and West Essex LMNS has made significant progress in implementing the Saving Babies Lives Care Bundle Version Three, achieving compliance in line with the Maternity Incentive Scheme Year 6 requirements. Key actions to embed and sustain robust assurance, improvement, and governance measures include:

- Policy and Procedure Development: Comprehensive procedures to ensure adherence to the Saving Babies Lives Care Bundle. This includes detailed guidelines on reducing smoking in pregnancy, fetal growth surveillance, and managing pre-existing diabetes in pregnancy.
- Training and Education: Continuous training programs have been implemented for healthcare professionals to ensure they are well-versed in the latest best practices and guidelines. This includes training on the use of digital tools for fetal growth assessment and the Maternal Early Warning Score (MEWS)
- Monitoring and Evaluation: Regular audits and evaluations are conducted to monitor compliance with the care bundle. This helps identify areas for improvement and ensures that best practices are consistently followed.

Future Plans:

- Enhanced Digital Integration: The LMNS plans to further integrate digital tools and platforms to improve data collection and patient record management. This will enable better tracking of patient outcomes and more efficient care delivery.
- Strengthening Workforce Support: Continued focus on growing, retaining, and supporting the workforce through targeted recruitment and retention strategies. This includes providing ongoing professional development opportunities and fostering a positive work environment.
- Collaborative Improvement Initiatives: The LMNS will continue to collaborate closely with providers and other stakeholders to implement collaborative improvement initiatives. This includes sharing best practices and learning from other regions to enhance the quality of care.
- Governance and Oversight: Strengthening governance structures to ensure robust oversight of maternity and neonatal services. This includes regular review meetings, performance monitoring, and accountability mechanisms to ensure continuolocus improvement.

Maternity Incentive Scheme Year 6

In Year 6 of the Maternity Incentive Scheme, the Hertfordshire and West Essex Local Maternity and Neonatal System (HWE LMNS) demonstrated significant progress:

- Compliance: All three trusts within HWE LMNS achieved compliance with all ten safety actions.

- Transitional Care Services: Demonstrated that they have robust transitional care services in place to minimise the separation of mothers and their babies, supporting the recommendations of the Avoiding Term Admissions into Neonatal units (ATAIN) Programme.
- Saving Babies' Lives Care Bundle: HWE LMNS was on track with the implementation of the Saving Babies' Lives Care Bundle Version Three, ensuring compliance with all elements.
- Multidisciplinary Training: Provided evidence of regular, multidisciplinary training for all staff involved in the care of women and babies, ensuring that training plans were comprehensive and up to date).
- Board-Level Safety Oversight: HWE LMNS demonstrated robust processes for providing assurance to the Board on maternity and neonatal safety and quality issues.

These efforts reflect the commitment of HWE LMNS to continuously improve maternity and neonatal safety and quality of care.

Environmental matters

The NHS launched its campaign For a Greener NHS in 2020, setting out a practical, evidence-based path to a Net Carbon Zero (NCZ) NHS. This work resulted in the publication of 'Delivering a Net Zero National Health Service'. This is underpinned by the acknowledgement that climate change itself undermines good health, exacerbating cardiovascular disease, asthma, and cancer. Tackling the issues around net carbon zero also reduce the burden of disease from air pollution, obesity, and poor diet whilst directly addressing health inequalities experienced across the country.

In response to this the ICB developed a Green Plan in collaboration with its ICS partners. Our sustainability mission statement is: The vision for a sustainable health and care system by reducing carbon emissions, protecting natural resources, preparing communities for extreme weather events and promoting healthy lifestyles and environments. The delivery of the Green Plan is overseen by a system-wide working group, chaired by an ICB Executive, and managed by a Sustainability Programme Manager. Committed to working ever more closely with the health, local authority, voluntary sector, research, and other partners through the new ICB structures to ensure sustainability is strongly integrated across all our services. This first plan covered 2022 to 2025 and the ICS partners are developing Trust level refreshed Green Plans for July 2025, which will feed into an overall ICS Green Plan which will be subsequently ratified and delivered against.

Our Green Plan provides direction and a framework for collaboration across the ICS footprint to deliver sustainable outcomes. The following ICS priority workstreams have been set up following an early review and streamlining areas of crossover:

- Estates and Adaptation
- Medicines.
- Travel and transport
- Sustainable procurement

From the ICS Green Plan we can demonstrate the following examples of progress:

- The Trusts and Local Authorities within Herts and West Essex are all working on the refresh of their green plans and are working to report against their current action plans individually and as a system, while developing those covering 2025-28.
- Trusts continue to improve their situation with regards to medical gases. No desflurane is now procured by any body within the East of England region.
- The medicines workstream continues to work towards medicine monitoring work and the improvement in use of and recycling of inhalers.
- The Sustainability Leads within the region meet fortnightly, the ICS representatives meet bi-monthly as a working group, bi-monthly with the ICB lead, and as part of the various work streams focusing on different areas.
- HWE ICS Procurement Service are working with Trusts to improve appropriate use of procurement and equipment. A piece of work, spearheaded by Essex Partnership University NHS Foundation Trust (EPUT), is looking at ways of improving the recycling and reusing NHS equipment across the system to improve use and reduce wastage.
- Trusts across HWE have been supported to access NHSE additional funding for different sustainable technologies (LED, Solar and Building Management Systems etc) and have received more than £1.5m in this financial year.
- Working closely with Council colleagues to integrate our approaches across the ICB areas, joining with our fellow ICBs in Essex, Suffolk and North East Essex (SNEE) and Mid and South Essex (MSE), as part of the Essex anchor group, and the Herts Growth Board/ Hertfordshire Climate Change and Sustainability Partnership (HCCSP).
- We are working with partners in Essex to look at the electric vehicle charging infrastructure, with a view to reflect this in Hertfordshire and include this within the travel and transport plan.

The decision, which will be reflected in the refreshed Green Plans, to delay the two new hospital programme sites to 2032, has a clear implication that the system will not meet its target of an 80% reduction, 536,000 tonnes of carbon to 104,000 tonnes.

Energy used (consumption in kWh)[1]	2022-23	2023-24	2024-25
Gas (natural) consumed	384,283	343,931	331,179
Cost of Gas (exc. VAT)	£17,465	£24,131	£26,529
kg CO2e[2]	192,141	171,965	165,589
Electricity consumed	440,630	412,684	343,823
Cost of Electricity (exc. VAT)	£63,316	£104,574	£96,913
kg CO2e[2]	220,315	206,342	171,911.5
Total Cost (All Energy Supplies) Exc. VAT	£80,781 (Charter House)	£128,705 (Charter House)	£123,442 (Charter House)

[1] Please note that Hertfordshire and West Essex ICB shares buildings with other organisations and pays a percentage of the overall cost for utilities. It is not possible to identify consumption by organisation so the figures shown are for the overall building.

[2] Greenhouse gas reporting: conversion factors 2023 - GOV.UK (www.gov.uk)

	General Waste (Tonnes)	Recycling (Tonnes)	Confidential Waste (Tonnes)
2023-24	2.803	1.268	2.886
2024-25	2.265	2.42	1.462

Material use (primary)	**2022/23**	**2023/24**	**2024/25**
Paper spend	£489.60	£697.50	£752.60
Paper products used	0.45 tonnes	0.625 tonnes	0.662 tonnes
kg CO2e[2]	141.1	196	207.7

Business travel

We continue to promote the vehicles categorised as 'Ultra Low' and 'Zero Emission' of which more than 90% of the lease car fleet vehicles available through the scheme are. Further investigation through a travel survey to be delivered in 2025/26 needs to be completed to support continued reduction in this field but the mothballing of Charter House will impact this significantly.

Financial Year	**Total Travel Mileage (cars) claimed as expenses (miles)**	**Total Travel Mileage (cars) claimed as expenses (£)**	**Total kg CO2e from Travel Mileage (cars)** Estimated using figures for the average car of unknown fuel type.
2021-22	HVCCG – no figure ENHCCG – 11,309 WECCG – no figure	HVCCG - £1,211 ENHCCG - £6,106 WECCG – no figure	c5,800
2023-24	128,828	£75,034	c66,200
2024-25	128,485	£80,902	c66,000

As part of the sustainability plan we are working as a system for a HWE Travel and Transport Strategy for delivery by December 2025 which will outline the work we will do to deliver fleet improvement which specifically impacts ICB staff where the requirement are that any vehicle provided on salary sacrifice schemes from 2027 be a non-combustion-based car – i.e. Electric. This will need to part of our internal considerations.

Task force on climate-related financial disclosures (TCFD)

The DHSC GAM has adopted a phased approach to incorporating the recommended Taskforce on Climate-related Financial Disclosures (TCFD), as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports.

Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally, by NHS England.

TCFD recommended disclosures, as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025-26 financial year.

For 2024/25, the phased approach incorporates the disclosure requirements of the following 'pillars': Governance, Risk management, and Metrics and targets

Governance

The climate related programme reports to the Director of Finance as Senior Responsible Officer (SRO) who reports into the Board, alongside an annual review and reports as required from the Sustainability Programme Manager. There is a bi-monthly ICS Sustainability Working Group which provides updates from across the System as to progress against Green Plans.

Once in place, the new ICB structure will include and ensure training for board members on climate related issues to improve leadership in this area.

The Sustainability Programme Manager reviews and initiates risks into the risk management process in consultation with the SRO. They are engaged with the corporate risk review process to ensure climate related perspectives are included in an overarching process.

The ICB has been following the phased approach outlined towards greater climate transparency and leadership. We have been working through the phase 2 and preparing for the phase 3 of the risks and disclosures in order to address these issues.

The phased approach outlined in the TCFD is shown below and is the roadmap for the progress the ICB is running through:

Phase 2 (2024/25)
Risk, Metrics and Targets
TCFD risk management disclosures:
Organisation's processes for identifying and assessing climate-related risks
Organisation's processes for managing climate-related risks
Processes for identifying, assessing and managing climate-related risks integration into the organisation's overall risk management approach
TCFD metrics and targets disclosures:
Metrics used by the organisation to assess climate-related risks and opportunities in line withs its strategy and risk management process
Targets used by the organisation to manage climate-related risks and opportunities and performance against target

Phase 3 (2025/26)
Strategy
TCFD strategy disclosures:
Climate related risks and opportunities the organisation has identified over the short, medium, and long term
Impact of climate-related risks and opportunities on the organisation's operations, strategy, and financial planning
Resilience of the organisation's strategy, taking into consideration different climate-related scenarios, including a 2•C and a 4 •C scenario

Risk Management

The ICB is the lead organisation for creating the climate related Green Plan across the system, however the risks related to the implementation of these issues are not principally for the ICB to recognise or manage as this would sit primarily with the Trusts.

The ICB has a clear and public process, which can be reviewed here, for the identifying and assessing risk, the process is being strengthened by the inclusion of the Sustainability Programme Manager intrinsically in the review of risk as part of the review group, which will ensure greater visibility of the management of these risks.

A process is being put in place in order to address the need to broaden the internal engagement of short-, medium- and long-term risks and opportunities in the new financial year, ensuring a forensic analysis is conducted within the organisation regarding the impact on the ICB itself but also the system as a whole.

The management of climate related risk is tied into the connection of sustainability and net zero carbon considerations into broader strategic considerations from the Joint Forward Plan, Estates Infrastructure Strategy, procurement strategies and consultations about different changes including the national contracts. The key element of this as outlined in the Health and Care Act 2022 is the ICS Green Plan

The ICB's climate change related risks over the reporting period are shown below, scores are noted as a snapshot on 28 March 2025, reported to ICB Board)

Risk 651 - Climatic risk of adverse weather events affecting healthcare services
If the health sector's vulnerability to existing and future climate risks continues, including high temperatures with overheating in buildings and external environments as UK temperatures increase and heatwaves become more common, heavy snow and low temperatures and their impact on health and wellbeing, particularly amongst the vulnerable, then as well as risk to life, health and wellbeing there may be productivity losses for healthcare workers resulting in implications for the future delivery of health and social care across the HWE system these events could cause pressure on healthcare services and organisational business continuity issues. **This risk is scored at 8**

Risk 366 - Risk to the delivery of health and social care services, including those working within the health sector, and the buildings and infrastructure required to deliver these services

If the population demography is disadvantaged due to the impact of climate change. Then- there is a risk to the delivery of health and social care services, including those working within the health sector, and the buildings and infrastructure required to deliver these services. Resulting in; Direct impacts on health and health inequalities, indirect impacts on health affecting the wider determinants of health and health inequalities, deferred and diffuse risks. Health are anticipated to be substantially negative; rising temperatures, patterns of precipitation and unpredictable weather will become more common (H&S) **This risk is scored at 10**

Metrics & Targets

There is a disconnect between the metrics for the ICS, the focus of the Green Plan specifically, and those which are outlined in the annual report for the ICB exclusively. The annual report gives clear updates on the gas/ electrical use, waste/ recycling levels, paper use and business travel for the ICB as indicative of how the ICB is progressing on this. No targets for these elements have been specified but as of July 2025 the ICB will no longer have an office to work out of reducing the utilities impact to zero, impacting the waste and paper elements as well. There will need to be further review of the business mileage in due course but this will be substantially impacted by the restructuring of ICBs nationally over the 2025/26 financial year.

We are currently in the process of addressing the refresh of the Green Plan for the whole of the Herts and West Essex system, looking at how far we have moved the dial from our 2019 baseline of 536,000 tonnes of carbon per annum, with a focus on achieving an 80% reduction for the System by 2032, and are assessing a clear suite of metrics which will help to demonstrate how risks can be measured by activity.

The Green Plan, as a reflection of the Health and Care Act 2022, is the target laden instrument for measuring progress, demonstrating the leadership required and managing the risk against climate related issues – primarily that HWE ICS would reach 104,000 tonnes of carbon by 2032, a reduction of 80%, before reaching net carbon zero by 2040.

Improve Quality

Quality Assurance and Oversight Priorities

Caring for our residents' wellbeing and supporting those who face the biggest challenges to living healthy and independent lives, remains at the heart of everything we want to achieve. As an underpinning part of this we ensure we have robust partnership arrangements to obtain quality assurance and support sustained quality improvement; to ensure that all patients and their families have positive and safe experiences, and that these enable improved outcomes and reduce health inequalities.

The Quality Assurance Model implemented by the Integrated Care System (ICS) is aligned to the National Quality Board's 'A shared commitment to quality', and includes the following key principles and recommendations regarding:

- A shared single view of quality
- How to work together to deliver quality
- Delivering quality care in systems, the seven steps
- Delivering quality care in systems; the key principles

From a governance perspective the HWE ICB has replaced the previous Quality Committee with the newly established, bi-monthly, System Transformation and Quality Improvement Committee.

This new Committee brings together quality, performance and transformation and seeks assurance that the ICB is delivering its functions in a way that secures continuous quality improvement, against each of the dimensions of quality set out in the National Quality Board guidance.

During 2024-25 the Nursing and Quality Team have identified and progressed work related to key opportunities in enhancing quality assurance and oversight, which will continue to be taken forward in 2025-26. Examples of this includes full implementation of a provider oversight framework for large providers covering acute, community and mental health, carrying on with our focus for dynamically maintaining effective oversight and risk for small community providers, proceeding developments of a system quality dashboard, and also a strong alignment to areas underpinned by equality and diversity. These have included partnership and quality improvement workstreams linked to international staff recruitment, ongoing partnership work through benchmarking compliance around statutory functions such as the Accessible Information Standards, and lastly a robust focus on Children and Young People aligned to Special Educational Needs and Disability (SEND) services.

In line with previous years' priorities, we have maintained our joint work in partnership with providers, overseeing a range of contractual quality responsibilities. This includes collaborative approaches in taking forward contract, quality and performance meetings, procurement activity including through patient choice accreditation of services, as well as activities linked to the annual contractual cycle such as contracts round negotiations for quality schedules and reporting, and also Quality Account requirements.

Patient Experience

Complaints Data

Patient Experience and Complaints

The ICB Patient Experience Team have received 2849 enquires from 01 April 2024 to 31 March 2025.

The team are working across the ICB in order that no patient or family experiences a "wrong door" with their concerns.

The majority of queries, 1997, have been managed by the team as informal concerns/queries (patient advice and liaison queries) some of the queries are complex, the team support the patient and the provider with gaining resolution.

The team have recorded 621 formal complaints, however 46% did not progress to a full investigation because insufficient information and/or consent to proceed was not provided by the person initially wanting to raise a complaint.

The team work together with patients and their families to identify the best route for a resolution or answer to the concern and in some cases the facilitation of a discussion between the patient/family and the relevant clinical staff results in a more expedient and satisfying conclusion than a formal response.

The team have received 177 queries from Members of Parliament on behalf of their constituents in relation to both general and highly specific health concerns. The team manage these concerns

in order to provide a response that the MP can share with the specific constituent and use to inform their wider health discussions.

The main theme of people's concerns has been access to services in primary and secondary care. The ICB is working with professionals in both sectors to improve access and options for patients and their families and to prevent negative experiences of healthcare within Hertfordshire and West Essex.

In line with system partners, the team are asking people who raise queries if they would like to share their demographic data. This is in order to gain a better understanding of whether there are groups of the population who may not use our service, so improvements can be made. To date there is insufficient data to share meaningful conclusions.

Patient Safety
National Patient Safety Strategy

Hertfordshire and West Essex ICB has continued to support implementation of the National Patient Safety Strategy, working with our ICS system partners to focus on the priorities, whilst ensuring we are meeting our oversight responsibilities.
.
Progress this year includes;

- Ongoing support of the ICB Patient Safety Specialist role. There are currently 3 Patient Specialists within the ICB.
- Further development and focus on the Patient Safety Partner role. We have 2 Patient Safety Partners working with the ICB and are supporting them to collaborate with others across the ICS.
- Ongoing work across the system and within the ICB to promote a just and psychologically safe culture.
- Development of the Patient Safety Specialist Network in HWE, expanding this network to include others working within Patient Safety across our system.
- Successful roll out of the Medical Examiner system for non-coronial community deaths and implementation of legislation and reforms to national death certification process which came into force in September 2024.
- Establishment of a system-wide Learning from Deaths Forum, focusing on identifying common themes from mortality reviews and sharing of learning and good practice to support improvement across the system.
- Continued work to support implementation of the Patient Safety Incident Response Framework (PSIRF) across our smaller and independent providers and working with our main providers to review their updated plans and priorities.
- Began working towards implementation of the Primary Care Patient Safety Strategy, including establishing an internal working group, presentation at the Primary Care Transformation Committee, and supporting a HWE practice to pilot PSIRF. A resource and shared learning page has been developed on the ICB's website for GPs.
- Led a successful 'After Action Review' session reviewing an incident that included multiple organisations within our system. Areas of learning for organisations and focus for quality improvement were identified and is being taken forward.

Patient Safety: Serious Incidents and Never Event Data

Herts and West Essex Integrated Care Board (ICB) have had 2 Serious Incidents reported in the 2024-25 reporting year under the older framework – these were reported by GP practices, who have not yet adopted the PSIRF approach.

In addition, 45 Patient Safety Incident Investigations (PSIIs) were reported in 2024-25 by those organisations who are working within the PSIRF framework. Although the ICB is notified of these incidents, we do not have the same responsibilities as under the previous SI framework, and these reports do not come to the ICB for scrutiny or sign off. Rather, our quality leads support conversations around these incidents at provider incident meetings and the ICB patient safety team collaborate with providers to ensure that learning is shared, and quality improvements are made.

Of these reported Incidents, 10 were classified as Never Events (22%) –all Never Events occurred within acute care settings. Immediate safety actions were taken to protect patients after each incident and a full investigation is underway for each case. The ICB continues to maintain oversight of Never Events, and reports will be reviewed by appropriate ICB colleagues.

Infection Prevention & Control (IPC)

System Working

The ICB Infection Prevention and Control (IPC) Team has continued to work collaboratively with system partners with responsibility for IPC, including local authorities and UKHSA. Throughout the year, the team have maintained a focus on their oversight role in line with the ICBs new operating model. This has included the review and development of new ways of working to ensure that appropriate assurances regarding IPC practices and procedures are being maintained, that collaboration across the system is facilitated, and that any learning is shared amongst our system partners working across the HWE Integrated Care System. In particular, a more integrated approach to IPC in HWE care homes has been developed in conjunction with local authority colleagues. This will address areas of disparity in IPC support and oversight in local care homes since the end of the pandemic.

The IPC team have worked closely with the ICB quality and contracts teams to review IPC quality metrics that are included within our system partner contracts. The arrangements and service specification for the management of infectious disease outbreaks and incidents in HWE have also been updated to ensure this includes appropriate pathways for swabbing, treatment and/or post exposure prophylaxis for outbreaks and infection related incidents within community settings.

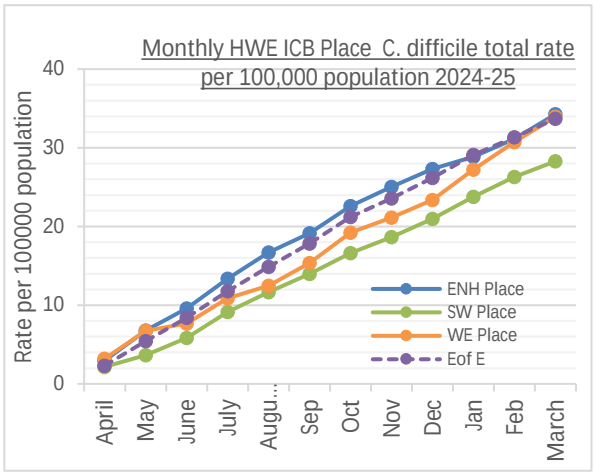
Also produced during the year were action cards outlining the out of hours system management of infectious diseases (including high consequence infectious disease) for on-call ICB managers. Training has been scheduled for on-call ICB staff regarding the implementation of these action cards and the related pathways for affected patients.

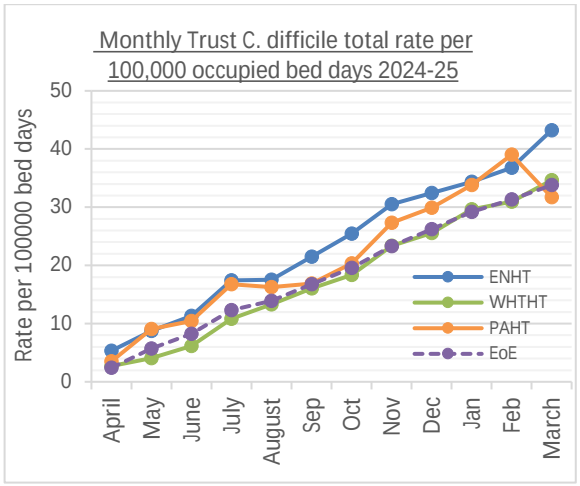
Healthcare Associated Infections (HCAI)

- **Clostridiodes difficile infections (CDI) -** Since 2021, the national incidence of CDI has been climbing. Increases have been seen in all age groups and across all regions. This increased morbidity has not only impacted patient outcomes but has also placed an increased burden on NHS services, especially IPC and isolation facilities. The causes of this

increase are likely multifactorial but have not yet been fully established. Consequently, at the end of 2024 UKHSA declared this increase as a national incident, introducing additional national and local epidemiological and microbiological investigation in order to better understand the recent increase and help target control measures and mitigations.

Whilst each of the ICB sub locations and acute trusts were above their ceilings set by NHSE on relation to the number of CDI cases reported, the following data benchmarks HWE against regional CDI infection rates.





System partners continue to review cases in line with PSIRF principles and any learning is discussed in the place based HCAI Oversight Group meetings and via each organisation's IPC committee. Both organisation and system level action plans have been developed and progress is monitored via these meetings.

- **Healthcare associated bloodstream infections -** Additional surveillance of these has continued to be undertaken (including those caused by *Staph aureus* and Gram-negative organisms) in line with PSIRF principles. In line with data collected regarding contributory risk factors, targeted programmes of work have been introduced by trusts e.g. focussed improvements the management of intravenous devices, and improvements with inpatient hand hygiene.
- **HCAI related outbreaks and incidents -** The ICB IPC team continue to offer support to IPC system partners in relation to complex HCAI incidents in order to minimise the impact on patients and the local health and social care system. This has been in line with the revised Memorandum of Understanding for the Delivery of Core Health Protection Functions within Hertfordshire and west Essex between the ICB, local NHS trusts, local authorities and UKHSA. This has included participation in incident management team meetings for the more complex or protracted incidents or outbreaks such as several that have been caused during the last year by legionella, invasive group A *Streptococcus,* TB, potential Mpox etc. Following several such incidents the ICB IPC team has arranged cross-organisation debriefs or round table events to collate and ensure cascade of any learning across the system.

Engaging people and communities

Actively involving and engaging with the people and communities in our area is a vital part of our work to reduce health inequalities and provide patient-centred services. Through engagement, involvement and consultation, we can ensure that patients' views shape and

influence the development and commissioning of services, helping to address the health and wellbeing challenges faced by our residents.

Meaningful involvement and engagement must guide all of our work, from neighbourhood and community planning to board-level decision making processes.

The ICB has adopted ten best practice principles, set out by NHS England, which are at the heart of our 'Working in Partnership with People and Communities' approach, and we draw on the strength of our networks of partner organisations to help us to listen and respond to the needs in our area.

The ICB's involvement and engagement framework covers the different ways people and communities should expect to influence decision-making about designing, procuring and monitoring NHS services, and how to give feedback and ideas.

The following is a summary of the ICB's public and stakeholder engagement work during 2024-25. It outlines the different ways in which we listen to and involve local people to inform decision-making.

Patient Engagement Forum (PEF)
Established in June 2023, the PEF ensures patient voices are heard at the ICB board level. Members attend public ICB Board meetings, pose questions, and meet with board members. The PEF has discussed topics such as mental health, primary care, and hospital provision. It has three working groups focusing on primary care, acute and community care, and mental health and learning disability.

The PEF follows a co-production approach. It has a patient Chair and patient members have worked with the ICB to develop their role and remit – they are key to leading how the forum works. Members use their insight into local views and issues to inform their feedback and interaction with the ICB Board.

The PEF is currently working on developing its people and community networks and connections so that they can bring other and more diverse patient voices to the ICB board and Primary Care Transformation Group. Forum members are also building a social media presence as part of the plan to broaden the network.

During the past year, the PEF has discussed the following:

- The new St Albans elective care hub
- Patient choice
- The new urgent and emergency strategy
- Risk stratification and data sharing
- The NHS App
- Patient feedback and contract management
- The new ICS website
- Complaints handling
- Safety in primary care.

Patient Engagement Forum member, Claire said:

"I have been a member of the Patient Engagement Forum since its inception and find it a most rewarding and stimulating safe space to deeply focus on patient and community led ideas, issues and solutions.

"It feels like we are very much involved in a once in a generation NHS shift towards a much more joined up health and care service which will benefit the 1.6 million patients in Hertfordshire and west Essex.

"It is a total privilege to be involved with the Patient Engagement Forum. It feels a very forward thinking, flexible and transparent collaboration between the ICS and patient representatives, all focused on growing existing community- based networks, so many more patients can be listened to and see action taken on their behalf."

Citizen representatives on the ICB Primary Care Transformation Committee
GP, pharmacy and other primary care services are the first point of contact with the NHS for most people, and we want to make sure that the ICB is close to and aware of patient experiences of primary care. The ICB has three citizen representatives who are full members of the Primary Care Transformation Committee, helping to ensure that independent patients' views are heard at this important meeting.

Quality Patient Group
The Quality Patient Group provides a patient and public perspective on quality and safety issues. This group, which is led by our patient safety partners, has been able to influence the ICB's quality strategy, input into workforce focus groups run by the Health Services Safety Investigations Body and brought patient voices into ICB 'deep dives' such as on maternity services.

Work with Healthwatch Herts and Healthwatch Essex
Healthwatch Hertfordshire and Healthwatch Essex were commissioned by the ICB to undertake a series of research projects this year, including:

- Understanding and awareness of type 2 Diabetes
- Hearing from the Armed Forces community about their experiences of local healthcare
- Understanding the views of international staff working in the NHS
- Navigating online access to primary care
- Orthodontic care in west Essex
- Community pharmacy

Findings, with recommendations, are reported to the ICB's Primary Care Transformation Board and actions agreed. As an example, the ICB has worked with Carers in Hertfordshire to run focus groups for unpaid carers to understand in more detail their experiences of accessing primary care services. The findings from these focus groups will be reviewed and taken into account in decision making.

We have also worked with Healthwatch Herts and Healthwatch Essex to look at how we can make participation in medical research more accessible for our residents. This work focused on local people with personal experiences of mental health issues and addiction, those with a learning disability and members of the English Traveller community and has provided powerful

insights to inform practice. We continue to work with Voluntary Community Faith and Social Enterprise (VCFSE) partners to support more inclusive participation in medical research.

Work with our Voluntary Community Faith and Social Enterprise (VCFSE) partners

Although Hertfordshire and west Essex is the second least deprived ICS area, we have pockets of significant deprivation and inequalities. In collaboration with system partners, an outcomes framework is being developed with clear metrics to help the ICB to evidence its performance in delivering on its legal duties to tackle inequalities. This will identify areas where we can reduce the avoidable variances in health outcomes that may be due to a person's ethnic background, circumstances in which they live (poverty, poor housing, disability, caring responsibilities) or other factors outside of their control. We can only tackle this in partnership with key community stakeholders. Together, we aspire to deliver more personalised and culturally appropriate services, in neighbourhood health teams.

An example of our work is the development of the Faith and Health Network led by One Vision, a charity in Watford which brings different cultural backgrounds and religious affiliations together, to address the needs of the community. One Vision are working with us to find people with high blood pressure and atrial fibrillation (an irregular heartbeat) in communities where it is common but under-diagnosed. Working in partnership with faith leaders across our area to deliver this message to diverse communities, One Vision makes use of trusted voices in trusted spaces and seeks to empower communities to manage their own health by having better knowledge and access to simple health monitoring equipment in local faith settings.

We have worked this year with the ADDA club and local councils to produce a cookbook to inspire diverse communities at risk of Type 2 diabetes to manage their condition, in tandem with lifestyle advice. We funded six short videos, made by and aimed at the South Asian community, although accessible to all. People with a South Asian ethnicity are particularly at risk of Type 2 diabetes.

Through a grant from Assura PLC's Community Fund, we have been able to commission more than 30 local PCN-level projects to address unmet need in communities. These included bereavement support, Carers Cafes and wellbeing courses. These projects have reached more than 1,000 people at risk of developing a long-term condition and experiencing poorer health outcomes. Our next phase focuses on the 'Living Well' course, where we are introducing a 'train the trainer' approach to enable 200 volunteers and VCSFE staff to learn how to deliver a healthy lifestyles course, which they can bring into the heart of communities at risk of developing preventable health conditions.

Building on work with the Patients Association

This year we have continued our work with the Patients Association to support the development of GP Practice Participation Groups (PPGs). The group is currently asking PPG members their thoughts on creating a PPG network across Herts and west Essex to share information, good practice, support development and importantly to hear the patient voice. A patient-led 'buddy' scheme has also launched, offering one to one support to practices to support PPG development. Our patient network has grown this year to nearly 700 members, whom we regularly communicate and engage with.

Community of Practice

The ICB has recently developed a participation 'community of practice' to bring together the

insight and expertise partners across Hertfordshire and west Essex who are engaging with local communities through their own work. Over the coming months we will work with this group to collate an online 'insight bank' of research and engagement projects, to be sited on the ICS website, which all ICS organisations can use and contribute to.

Training for ICB staff on our duty to involve
We understand the importance of all our staff understanding the benefits of involving local people and communities in developing and commission services, including the legal duty to involve. We regularly offer training and awareness sessions on this and have recently delivered bespoke sessions to our medicines optimisation and primary care teams and to our wider staff body through learning lunches and staff briefings.

ICB's Youth Council heads into its second year
The ICB's Youth Council has now begun its second year, gathering the voices and experiences of young people to help improve their experiences of using local services.

The group of youth ambassadors, aged 12 to 19 years old, meet during term time and offer a vital insight and provide crucial first-hand experience into the needs and concerns of children, teenagers and young people and their health.

The group has worked with the Patients Association on eight short videos aimed at improving young people's experiences at GP surgeries. They have also suggested ways the NHS could promote the NHS App to young people and worked closely with the ICB to produce a number of web pages for young people, including on the important topic of vaping.

Reader Panel
The panel, made up of around 60 patients, carers, community members and practice staff review patient leaflets and other material, feeding back on whether the information is easy to understand, accessible and free from jargon.

Their involvement has led to significant changes in content to make information more relatable for the intended audience, changes to language to use more familiar terminology and amendments to layout and font size to make the information clearer and avoid ambiguity.

As an example of the panel's work, this year they have commented on a children services survey, blood glucose monitoring information, content on the ICB website, a survey for over 65s and a health information booklet for older people.

Reducing health inequalities

Hertfordshire and West Essex ICB is committed to taking action on the inequalities experienced by the population that we serve. The ICB continues to support a number of initiatives which aim to improve social inclusion, reduce isolation and improve mental wellbeing in some of the most disadvantaged communities, and with those living with long-term conditions.

While many of our population enjoy good health and have better health outcomes compared with the rest of the country, we know that significant health inequalities exist and some of our residents are dying from illnesses such as circulatory diseases, cancer and respiratory diseases at a younger age than we would expect. Reducing health inequalities is a feature of all the ICS

Transformation Programmes, this ambition is embedded within our whole system population health outcomes.

Population Health Management enables this transformational work through the creation of tools to segment populations and stratify individuals based on several intersectional characteristics, whose outcomes can be improved. An example of how these tools are being put to use is through the implementation of Integrated Neighbourhood Teams and the identification of those whose outcomes will be improved through proactive care reflecting geographic, demographic and epidemiological differences. The Population Health Management team, work to produce a number of resources including a health needs analysis at the following site: https://www.hertsandwestessex.ics.nhs.uk/wp-content/uploads/2025/02/HWE-Overview-of-the-population-2025-24-February-2025-1.pdf

Our continued plans for reducing health inequalities over the next five years set out our ambition to improve health equity, in line with our Integrated Care Strategy, Medium Term plan and principles of the NHS Long Term Plan (LTP). This plan sets out the approach we will take in closing the gap in variances of outcomes for people that may be due to ethnic background, circumstances in which they live or other factors outside of their control. In the first year of the plan, we will continue work to clarify our performance in the Core20Plus5 framework for adults and children and young people.

We will continue work to tackle inequity of outcomes based on our developed population health needs assessment on the picture of health needs including wider determinants for the population of the ICS, targeting specific groups such as ethnically diverse groups, those who may be unpaid carers, veterans and members of the Gypsy, Roma Traveller community, refugees and migrants, victims of domestic violence and those living with a serious mental health illness or a learning disability.

Research Engagement Network Development

Working with the Innovation Research and Life Sciences team at NHS England, the ICB has been building on the previous project to support more inclusive participation in research, we have to date;

- Developed a strong Research Engagement Network - partners from across the ICS working together to improve research participation
- Research mapping and characteristics of research participants - identifying the gaps
- Engagement with underrepresented groups - understanding the barriers they face to research participation, and co-producing solutions to address these
- Engagement with the research community – understanding the challenges they face and how they can be addressed
- Events with underrepresented groups – understanding barriers to accessing health care and research participation and starting to promote #bepartofresearch.

Our next steps include:

- Recruitment and training of Research Champions – supporting with raising awareness and recruitment to research opportunities
- Communications programme – involving all system partners to be share information about what is research, how to access, and registration to #bepartofresearch and sharing materials in accessible formats

- Engagement programme – using events across the calendar year to engage with communities, share opportunities and promote #bepartofresearch
- Funding programme – resource for researchers to book spaces and compensate the public for PPIE activity
- Develop community-led research project
- Development offer for new Community Researchers
- Sharing and learning – sharing best practice with stakeholders across the system as well as regionally and nationally (in-person collaboration event with all ICS partners)

Assura and Hertfordshire and West Essex ICS Grants Programme

Assura PLC (via The Assura Community Fund) and Hertfordshire and West Essex Integrated Care Board are continuing their partnership by providing small grants and working in partnership with VCSE partners, Primary Care Networks, and Integrated Neighbourhood Teams, to support a grants programme, to reduce health inequalities, help prevent poor health - and improve opportunities for better lives in Hertfordshire and West Essex. A number of projects have been grant funded by Assura PLC to date, including a supporting the capacity building of a Faith and Health network, support faith leaders to connect with health leaders and support their communities in a different way, also funded a lifestyles wellbeing course, training a number of volunteers to be able to deliver their own lifestyles wellbeing course to their own communities.

Working with communities to tackling Cardiovascular disease, namely hypertension, working with partners in local government and community groups that support inclusion health groups like those living with learning disabilities. The ICB is supporting training of staff and gifting blood pressure machines to groups in order to support communities to have better access to equipment and more enablement to better manage any health conditions likes hypertension, proactively and in a timely way.

Health and wellbeing strategy

Health and wellbeing boards are responsible for commissioning a Joint Strategic Needs Assessment (JSNA) for the local population and setting the Joint Health and Wellbeing Strategy.

These strategies set key countywide strategic priorities, the priorities of member organizations and system partners, agreed outcomes and how progress and assessment will be measured and a small number of key strategic priorities for action, where there is an opportunity for partners including the NHS, local authority, education, and the voluntary and community sector to ‘have a real impact’ through local initiatives and action. The overall aim of the strategy is that we see an improvement in health and wellbeing outcomes for people of all ages and a reduction in health inequalities by having a focus on supporting poor health prevention and promoting health improvement

The overall ambition of the Health and Wellbeing Boards is to reduce the gap in life expectancy, increase years of healthy life expectancy and reduce the differences between health outcomes in our population.

The Health and Wellbeing Boards bring together the NHS, public health, adult social care and children’s services, including elected representatives from the County and District Councils, Healthwatch and the Police and Crime Commissioner, to plan how best to meet the needs of the population and tackle local inequalities in health.

The ICB works with partners, taking a joined-up approach to tackle the causes of poor health as well as supporting people to make healthier lifestyle choices and improving healthcare.

The Essex Joint Health and Wellbeing Strategy 2022-2026 identifies five key overarching priority areas:

- Improving mental health and wellbeing
- Physical activity and healthy weight
- Supporting long term independence
- Alcohol and substance misuse
- Health inequalities and the wider determinants of Health

The Hertfordshire Health and Wellbeing Strategy 2022-2026 is based around these four life stages:

- Starting well
- Developing well
- Living and working well
- Ageing well

The ICB demonstrates its support to the delivery of the local health and wellbeing strategies and the systems Integrated Care Strategy, which is informed by the health and wellbeing strategies, through its Joint Forward Plan. Our Joint Forward plan is aligned to the six priorities of our Integrated Care System (ICS) and our local health and wellbeing strategies. The Joint Forward Plan is developed and published each year, within it we provide an update on progress in delivering our strategic ambitions (including those within the local health and wellbeing strategies) and also our plans for the next 5 years that will support achievement of these strategic ambitions. Our current Joint Forward Plan can be viewed here: Hertfordshire and West Essex Joint Forward Plan 2025 - 2030 - Herts and West Essex ICS.

The ICB consulted with Hertfordshire Health and Wellbeing Board and Essex Health and Wellbeing Board in preparation of this report. This Annual Report will be received by each Board in summer 2025.

Key areas of contributions by the ICB in delivering the strategy over the last year include:

- **Prevention services –** include the Women's Health Strategy, primary care dental services, Making Every Adult Matter, mental health services, and children and young people's services. The Board has monitored progress, sought feedback from partners and stakeholders, and received regular updates on delivery.
- **Hospital Discharges -** Oversight of system-wide efforts to improve discharge processes and outcomes.
- **Dementia Strategy -** Supporting the delivery of a coordinated, multi-agency approach to people with dementia, their families and carers.
- **Domestic Abuse Strategy -** Continued focus on multi-agency approaches to tackling domestic abuse.
- **Age-Friendly Hertfordshire -** Promoting age-inclusive policies and practices across the system.
- **All-Age Autism Strategy -** Supporting the delivery of a coordinated, life-course approach to autism.
- **Support for SEND -** Ensuring partners work collaboratively to deliver the SEND Priority and Improvement Action Plan, with regular progress updates to the Board.

Preparing for Emergencies

The ICB has a responsibility in law to be fully prepared and able to respond effectively in the event of an incident which challenges the capacity or capability of the local health system. This responsibility is assessed through NHSE Core Standards for EPRR process.

In 2024-25 HWE ICB achieved an overall rating of fully compliant with **NHS England's Core Standards for Emergency Preparedness, Resilience and Response (EPRR). The individual assessment ratings for each standard are shown below:**

Domain	Self-assessment rating
Governance	FULL COMPLIANCE
Duty to assess risk	FULL COMPLIANCE
Duty to maintain plans	FULL COMPLIANCE
Command and Control	FULL COMPLIANCE
Training and exercise	FULL COMPLIANCE
Response	FULL COMPLIANCE
Warning and informing	FULL COMPLIANCE
Co-operation	FULL COMPLIANCE
Business Continuity	FULL COMPLIANCE
Overall rating	FULL COMPLIANCE

In 2024/25 the ICB has focused on:

- Continued management of new and ongoing incidents, e.g. industrial action, GP Collective Action, extreme health system pressures, various power outages, Crowd Strike, a fire at Harvey House Surgery GP Practice and UK Civil Unrest.
- Horizon scanning and ensuring preparedness for potential emerging risks, e.g. measles outbreak. Reviewing current risk management processes in conjunction with the Local Resilience Forum to ensure that these are more robust.
- Further development of the System Co-ordination Centre in line with best practice in other areas and evolving NHSE requirements
- Ongoing development of our automated resilience system called System Health Resilience Early Warning Dashboard (SHREWD)
- Completion of exercise plans for 2024-25 including cyberattack, severe weather, hospital evacuation, measles outbreak and communications exercises
- Business continuity planning, including plans for any potential national power outage or infectious disease outbreak
- The introduction of the Assurance Framework for Commissioned Providers' and Suppliers' Business Continuity Plans
- Preparedness for the switch off of the Public Switched Telephone Network (PSTN) in 2027
- Participation in the review of the current Essex and Hertfordshire Local Resilience Forum's strategy and structures
- Review of the Local Health Resilience Partnership 3 year strategy and 3 year exercise plan
- Completion of the 2024/25 NHSE Core Standards for EPRR assurance process

- Co-ordination of an annual training plan across the Integrated Care System (ICS) which meets the requirements of the National Minimum Occupational Standards for EPRR. We have also looked at how we might manage health system EPRR training for 2025-26 differently and more cost effectively.
- Timely annual review of all EPRR policies and plans

Digital, data and technology

The work of Hertfordshire, Bedfordshire and Luton (HBL) ICT

Hosted by Hertfordshire and West Essex ICB, HBL ICT provides IT services to the four member organisations forming the HBL Partnership. 2024 has been a milestone year for HBL ICT as we have entered of 10th anniversary, having been formed in October 2014. During this time, we have taken great pride in becoming a highly effective and respected ICT service provider, delivering a cost-effective service that delivers without compromising on quality.

We understand that we need to develop and innovate our services so that we can meet the demands of our customers. During 2024, we have continued to make significant investments in our cyber defences, made significant progress in the deployment of MS Win11 operating system to all end user devices across the enterprise and investment of Robotic Process Automation (RPA) within Primary Care to improve digital services, freeing up the scarce clinical resource time. In August, we introduced GPIT services for west Essex HCP into the Partnership, ensuring consistency in GPIT service delivery across the HWE ICS.

We have continued to make significant improvements to our communication channels, including ongoing development of our virtual agent and chat facilities to make our technicians more accessible to support our customers.

We have made significant progress in the redesign of our core infrastructure, including relocating our on-premises data centre to a new commercial site in Enfield and replacing our core technology stacks via a revenue based leasing model in partnership with HPE as a strategic supplier. This strategic digital shift delivers a more sustainable technology model with greater flexibility and reducing the cost of ownership, making technology more accessible, adaptable and affordable to the partnership.

Looking ahead, 2025 we will focus on delivering a 5-year business and digital strategy ‘Digital Once’, focussing of the strategic outcomes commenced in the past two years, removing duplication in the system, delivering scalable solutions and resolving technology issues swiftly. An additional component of our strategy is to progress with generative AI technologies as this will further drive efficiencies across our enterprise.

In delivering our strategy we will ensure that HBL ICT maintains its importance and relevance to our member organisations and enabling their planned digital strategies and digital transformation agendas.

Cyber security continues to dominate the daily operations of HBL ICT as we are continually managing the emergent threats that cyber security brings. These threats need to be constantly manged to protect our business and patient data. To that end, we have published our first cyber security strategy which covers HBL and the partnership. It focuses on key strategic objectives to

further strengthen our position such as user awareness and culture, threat detection and prevention, defence in depth, and response and recovery.

Our investments in developing a highly secure, resilient and robust IT infrastructure, underpinned by tight control processes and patching regime enables HBL Partnership to continue to deliver a highly available service. Multi-Factor Authentication (MFA)has recently been introduced, as a further defence, to all our email accounts as we know that email systems present a significant threat if not manged diligently.

Our 'Security Operations Centre' provides proactive management and monitoring of all services working with strategic 3rd Party Suppliers and NHS England. This includes being part of the NCSC (National Cyber Security Centre) early warning system, a government organisation that monitors suspicious activity across any system that is externally accessible from the public internet.

Financial review

Hertfordshire and west Essex Integrated Care Board's Annual Accounts are included within this Annual Report. The accounts have been prepared in accordance with directions issued by the Department of Health and Social Care and NHS England.

Integrated Care Boards (ICBs) have a statutory duty to keep their expenditure on each of day-to-day operational costs (revenue costs), administration costs, and capital costs within resources allocated to them for each of these cost headings.

NHS England also set other financial rules for ICBs in 2024/25. These were:

- To comply with the mental health investment standard by increasing spending on mental health services by a prescribed minimum percentage
- To comply with the minimum percentage increase in contributions to the Better Care Fund
- To comply with the delegated Dental services ringfenced allocation and to return allocation that was not utilised during the financial year

Additionally, ICBs and their partner Trusts and Foundation Trusts, making up the Integrated Care System (ICS), have a statutory duty to keep their expenditure on revenue and capital within the resources allocated. This means that financial performance is assessed for each organisation separately and in aggregate.

The Trusts and Foundation Trusts making up Hertfordshire and West Essex ICS, for the purpose of financial performance, are:

- East and North Hertfordshire NHS Trust
- Hertfordshire Community NHS Trust
- Hertfordshire Partnership University NHS Foundation Trust
- The Princess Alexandra Hospital NHS Trust
- West Hertfordshire Teaching Hospitals NHS Trust

For ICBs, financial performance is assessed by comparing expenditure to resource allocations issued and authorised for spending.

For Trusts and Foundation Trusts, financial performance is assessed by comparing revenue expenditure to income received and capital expenditure compared to the allocated capital resource limit. Trusts receive income from several sources, including Hertfordshire and West Essex ICB, other ICBs, NHS England, and non-NHS sources.

ICB Funding

The funding allocation to Hertfordshire and West Essex ICB for the period 1 April 2024 to 31 March 2025 is set out in the table below. The total authorised allocation for spending by the ICB was £ 3.876bn.

Description of Allocation	Allocation for the ICB £'000
Programme Costs	3,077,234
Primary Care Delegated Functions	447,549
Specialised Commissioning Costs	321,735
Administration Costs	29,449
Total Funding	**3,875,967**

Financial performance

As set out in the table below, there are a number of financial duties and rules that ICBs and the wider System have to comply with.

The most challenging performance requirement was to keep revenue expenditure within the resource allocation/income. The greatest challenge was for the Trusts, with aggregate deficits being seen during the year, and recovery actions failing to make an impact. This led to deficits being forecast and the ICB having to review its own expenditure to achieve system financial balance.

During the year, additional funding of £20m was received to cover the planned deficit position, moving the System to breakeven. This helped the overall position, with four of the Trusts ended the year with an aggregate deficit of £8.637m. The remaining Trust and the ICB achieved an underspend of £8.679m, resulting in the System overall achieving balance with a small underspend.

The financial requirements were achieved in 2024/25, with performance on each requirement set out in the table below:

Duty	ICB Performance	ICS Performance
Revenue expenditure does not exceed allocations/income	✓ Achieved an underspend of £7.2m	✓ Achieved an underspend of £0.042m
Capital resource use does not exceed resource allocation	Not applicable	✓ Achieved an underspend of £0.017m
Revenue administration expenditure does not exceed the allocation	✓ Achieved an underspend of £0.634m	Not applicable
Mental Health Investment Standard	✓	

	Achieved an increase of 6.83% against a target of 6.67%	Not applicable
Better Care Fund minimum contribution increase	✓ Achieved an increase of 5.66%	Not applicable

Capital Resourses

The Integrated Care System (ICS) published a Joint Capital Resource Use Plan for 2024/25, outlining the distribution of capital funding to the trusts within the ICS. Upon receiving the capital allocations from NHS England, the funds were transferred to the respective trusts. Each trust is then responsible for reporting the expenditure and the achievement of its capital allocation targets.

Looking forward to 2025/26

While the ICB had a good financial performance in 2024/25, this was partially the result of additional non-recurrent funding received during the year and the utilisation of non-recurrent reserves. The position at the end of 2024/25 is more fragile than at the start of the year.

In addition to this, the financial settlement for 2025/26 is poorer than 2024/25 with the reduction in the ICBs allocation through the application of 0.5% convergence factor. The headline efficiency challenge for the System in 2025/26 has significantly increased compared with 2024/25 with efficiencies in excess of 5% needed to enable the System to achieve the NHS planning and priorities guidance including to achieve the financial control totals.

For the ICB, both Continuing Healthcare and GP prescribing remain the highest financial risks.

Continuing Healthcare is a volatile area of spend and there has been an increase in the average cost of care packages, both as a result of the increase in the national living wage in 2024/25, but also because of the complexity of need of patients. In 2025/26, there will be the additional pressure of increases in the employer contributions to National Insurance costs.

GP Prescribing is a risk area with supply chain and other issues leading to more drugs having national concession pricing leading to significant cost pressures. Additionally new drugs and guidance published can put pressure on an already stretched prescribing budget.

Pressures are also continuing at the Trusts and their financial positions are also likely to add risk to overall System balance.

The drive for productivity improvements, transformation changes, reductions in workforce and greater efficiencies continues, but it is highly likely that 2025/26 will be an extremely difficult year financially for the System.

Review of statutory duties

Hertfordshire and West Essex Integrated Care Board has reviewed all of the statutory duties and powers conferred on us by the National Health Service Act 2006 (as amended) and other associated legislation and regulations.

We are clear about the legislative requirements associated with each of the statutory functions for which we are responsible, including any restrictions on the delegation of those functions.

Spend over £5m

An ICB does not deliver direct patient care services, but identifies population needs and plans to meet these through contracts with the NHS and other organisations. This includes primary care services and secondary care services in the community and in hospitals, covering both physical and mental health needs. Acute hospital services - where a patient receives short-term treatment for a severe injury or illness, an urgent medical condition, or during recovery from surgery - are provided for our residents by NHS hospitals and community trusts, NHS foundation trusts, and other independent providers of health services.

The healthcare organisations with whom the ICB spent more than £5m in 2024/25 – together with the broad categories of care they provide - are set out here:

Provider	Service Category
Barts Health NHS Trust	Acute - NHS Hospitals
Bedfordshire Hospitals NHS Foundation Trust	Acute - NHS Hospitals
Barking, Havering and Redbridge University Hospitals NHS Trust	Acute - NHS Hospitals
Buckinghamshire Healthcare NHS Trust	Acute - NHS Hospitals
BUPA Care Homes	Continuing Healthcare
Cambridge University Hospitals NHS Foundation Trust	Acute - NHS Hospitals
Central London Community Healthcare NHS Trust	Community Services
Circle Health Care Group (Formerly BMI Healthcare Ltd)	Acute - Independent Hospitals
Community Health & Eye Care Ltd (CHEC)	Acute and Community
Connect Health Ltd	Community Services
East of England Ambulance Service NHS Trust	Ambulance
East & North Hertfordshire NHS Trust	Acute - NHS Hospitals
Elysium Healthcare Ltd	Continuing Healthcare
Essex County Council	Community Services & Mental Health
Essex Partnership University NHS Foundation Trust (EPUT)	Community Services & Mental Health
Great Ormond Street NHS Foundation Trust	Acute - NHS Hospitals
Guy's And St Thomas' NHS Foundation Trust	Acute - NHS Hospitals
HCRG Ltd	Community Services
Hertfordshire County Council	Community Services & Mental Health
Hertfordshire Community NHS Trust	Community Services
Hertfordshire Partnership NHS Foundation Trust	Mental Health and Community Services
Herts Urgent Care Ltd	Community Services & Urgent Care
Imperial College Healthcare NHS Trust	Acute - NHS Hospitals
London North West University Healthcare NHS Trust	Acute - NHS Hospitals
Mid and South Essex Hospitals NHS Foundation Trust	Acute - NHS Hospitals
Moorfields Eye Hospital NHS Foundation Trust	Acute - NHS Hospitals
North Middlesex University Hospital NHS Trust	Acute - NHS Hospitals
North East London NHS Foundation Trust	Acute - NHS Hospitals
Ramsay Healthcare UK - Pinehill	Acute - Independent Hospitals
The Princess Alexandra Hospital NHS Trust	Acute - NHS Hospitals & Community
Ramsay Healthcare UK-Rivers Hospital	Acute - Independent Hospitals
Royal Free London NHS Foundation Trust	Acute - NHS Hospitals
Royal National Orthopaedic Hospital NHS Trust	Acute - NHS Hospitals

Royal Papworth Hosp NHS Foundation Trust	Acute - NHS Hospitals
SPIRE Healthcare LTD	Acute - Independent Hospitals
University College London Hospitals NHS Foundation Trust	Acute - NHS Hospitals
West Hertfordshire Teaching Hospital NHS Trust	Acute - NHS Hospitals & Community

Two years ago, all ICBs in the country were instructed by the government to reduce their running costs. Thanks to a huge effort, we largely achieved the planned running cost reductions agreed in the first year.

We adopted ambitious and challenging cost improvement programmes that saved money without impacting on the quality of our services and focused on the planned new schemes that were achievable. We also decided to adopt five transformation priorities that the whole system got behind and from April 2025, we are implementing a new way of working which will see more localised commissioning and delivering of services that will benefit populations in local areas.

ACCOUNTABILITY REPORT

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

It comprises three sections:

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

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

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

Corporate Governance Report

Governance Structure

The ICB governance structure comprises of the ICB Board, ten Board Committees, the statutorily required Audit and Risk Committee and Remuneration Committee, and eight of which have been put in place by the ICB as standing committees. These are the Strategic Finance and Commissioning Committee, System Transformation and Quality Improvement Committee, Strategy Committee, People Committee, and the four Health Care Partnership Boards (East and North Hertfordshire, South West Hertfordshire, West Essex and Mental Health and Learning Disabilities and Autism). The ICB GP practice membership can be found on page 20 of the HWE-ICB-Governance-Handbook. The ICBs Corporate Structure can be found on the ICB website ICB-Structure-Chart. The ICB's governance structure is included below for reference:

Board

The Board is responsible for developing a plan and allocating resource to meet the health and care needs of the population. Establishing joint working arrangements with partners that embed collaboration as the basis for delivery within the plan. Establishing governance arrangements to support collective accountability for whole-system delivery and performance. Arranging for the provision of health services including contracting arrangements, transformation, development of PCN's, working with local authority Voluntary, Community, Faith and Social Enterprise (VCFSE)

sector and partners to put in place personalised care for people. The Board meet regularly, every other month in both public and private sessions.
https://www.hertsandwestessex.ics.nhs.uk/about/icb/board/members/

Audit and Risk Committee

The Audit and Risk Committee is a committee of the Board. It provides assurance to the Board that the organisation's overall internal control and governance system operates in an adequate and effective way. The committee's work focuses on the adequacy of the controls on finance and risk management. It does this by reviewing the assurance framework, strategic and operational risk and obtaining independent assurance on controls. It also oversees internal and external audit arrangements, for both financial and non-financial systems. As part of its role the committee reviews audit reports and monitors implementation of recommendations. Members also undertake in-depth analysis of specific risks. During its work, activities and areas of review throughout the year, the committee ensured that any areas of particular concern were brought to the Board's attention through the Governance Report.
The work of the **Audit and Risk Committee** during this reporting period has included:

- Approved the internal audit programme consistent with the needs of the ICB;
- Scrutinised the findings from internal audits and recommendations for improvement and monitored progress with the implementation of the recommendations;
- Reviewed and provided challenge of assurance reports and updates on areas covered under the Committee terms of reference, including information governance and risk;
- Reviewed the ICB's Corporate Risk Register and the Board Assurance Framework and provided assurance to the Board that it accurately records the strategic risks to the ICB's objectives with the measures and controls to manage them;
- Monitored progress with the Counter Fraud Workplan and discussed outcomes of the work;
- Reviewed the annual report and financial statements prior to submission with particular focus on compliance with accounting policies, practices and estimation techniques;
- Scrutinised external audit reports, including the report to those charged with governance;

System Transformation and Quality Improvement Committee

The System Transformation and Quality Improvement Committee is a committee of the Board and provides the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services against each dimension of quality set out by NHS England and the National Quality Board and enshrined in the Health and Care Act 2022. The committee plays a key role in ensuring key national policy areas such as the Long Term Plan requirements, Operating Plan, Fuller Recommendations, Primary Care contract requirements and oversight of transformation with a view to continuously improve quality and enhance performance.
The work of the **System Transformation and Quality Improvement Committee** during this reporting period has included:

- Oversight of quality and performance risks and mitigation
- Receiving integrated performance and quality reports from across the system, which enabled the Committee to review how acute, community, mental health and primary care providers across the system are performing and how performance and quality concerns are being addressed. The Committee is focussed on improving the quality of

performance reports to enable ICB decision-making and improving outcomes for our population.
- Receiving reports on quality, performance and transformation from Health Care Partnerships for assurance
- Receiving quality and performance improvement reports and related transformation work and monitoring key ICB quality priorities
- Providing strong direction that the patient voice is heard across the system and patient involvement is strongly embedded in quality improvement.

- Discussion on and oversight of the implementation of the Patient Safety Incident Response Framework (PSIRF).
- Receiving deep dives on key agendas such as maternity and the Medium Term Plan priorities

Strategic Finance and Commissioning Committee

The Strategic Finance and Commissioning Committee is a committee of the Board. The committee focus is on improving the health and wellbeing outcomes of the ICBs population taking into account financial resource alongside national and local evidence to support affordability. Providing oversight and development of strategic finance management. Providing oversight and accountability of strategic commissioning and providing oversight and assurance in the delivery of ICB strategic priorities by HWE Health Care Partnerships.
The work of the **Strategic Finance and Commissioning Committee** during this reporting period has included:

- Review of the finance risk register
- Receiving ICB and system finance reports including capital position and year end forecasts
- Receiving updates on the system financial recovery programme
- Scrutinising presentations on the financial plan
- Discussions on updates on current key procurement and contracting issues and on the progress of key projects
- Reviewing progress in terms of system transformation and efficiency activities
- Approving commissioning business cases supporting transformation across the ICS
- Receiving finance and commissioning reports from Health Care Partnerships for assurance
- Reviewing capital updates, plans and investments

Strategy Committee

The Strategy Committee is a committee of the Board. The committee has oversight, assurance and provides constructive challenge to ensure the ICB and partner organisations deliver on the 5 strategic priorities. Monitoring the progress of the implementation of the Medium Term Plan, and amends that plan as needed. Advises the ICB on the alignment of plans and strategies. Promotes the adoption of Population Health Management across the ICS and provide regular updates to the board on progress in this area. Promotes and facilitates the use of research and evidence generated by research.
The work of the **Strategy Committee** during this reporting period has included:

- Monitoring implementation of the Research and innovation strategy
- Oversight of the Health Inequalities programme
- Receiving the Population Health Management Strategy
- Receiving updates on the Care Closer to Home model
- Receiving updates on the University of Hertfordshire Partnership programme
- Oversight of the Business Intelligence and Population Health Management platform development
- Reviewing the Urgent and Emergency Care (UEC) Strategy development

- Reviewing progress on frailty programme and work to reduce emergency admissions
- Receiving updates on work to improve care for those in mental health crisis
- Reviewed progress on children's community and outpatient care

Mental Health and Learning Disability Health and Care Partnership Board

The Mental Health and Learning Disability and Autism (MHLDA) Health and Care Partnership Board is a committee of the Board. Providing multi-agency, system leadership, the role of the MHLDA Health and Care Partnership Board is to support people living with mental illness, learning disabilities and autism in Hertfordshire to live longer happier and healthier lives.
The work of the **Mental Health and Learning Disability Health and Care Partnership Board** during this reporting period has included:

- Providing strategic direction and reviewing progress from the delivery sub-committees; Hertfordshire Suicide Prevention Board, Crisis Care Partnership Board, CYP Emotional and Mental Wellbeing Board, Primary and Community MH Transformation Board, Neurodiversity Strategic Partnership Board.
- Developed an integrated delivery plan
- Oversight of the Dementia Strategy delivery
- Receiving the LeDER annual report
- Receiving the SEND report
- Receiving updates from the Mental Health and Substance Use Steering Group
- Receiving assurance form the Clinical and Professional Advisory Committee, Co-production Group and MH VCFSE Alliance

East and North Hertfordshire Health and Care Partnership Board

East and North Hertfordshire Health and Care Partnership Board is a committee of the ICB Board and provides Strategic Leadership across the HCP area, has accountability for the development and delivery of the financial plan. Scrutinises and approves recommendation of the HCP Commissioning Finance and Planning Committee, HCP Quality and Performance Committee ,and Clinical Professional Committee. Has joint accountability for the transformation development and implementation. Leads the resolution of strategic challenges, issues and risks between HCP partners and maintains alignment of individual organisation strategies and activities to drive local planning and prioritisation.

The work of the E**ast and North Hertfordshire Health and Care Partnership Board** during this reporting period has included:

- Oversight of finance, quality and performance risks and mitigation
- Providing strategic direction and reviewing progress and of system transformation activities
- Providing integrated clinical leadership
- Oversight of the Care Closer to Home model and the development of Integrated Neighbourhood Teams
- Oversight of the frailty programme and reducing avoidable emergency admissions and other key areas of delivery related to the HWE Medium Term Plan

South and West Hertfordshire Health and Care Partnership Board

The South and West Hertfordshire Health and Care Partnership Board is a committee of the Board and provides strategic leadership across the HCP area, has accountability for the development and delivery of the financial plan and delegated budgets, has joint accountability for the transformation development and implementation. The HCP Board is underpinned by the Performance and Quality improvement Committee and Finance and Commissioning Committee. The Board leads on the resolution of strategic challenges, issues and risks between HCP partners and maintains alignment of individual organisation strategies and activities to drive local planning and prioritisation.

The work of the **South and West Hertfordshire Health and Care Partnership Board** during this reporting period has included:

- Oversight of finance, quality and performance and associated risks and mitigation
- Providing strategic direction and reviewing progress and of system transformation activities such as; Care Closer to Home model, Integrated Neighbourhood Teams, The Hemel Health Hub programme and Proactive Care Pilot
- Developed an integrated delivery plan
- Providing integrated clinical leadership
- Successfully reviewing 7 South West Hertfordshire community contracts and recommending business cases to the ICB Board

West Essex Health and Care Partnership Board

West Essex Health and Care Partnership Board is a committee of the ICB Board and provides strategic leadership across the West Essex area. The Partnership is made up of NHS, Local & District Authorities, the voluntary sector and the ICB working in partnership with the vision “To help everyone in our area live long and healthy lives by supporting independence and providing seamless care”. The WE HCP Board has joint accountability for the planning, transformation, development and implementation of services, for the development and delivery of the financial plan and delegated budgets and leads the resolution of strategic challenges, issues and risks between HCP partners. The work of the **West Essex Health and Care Partnership Board** during this reporting period has included:

- Providing strategic direction and reviewing progress of the 24/25 Delivery Plan and of transformation
- Developing a 3 year Integrated Delivery Plan for 2025-2028
- Providing integrated clinical leadership
- Oversight of finance, quality and performance risks and mitigation
- Developing the WE Care Closer to Home model with partners
- Receiving updates on prevention and wider determinants transformation programmes
- Scrutinised recommendations of the HCP Transformation and Quality lmprovement Committee, Finance and Commissioning Committee and Operational Delivery and Performance Committee

Remuneration Committee

The Remuneration Committee is a committee of the Board. It makes recommendations to the Board on determinations about pay and remuneration for all ‘Very Senior Managers’, and Board members, including GPs and Lay Members of the Integrated Care Board. A Very Senior Manager typically has Executive Director level responsibility and reports to the Accountable Officer. No individual is involved in determining their own remuneration.

People Board

People Board is a committee of the Board and is responsible for ensuring delivery of the Long Term Workforce Plan as well as the NHS people promise. The committee ensures there is a clear understanding of the current and future workforce, building workforce capacity and capability to meet population health needs. The committee supports the system to develop inclusive, innovative new working practices, provides workforce leadership, provides effective integrated workforce and oversees the system delivery of the requirements of the People Plan through effective multi-disciplinary working incorporating health, social care, education and VCFSE system partners. The People Board oversees the system workforce transformation programme leadership development and broader social and economic development.
The work of the **People Board** during this reporting period has included:

- Oversight of workforce risks and mitigation
- Oversight of system workforce transformation programmes
- Exploring workforce productivity
- Oversight of system workforce financial recovery workstream
- Receiving deep dives on Sustainable workforce supply, Primary medical care workforce, Social care workforce, Education talent and leadership, Equality diversity and inclusion, Staff wellbeing and experience.
- Updates on partnership working with the University of Hertfordshire
- Receiving updates on integrated system workforce planning
- Reviewing progress against the operational plan and workforce KPI's

Board

7 meetings in 2024/25

Member Attendances:	**Total**
Paul Burstow (Chair)	7
Jane Halpin	7
Alan Pond	7
Natalie Hammond	4
Rachel Joyce	6
Catherine Dugmore*	6
Gurch Randhawa	7
Ruth Bailey	5
Thelma Stober	7
Nick Moberly	6
Elliot Howard-Jones	6
Karen Taylor	6
Matthew Coats	3
Adam Sewell-Jones	6
Lance McCarthy**	1
Thom Lafferty***	3
Prag Moodley	5
Ian Perry,	6
Nicolas Small****	1
Trevor Fernandes	4
Chris Martin	6
Angie Ridgwell	3
Joanna Marovitch	2
Regular Attendees:	

Beverley Flowers	3
Frances Shattock	4
Tania Marcus	4
Toni Coles	5
Matt Webb	3
Sharn Elton	4
Avni Shah	4
Michael Watson	5
Simone Surgenor	5

*Catherine Dugmore in post April 2024 to Feb 2025
** Lance McCarthy in post April 2024 to July 2024
***Thom Lafferty in post Nov 2024 to March 2025
****Nicolas Small in post April 2024 to May 2024

Audit and Risk Committee

6 meetings in 2024/25

Member Attendances:	**Total**
Catherine Dugmore* (Chair to February 2025)	6
Gurch Randhawa	6
Thelma Stober (Chair from March 2025)	3

*Catherine Dugmore in post April 2024 to Feb 2025

Remuneration Committee

4 meetings in 2024/25

Member Attendances:	**Total**
Ruth Bailey (Chair)	4
Catherine Dugmore*	1
Tania Marcus	4
Ian Perry	1
Gurch Randhawa	4
Trevor Fernandes	3
Thelma Stober	2
Jane Halpin	3
Prag Moodley	1
Regular Attendees:	
Keeley Cooper	3
Simone Surgenor	4

*Catherine Dugmore in post April 2024 to Feb 2025

System Transformation and Quality Improvement Committee

5 meetings in 2024/25

Member Attendances:	**Total**
Paul Burstow (Chair)	5
Alan Pond	5

Natalie Hammond	4
Rachel Joyce	5
Catherine Dugmore*	5
Gurch Randhawa	5
Ruth Bailey	3
Thelma Stober	5
Nick Moberly	3
Elliot Howard-Jones	5
Karen Taylor	4
Matthew Coats	2
Adam Sewell-Jones	5
**Lance McCarthy	1
***Thom Lafferty	1
Prag Moodley	3
Ian Perry	4
Nicolas Small	1
Trevor Fernandes	3
Chris Martin	4
Angie Ridgwell	2
Regular Attendees:	
Jane Halpin	2
Beverley Flowers	3
Frances Shattock	3
Tania Marcus	3
Toni Coles	3
Matt Webb	2
Sharn Elton	3

*Catherine Dugmore in post April 2024 to Feb 2025
** Lance McCarthy in post April 2024 to July 2024
***Thom Lafferty in post Nov 2024 to March 2025

Strategic Finance and Commissioning Committee

5 meetings in 2024/25

Member Attendances:	**Total**
Nick Moberly (Chair)	5
Alan Pond	4
Scott Cruddington	1
Toni Coles	5
Elizabeth Disney*	1
Catherine Dugmore**	3
Sharn Elton	4
Natalie Hammond	3
Rachel Joyce	5
Tania Marcus	2
Chris Martin	2
Gurch Randhawa	3

Frances Shattock	2
Matt Webb	4
Avni Shah	3
David Evans	1
Regular Attendees:	
Simone Surgenor	5
Debbie Griggs	3
Michael Watson	2
James Olweny	2
Grant Neofitou	3
Pamela Shepherd	2
Colin Sach	2
Jo Oliver	3

*Elizabeth Disney in post March 2024 to August 2024
**Catherine Dugmore in post March 2024 to February 2025

Strategy Committee

6 meetings in 2024/25

Member Attendances	Total
Gurch Randhawa (Chair)	6
Beverley Flowers	6
Jane Halpin	2
Nick Moberly	4
Regular attendees:	
Paul Burstow	5
Rachel Joyce	3
Natalie Hammond	3
Adam Sewell-Jones	3
Matthew Coats	2
Scott Crudgington	3
Elizabeth Disney*	2
David Evans	4
Steve Madden	5
Emma Nicol	6
Simone Surgenor	3
Michael Watson	6
Chris Martin	2
Toby Hyde	2
Avni Shah	3
Frances Shattock	3
Sam Williamson	2
Toni Coles	4
Thom Lafferty**	2

*Elizabeth Disney in post March 2024 to August 2024
**Thom Lafferty in post Nov 2024 to March 2025

People Board

6 meetings in 2024/25

Member Attendances	Total
Ruth Bailey (Chair)	6
Tania Marcus	6
Nick Moberly	3
Mark Edwards	6
Emily Carter	6
Alison Ryder	1
Tom Hennessey	5
Thom Pounds	3
Lorraine Hammond-Di Rosa	3
Natalie Hammond	3
Marcus Riddell	5
Sally Hopper	2
Giovanna Leeks	3
Nigel Mason	5
Lee Mummery	5
Sally Judges	5
Cathrine Ward	6
Sarah Dixon	3
Jayna Gadawala	3
Attendees:	
Connie Chambers	2
Michelle Airey	3
Jo Humphries	4
Enoch Kangaraj	2
Sharon Bromley	3
Julie Warrener	3
Saira Shah	1
David Wallace	2
Jennifer Beard	1

Personal data related incidents

The ICB has had no reportable data related incidents within 2024/25

Modern Slavery Act

The 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.

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 the Hertfordshire and West

Essex Integrated Care Board 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 the Accountable Officer of Hertfordshire and West Essex Integrated Care Board. 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 Hertfordshire and West Essex Integrated Care Board 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.

Dr Jane Halpin

Accountable Officer

20th June 2025

Governance Statement

Introduction and context

Hertfordshire and West Essex ICB is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended).
The Hertfordshire and West Essex 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 April 2024 – 31 March 2025, the Integrated Care Board was not subject to any directions from NHS England issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended).

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Hertfordshire and West Essex 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 Hertfordshire and West Essex ICB's Accountable Officer Appointment Letter including responsibility for the preparation of the financial statements and for being satisfied that Annual Report and Accounts give a true, fair, balanced and understandable view. I am responsible for ensuring that the Hertfordshire and West Essex 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. As far as I am aware, there is no relevant audit information of which the entity's auditors are unaware.

Governance arrangements and effectiveness

The main function of the Board 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. You can read more about the NHS Hertfordshire and West Essex Integrated Care Board Constitution here: Constitution - hertsandwestessex.ics.nhs.uk

Committee effectiveness

To ensure the effectiveness of the Board, members have undertaken mandatory training throughout the year annual mandatory training enables the members to regularly keep their knowledge and skills up to date.
Further board development has been undertaken during this period, which included Information Governance, Health and Care Partnership delivery plans, Finance Planning, Risk appetite,

Governance review, Finance update, New Hospital Programme, System future operating model, Finance update, NHS Equality Delivery System, Frailty / End of Life. The highlights of the Board during this period which align with the ICB's objectives are outlined below:

- **Objective 1**: Ensuring every child has the best start in life (Improving emergency pathways for children and young people, reducing waiting times in targeted children's services, Herts/Essex SEND inspection, Implementing Saving Babies Lives Care Bundle v3, Improve paediatric access to NHS dentistry)
- **Objective 2**: Increase healthy life expectancy, and reduce inequality (Cardiovascular Disease, Armed Forces Community, Prevention)
- **Objective 3**: Improve access to health and care services (Diagnostics and Same Day Emergency Care)
- **Objective 4:** Increase the numbers of citizens taking steps to improve their wellbeing
- **Objective 5:** Achieve a balanced financial position annually.

In addition, each member is allocated sufficient time to discharge their respective duties and responsibilities effectively.
The Audit and Risk Committee supports the Board and the Accountable Officer by reviewing the internal controls, the level of assurances to gain confidence about the reliability and quality of these assurances. The scope of the committee's work is defined in the terms of reference, and the Committee reviews the work of Internal Audit and External Audit and Financial Reporting.

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance. However, the ICB follows the principles in the code that are most relevant to it given its size and nature but does not comply with the code as a whole. The Governance Statement discusses the most relevant parts of the code where the ICB has complied.

Discharge of statutory functions

The 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 allocated to a lead Executive Director. The ICB commissioned our internal auditors to conduct a statutory duty mapping exercise, this highlighted some areas for improvement. Plans to ensure that all directorates and their structures provide the necessary capability and capacity to undertake all of the ICB's statutory duties robustly are underway. Each director knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; has taken all the steps that he or she ought to have taken to make himself/herself aware of any such information and to establish that the auditors are aware of it.

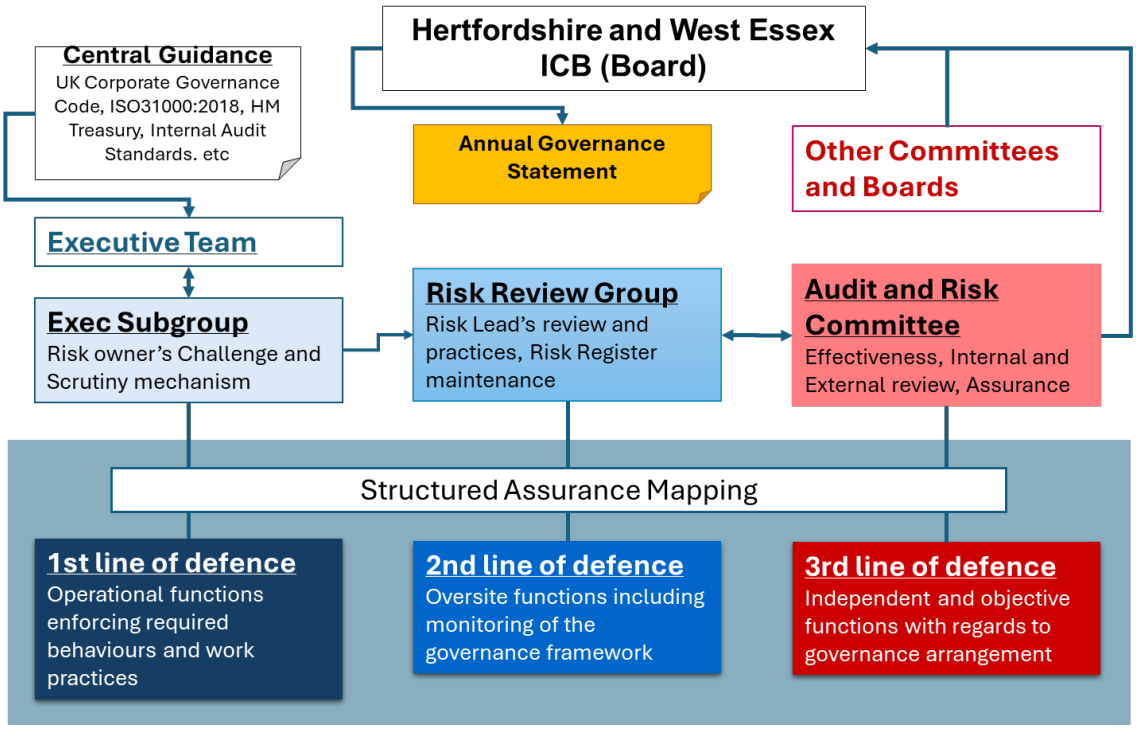
Risk management arrangements and effectiveness

In 2024-25, the Board reaffirmed its commitment to strategic risk governance, aligning with the HWE ICB Strategic Framework, which delineates five Strategic Objectives shaping the Hertfordshire and West Essex ICB's priorities for 2022-2027, including:

1. Increasing healthy life expectancy aligns with risk reduction by preventing premature mortality.
2. Focusing on children's well-being reduces long-term health risks.
3. Improving access to services minimizes risks associated with delayed care.

4. Encouraging citizen engagement in well-being activities enhances overall community health.
5. Achieving a balanced financial position ensures sustainability and risk resilience.

The Board has refined its risk appetite framework, tailoring risk tolerance thresholds to reflect operational realities, systemic interdependencies, and regulatory expectations. For further information relating to risk appetite levels, key risk domains, refer to the HWE ICB Risk Management Policy



- Works closely with internal and external auditors to validate risk management effectiveness.

Risk Registers

The ICB employs a structured risk stratification approach, ensuring that risks are escalated appropriately based on severity, probability, and systemic impact:

1. Corporate Risk Register – Captures all high-scoring risks (12 and above), ensuring automatic escalation to the Board and Executive Team for top-tier oversight and mitigation planning.
2. Directorate and Project Risk Registers – Manage operational and localized risks (below 12), with periodic review and escalation protocols where necessary.

The Executive Team's establishment of a dedicated peer challenge subgroup has further strengthened the risk oversight ecosystem, allowing for collective scrutiny of emerging risks; rigorous challenge of mitigation strategies; and deep dives on specific risks.

Delegated Risk Responsibilities

Risk management responsibilities within the organisation are distributed across key leadership roles, ensuring structured oversight and clear lines of accountability:

- Chief of Staff – Holds overarching responsibility for the ICB's risk management framework, ensuring alignment with corporate governance principles.
- Director of Nursing and Quality – Leads on clinical risk governance, ensuring compliance with patient safety, regulatory, and quality assurance standards.
- Chief Finance Officer – Assumes stewardship of financial risk, ensuring the integrity of financial controls, fiduciary responsibilities, and information governance.

Risk Management Training and Compliance

The Board and senior leaders have undertaken specialised risk governance training and leadership development programs to enhance their risk oversight capabilities. Additionally, risk management training is a mandatory competency for all staff and managers.

As of 31 March 2025, the ICB recorded 91.7% compliance in risk management training, underscoring a commitment to risk literacy, corporate governance, and continuous professional development across the organization.

The ICB's major risks (scored 16+) over the reporting period are shown overleaf, scores are noted as a snapshot on 28 March 2025, reported to ICB Board). The key controls demonstrate how the ICB has acted to manage these risks, outcomes are assessed on a regular basis through risk review at ICB Boards and Committees. The risk scoring matrix can be found on page 17 of the HWE ICB Risk Management Policy.

ID	Description	Current risk score	Controls
608	**Failure to meet UEC targets:** If UEC targets are not met and patients are not assessed with a management plan and treated, admitted and/or discharged out of the Emergency Department within 4hrs, then there is an immediate risk to patient health and wellbeing, resulting in a significant risk to patient outcomes. Additionally, there is a reputational risk to the ICB which carries a risk of NHSE interventions. The delays in assessment and treatment could cause patients with serious illnesses/conditions to wait for long periods, increasing the risk of harm to their health. These delays could also negatively impact performance targets, leading to reputational risk.	**20**	Operations Directorate UEC plans and UEC Priority Metrics. Actions linked to Performance Improvement Trajectories. Cross reference to UEC mitigations for ENH / SWH / WE place required Performance is discussed at weekly place based senior team meetings and monitored at fortnightly place based performance meetings with providers and NHSE. Performance and operational action taken to monthly System Resilience group / Local Delivery Board meetings and discussed in line with UEC action plans with escalations to monthly UEC Board. Additionally, performance is monitored at the bi-monthly Performance Committee with escalations to the ICB board. This risk complements the Operations Directorate UEC plans and Board Assurance Framework related to UEC Priority Metrics. Actions linked to Performance Improvement Trajectories. Cross reference to UEC mitigations for ENH / SWH / WE place required Risks relating to mental health patients in ED units are also being addressed in the appropriate forums and links to risk 609. Clinical harm processes for 12 hour breaches and corridor care are in place across the ICS with minimal harm identified. Quality risks related to UEC performance (including ambulance handover times) are discussed at Quality Review Meetings with system partners for ICB oversight and escalation as required. HWE System Incident Meeting is in place providing a system-wide review of patient harm due to delayed 999 responses and identify improvement actions. ICB oversight of patient safety incidents includes those linked to UEC performance. Learning related to UEC performance shared through Patient Safety Incident Response Framework (PSIRF) processes. This risk score increased over the winter period due to deteriorating performance relating to winter pressures and is expected to be reduced in early 2025-26 due to improving performance against the Emergency Department 4 hour target and the Category 2 ambulance response times during early 2025.
679	**Financial Efficiency Risk:** If the Integrated Care System and its component organisations fail to deliver the agreed efficiencies contained within the 24/25 financial plan, and the additional measures required to deliver that plan, then the system will end the year with a financial deficit, resulting in reduced funding in future years and potential harm to future service delivery and organisational reputation.	**20**	Budgetary control framework in each organisation and assessment against HFMA governance control and grip framework. Triple-lock framework which requires expenditure in scope to be second/third approved by ICB and NHSE. Income and expenditure reporting and analysis and maintain oversight of financial position at least monthly Efficiency programme and organisational oversight and reporting through Programme Management Offices. The current risk score is the same as last year.

649	**Paediatric Audiology Service Delays and Patient Safety Concerns:** IF the timeliness and quality of care provided across the HWE paediatric audiology services (recognising current quality challenges identified at ENHT) does not meet the UKAS accredited standards, THEN there is a risk that access to time critical testing does not occur in a safe and timely way RESULTING in potential harm to our population both in terms of safety and patient experience.	**16**	Further site visits taking place to clarify urgent estate needs. Limited mutual aid in place, discussions taking place within ICS and via NHSE outside the ICS. System - Audiology reviews with all appropriate providers via QI/assurance mechanisms. NHSE Desktop reviews completed for PAH and HCT. ICB Internal weekly escalation meetings occurring with key leads such as performance and estates Monthly whole HWE system audiology meeting established. Chaired by ICB Director of Nursing/ System Quality Director. NHSE/ICB site visits undertaken for PAH and HCT Nov 24 (awaiting reports) Mapping of estates and workforce at system level to support improvement actions. Demand and capacity modelling complete. NHSE/ICB site visits undertaken for PAH and HCT November 2024, reports have been shared. NHSE regional and national reporting established. Exploring options for capital estates funding. ENHT - ICB led fortnightly oversight meetings ENHT to progress action plans, trajectories and known interdependencies. Regular updates to ICB STQI Committee, System Quality Group, Regional Quality Group, Board etc NHSE oversight and support via new regional PMO team. Jumbo clinics in place for over 5 pathway. The current risk score remains the same as it was in the previous year.
610	**Planned Care Improvement:** If waiting lists for elective and diagnostics are not reduced, there a risk to patient health and outcomes, then patient's conditions may worsen resulting in deterioration of patient health. Additionally, there is a reputational risk to the ICB which carries a risk of NHSE interventions.	**16**	Work is continuing at both system and providers to reduce waiting lists with a focus on 65ww. Performance is discussed at weekly place based senior team meetings and monitored at fortnightly place-based performance meetings with providers. ICB wide issues are discussed at the planned care group which will escalate to the Planned Care Committee. Additionally, performance is monitored at the bi-monthly performance Committee and escalated to the ICB board. Work is continuing at both system and providers to reduce waiting lists with a focus on 78ww and 65ww. Work is ongoing regarding the High Volume Low Complexity (HVLC) programme with a focus on improving efficiency and increasing theatre utilisation Quality risks related to elective recovery are discussed at Quality Review meetings with system partners for IB oversight and escalation as required. Harm oversight linked to elective recovery is maintained through Patient Safety Incident Response Framework (PSIRF) processes. The risk score has been reduced from a score of 20 since last year.

Capacity to handle risk

Our capacity to handle risk is underpinned by strong leadership and an effective governance structure. The Board delegates ownership and accountability and responsibility for embedding a risk-aware culture across the organisation to the Executive Team. The Executive Team provides strategic leadership and governance, ensuring that risk-taking activities align with the Integrated Care Board's (ICB) risk appetite and tolerance thresholds.

Role	Responsibilities in Risk Management	Summary of key duties
Board	The Board holds ultimate responsibility for determining acceptable risk levels aligned with organisational objectives. Key points include: 1. **Executive Members**: Responsible for risk management processes within their respective areas. 2. **Non-Executive Members**: Scrutinise risk management systems and processes.	• Objective Setting • Risk Reporting, Scrutiny and Assurance • Robust Structure • Collaboration • Governance Code Adherence
Chief Executive	The Chief Executive, also known as the Accountable Officer, holds overall responsibility for risk management within the ICB.	• Policy Implementation • Cultural Emphasis • Strategic Focus
Executive Team, and subgroup	The Executive Team oversees the implementation of corporate risks through its Executive Subgroup. This subgroup is designated to allow peer to peer challenge on key risks.	• Risk Identification and Management • Reporting Structure • Directorate-Level Processes • Cultivating Risk Awareness
Chief of Staff	The Chief of Staff is pivotal in advising the Accountable Officer on ICB risks.	• Accountability • Risk Oversight • Agenda Prioritisation • Control Framework
Senior Information Risk Owner (SIRO)	The Chief Finance Officer (CFO) of the ICB serves as the designated SIRO, responsible for information risk management	• Ownership and Accountability • Counter Fraud Measures • Culture Promotion • Stakeholder Collaboration: • Compliance
Audit and Risk Committee (ARC)	The Audit and Risk Committee oversees strategic and system risks related to ICB objectives.	• Auditor Appointments: • Mitigating Risks • Independence and Objectivity • Continuous Improvement
Risk Review Group (RRG)	As a subcommittee of the ARC, the RRG evaluates both ICB and ICS risk management practices, identifies concerns,	• Framework Assessment • Enhancing Discussions

	and provides regular reports and recommendations	• Mitigation Oversight • Adaptive and collaborative Approach
All Staff	All staff must comply with this Risk Management Policy and assisting in the risk management process	• Risk Identification. • Estimate risk severity based on likelihood and impact on objectives at any level. • Controls Review and Strengthening • Effective Risk Communication

Strategic Risk Identification and External Engagement

Strategic risks are proactively identified and assessed by the Executive Team, using a risk-based approach aligned with the ICB's Strategic Objectives. This process is informed by:

- Enterprise risk scanning
- Risk intelligence from external regulatory bodies
- Engagement with system-wide stakeholders

The ICB is an active participant in the Health and Wellbeing Board and contributes to County Council scrutiny forums, providing a collaborative platform for multi-agency risk discourse. This engagement mechanism enhances stakeholder inclusion, ensuring that risks with system-wide implications are understood, communicated, and managed effectively.

Additionally, the highest-scoring risks are formally escalated and published for Board review, reinforcing transparency and public engagement on material risks impacting service delivery and community health outcomes. Stakeholders actively participate in discussions related to risks that directly affect them.

Corporate Risk Governance and Oversight

Corporate risks are subject to scrutiny at the Executive Subgroup and monthly review by the Risk Review Group (RRG), ensuring ongoing monitoring, challenge, and validation of risk controls. Our control mechanisms are multifaceted, including policy and procedure reviews, staff training, technology solutions and oversight forums. These controls are designed to implement measures to prevent risks from materialising and review effectiveness by developing strategies to manage and mitigate risks. The findings are formally documented and escalated to the Audit and Risk Committee (ARC), which provides independent oversight and assurance. Any recommendations or corrective actions arising from the ARC's review are relayed to risk leads, fostering a continuous improvement cycle in risk governance.

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the Integrated Care Board 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.

Internal Audit

The organisation uses an internal audit function to monitor the internal controls in operation to identify areas of weaknesses and make recommendations to rectify them. The system is embedded in the activity of the organisation through an annual Internal Audit Work Plan. RSM provides the Internal Audit services for the organisation. The Head of Internal Audit reports independently to the Chair of the Audit and Risk Committee. It provides objectivity and independent assurance on the effectiveness of its internal control system, including the application of the Risk Management Framework. The annual Head of Internal Audit Opinion provides independent overarching assurance to the organisation.

Annual audit of conflicts of interest management

The Health and Care Act 2022 places responsibility on ICBs to manage conflicts of interest. The Conflicts of Interest policy is included in the ICB's governance handbook. NHS England published updated Managing conflicts of interest in the NHS guidance in September 2024 and supporting national e-learning module for managing conflicts of interest in ICBs which is mandated for all ICB staff to undertake. The ICB has systems in place to provide assurance that on an annual basis their registers of interest are accurate, up to date and published for members of the Board and Executive Directors. You can read our register of interests here: Declaration of interests – Hertfordshire and West Essex NHS ICB

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by a Data Security and Protection toolkit and the annual submission process provides assurances to the integrated care board, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively. Risks to data security are managed through a series of management, technical, operational and privacy controls.

Data Security and Protection Toolkit

The Data Security and Protection Toolkit (DSPT) is an assessment tool that all organisations must complete if they have access to NHS patient data and systems it provides assurance around the controls, they have in place to manage information risk.
In 2024/25 ICBs are required to measure and publish their performance against the new National Cyber Security Centre (NCSC) Cyber Assurance Framework aligned DSPT by the end of June 2025. The audit rated the risk assurance rating as very high, 8 or 9 agreed actions recommended to reduce this risk are due to be completed by the end of June.
The ICB places high importance on ensuring robust information governance systems and processes are in place to help protect patient confidentiality and corporate information. Policies and processes for the management of information have been agreed at the Executive Committee of the Board.
We have established an Information Governance Management Framework and have developed information governance processes and procedures in line with the Information Governance Toolkit. We ensure that all staff members undertake mandatory information governance training annually, and ensure they know their roles and responsibilities.
Incident reporting is openly encouraged through staff training and there are processes in place for incident reporting, and investigation of serious incidents. The Chief Finance Officer is the Senior Information Risk Owner and continues to embed an information risk culture throughout the organisation. The ICB has an appointed Data Protection Officer, in line with the General

Data Protection Regulation. The Director of Nursing is the Caldicott Guardian and provides oversight to ensure personal data is processed in accordance with Caldicott Principles.

Business Critical Models

HWE ICB can confirm that an appropriate framework and environment are in place to provide quality assurance of business-critical models. There are several aspects of the 2013 MacPherson review which are of relevance to the ICB to increase the robustness of the modelling work we undertake, as well as providing assurance to the relevant committee and board of the level of confidence which can be taken from the modelling estimates.

All models have appropriate quality assurance of their inputs, methodology and outputs in the context of the risks their use represents. All models are managed within a framework that ensures that appropriately specialist staff are responsible for developing and using the models as well as quality assurance. There is a single Senior Responsible Owner (SRO) for each model through its life cycle and clarity from the outset on how quality assurance (QA) is to be managed. Business cases using results from models summarise what QA processes have been undertaken, including the extent of expert scrutiny and challenge. They also confirm if the SRO is content that the QA process is compliant and appropriate with any model limitations, risks, and the major assumptions are understood and applied in generating in generating the model outputs. This includes end-users of any model prepared.

The ICB's data provider, Oracle, has all requirements necessary to ensure quality assurance of business-critical models included in their Service Level Agreement (SLA).

The ICB uses activity models that are based on official government produced information; for example, population demographics, provided by the Office for National Statistics (ONS). As a nationally recognised body, it is assumed that the ONS will have undertaken quality assurance processes about the construction of these models. The ICB used a risk stratification model which was made available by Oracle and is included in the list of risk stratification approved organisations. This model is used to identify a discrete group of patients at risk of being admitted to the hospital as an emergency, who may be better looked after through local community or primary care services.

Third Party Assurance

Third party supplier assurance of the Oracle system is provided by satisfactory completion of the Data Security and Protection Toolkit, Oracle are entered on the data protection register with the ICO, further assurance is provided by the inclusion of a confidentiality clause in the contract between the ICB and Oracle.

Data Quality

Monthly data quality reports are provided for Admitted patient care, Outpatients, A&E/Emergency Care, Maternity in acute hospitals are published by NHS Digital. These are reviewed by the ICB's Business Intelligence Team. The ICB have access to the national Hospital Episode Statistics (HES), through the ICB's local data platform, to undertake bespoke comparative data analysis to be compared alongside any national benchmarking reports such as Right Care. The ICB also receives data from the General Practices, again through the ICB's local data platform, and we use this data to check against the nationally released data, Quality Outcome Framework (QOF). The ICB now has a Data Quality Group that monitors key data points, particularly between the providers sending the data to the Commissioning Support Unit (Arden and Gem) and when the data is received and processed by the ICB data tool Data Environment and Longitudinal record for Performance and Population Health Intelligence

(DELPPHI) provided by Oracle, The quality of the data used by the ICB and to inform the Board is acceptable.

Nationally Outsourced Services

The ICB receives some administrative services from nationally commissioned organisations and in 2024/25 also received Service Auditor Reports on these services, which it reviews:

- **Electronic Staff Record system provided by NHS Business Services Authority and IBM UK Ltd -** *No exceptions were noted across the control objectives.*
- **Prescription payments provided by NHS Business Services Authority (BSA) -** *No exceptions were noted across the 6 control objectives.*
- **Dental payments by NHS Business Services Authority (BSA) -** *No exceptions were noted across the control objectives.*
- **Primary Care Support England services for processing GP and pharmacy payments and pensions administration provided by Capita -** *auditors noted exceptions on 3 out of 15 control objectives, key actions have been introduced to address the improvements identified, such that these do not appear to represent a significant risk to the ICB.*
- **Finance and accounting services provided by NHS Shared Business Services -** *Three exceptions were highlighted against the 57 controls, whilst noting the exceptions, we do not consider these sufficiently significant to impact on our overall Head of Internal Audit Opinion.*

Control issues

- According to the Head of Internal Audit Opinion, the Board can have reasonable assurance since the controls on which the ICB relies to manage issues are appropriately designed, consistently applied, and operating effectively.

The auditors have highlighted two significant issues

- Lack of formal documentation for CHC expenditure and the fact that management has been unable to provide sufficient documentation to support CHC funding.
- Secondly risk in budgeting and monitoring of cost improvement plans (CIPs) budgeting processes, particularly regarding the identification, achievement, and monitoring of CIPs.

To address these issues, the ICB will focus on:

- Strengthening documentation and monitoring to ensure proper documentation for CHC and implement robust monitoring mechanisms to track and support all supporting activities.
- Improving budgeting and cost control processes by focusing on refining budget-setting, CIP development, and ongoing monitoring processes to meet financial targets and mitigate risks to service delivery.

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

To ensure the Integrated Care Board resources are used economically, efficiently and effectively the ICB has implemented processes, which are described below:

- the ICB has reviewed detailed financial policies, which set out the systems to be adhered to in order to ensure that resources are used efficiently

- developed and implemented strategic and operational plans, which include an agreed annual budget approved by the Board
- corporate wide process for the development and review of business cases for investment. Processes include assessment of value for money and contribution to the achievement of ICB strategic objectives
- reports on finance and quality presented on a two monthly basis to the Board, with actions identified when performance is off track
- implementation of an internal audit programme that is targeted at the strategic risks and key financial control processes
- annual fraud risk assessment undertaken by an independent party, providing recommendations for key actions
- comprehensive fraud and bribery policies agreed and in place with local counter fraud specialist delivering an agreed work plan
- requirement as part of mandatory training that all staff undertake counter fraud and bribery training
- training for staff to be Speak up, Listen up and Follow up to support the Freedom to Speak Up process.
- NHS Right Care allows the organisation to compare the amount we spend, the health services we commission and the health of our population against that of other areas in England. These comparisons help the ICB to identify whether our population is receiving high quality, efficient and effective health services
- regular reporting to the Board on financial planning, in-year performance monitoring and central management costs

Commissioning of delegated specialised services

Hertfordshire and West Essex Integrated Care Board signed a delegation agreement with NHS England and held full commissioning responsibilities for delegated services during the 2024/25 reporting period. To the best of ICB leadership's knowledge, the commissioning of all delegated services has been compliant with the 10 core commissioning requirements – as set out in the 2024/25 Delegated Commissioning Assurance Guidance, published by NHS England – including the requirement that all conditions set out in the DA are being met.
The ICB leadership is able to provide the necessary evidence of core commissioning requirements compliance through the Regional Joint Commissioning Consortium, should NHS England or a third party (e.g. external auditors) ask for such evidence

Counter fraud arrangements

The Integrated Care Board commissions RSM to provide the counter fraud provision by way of a nominated lead local counter fraud specialist (LCFS). The LCFS is accredited by the NHS Counter Fraud Authority and qualified to undertake the duties of that role.

RSM provides the Integrated Care Board with a LCFS Annual Report, which details all work undertaken in respect of counter fraud activities for the reporting year and measures each task as specified in the NHS Counter Fraud Authority Standards for NHS Commissioners: Fraud, Bribery and Corruption. The LCFS work plan is designed to meet the requirements set out in the standards and each task is designed to provide compliance with each of the standards described. The LCFS work plan is designed to address the locally and nationally identified fraud risk areas in conjunction with the Chief Finance Officer.

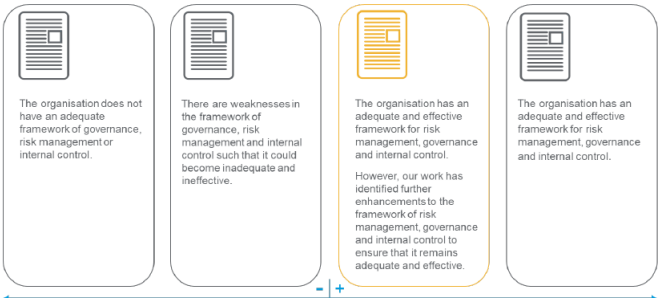
The Chief Finance Officer holds Board level responsibility for the delivery of the LCFS work and provides the support to the LCFS in achieving this. The LCFS works with the Chief Finance Officer in submitting the annual NHS Counter Fraud Authority Self-Review Tool. An action plan

is produced on the findings of this tool which is monitored at Audit and Risk Committee for any areas not deemed as fully compliant with the standards.

Please see page 27 of The ICBs Integrated Governance Handbook for the ICBs 'whistleblowing' procedures.

Head of Internal Audit opinion

Following completion of the planned audit work for 2024/25 for the ICB, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance and internal control. The Head of Internal Audit concluded that: The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective



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

Area of Audit	Level of assurance given
Conflicts of Interest	Reasonable Assurance
Governance	Reasonable Assurance
Children's Services	Reasonable Assurance
Digital Strategy	Reasonable Assurance
Key Financial Controls - Payroll	Reasonable Assurance
Primary Care – GP IT Services	Reasonable Assurance
Continuing Healthcare	Partial Assurance
Risk Management	Reasonable Assurance
Data Security and Protection Toolkit (DSPT)	Risk rating very high

Continuing Healthcare audit has received "partial assurance". Detailed actions with specific timescales have been agreed, will be undertaken and reported to both the Audit and Risk Committee and the audit team. Three high priority and seven medium priority management actions were recommended. These related to the timely completion of cases, compliance with the process for undertaking reviews, updating policies, implementing a new patient management system and formalising provider selection processes.

The DSPT audit has been rated as very high risk, this is indicated when four or more outcomes are rated as not meeting requirements. Detailed actions with specific timescales have been agreed, will be undertaken and reported to both the Audit and Risk Committee and the audit team. Nine medium and two priority management actions were recommended, two of which have already been implemented at the time the report was issued. These relate to updating policies, documenting processes, reporting of supply chain and testing processes.

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

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the ICB who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports. Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the ICB achieving its principles objectives have been reviewed. I have been advised on the implications of the result of this review by:

- The Board
- The Audit and Risk Committee
- System Transformation and Quality Improvement Committee
- Internal audit
- External audit

Conclusion

As Accountable Officer, and based on the review processes outlined above, I can confirm that the Governance Statement is a balanced reflection of the actual controls position and there are no significant internal control issues identified for the Integrated Care Board.

Dr Jane Halpin

Accountable Officer

20th June 2025

Remuneration and Staff Report

Remuneration Report

Membership of the ICB's Remuneration Committee can be found at page 52 of this report

2024/25 Fair Pay Disclosure (audited element of remuneration report)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. These ratios provide a reference point to inform movements in the gap between the workforce and the highest paid director.

Total remuneration disclosed consists of salary and allowances, benefits-in-kind but not severance payment, there was no Non Consolidated performance related pay in 2024-25. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The total banded remuneration of the highest paid director/Member in Hertfordshire and West Essex ICB in the financial year 2024-25 was £245K to £250K (£235k to 240k in 2023-24). This was 4.64 times the median remuneration of the workforce, which was £53,342.

YEAR	25th Percentile total remuneration ratio	Median total remuneration ratio	75th Percentile total remuneration ratio
2024-25	**247,500:38,307**	**247,500:53,342**	**247,500:64,337**
	6.46	**4.64**	**3.85**
YEAR	25th Percentile total remuneration ratio	Median total remuneration ratio	75th Percentile total remuneration ratio
2023-24	**237,500:36,310**	**237,500:48,204**	**237,500:60,983**
	6.54	**4.93**	**3.89**

The change from the previous financial year in respect of the salary of the highest paid Director relates to a pay award.

The change from the previous year in respect of average employees' salary and allowances, (2024-25 £55,275: 2023-24 £52,027) is due to Agenda for change pay awards, and a change in the grade profile of staff.

Average employees' salary and allowances in 2024/25 was £55,275. In 2024-25 no employee received remuneration in excess of the highest paid director/member. Remuneration ranged from £4,171 to highest paid director. Remuneration for the lowest paid employee relates to a time commitment below the normal contractual hours, and therefore the annualised FTE calculation reflects the different terms.

Average salary in 2024-25	£ 55,275.00	Performance pay and bonuses in 2024-25	£0.00
Average salary in 2023-24	£ 52,027.00	Performance pay and bonuses in 2023-24	£0.00
Percentage increase	6.24%	Percentage increase	0%

Highest paid Director banding 2024-25	£245k-250K	Performance pay and bonuses in 2024-25	£0.00
Highest paid Director banding 2023-24	£235k-240K	Performance pay and bonuses in 2023-24	£0.00
Percentage increase	5.00%	Percentage increase	0%

Policy on the remuneration of senior managers

The ICB benchmarks with local ICBs to ensure that remuneration is in line with the local economy. Remuneration for all senior roles is agreed via the Remuneration Committee. For all other staff, the Agenda for Change framework is applied.

Remuneration of Very Senior Managers

The Accountable Officer of the ICB, Chief Finance Officer, Medical Director, Nursing Director and Director of Strategy are paid a salary in excess of £150,000 per annum. This has been approved by NHS E and the national remuneration committee considering senior manager pay and benchmarking was undertaken with similar sized organisations to ensure that salaries are competitive and in line with that of similar systems

Employee benefits and staff numbers (subject to audit)

Employee benefits	Total £'000	2024-25 Permanent Employees £'000	Other £'000
Salaries and wages	43,591	42,190	1,401
Social security costs	4,823	4,823	0
Employer Contributions to NHS Pension scheme	8,640	8,640	0
Other pension costs	6	6	0
Apprenticeship Levy	202	202	0
Termination benefits	102	102	0
Total employee benefits expenditure	**57,364**	**55,963**	**1,401**

Employee benefits	Total £'000	2023-24 Permanent Employees £'000	Other £'000
Salaries and wages	42,154	39,710	2,444
Social security costs	4,479	4,479	0
Employer Contributions to NHS Pension scheme	6,970	6,970	0
Other pension costs	9	9	0
Apprenticeship Levy	187	187	0
Termination benefits	231	231	0
Total employee benefits expenditure	**54,030**	**51,586**	**2,444**

Average number of people employed (subject to audit)

	Total Number	2024-25 Permanently employed Number	Other Number
Total for ICB	**740.9**	**717.7**	**23.2**

	Total Number	2023-24 Permanently employed Number	Other Number
Total for ICB	726.0	705.7	20.3

Senior manager remuneration (including salary and pension entitlements)

Remuneration for members of the Board - Salaries and allowances April 2024 - March 2025

Table 1:Single total figure (Subject to Audit)

			2024-25						
Name	Role	Note	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	Other remuneration	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)
			£000	£	£000	£000		£000	£000
Jane Halpin	Accountable Officer	1,6	245-250	300	0	0	0	0	250-255
Paul Burstow	ICB Chair	1	65-70	0	0	0	0	0	65-70
Alan Pond	Chief Finance Officer	1,6	190-195	300	0	0	0	0	190-195
Rachel Joyce	Medical Director		160-165	0	0	0	0	0	160-165
Natalie Hammond	Director of Nursing & Quality	8	180-185	0	0	0	0	707.5-710	890-895
Elizabeth Disney	Director of Operations (to 30 August 2024)	6	60-65	100	0	0	0	10-12.5	70-75
Beverley Flowers	Director of Strategy		160-165	0	0	0	0	20-22.5	180-185
Adam Lavington	Director of Digital Transformation		130-135	0	0	0	0	25-27.5	155-160
Tania Marcus	Chief People Officer	6	145-150	100	0	0	0	27.5-30	170-175
Avni Shah	Director of Primary Care Transformation	7	135-140	1100	0	0	0	22.5-25	160-165
Frances Shattock	Director of Performance		145-150	0	0	0	0	37.5-40	185-190
Toni Coles	Managing Director (WE)	1	135-140	0	0	0	0	0	135-140
Sharn Elton	Managing Director (ENH)	6	145-150	100	0	0	0	37.5-40	180-185
Matthew Webb	Managing Director (SWH)	6	135-140	100	0	0	0	17.5-20	155-160
Michael Watson	Chief of Staff (from 1 October 2024)		60-65	0	0	0	0	15-17.5	75-80
Dr Prag Moodley	Partner Member-Primary Medical Services	2,5	90-95	0	0	0	0	0	90-95
Dr Ian Perry	Partner Member-Primary Medical Services	2	65-70	0	0	0	0	0	65-70
Dr Nicholas Small	Partner Member-Primary Medical Services (to 31 May 2024)	3	10-15	0	0	0	0	0	10-15
Dr Trevor Fernandes	Partner Member-Primary Medical Services (from 1 July 2024)	2,5	50-55	0	0	0	0	0	50-55
Catherine Dugmore	Lay Member (to 28 February 2025)	4	10-15	0	0	0	0	0	10-15
Ruth Bailey	Lay Member	4	15-20	0	0	0	0	0	15-20
Professor Gurch Randhawa	Lay Member	4	15-20	0	0	0	0	0	15-20
Thelma Stober	Lay Member	4	15-20	0	0	0	0	0	15-20
Nick Moberly	Lay Member	4	15-20	0	0	0	0	0	15-20

Notes

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 of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Note 1 - Members who chose not to be covered by the pension arrangements during the reporting period.

Note 2 - Where a GP Board member is working under a "contract for services" and the GP is set up on the payroll system to satisfy HMRC rulings, the position is pensionable under the "Practioner Pension Scheme". The ICB must make the post non pensionsable on the payroll and submit a GP Solo form with the employer's pension contribution of 14.3% plus an administration levy of 0.08% to the NHS Pension Authority. The salary banding above comprises of gross payment plus employer pension contribution, where applicable.

Note 3 - The GP member chose not to be covered by the Practitioner pension arrangements during the reporting period.

Note 4 - As Lay members do not receive pensionable remuneration, there will be no entries in respect of pension benefits.

Note 5 - The total remuneration includes £5,000-£10,000 relating to a locality lead role.

Note 6 - The taxable benefits relate to the re-imbursement of mileage incurred on official duties. The benefit arises from the mileage allowance payments made to all staff, to reimburse them for expenses related to the use of their own vehicle for business travel. Hertfordshire & West Essex ICB pays the rate per mile set out in Agenda for Change, which exceeds the HMRC "approved mileage allowance payments" rate of 45p a mile. The excess amount is taxable and is disclosed above.

Note 7 - The taxable benefit relates to the member having a lease car. The member has a salary sacrifice arrangement for their vehicle which has the effect of reducing the salary paid during 2024-25.

Note 8 - The notable rise in pension benefits for the member from the 2023/24 to 2024/25 financial year is attributable to the employment duration. In 2023/24 the member was employed by the ICB for part year, whereas in 2024/25 she was employed for the entire year. This shift from part year to full year employment results in the appearance of a significant increase in pension benefits when reporting the current period.

Note 9 - The following are Partner Members on the Board but because neither they or their employing organisation receive remuneration in respect of their Board attendance and associated activities no further disclosure is required.

Elliot Howard-Jones - Chief Executive, Hertfordshire Community NHST

Thomas Lafferty - Chief Executive, Princss Alexandra Hospital NHST, replaced Lance McCarty 4 November 2024.

Karen Taylor - Chief Executive, Hertfordshire Partnership University NHS FT

Angie Ridgewell - Chief Executive, Hertfordshire County Council

Christopher Martin - Director of Wellbeing, Public Health & Communities, Essex County Council

Matthew Coats - Chair, South and West Herts Health and Care Partnership board, and Chief Executive officer, West Hertfordshire Teaching Hospital NHS Trust

Adam Sewell-Jones - Chief Executive, East and North Hertfordshire NHS Trust

Joanna Marovitch - Voluntary, Community, Faith and Social Enterprise Alliance Representative

Remuneration for members of the Board - Salaries and allowances April 2023 - March 2024

Table 1:Single total figure (Subject to Audit)

			2023-24						
Name	**Role**	**Note**	**Salary (bands of £5,000)**	**Expense payments (taxable) to nearest £100**	**Performance pay and bonuses (bands of £5,000)**	**Long term performance pay and bonuses (bands of £5,000)**	**Other remuneration**	**All pension related benefits (bands of £2,500)**	**TOTAL (bands of £5,000)**
			£000	**£**	**£000**	**£000**		**£000**	**£000**
Jane Halpin	Accountable Officer	1,7	235-240	400	0	0	0	0	235-240
Paul Burstow	ICB Chair	1	65-70	0	0	0	0	0	65-70
Alan Pond	Chief Finance Officer	1,7	180-185	200	0	0	0	0	180-185
Rachel Joyce	Medical Director	9	160-165	0	0	0	0	0	160-165
Jane Kinniburgh	Director of Nursing & Quality (to 30 April 2023)	1,5	10-15	0	0	0	0-5	0	15-20
Natalie Hammond	Director of Nursing & Quality (from 31 July 2023)	7	115-120	0	0	0	0	30-32.5	145-150
Elizabeth Disney	Director of Operations	7	140-145	200	0	0	0	12.5-15	155-160
Beverley Flowers	Director of Strategy	9	150-155	0	0	0	0	0	150-155
Adam Lavington	Director of Digital Transformation	7	120-125	100	0	0	0	62.5-65	185-190
Tania Marcus	Chief People Officer	7	135-140	100	0	0	0	60-62.5	195-200
Avni Shah	Director of Primary Care Transformation	8,9	130-135	1100	0	0	0	0	130-135
Frances Shattock	Director of Performance		140-145	0	0	0	0	32.5-35	175-180
Toni Coles	Managing Director (WE)	1	125-130	0	0	0	0	0	125-130
Sharn Elton	Managing Director (ENH)	7,9	135-140	100	0	0	0	0	135-140
Matthew Webb	Managing Director (SWH)	7,9	125-130	100	0	0	0	0	125-130
Dr Prag Moodley	Partner Member-Primary Medical Services	2,6	120-125	0	0	0	0	£NIL	120-125
Dr Ian Perry	Partner Member-Primary Medical Services	2	80-85	0	0	0	0	£NIL	80-85
Dr Nicholas Small	Partner Member-Primary Medical Services	3	75-80	0	0	0	0	0	75-80
Catherine Dugmore	Lay Member	4	15-20	0	0	0	0	0	15-20
Ruth Bailey	Lay Member	4	15-20	0	0	0	0	0	15-20
Professor Gurch Randhawa	Lay Member	4	15-20	0	0	0	0	0	15-20
Thelma Stober	Lay Member	4	15-20	0	0	0	0	0	15-20
Nick Moberly	Lay Member (from 1 December 2023)	4	5-10	0	0	0	0	0	5-10

Notes

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.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Note 1 - Members who chose not to be covered by the pension arrangements during the reporting period.

Note 2 - Where a GP Board member is working under a "contract for services" and the GP is set up on the payroll system to satisfy HMRC rulings, the position is pensionable under the "Practioner Pension Scheme". The ICB must make the post non pensionable on the payroll and submit a GP Solo form with the employer's pension contribution of 14.3% plus an administration levy of 0.08% to the NHS Pension Authority. The salary banding above comprises of gross payment plus employer pension contribution, where applicable.

Note 3 - The GP member chose not to be covered by the Practitioner pension arrangements during the reporting period.

Note 4 - As Lay members do not receive pensionable remuneration, there will be no entries in respect of pension benefits.

Note 5 - Other renumeration relates to payment in lieu of annual leave.

Note 6 - The total remuneration includes £20,000-£25,000 relating to a locality lead role.

Note 7 - The taxable benefits relate to the re-imbursement of mileage incurred on official duties. The benefit arises from the mileage allowance payments made to all staff, to reimburse them for expenses related to the use of their own vehicle for business travel. Hertfordshire & West Essex ICB pays the rate per mile set out in Agenda for Change, which exceeds the HMRC "approved mileage allowance payments" rate of 45p a mile. The excess amount is taxable and is disclosed above.

Note 8 - The taxable benefit relates to the member having a lease car. The member has a salary sacrifice arrangement for their vehicle which has the effect of reducing the salary paid during 2023-24.

Note 9 - Members affected by the Public Service Pensions Remedy where their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted for a zero.

Note 10 - The following are Partner Members on the Board but because neither they or their employing organisation receive remuneration in respect of their Board attendance and associated activities no further disclosure is required.

Elliot Howard-Jones - Chief Executive, Hertfordshire Community NHST

Lance McCarthy - Chief Executive, Princess Alexandra Hospital NHST

Karen Taylor - Chief Executive, Hertfordshire Partnership University NHS FT

Owen Mapley - Chief Executive, Hertfordshire County Council

Lucy Wightman - Director of Wellbeing, Public Health & Communities, Essex County Council

Joanna Marovitch - Chief Executive, Hertfordshire Mind Network

HERTFORDSHIRE & WEST ESSEX ICB

Table 2: Pensions Benefits (Subject to Audit)

Table 2: Pension Benefits April 2024 - March 2025

Name	Role	Note	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2025 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2024	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2025	Employer's contribution to stakeholder pension
			£000	£000	£000	£000	£000	£000	£000	£000
Jane Halpin	Accountable Officer	1	0	0	0	0	0	0	0	0
Paul Burstow	ICB Chair	1	0	0	0	0	0	0	0	0
Alan Pond	Chief Finance Officer	1	0	0	0	0	0	0	0	0
Rachel Joyce	Medical Director	5	0	0	5-10	0	0	0	113	0
Natalie Hammond	Director of Nursing & Quality	6	30-32.5	85-87.5	105-110	290-295	1625	750	2499	0
Elizabeth Disney	Director of Operations (to 30 August 2024)		0-2.5	0	15-20	5-10	199	5	242	0
Beverley Flowers	Director of Strategy		0-2.5	0	60-65	160-165	1364	31	1,506	0
Adam Lavington	Director of Digital Transformation	5	0-2.5	0	25-30	0	322	16	376	0
Tania Marcus	Chief People Officer		0-2.5	0	30-35	75-80	635	23	719	0
Avni Shah	Director of Primary Care Transformation		0-2.5	0	45-50	115-120	858	23	955	0
Francis Shattock	Director of Performance	5	2.5-5	0	10-15	0	117	24	168	0
Toni Coles	Managing Director (WE)	1	0	0	0	0	0	0	0	0
Sharn Elton	Managing Director (ENH)		2.5-5	0-2.5	70-75	185-190	1,490	53	1,660	0
Michael Watson	Chief of staff (from 1 October 2024)	5	0-2.5	0	10-15	0	111	7	148	0
Matthew Webb	Managing Director (SWH)		0-2.5	0	50-55	125-130	1029	23	1138	0
Dr Prag Moodley	Partner Member-Primary Medical Services	2	0	0	0	0	0	0	0	0
Dr Ian Perry	Partner Member-Primary Medical Services	2	0	0	0	0	0	0	0	0
Dr Nicholas Small	Partner Member-Primary Medical Services (to 31 May 2024)	3	0	0	0	0	0	0	0	0
Dr Trevor Fernandes	Partner Member-Primary Medical Services (From 1 July 2024)	2	0	0	0	0	0	0	0	0
Catherine Dugmore	Lay Member	4	0	0	0	0	0	0	0	0
Ruth Bailey	Lay Member	4	0	0	0	0	0	0	0	0
Professor Gurch Randhawa	Lay Member	4	0	0	0	0	0	0	0	0
Thelma Stober	Lay Member	4	0	0	0	0	0	0	0	0
Nick Moberly	Lay Member	4	0	0	0	0	0	0	0	0

Notes

The total accrued pension, lump sum and cash equivalent transfer value are as at 31 March 2025.

As part of the changes to public pension schemes, both the 1995 and 2008 Sections of the 1995/2008 Scheme closed on 31 March 2022. All active members of the 1995/2008 Scheme were automatically moved to the 2015 Scheme on 1 April 2022.

Note 1 - Members who chose not to be covered by the pension arrangements during the reporting period.

Note 2 - Where a GP Board member is working under a "contract for services" and the GP is set up on the payroll system to satisfy HMRC rulings, the position is pensionable under the "Practitioner Pension Scheme". The ICB must make the post non-pensionable on the payroll and for GPs who are members of the Practitioner scheme, submit GP SOLO forms to reflect the employers pension contribution of 14.3% plus 0.08% administration levy to the NHS Pensions Authority .

Note 3 - Member who chose not to be covered by Practitioner pension arrangements during the reporting year.

Note 4 - As Lay Members do not receive pensionable remuneration, there will be no entries in respect of pensions.

Note 5 - No lump sum is shown for those senior managers who only have membership in the 2015 Scheme or 2008 Section

Note 6 - The notable increase in pension benefits for the member for 2024/25 financial year is attributable to the employment duration. In 2023/24 the member was employed by the ICB for part year, whereas in 2024/25 she was employed for the entire year. This shift from part year to full year employment results in the appearance of a significant increase in pension benefits when reporting the current period.

Note 7 - NHS employees contribute towards their pension benefits. In 2024/25 contribution rates were based on actual pensionable earnings. Employee contribution rates were 12.5% where individuals earned in excess of £62,925.

The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.

Note 8 - Cash equivalent transfer values (CETV)

A cash equivalent transfer value (CETV) is the actuarially assesed 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 benefit's and any contingenet 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.

Note 9 - 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 pension scheme or arrangement).

Compensation on early retirement or for loss of office (subject to audit)

No payments were made in 2024-25

Payments to past members (subject to audit)

No payments were made in 2024-25 to any individual who had previously been a director of the ICB.

HERTFORDSHIRE & WEST ESSEX ICB

Table 2: Pensions Benefits (Subject to Audit)

Table 2: Pension Benefits April 2023 - March 2024

Name	Role	Note	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2024 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2024 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2023	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2024	Employer's contribution to stakeholder pension
			£000	£000	£000	£000	£000	£000	£000	£000
Jane Halpin	Accountable Officer	1	0	0	0	0	0	0	0	0
Paul Burstow	ICB Chair	1	0	0	0	0	0	0	0	0
Alan Pond	Chief Finance Officer	1	0	0	0	0	0	0	0	0
Rachel Joyce	Medical Director	2	0	17.5-20	55-60	150-155	903	0	101	0
Jane Kinniburgh	Director of Nursing & Quality (to 30 April 2023)	1	0	0	0	0	0	0	0	0
Natalie Hammond	Director of Nursing & Quality (from 31 July 2023)		0-2.5	30-32.5	70-75	195-200	1175	207	1625	0
Elizabeth Disney	Director of Operations	6	0-2.5	0	10-15	5-10	130	37	199	0
Beverley Flowers	Director of Strategy	6	0	35-37.5	55-60	150-155	1103	128	1,364	0
Adam Lavington	Director of Digital Transformation	7	2.5-5	0	20-25	0	188	98	322	0
Tania Marcus	Chief People Officer		0-2.5	30-32.5	25-30	70-75	400	176	635	0
Avni Shah	Director of Primary Care Transformation	6	0	22.5-25	40-45	105-110	672	100	858	0
Francis Shattock	Director of Performance	7	2.5-5	0	5-10	0	60	32	117	0
Toni Coles	Managing Director (WE)	1	0	0	0	0	0	0	0	0
Sharn Elton	Managing Director (ENH)	6	0	25-27.5	60-65	175-180	1,230	117	1,490	0
Matthew Webb	Managing Director (SWH)	6	0-2.5	0	45-50	120-125	931	0	1029	0
Dr Prag Moodley	Partner Member-Primary Medical Services	3	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL
Dr Ian Perry	Partner Member-Primary Medical Services	3	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL
Dr Nicholas Small	Partner Member-Primary Medical Services	4	0	0	0	0	0	0	0	0
Catherine Dugmore	Lay Member	5	0	0	0	0	0	0	0	0
Ruth Bailey	Lay Member	5	0	0	0	0	0	0	0	0
Professor Gurch Randhawa	Lay Member	5	0	0	0	0	0	0	0	0
Thelma Stober	Lay Member	5	0	0	0	0	0	0	0	0
Nick Moberly	Lay Member (from 1 December 2023)	5	0	0	0	0	0	0	0	0

Notes

The total accrued pension, lump sum and cash equivalent transfer value are as at 31 March 2024.

As part of the changes to public pension schemes, both the 1995 and 2008 Sections of the 1995/2008 Scheme closed on 31 March 2022. All active members of the 1995/2008 Scheme were automatically moved to the 2015 Scheme on 1 April 2022.

Note 1 - Members who chose not to be covered by the pension arrangements during the reporting period.

Note 2 - Reduction in CETV (restated) relates to pension age of individual.

Note 3 - Where a GP Board member is working under a "contract for services" and the GP is set up on the payroll system to satisfy HMRC rulings, the position is pensionable under the "Practitioner Pension Scheme". The ICB must make the post non-pensionable on the payroll and for GPs who are members of the Practitioner scheme, submit GP SOLO forms to reflect the employers pension contribution of 14.3% plus 0.08% administration levy to the NHS Pensions Authority .

Note 4 - Member who chose not to be covered by Practitioner pension arrangements during the reporting year.

Note 5 - As Lay Members do not receive pensionable remuneration, there will be no entries in respect of pensions.

Note 6 - The member is affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted for a zero.

Note 7 - No lump sum is shown for those senior managers who only have membership in the 2015 Scheme or 2008 Section

Note 8 - NHS employees contribute towards their pension benefits. In 2023/24 contribution rates were based on actual pensionable earnings. Employee contribution rates were 13.5% where individuals earned in excess of £75,633.

The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.

Note 9 - Cash equivalent transfer values (CETV)

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 membership of the pension scheme. This may be more than 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 factors used to calculate a CETV increased on 30 March 2023 which will affect the calculation of the real increase in CETV.

Note 10 - The real increase in CETV 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 pension scheme or arrangement).

Compensation on early retirement or for loss of office (subject to audit)

No payments were made in 2023-24

Payments to past members (subject to audit)

No payments were made in 2023-24 to any individual who had previously been a director of the ICB.

Staff Report

As at 31 March 2025, Hertfordshire and West Essex ICB employed a total of 759 staff (709.95 full time equivalents).

These figures include all Board members and staff on external secondment to partnership organisations. The ICBs staff turnover is captured as part of NHS Digital's NHS workforce statistics, the series is an official statistics publication complying with the UK Statistics Authority's code of practice NHS Workforce Statistics

The table below details how many senior managers are employed by the ICB by banding (as at 31 March 2025).

Agenda for change band	Headcount	FTE
8a	126	115.21
8b	106	101.80
8c	44	42.60
8d	29	27.57
9	12	12
Very Senior Manager (VSM)	16	15.60
Medical & Dental (M&D)[3]	11	9.90

Equality and Diversity
The Equality Act 2010: The Public Sector Equality Duty Section 149 of the Equality Act 2010 states that a public authority must have due regard to the need to:
• eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
• advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
• foster good relations between persons who share a relevant protected characteristic and persons who do not share it.
The ICB works to meet the General and Specific Duties required by the Public Sector Equality Duty (PSED). Further information on how these Duties are met is on the ICB website at https://www.hertsandwestessex.ics.nhs.uk/about/icb/information/equality-diversity-and-health-inequalities/

Throughout 2024/25, Hertfordshire and West Essex ICB engagement approach was fully cognisant of this duty and it will continue to promote equality of opportunity for the population of Hertfordshire and West Essex in the context of all its commissioning engagement activities in the future. The ICB met statutory responsibilities around data publication and will meet the NHS requirements in using the NHS Equality Delivery System (EDS) and the Workforce Race Equality Standard (WRES) as tools to enable us to review our equality and diversity work and identify where improvements can be made.

NHS Workforce Race Equality Standards (WRES)
The ICB is not required to implement WRES in respect of its own workforce. It is recognised that the small size of many ICBs means that the interpretation of the indicators should be approached with caution. However the ICB does report on WRES as part of it's annual equality data report. The report is available on the ICB equalities reports page (link to the page)

The ICB's profile for staff-declared ethnicity appears in the table below (at 31 March 2025).

[3] This figure includes GPs who are Board members, GPs who are offering clinical support to the ICB such as public health doctors, clinical fellows and named GPs who perform a safeguarding role

Staff composition

	As of 31 March 2025	
Gender	**Headcount**	**%**
Male	194	25.60%
Female	565	74.40%
Disability Status		
Disabled	44	5.80%
Non-disabled	701	92.40%
Prefer Not To Answer	3	0.40%
Unknown	11	1.40%
Ethnicity		
White	513	67.60%
BAME	235	31.00%
Unspecified/Not Stated	11	1.40%
Age Band		
Under 20	1	0.10%
21 to 40	206	27.10%
41 to 50	230	30.30%
51 to 65	297	39.10%
66 +	25	3.30%
Religion		
Atheism	127	16.70%
Buddhism	6	0.80%
Christianity	334	44%
Hinduism	46	6.10%
I do not wish to disclose my religion/belief	123	16.20%
Islam	38	5.00%
Jainism	7	0.90%
Judaism	8	1.10%
Other	54	7.10%
Sikhism	9	1.20%
Undeclared/Unspecified	7	0.90%
Sexual Orientation		
Bisexual	13	1.70%
Gay or Lesbian	15	2.00%
Heterosexual	648	85.40%
Other	4	0.50%
Undecided	2	0.30%
Not Stated	77	10.10%
Marital Status		
Married / Civil Partnership	451	59.40%
Single	203	26.70%
Separated	6	0.80%
Divorced	64	8.40%
Widowed	11	1.50%
Unknown	24	3.20%

Gender pay gap reporting regulations
All public sector organisations in England employing 250 or more staff are required to publish gender pay gap information annually, both on their website and on the designated government website at www.gov.uk/genderpaygap. Gender pay reporting is different to equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman. The gender pay gap shows the difference in the average pay (both mean and median) between all men and women in our workforce. Calculations are based on the hourly rate of ordinary salary paid to each employee on a snapshot date in the financial year. This includes staff employed under Agenda for Change terms and conditions, clinical advisers and very senior managers.

Hertfordshire and West Essex ICB employs more women than men, with women making up approximately 74% of the workforce. The mean gender pay gap is the difference between the average hourly earnings of men and women and gives us an overall indication of the size of our gender pay gap, if any. On 31 March 2025 the mean gender pay gap was 17.9997% which is a decease on the 2024 figure of 20.16% The median pay gap is the difference between the midpoints in the ranges of hourly earnings of men and women. It takes all salaries in the sample, lines them up in order from lowest to highest, and picks the middle salary. We believe this is a more representative measure of the pay gap because it is not affected by outliers – a few individuals at the top or bottom of the range. On 31 March 2025 the median gender pay gap was 8.758%. This means that typically men are paid 8.758% more in the ICB than women.

Pay Band by Gender – 31 March 2025

	Male employees are 25.6% of the workforce		
Pay Band	Headcount	Male %	Female %
Band 2	0	0%	0%
Band 3	4	0%	100%
Band 4	65	7.7%	92.3%
Band 5	98	35.7%	64.3%
Band 6	105	21.0%	79.0%
Band 7	143	25.2%	74.8%
Band 8a	126	19.0%	81.0%
Band 8b	106	33.0%	67.0%
Band 8c	44	31.8%	68.2%
Band 8d	29	44.8%	55.2%
Band 9	12	8.3%	91.7%
Very Senior Managers (VSM)	16	43.7%	56.3%
Medical & Dental/Other	11	18.2%	81.8%

Equality and Diversity Action Planning and the NHS Equality Delivery System (EDS)
Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS in accordance EDS guidance documents. The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight. The EDS Report is a template which is designed to give an overview of the organisation's most recent EDS implementation and grade. The report is available on the ICB equalities reports page (link

to the page).

The ICB Equality, Diversity and Inclusion Policy and Strategy 2023-27 is available on the ICB equalities reports page (link to the page) and includes an overarching action plan for 2023-27 to give a direction of travel to the EDI work in the organisation.

The Inclusive Career Development Programme has been developed to implement a consistent framework of leadership development for colleagues in Bands 2-4 from across the ICS for equality groups currently underrepresented in leadership roles; to support career progression. The programme includes the completion of a service improvement project within the participants work area that aims to improve patient outcomes, improved system performance and personal/professional learning.
The ICB runs EDI training and awareness sessions including within the corporate induction programme for all new starters. 'Lunch and learn' training and awareness sessions and support to individual colleagues and teams upon request.

Disability
The ICB holds the Disability Confident award which recognises our commitment to recruiting and developing disabled employees. At 31 March 2025, 92.4% of staff have declared they have no disability, with 5.8% declaring a disability and the remaining 1.8% undeclared. The ICB recognises the benefits of a diverse workforce and is committed to supporting applicants and employees with a disability to be part of it's workforce, and values their contribution to delivery of patient care. The Disability in the Workplace policy underpins these principles.

Sickness absence data

Total days lost:	6,279.12 (equivalent calendar days)
Total absence (FTE)	6,130.89 Days out of a total of 259,131.75 available FTE days
Average absences per employee:	8.27 Days (average of total days lost by ICB employee headcount) note calendar days, not working days
Of total days lost, long term absence episodes:	51
Long term days total:	3,541.4 days (included in total days lost)

Staff engagement percentages

Staff Survey

The 2024 NHS National Staff Survey saw an 82% response rate from our staff.

The ICB has created action plans through 'The Big 5' campaign, which will take place across 5 months (May to September) with 5 themes with one Executive lead sponsoring each month. The full reports can be viewed here: NHS Staff Survey dashboard

Staff policies

The ICB is committed to review all staff policies every two years or sooner if there is a change in legislation, audit compliance or national direction. Staff policies are reviewed at the Policy

Forum which is a sub-group of the Staff Partnership Forum with HR, trade union, management and staff representation Policies - Herts and West Essex ICB website

Staff Partnership Forum

The Staff Partnership Forum meets regularly and is a chance for staff and trade union representatives to discuss key issues affecting their working lives with executive members and make plans for improvements and is co-chaired by the Chief People Officer and Staff-side chair.

The forum has worked to address key issues that were raised in previous years' national staff surveys. Other actions taken to support the workforce included:

- Provide a forum to air staff views on key issues.
- Advise senior leadership team and make recommendations on strategies and actions that impact on staff.
- Provide support for a range of key projects.
- Provide a testing forum for a range of policies and strategies of relevance to staff.
- Promote staff engagement.
- Work in close liaison with health and wellbeing champions
- Matters relating to Health and Safety

A working in partnership framework has been agreed between the ICB and recognised trade unions.

Trade Union Facility Time Reporting Requirements

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
2	2

Percentage of time	Number of employees
0%	0
1-50%	2
51%-99%	0
100%	0

First Column	Figures
Provide the total cost of facility time	£5,675.19
Provide the total pay bill	£55,860,490.42
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.01%

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	9.63%

Expenditure on consultancy

Off-payroll engagements

Table 1: Length of all highly paid off payroll engagements

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

	Number
Number of existing engagements as of 31 March 2025	58
Of which, the number that have existed:	
for less than one year at the time of reporting	24
for between one and two years at the time of reporting	32
for between 2 and 3 years at the time of reporting	2
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

The ICB has undertaken a risk-based assessment as to whether assurance is required that the individual is paying the correct amount of Tax and NI. The ICB has concluded that the risk of significant exposure in relation to these individuals is minimal.

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll appointments engaged at any point between 1 April 2024 and 31 March 2025, greater than £245 per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2024 and 31 March 2025	110
Of which:	
No. not subject to off-payroll legislation	0
No. subject to off-payroll legislation and determined as in-scope of IR35	110
No. subject to off-payroll legislation and determined as out of scope of IR35	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
(3) There was no non-compliance with off payroll legislation.

Table 3: Off-payroll board member/senior official engagements

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

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the reporting period	3
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 must include both on payroll and off-payroll engagements	23

Notes

The off-payroll engagement relate to GP Board members under a contract for services. The length of time for each engagement for each person is 2 years 8 months.

Exit packages, including special (non-contractual) payments

Exit packages agreed in the financial year (subject to audit)

	2024-25 Compulsory redundancies		2024-25 Other agreed departures		2024-25 Total	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	2	15,428	0	0	2	15,428
£10,001 to £25,000	1	20,599	0	0	1	20,599
£50,001 to £100,000	0	0	1	79,405	1	79,405
Total	**3**	**36,027**	**1**	**79,405**	**4**	**115,432**

	2023-24 Compulsory redundancies		2023-24 Other agreed departures		2023-24 Total	
	Number	£	Number	£	Number	£
Less than £10,000	1	1,522	0	0	1	1,522
£50,001 to £100,000	0	0	3	268,443	3	268,443
Total	1	1,522	3	268,443	4	269,965

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Terms and Conditions (Agenda for Change). Exit costs in this note are the full costs of departures agreed in the year.

Analysis of Other Agreed Departures

	2024-25 Other agreed departures		2023-24 Other agreed departures	
	Number	**£**	Number	£
Voluntary redundancies including early retirement contractual costs	1	79,405	3	268,443
Total	**1**	**79,405**	3	268,443

Parliamentary Accountability and Audit Report

Hertfordshire and West Essex Integrated Care Board is not required to produce a Parliamentary Accountability and Audit Report but has opted to include disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Accounts from page 99.

An audit certificate and report is also included in this Annual Report at page 92.

ANNUAL ACCOUNTS

NHS Hertfordshire and West Essex ICB - Statement of Accounts for the year ended 31 March 2025

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

	Note	2024-25 £'000	2023-24 £'000
Income from contracts with customers	2	(52,509)	(51,383)
Other operating income	2	(1,481)	(3,020)
Total operating income		**(53,990)**	(54,403)
Staff costs	3.1	57,364	54,030
Purchase of goods and services	4	3,858,658	3,282,518
Depreciation	4	662	1,044
Provision expense	4	4,302	(2,344)
Other Operating Expenditure	4	1,706	1,879
Total operating expenditure		**3,922,692**	3,337,127
Net Operating Expenditure		**3,868,702**	3,282,724
Finance expense		65	34
Net expenditure for the year		**3,868,767**	3,282,758
Total Comprehensive Expenditure for the year ended 31 March 2025		**3,868,767**	3,282,758

The notes on pages 105 to 115 form part of this statement.

Statement of Financial Position as at 31 March 2025

	Note	31 March 2025 £'000	31 March 2024 £'000
Non-current assets			
Property, plant and equipment		235	419
Right-of-use assets		1,552	2,030
Trade and other receivables	6	0	11
Total non-current assets		**1,787**	2,460
Current assets			
Trade and other receivables	6	17,009	16,124
Cash	7	24	946
Total current assets		**17,033**	17,070
Total assets		**18,820**	19,530
Current liabilities			
Trade and other payables	8	(163,340)	(197,919)
Lease Liabilities		(514)	(478)
Provisions		(5,489)	(4,548)
Total current liabilities		**(169,343)**	(202,945)
Total Assets less Current Liabilities		**(150,523)**	(183,415)
Non-current Liabilities			
Lease Liabilities		(1,097)	(1,558)
Provisions		(2,393)	(218)
Total non-current liabilities		**(3,490)**	(1,776)
Assets less Liabilities		**(154,013)**	(185,191)
Financed by Taxpayers' Equity			
General fund		(154,013)	(185,191)
Total taxpayers' equity		**(154,013)**	(185,191)

The notes on pages 105 to 115 form part of this statement.

The financial statements on pages 101 to 115 were approved by the Audit and Risk Committee (on behalf of the Board) on 20th June 2025 and signed on its behalf by:

Dr Jane Halpin
Accountable Officer

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

	General fund £'000
Changes in taxpayers' equity for 2024-25	
Balance at 1 April 2024	**(185,191)**
Changes in NHS Integrated Care Board taxpayers' equity for 2024-25	
Net operating expenditure for the financial year	(3,868,767)
Net funding	3,899,945
Balance at 31 March 2025	**(154,013)**

	General fund £'000
Changes in taxpayers' equity for 2023-24	
Balance at 1 April 2023	(182,728)
Changes in NHS Integrated Care Board taxpayers' equity for 2023-24	
Net operating expenditure for the financial year	(3,282,758)
Net funding	3,280,295
Balance at 31 March 2024	**(185,191)**

The notes on pages 105 to 115 form part of this statement.

Statement of Cash Flows for the year ended 31 March 2025

	Note	**2024-25 £'000**	2023-24 £'000
Cash Flows from Operating Activities			
Net operating expenditure	SOCNE	(3,868,702)	(3,282,724)
Depreciation	4	662	1,044
Movement in trade & other receivables	6	(874)	4,605
Movement in trade & other payables	8	(34,579)	55
Provisions utilised		(1,187)	(529)
Increase in provisions		4,302	(2,345)
Net Cash Outflow used in Operating Activities and before Financing		**(3,900,378)**	(3,279,894)
Cash Flows from Investing Activities			
Payments for property, plant and equipment		0	(23)
Net Cash Outflow used in Investing Activities		**0**	(23)
Net Cash Outflow before Financing		**(3,900,378)**	(3,279,917)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		3,899,945	3,280,295
Repayment of lease liabilities		(489)	(519)
Net Cash Inflow from Financing Activities		**3,899,456**	3,279,776
Net Decrease in Cash	7	**(922)**	(141)
Cash at the Beginning of the Financial Period	7	**946**	1,087
Cash at the End of the Financial Period		**24**	946

The notes on pages 105 to 115 form part of this statement.

Notes to the financial statements

1 Accounting Policies

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

1.1 Going Concern

These accounts have been prepared on the going concern basis.

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. The financial statements for this ICB are therefore prepared on a Going Concern basis as they will continue to provide the services in the future.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention.

1.3 Pooled Budgets

The ICB has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 with Hertfordshire County Council (HCC) and Cambridgeshire and Peterborough ICB for the provision of a number of services, including:

(1) Services under the Better Care Fund (BCF). Although the BCF consists of a number of commissioning arrangements, only services jointly-commissioned with HCC, including the protection of social care services, are relevant to the pooled budget arrangement.

(2) Mental Health and Learning Disability Services which are jointly-commissioned.

(3) Equipment Services.

(4) Intermediate Care Services.

An assessment has been carried out of these arrangements under the appropriate accounting standards and they are deemed to meet the definition of being under joint control under IFRS 11 Joint Arrangements. Under this type of arrangement, a joint operation is considered to be in place and this means that the ICB recognises:

· its assets, including its share of any assets held jointly;
· its liabilities, including its share of any liabilities incurred jointly;
· its revenue from the sale of its share of the output of the joint operation;
. its share of the revenue from the sale of the output by the joint operation; and
· its expenses, including its share of any expenses incurred jointly.

1.4 Income

The main source of funding for the ICB 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.

Income 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.

The main source of invoiced income for the ICB is in the provision of Information and Technology Services. The majority of these services are subject to service level agreements over a period of twelve months and cover a range of activity such as, but not limited to, network maintenance, provision of data lines, servers, storage capacity, digital telephony and help desk facilities to various NHS organisations.

Since 1 April 2023, the ICB also receives income from the delegation of commissioning functions from NHS England in respect of community pharmacy, dental and primary care ophthalmology services.

Notes to the financial statements

1.5 **Employee Benefits**

1.5.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees.

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.

1.5.2 **Retirement Benefit Costs**

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

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

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

1.6 **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.

1.7 **Cash**

Cash is cash in hand and deposits with the Government Banking Service repayable without penalty on notice of not more than 24 hours.

1.8 **Financial Assets**

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

1.9 **Financial Liabilities**

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

1.10 **Losses and Special Payments**

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

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

1.11 **New and revised IFRS Standards in issue but not yet effective**

IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2025: early adoption is not therefore permitted. Although an impact assessment of this new standard is still underway, it is very unlikely that the ICB will have any transactions that are covered by this standard. The ICB has therefore concluded that this standard does not have a material impact on its financial statements for 2024-25, had this standard been implemented in that year.

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The impact of this standard is unknown once it is applied as an assessment has not yet been undertaken.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. As the ICB does not have any subsidiaries, there will be no impact of this standard on its financial statements for 2024-25, had this standard been implemented in that year.

2 Operating Income

	2024-25 Total £'000	2023-24 Total £'000
Revenue from contracts with customers		
Education, training and research	0	19
Non-patient care services to other bodies	10,808	11,248
Prescription fees and charges	17,287	16,896
Dental fees and charges	24,234	22,940
Other revenue	180	280
Total Income from sale of goods and services	52,509	51,383
Other operating income		
Non cash apprenticeship training grants revenue	51	27
Other non contract revenue	1,430	2,993
Total Other operating income	1,481	3,020
Total Operating Income	**53,990**	54,403

2.1 Disaggregation of Income - Income from sale of goods and services (contracts)

2024-25	Education, training and research £'000	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract Income £'000	Total £'000
Source of Revenue						
NHS	0	10,803	0	0	19	10,822
Non NHS	0	5	17,287	24,234	161	41,687
Total	**0**	**10,808**	**17,287**	**24,234**	**180**	**52,509**

2023-24	Education, training and research £'000	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract Income £'000	Total £'000
Source of Revenue						
NHS	16	11,245	0	0	158	11,419
Non NHS	3	3	16,896	22,940	122	39,964
Total	**19**	**11,248**	**16,896**	**22,940**	**280**	**51,383**

3. Employee benefits

3.1 Employee benefits

	2024-25 Total £'000	2023-24 Total £'000
Salaries and wages	43,591	42,154
Social security costs	4,823	4,479
Employer Contributions to NHS Pension scheme	8,640	6,970
Other pension costs	6	9
Apprenticeship Levy	202	187
Termination benefits	102	231
Gross employee benefits expenditure	**57,364**	**54,030**

3.2 Ill health retirements

Ill health retirement costs are met by the NHS Pension Scheme and are not included in table 3.1 above. There were no ill health retirements in 2024-25 (£432k for 2023-24).

3.3 Pension costs

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

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

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

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

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

4. Operating expenses

	2024-25 Total £'000	2023-24 Total £'000
Purchase of goods and services		
Services from other ICBs and NHS England	408	459
Services from foundation trusts	650,965	443,667
Services from other NHS trusts	1,783,376	1,509,724
Purchase of healthcare from non-NHS bodies	610,906	551,444
Purchase of social care	44,131	42,068
General Dental services and personal dental services	96,686	88,147
Prescribing costs	242,694	242,706
Pharmaceutical services	52,878	47,839
General Ophthalmic services	14,554	14,387
GP Primary Care Services	304,592	285,646
Supplies and services – clinical	106	122
Supplies and services – general	31,639	35,671
Consultancy services	479	171
Establishment	13,825	12,498
Transport	3,450	1,813
Premises	3,961	3,476
Audit fees (Note 1)	221	214
Other non statutory audit expenditure		
· Other services (Note 2)	35	39
Other professional fees (Note 3)	735	602
Legal Fees	1,689	589
Education and training	1,278	1,209
Non cash apprenticeship training grants	50	27
Total Purchase of goods and services	**3,858,658**	3,282,518
Depreciation		
Depreciation	662	1,044
Total Depreciation	**662**	1,044
Provision expense		
Provisions	4,302	(2,344)
Total Provision expense	**4,302**	(2,344)
Other Operating Expenditure		
Chair and Non Executive Members	163	152
Grants to Other bodies	559	647
Research and development (excluding staff costs)	0	15
Expected credit (gain) on receivables	0	(5)
Other expenditure	984	1,070
Total Other Operating Expenditure	**1,706**	1,879
Total operating expenses (excluding employee benefits)	**3,865,328**	3,283,097

Note 1

Audit fee is shown inclusive of VAT and the net amount was £183.9k (£178.5k 2023-24)
Limitation on auditor's liability for external audit work carried out for 2024-25 is £1million (£1m 2023-24)

Note 2

Fees for non audit assurance services in relation to the Mental Health Investment Standard is shown inclusive of VAT and the net amount was £28.8k (£28.3k 2023-24).

Note 3

Other professional fees includes the sum of £107k for Internal Audit Fees (£115k 2023-24). Internal audit fees is shown net of VAT.

5 Better Payment Practice Code

Measure of compliance

Non-NHS Payables	**2024-25 Number**	**2024-25 £'000**	2023-24 Number	2023-24 £'000
Total Non-NHS Trade invoices paid in the Year	62,550	1,117,156	67,759	1,044,620
Total Non-NHS Trade Invoices paid within target	61,825	1,106,915	65,790	998,081
Percentage of Non-NHS Trade invoices paid within target	98.84%	99.08%	97.09%	95.54%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,630	2,512,084	1,855	1,965,712
Total NHS Trade Invoices Paid within target	2,533	2,500,711	1,726	1,960,564
Percentage of NHS Trade Invoices paid within target	96.31%	99.55%	93.05%	99.74%

The Better Payment Practice Code is a measure of compliance for the ICB to pay all NHS and non-NHS trade payables within 30 calendar days of receipt of goods and services or a valid invoice (whichever is later), unless other payment terms have been agreed.

6 Trade and other receivables

	Current 31 March 2025 £'000	**Non-current 31 March 2025 £'000**	Current 31 March 2024 £'000	Non-current 31 March 2024 £'000
NHS receivables: Revenue	4,232	0	3,091	0
NHS prepayments	85	0	127	0
NHS accrued income	0	0	116	0
Non-NHS and Other WGA receivables: Revenue	1,261	0	646	0
Non-NHS and Other WGA prepayments	9,482	0	7,819	11
Non-NHS and Other WGA accrued income	13	0	98	0
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	0	0	3,529	0
VAT	1,900	0	670	0
Other receivables and accruals	36	0	28	0
Total Trade and Other Receivables	**17,009**	**0**	**16,124**	**11**
Total current and non current	**17,009**		**16,135**	

7 Cash

	2024-25 £'000	2023-24 £'000
Balance at start of the period	946	1,087
Net change in the period	(922)	(141)
Balance at 31 March	**24**	**946**
Made up of:		
Cash with the Government Banking Service at 31 March	**24**	**946**

8 Trade and other payables

	Current 31 March 2025 £'000	Current 31 March 2024 £'000
NHS payables: revenue	6,638	20,381
NHS accruals	22,426	27,147
Non-NHS and Other WGA payables: Revenue	24,357	34,563
Non-NHS and Other WGA accruals	98,501	106,155
Non-NHS and Other WGA deferred income	2,810	1,866
Social security costs	586	602
Tax	631	574
Other payables and accruals	7,391	6,631
Total Trade and Other Payables	**163,340**	**197,919**

9 Financial instruments

9.1 Financial risk management

International Financial Reporting Standard 7 (Financial Instruments: Disclosures) 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 the 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 ICB's standing financial instructions and policies agreed by the Board.

9.1.2 Liquidity risk

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

9.2 Financial assets

	Financial Assets measured at amortised cost 31 March 2025 £'000	Financial Assets measured at amortised cost 31 March 2024 £'000
Trade and other receivables with NHSE bodies	4,010	2,762
Trade and other receivables with other DHSC group bodies	222	580
Trade and other receivables with external bodies	1,316	4,171
Cash and cash equivalents	24	946
Total at 31 March	**5,572**	**8,459**

9.3 Financial liabilities

	Financial Liabilities measured at amortised cost 31 March 2025 £'000	Financial Liabilities measured at amortised cost 31 March 2024 £'000
Trade and other payables with NHSE bodies	1,548	1,925
Trade and other payables with other DHSC group bodies	28,289	45,949
Trade and other payables with external bodies	131,086	149,038
Total at 31 March	**160,923**	196,912

10 Operating segments

The ICB considers they have only one segment: Commissioning of healthcare services.

	2024-25 £'000	2023-24 £'000
Commissioning of healthcare services	**3,868,767**	3,282,758

11 Pooled budgets

This ICB has entered into a pooled budget with Hertfordshire County Council and Cambridgeshire and Peterborough ICB. The pool is hosted by Hertfordshire County Council.

Under the arrangement funds are pooled under Section 75 of the NHS Act 2006 for the commissioning of services as follows: mental health, learning disabilities, child and adolescent mental health, integrated health and social care community equipment service, residential and nursing care in a number of care homes and social care services complementary to the NHS. The pooled budget only includes that expenditure over which the partners have joint control.

The ICB's share of the income and expenditure handled by the pooled budget were as follows:

2024-25	**Mental Health, Learning Disabilities & CAMHS**		**Integrated Equipment Service**		**Intermediate Care**		**Social Care Services**		**All pooled funds**
	Total Pooled-Budget	**ICB**	**Total Pooled-Budget**	**ICB**	**Total Pooled-Budget**	**ICB**	**Total Pooled-Budget**	**ICB**	**Total ICB Contribution**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Contribution	431,855	238,892	8,271	3,999	7,283	2,516	31,377	32,429	277,836
Expenditure	432,504	239,449	7,232	3,497	7,283	2,516	28,320	32,429	277,891
Total Variance	(649)	(557)	1,039	502	0	0	3,057	0	(55)

2023-24	Mental Health, Learning Disabilities & CAMHS		Equipment Service		Intermediate Care		Protection of Social Care Services		All pooled funds
	Total Pooled-Budget	ICB	Total Pooled-Budget	ICB	Total Pooled-Budget	ICB	Total Pooled-Budget	ICB	Total ICB Contribution
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Contribution	416,570	225,203	8,094	3,913	6,918	2,516	31,377	32,429	264,061
Expenditure	416,674	225,320	8,480	4,100	6,918	2,516	23,361	32,429	264,365
Total Variance	(104)	(117)	(386)	(187)	0	0	8,016	0	(304)

12 Related party transactions

Details of related party transactions with individuals are as follows:

During the year, other than that declared below, none of the Department of Health and Social Care Ministers, ICB Board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the ICB.

Details of payments made by the ICB to the practices and related parties disclosed by the GP Partner members - Primary Medical Services were as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Maynard Court Surgery - Dr I Perry	1,451	0	1	0
Stanmore Medical Group - Dr. P Moodley	7,309	0	11	0

Payments were also made to the following Primary Care Networks (PCN) of which GP Partner members are from GP practices forming the PCN:

Epping Forest PCN - Dr. I Perry	2,812	0	41	0
Stevenage North PCN - Dr. P Moodley	2,346	0	0	0

Payments were made to the following where Governing Body members had declared an interest.

Cambridgeshire Community Services	230	0	0	0
Haverfield Surgery	584	0	0	0
Kestrel Nursing Home	764	0	0	0
King George Surgery	3,623	0	24	0
NHS Property Services	3,408	4	947	0
St Andrews Healthcare	1,753	0	296	0
Stellar Healthcare	2,863	51	435	0
Peabody Trust	7	0	0	0
Herts Mind Network	871	0	12	0

The Department of Health and Social Care is regarded as the parent department. During the year the ICB has had a number of material transactions with entities for which the Department is regarded as the parent department. The ICB has adopted a disclosure level of over £15million and the most significant related parties are listed below. In addition, the ICB had a number of material transactions with other local government bodies. Where appropriate, these entities have also been reflected in the list below:

Barking, Havering & Redbridge University Hospitals NHS Trust
Barts Health NHS Trust
Buckinghamshire Healthcare NHS Trust
Central London Community Healthcare NHS Trust
East & North Hertfordshire NHS Trust
East of England Ambulance Service NHS Trust
Hertfordshire Community NHS Trust
Imperial College Healthcare NHS Trust
North Middlesex University Hospital NHS Trust (now part of Royal Free London NHS Foundation Trust from 1 January 2025)
Royal National Orthopaedic Hospital NHS Trust
The Princess Alexandra Hospital NHS Trust
West Hertfordshire Teaching Hospitals NHS Trust
Cambridge University Hospitals NHS Foundation Trust
Essex Partnership University NHS Foundation Trust
Great Ormond Street Hospital for Children NHS Foundation Trust
Guy's & St Thomas' NHS Foundation Trust
Hertfordshire Partnership University NHS Foundation Trust
Bedfordshire Hospitals NHS Foundation Trust
Mid & South Essex NHS Foundation Trust
Moorfields Eye Hospital NHS Foundation Trust
Royal Free London NHS Foundation Trust
University College London Hospitals NHS Foundation Trust
Hertfordshire County Council

12a Related party transactions (2023-24)

Details of related party transactions with individuals are as follows:

During the year, other than that declared below, none of the Department of Health and Social Care Ministers, ICB Board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the ICB.

Details of payments made by the ICB to the practices and related parties disclosed by the GP Partner members - Primary Medical Services were as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Maynard Court Surgery - Dr I Perry	1,373	0	1	0
Schopwick Surgery - Dr N Small	2,016	0	2	0
Stanmore Medical Group - Dr. P Moodley	6,659	0	16	0
The following are payments made in the normal course of business to GP Federations of which GP practices are shareholders:				
Herts Health Ltd. - Dr N Small	80	0		
Payments were also made to the following Primary Care Networks of which GP practices are members:				
Epping Forest PCN - Dr. I Perry	2,604	0	0	0
Herts Five PCN - Dr N Small	3,475	0	16	0
Stevenage North PCN - Dr. P Moodley	2,607	0	3	0
Payments were made to the following where Governing Body members had declared an interest.				
Cambridgeshire Community Services	218	0	0	0
Haverfield Surgery	567	0	4	0
Hertfordshire Mind Network	860	0	294	0
Kestrel Nursing Home	967	0	67	0
King George Surgery	2,992	0	23	0
NHS Property Services	3,235	4	346	0
St Andrews Healthcare	2,326	0	122	0
Stellar Healthcare	1,811	0	43	0

The Department of Health and Social Care is regarded as a related party. During the year the ICB has had a number of material transactions with entities for which the Department is regarded as the parent organisation. The ICB has adopted a disclosure level of £15million and the most significant related parties are listed below. In addition, the ICB had a number of material transactions with other local government bodies. Where appropriate, these entities have also been reflected in the list below:

Barts Health NHS Trust
Buckinghamshire Healthcare NHS Trust
Central London Community Healthcare NHS Trust
East & North Hertfordshire NHS Trust
East of England Ambulance Service NHS Trust
Hertfordshire Community NHS Trust
The Princess Alexandra Hospital NHS Trust
West Hertfordshire Hospitals NHS Trust
Cambridge University Hospitals NHS Foundation Trust
Essex Partnership University NHS Foundation Trust
Hertfordshire Partnership University NHS Foundation Trust
Bedfordshire Hospitals NHS Foundation Trust
Mid and South Essex NHS Foundation Trust
Royal Free London NHS Foundation Trust
University College London Hospitals NHS Foundation Trust
Essex County Council
Hertfordshire County Council

13 Events after the end of the reporting period

In March 2025, the Government announced that NHS England would be abolished and directed ICBs across the country to reduce running costs by 50% in the upcoming 2025-26 financial year. At the time of writing, ICBs are awaiting more details about the announcement, including what it means for the future of some services and staffing.

14 Losses and special payments

The total number of losses and special payment cases and their total value, were as follows:

Losses	**2024-25 Total Number of Number**	**2024-25 Total Value of £'000**	2023-24 Total Number of Number	2023-24 Total Value of Cases £'000
Fruitless payments	1	1	0	0
Claims abandoned	1	1	0	0
Total	**2**	**2**	**0**	**0**

Special Payments	**2024-25 Total Number of Cases Number**	**2024-25 Total Value of Cases £'000**	2023-24 Total Number of Cases Number	2023-24 Total Value of Cases £'000
Compensation payments (on accruals basis)	0	0	2	67
Total	**0**	**0**	**2**	**67**

15 Financial performance targets

The ICB has a number of financial duties under the NHS Act 2006 (as amended).
The ICB performance against those duties was as follows:

	2024-25 Target £'000	**2024-25 Performance £'000**	**2024-25 Duties Achieved?**	2023-24 Target £'000	2023-24 Performance £'000	2023-24 Duties Achieved?
Expenditure not to exceed income	3,929,957	3,922,757	Yes	3,351,149	3,337,161	Yes
Capital resource use does not exceed the amount specified in Directions	0	0	Yes	2,382	2,261	Yes
Revenue resource use does not exceed the amount specified in Directions	3,875,967	3,868,767	Yes	3,296,746	3,282,758	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	Yes	0	0	Yes
Revenue administration resource use does not exceed the amount specified in Directions	29,449	28,815	Yes	32,675	31,136	Yes

16 Contingent Liability

The ICB is one of twenty two ICBs defending a legal settlement claim in respect of the procurement for the provision of healthcare waste collection and disposal services.