



**Hertfordshire and
West Essex**
Integrated Care Board

Hertfordshire and West Essex Integrated Care Board

Annual Report 2025/26

1 April 2025 – 31 March 2026

Contents

Annual Report Statement from Jan Thomas, Chief Executive Officer and Robin Porter, Chair.....	3
<u>PERFORMANCE REPORT</u>	4
<u>Chief Executive's summary of key performance</u>	4
<u>Performance Overview</u>	4
<u>Performance analysis</u>	9
<u>Environmental matters</u>	16
<u>Improve Quality</u>	19
<u>Engaging people and communities</u>	22
<u>Reducing health inequalities</u>	23
<u>Health and wellbeing strategy</u>	24
<u>Preparing for Emergencies</u>	26
<u>Digital, data and technology</u>	27
<u>Financial review</u>	28
<u>ACCOUNTABILITY REPORT</u>	33
<u>Corporate Governance Report</u>	33
<u>Risk management arrangements and effectiveness</u>	40
<u>Internal Control Framework</u>	48
<u>Head of Internal Audit opinion</u>	52
<u>Remuneration and Staff Report</u>	57
<u>Remuneration Report</u>	57
<u>Staff Report</u>	69
<u>ANNUAL ACCOUNTS</u>	84

Annual Report Statement from Jan Thomas, Chief Executive Officer and Robin Porter, Chair

Welcome to our 2025/26 Annual Report.

The past year has brought significant challenge, alongside steady progress. Demand for services remained high, and we also worked through major organisational change, including plans to reduce running costs and reshape how we work. Throughout this period, teams across the system stayed focused on supporting our population.

Over the year, the ICB saw encouraging progress in several areas. Improvements in urgent and emergency care helped reduce waiting times in A&E and improve ambulance handovers. Across the system, providers continued to respond to sustained demand, with some organisations - including West Hertfordshire Teaching Hospitals NHS Trust - recognised nationally for the progress they have made.

The ICB continued to strengthen care closer to home, helping more people, particularly those who are frail or older, to remain independent. Through urgent community response services such as falls cars, medicines optimisation, and 'hospital at home,' teams worked across primary care, community and hospital services to reduce avoidable admissions and improve patient experience.

Improving access to primary care remained a key priority. GP practices introduced new ways of managing demand, including online triage, helping more people get the support they need. In addition, more than 10,500 urgent dental appointments were made available during the year, alongside around 11,000 emergency dental appointments accessible through NHS 111.

The ICB also made progress in supporting earlier diagnosis. Targeted lung health checks identified people with no symptoms who were found to have lung cancer, enabling them to begin treatment earlier and improving outcomes. Community diagnostic centres across the area also helped many thousands of people access tests more quickly and closer to home.

At the same time, challenges remained. Demand for mental health services, particularly for children and young people, continued to grow, and waiting times for some community services remained high. Improving access to these services remains a clear priority.

All of this has taken place during a period of significant change for colleagues across our organisations. We would like to thank staff for their professionalism, resilience and commitment throughout the year.

During 2025/26, work progressed to establish Central East Integrated Care Board, bringing together Hertfordshire with neighbouring systems (Cambridgeshire and Peterborough plus Bedford, Luton and Milton Keynes) as part of a new, larger ICB, while west Essex will join a new Essex ICB. This marks an important transition from the organisation reflected in this report.

From 1 April, we move forward as part of Central East, serving 3.5 million people. Guided by a clear purpose, to do what best serves our population – and supported by our strategy, *Our Way*, this creates an opportunity to work in a more focused and joined-up way to improve outcomes, experience, and sustainability for the communities we serve.

Accountable Officer
Organisation
Signature

Jan Thomas, Chief Executive
NHS Hertfordshire & West Essex Integrated Care Board

Date

23 June 2026

PERFORMANCE REPORT

Chief Executive's summary of key performance

Performance Overview

This section provides an outline of the performance of NHS Hertfordshire and West Essex Integrated Care Board (ICB) from 1 April 2025 to 31 March 2026. It gives an overview of how we have commissioned services and discharged our statutory functions on behalf of the population we serve.

This is the final Annual Report and Accounts for Hertfordshire and West Essex ICB. By the time this document is published, new configurations of ICBs will be in place, with Hertfordshire forming part of the new Central East ICB and west Essex joining Essex ICB.

Our strategic approach

Our Hertfordshire and West Essex Medium Term Plan, agreed in June 2024, described the ICB's vision for Hertfordshire and west Essex for 2024-26, our key priorities and the shifts in our care model we needed to make to achieve these. It set out where we will focus our efforts and investment and how our operating model would develop.

Since the government announced changes to ICBs in March 2025, to come into effect on 1 April 2026, Hertfordshire and West Essex ICB has been working closely with the other ICBs in the Central East cluster to develop Strategic Commissioning Intentions for 2026-31. These intentions set out our broad aims for the next five years, how we will work and what we will focus on – all grounded in the guiding question: What will best serve our population?

We have used them as a basis for dialogue with providers and partners across the Central East area during 2025/26, and to develop 'Our Way', our delivery strategy for the next five years. This document will align with Provider Delivery Plans and Neighbourhood Health Plans. You can read Our Way [here](#).

Our work during 2025/26 has also been underpinned by a number of wider plans, currently covering the Hertfordshire and west Essex geography. These include:

- **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.
- **ICS Urgent and Emergency Care Strategy (UEC) 2024 – 2029**, which sets out the approach to urgent and emergency care transformation, aligning to the national UEC recovery delivery plan and performance improvement requirements.

Read more about our [plans, strategies and priorities](#) on the ICB website.

Review of 2025/26

Vaccinations

This year's flu vaccination programme saw 509,500 people protected by a flu vaccine, delivered in the main by GP practices and pharmacies, with support for some patient groups from the East of England Community and School Health Immunisation team. Overall, uptake of the flu vaccine was slightly lower in over 65s (75.29%) compared to last year (78%), and higher than last year (46.23% 25/26) in those aged under 65 in a clinical risk group. Engagement and partnership work focused on supporting carers and those with long term conditions to take up their flu vaccine, using local data to highlight the risks to their health if they remained unvaccinated.

The threat of measles remained present this year, with large outbreaks just beyond our border in north London. We worked collaboratively with public health colleagues in county councils to share messages through trusts local figure and encourage vaccination, including catch up clinics for children and young people who had missed any of their routine vaccinations.

Winter

Levels of flu, COVID, winter vomiting bugs and respiratory illnesses circulated earlier this winter, putting an extraordinary level of pressure on our hospitals. There was an overall increase in A&E attendances during what is already a challenging time for the NHS, however performance on other metrics were encouraging, with Type 1 A&E four-hour performance strong in HWE at 60.3% against the national performance of 57.3%. Collaboration between the ICB and partners has continued to strengthen, 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 seven days a week.

Industrial action by Resident Doctors this year continued to have an impact on delivery of planned care, although was much more limited in scope than in previous years.

To support timely discharge home from hospital, the Hertfordshire and West Essex system launched the 'home for lunch' campaign to encourage families and friends of hospital inpatients to plan ahead and help get their loved one's home from hospital as soon as they are ready.

Cancer

While teams are working hard to keep improving cancer waiting lists ensuring people were treated as quickly as possible, we began 2026 consulting with the public, in partnership with NHS England, on the future model of care 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 lack of adjacent acute facilities and the extensive renovation and maintenance needed on the buildings they work from makes it challenging for them to deliver the most modern cancer care.

The consultation recommends that services are relocated to a brand new facility at the Watford General Hospital site, with satellite radiotherapy services in either Stevenage or Luton. Public meetings, online sessions and roadshows have been held, and the views of local people and stakeholders will be considered as part of the decision-making process later this year.

Hypertension

Detecting hidden hypertension continued to be one of our priority community campaigns in 2025/26, with the One Vision Community Cardiovascular Health Improvement Project delivering 15 culturally supportive health outreach events aimed at Black and Asian communities with low engagement GP services and who are at higher cardiovascular risk. More than 800 people had blood pressure tests at these events with follow-ups and management plans put in place for those who needed them.

The ICB continued to deliver its 'Invincible feeling, invisible danger' high blood pressure campaign. So far in 2025/26, (data available up until December 2025), almost 60,300 over 40s had received a blood pressure check at a pharmacy in Hertfordshire and west Essex. Many thousands more have also been able to access this life-saving intervention at healthy hubs, libraries in Essex, dentists, opticians and through partnership events at Stevenage Football Club.

Reducing waiting times for tests and surgery

Our Community Diagnostic Centre (CDC) programme 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. These 'one-stop-shops' 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 have CDCs in Welwyn Garden City, St Albans (from June 2026), Hemel Hempstead, Bishop's Stortford, and the newest opened in March 2026 in Epping which complements the range of tests and treatments available in Bishop's Stortford for people on the Herts/Essex border.

The new surgical centre [at St Albans City Hospital](#), is due to open in summer 2026 to help 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. 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.

Weight loss injections

This year the ICB launched a support programme to enable eligible patients to access the weight loss injection Tirzepatide (known as Mounjaro). Only people with the highest medical need will be able to be prescribed Tirzepatide on the NHS, in line with national NHS England guidance. It is available for a small number of people whose body mass index is 40 or more (or 37.5 or more if the person is from a higher risk ethnic

background*) **and** who have been diagnosed with four or more specific obesity-related health conditions. GPs and other healthcare professionals can refer patients to this service to receive the medication following a discussion with them about the commitment and lifestyle changes required alongside the injections.

Access to urgent NHS dentistry

Thousands of additional urgent dental appointments were made available across Hertfordshire and West Essex as part of a drive to improve access to urgent dental treatment for local people. 74 dental practices are now providing additional urgent appointments during their normal opening hours, providing 10,500 more urgent courses of treatment for local patients.

These additional urgent appointments are part of a national NHS scheme to extend dental access for patients needing immediate treatment. They are open to anyone needing urgent treatment for teeth or gum problems whether or not they are registered with that practice.

The extra sessions in local practices are on top of around 11,000 appointments that are available each year through the local NHS urgent dental care pilot service which provides appointments booked directly through NHS111.

Neighbourhood health

Integrated Neighbourhood Teams are now established across Hertfordshire and West Essex, serving populations of around 30,000–50,000. Shared caseloads, targeted support for frailty, and population health data are helping people stay well at home and reducing avoidable admissions.

Neighbourhood health has also underpinned prevention and inequalities work, with recent community-based blood pressure checks and volunteer training demonstrating how local partnerships can improve trust and reach.

South West Hertfordshire and West Essex Health and Care Partnerships (HCP) both secured a place in Wave 1 of the National Neighbourhood Health Programme. Participation in the first cohort provides targeted national support, peer learning with exemplar sites and a structured evaluation framework to accelerate improvement.

Primary Care

Overall, our population is having a more positive experience of accessing primary care than in the previous year. Localised Primary Care Network (PCN) run initiatives, such as 'same day' clinics are improving urgent access, supported by better telephony, the NHS App and Pharmacy First. The roll-out of online booking throughout the hours that a practice is open has also been achieved for each of our practices. January 2026 data shows that more than 65% of all GP practice appointments were face to face, a consistent figure throughout the year.

Children and young people

With escalating mental health issues among children and young people and reducing waiting times is one of our pressing strategic priorities. There has been 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 a Neurodiversity Support Offer for children and young people in Hertfordshire is in place – comprising courses and workshops to support young people with a diagnosis of Autism and/or ADHD and their families and carers. Courses have had good take-up and feedback from providers and people accessing the courses being generally positive. Mental Health Support Teams in schools have 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, a

residential children's home, Cherry Trees Cottage which opened in December 2023, 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 deliver the action plan we put in place for services for children with Special Educational Needs and Disabilities in Hertfordshire after an Ofsted and Care Quality Commission (CQC) inspection of services carried out in 2023 found the services, offered by the NHS and Hertfordshire County Council generally required improvement.

Paediatric audiology remains a concern with intensive work underway to bring down the backlog. However, services became fragile due to national shortages of suitably qualified audiologists, with some providers such as East and North Hertfordshire NHS Trust conducting reviews of historical activity after quality concerns. The ICB and NHS England (NHSE) met monthly with providers to understand issues and try to improve performance.

Hemel Health Campus

In 2024/25, Hertfordshire and West Essex Integrated Care Board (HWE ICB), West Hertfordshire Teaching Hospital NHS Trust (WHTHT) and Dacorum Borough Council (DBC) agreed to work in partnership to develop a Strategic Outline Business Case examining options to improve the health services in Hemel Hempstead.

The new Central East ICB supports the ambition to bring together hospital, primary care, mental health, social care, wellbeing and community health services in a modern and accessible facility which can support our growing population to live healthier lives for longer.

As a strategic commissioner our role will be to ensure that the right health interventions are in place to improve lives, reduce avoidable harm, and use public resources to support the best interests of our population.

We acknowledge the challenges presented by the current Hemel Hempstead Hospital estate. The buildings are ageing, inefficient and costly to maintain, and do not readily support modern models of care. A more efficient and accessible health facility has the potential to deliver clear benefits for patients, staff and the wider system.

The ICB recognises both the scale of the challenge and the opportunity for improved healthcare this project represents. We are committed to acting earlier to prevent illness and detect disease, making care easier to access, and supporting people closer to home wherever possible. The next stage of the development of this project will need to focus on strengthening the funding and delivery approach so that the project can move forward with greater certainty.

We value the work that has already been undertaken by all organisations involved and remain committed to supporting partners as future funding sources are explored, in line with NHS England requirements. We look forward to continuing to work with our system partners to improving health and wellbeing in Hemel Hempstead and the wider area.

Risks

While our system works hard to deliver good quality services and a positive patient experience, there are some areas of challenge that need improvement. 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 were 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 waiting lists for elective and diagnostic care are not reduced. While the delivery of CDCs is supporting the improvement pathway that planned care is on, and the overall patient list has been going down since March 2024, there are areas such as 6-week diagnostic waits where improvement has stalled. Weekly senior meetings and fortnightly review at place is helping to oversee this area of work. This year saw more 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 Situation Report (SITREP) arrangements, business continuity plans, incident report plans and an on call system to manage out of hours issues.

An ongoing risk that 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.

High vacancy rates in the Continuing Healthcare team is impacting on the ICB's ability to effectively manage the service. Agency staff have been recruited to ensure delivery continues with plans in place to improve retention in what is a high pressure and important service.

Accountable Officer
Organisation
Signature

Jan Thomas, Chief Executive
NHS Hertfordshire & West Essex Integrated Care Board

Date

23 June 2026

Performance analysis

Summary of Performance 2025/26

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 2025/26 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 should be assessed the same or next day according to clinical need.

The number of attended GP appointments increased by 1.95% in 2025/26 compared to 2024/25, 67.6% of appointments were face-to-face, which was a drop of 0.55 percentage points compared to 2025/26. 87.88% of appointments were booked within 14 days of the patient contacting their surgery. This was a decrease of 0.5 percentage points when compared to 2025/26.

Primary Care	2025/26 (000s)	2024/25 (000s)	2023/24 (000s)	2022/23 (000s)
Number of GP appointments attended	8,416	8,255	8,256	7,886
Proportion of Face-to-Face appointments	66.18%	67.8%	67.8%	69.7%
Proportion of attendances which took place within 14 days of booking (IIF ACC-08 definition1)	87.88%	88.4%	88.4%	86.6%

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 2025/26, 85.1% of urgent community responses were reached within 2 hours. This is a 0.4 percentage point decrease compared to 2024/25. Performance has been above the 70% target for the whole of 2025/26.

Urgent 2 Hour Community Response	Target	2025/26	2024/25	2023/24
To reach patients within 2 hours	70%	85.1%	82.5%	80.1%

Urgent and Emergency Care (UEC)

The national requirement for 2025/26 was that 76% of patients attending A&E are treated, admitted or transferred within 4 hours of arrival. This differed from the previous year target (2024/25) of 78%.

The system level performance against the four-hour standard was 77.9%. This is an improvement of 4.5 percentage points compared to 2024/25

A&E	Target	2025/26	2024/25	2023/24
Treated / Admitted / Transferred in under 4 Hours	76%	77.9%		
	78%		73.4%	67.6%

February 2026 Year to Date, Operational Planning Monitor (HWE ICS System Providers, Percentage of Attendances at Type 1, 2, 3 A&E Departments departing in less than 4 hours).

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)

EEAST Ambulance Response	Target	2025/26	2024/25	2023/24
C1 People with life threatening injuries and illness (mean)	Mean <7 minutes	08:42	09:38	09:13
C2 Emergency calls (mean)	Mean <18 minutes	33:44	50:17	48:39
C3 Urgent calls (90 th centile)	90 th centile <120 minutes	247:48	429:50	348:51
C4 Less urgent calls (90 th centile)	90 th centile <180 minutes	429:28	656:31	670:03

Elective

18-week referral to treatment (RTT) breaches showed improvement throughout 2025/26. One of the main focusses of 24/25 was to reduce 65 week waits to zero. To aid recovery a performance target was set such that no patient should have been waiting longer than 65 weeks (with the exception of patient choice) 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 2025/26 reaching 64.8% across the year which is an improvement of 9.2 percentage points compared to 2024/25. Recovery is underway with the goal in the operating plan to reach the constitutional of 92% target by 2029

RTT Waiting Times		Target	2025/26	2024/25	2023/24
65 Weeks*	Number of patients breaching 65 week wait	0	54	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%	64.8%	55.6%	51.6%

Waiting times for cancer treatment

Cancer Waiting Times	Target	2025/26	2024/25	2023/24
28 day Faster Diagnosis Standard (FDS)	77%	78%	78.3%	74.5%

31 day Decision to treat to treatment standard	96%	94%	95.8%	93.05%
62 day referral to treatment standard	85%	75%	74.6%	69.6%

Diagnostics

Diagnostic Waiting Times		Target	2025/26	2024/25	2023/24
6 Weeks	Percentage of patients whose diagnostic test is undertaken less than 6 weeks from request	95%	65%	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	2025/26	2024/25	2023/24
Acute MH Inpatient Care	Number of people in an out of area inappropriate placement*	-	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. We continue to work to increase the number of young people with learning disability on GP registers, boost AHC attendance, and educate families about these services. We also focused on improving how quickly learning disabilities are identified and ensuring consistent use of clinical terminology

We have continued our work with Partners at a county level on the Learning from Lives and Deaths Review (LeDeR) programme of reviews, annual reports and implementing the learning from the programme. Learning and insights from the reports have been disseminated by local working groups to implement the learning across forums, boards, services to inform service improvement and outcomes. Efforts are ongoing to progress improvements based on the report's recommendations specific to each area.

Mental Health

Collaborative partnership working (MH Trust, ambulance Trust, commissioners, police and county councils) saw a phased mobilisation of three new Mental Health Response Vehicles across the ICS. Staffed with a Qualified Paramedic or Emergency Medical Technician and a Mental Health professional, this new scheme responds to and supports people in mental health crisis. Over 1000 people (data April – Dec 2025) were seen and, alongside other mental health crisis initiatives across the ICB, the vehicles have helped to reduce the attendance of people in mental health crisis at hospital emergency departments improving patient experience and delivering care at the right time, in the right place and through the right professionals.

Supporting patients in Mental Health crisis was a key priority of our Medium Term Plan. One example of the impact of our focus in this area is the over 2,300 people who were transferred from emergency departments in the system, to our Mental Health Crisis centre since it opened in February 2024 (data to Oct 2025), over 2,300 people have been supported with only 10% being assessed as needing an inpatient admission.

Hertfordshire continued to deliver an effective 24/7 integrated Crisis offer for Children and Young People (CYP), in line with the NHS 10-year Plan, and successfully reduced admissions onto wards following an assessment and discharge plan for people who present in crisis aligning well with the arrival of NHSE guidance for urgent and emergency mental health care for children and young people this will be a continued focus of work into next year.

Against a background of growing demand, we are committed to improving access to services for people with autism and attention deficit hyperactivity disorder (ADHD). Implementation of clinical pathway for assessment of young people with Autism and/or ADHD commenced in Q4 2024/25 with full service go-live in Autumn 2025/26.

The ICB continued to target improving the uptake of physical health checks for people with a Serious Mental Illness and to increase the number of physical health checks undertaken within in primary with outreach provision in Hertfordshire with Voluntary, Community, Faith, and Social Enterprise (VCSFE) partners, and with the mental health providing a similar service in west Essex leading to year on year increases in the number of people accessing a physical health check.

Older adult mental health services continued to be a focus in 2025/26. Working closely with Princess Alexandra Hospital (PAH) implementation of the dementia and delirium strategy continues with aims and outcomes that supported the transfer of those living with dementia and preventing admission where possible through appropriate assessment and support from community mental health teams, including intensive support. Alzheimer's UK was working within PAH to prevent unnecessary admissions and support timely discharges for those living with dementia in west Essex supporting discharge from hospital. Essex Partnership University Trust (EPUT) dementia leads have been supporting the programme to provide training to staff on community wards to raise awareness and understand of the needs of those living with dementia.

Dementia diagnosis rates overall continue to hover around the national target with some significant variation across the ICB area. Focused improvement across 2025/26 has seen improved diagnosis performance within 12 weeks to around 80%. The ICB has continued to engage in regional and national forums about these new disease modifying treatments

The [Hertfordshire Dementia Strategy](#) delivery is underway and ensures links with ICB frailty programmes to improve access to health care services for people with dementia and contributing to the 25% reduction targets for the acute trusts. Other work this year has included work to understand and improve our response for people with young onset and rare forms of

dementia to provide interventions specific to people's circumstances. In Hertfordshire, the ['Memory Support Hertfordshire'](#) community support service continues to provide targeted dementia specific support to people with dementia and their carers. A Hertfordshire dementia friendly accreditation scheme has been developed to maintain and develop community led dementia awareness since the ending of the national scheme.

Hertfordshire and West Essex participated in an East of England procurement exercise to commission a crisis text Services across the regional footprint. The contract went live from 1 April 2026, enabling people of all ages seeking support for their mental health to access digitally supported services through SMS texts, What's App and Webchat platforms.

You can read about ICB spending on mental health on page 30 (MHIS).

Children and Young People (CYP) Safeguarding

In 2024, the revised Safeguarding Accountability and Assurance Framework (SAAF) set out clear expectations for the safeguarding roles and responsibilities of all NHS commissioning organisations and Integrated Care Boards (ICBs). The SAAF articulates the statutory duties placed on ICBs under safeguarding legislation and ensures that the safeguarding responsibilities within the Health and Care Act 2022 are fully embedded across Integrated Care System (ICS) commissioning arrangements to ensure that NHS commissioned services maintain safe and effective systems that safeguard children, young people and adults at risk and processes are robust to reduce harm.

In addition, the Health and Care Act 2022 places specific requirements on ICBs to prioritise safeguarding arrangements for babies, children and young people, including those with special educational needs and disabilities (SEND) and those in the care of the local authority up to age 25. Our safeguarding priorities are informed by the core principles of the statute, ensuring that the needs, voices and lived experiences of our population are critical to our day-to-day safeguarding activities and informed by the NHS 10-year Plan and strategic objective to reduce health inequalities for this vulnerable population group.

This year, safeguarding remained the golden thread within ICB commissioning contracts. The safeguarding team continued to ensure that respective Boards and Partnerships remain sighted on, and compliant with, their statutory responsibilities and with NHS England priorities, which include:

- Child Protection – Information Sharing (CP-IS)
- Children in Care (CIC) / Looked After Children (LAC)
- Child Exploitation (CE)
- Child Death Review processes
- Domestic Abuse & Violence Against Women and Girls
- Neglect
- Modern Slavery
- Prevent

Joint leadership across Safeguarding Adults Boards and Safeguarding Children Partnerships

Over the past year, the ICB's safeguarding functions have supported and led the delivery of multi-agency strategic priorities across the Hertfordshire Safeguarding Children Partnership (HSCP), Hertfordshire Safeguarding Adults Board (HSAB), Essex Safeguarding Children Board (ESCB) and Essex Safeguarding Adults Board (ESAB). This work aligns with the ICB's three-year strategic delivery plan and is underpinned by a shared commitment to quality, improving safeguarding outcomes for our population, reducing inequalities and keeping people safe.

During this period, the safeguarding team continued to work closely with partners across the system to ensure statutory compliance, strengthen assurance, and improve outcomes across the ICS. Work to prevent harm and reduce the impact of adverse childhood experiences. These included:

Full participation in Domestic Homicide Reviews; Child Safeguarding Practice Reviews; Safeguarding Adult Reviews; Joint Local Reviews, Care Leaver Death Reviews and Child Death Reviews.

The designated professionals supported the multiagency sub-group activities, including task and finish groups as members and sub-group Chairs. To ensure that policies and processes are robust, multiagency audits are completed and a system of learning and developments to implement lessons learnt and support the planning and implementation of the Children Wellbeing and School Bill, 2025.

Compliance with the Children Act 2024 to provide leadership and assurances on audit activities to complete the JTAI action plan; HSAB self-assessment as well as deep dive audits into child exploitation and other safeguarding themes. Work is also progressing to transfer the ICB-led Section 11 audit to the multiagency governance arrangement.

The team continued to focus on the delivery of and access to Level 4 safeguarding training and supervision, with particular emphasis on embedding of learning from national and local reviews. Community of Practice activities with NHS Providers have driven a shared vision for safeguarding to improve quality and outcomes.

The safeguarding team maintained the NHS Safeguarding Integrated Data Collections Framework as mandated by NHSE. Providers are required to submit the Safeguarding Compliance Assurance Tool (SCAT) directly to NHSE.

Designated professionals convened bi-monthly meetings with named safeguarding and Children in Care professionals across both ICSs, aimed at supporting the implementation of national and local priorities. Safeguarding activities were routinely shared at assurance meetings and reflected in quality accounts and annual reports.

Additional strategic oversight is maintained through the ICB Nursing and Quality Senior Management Meetings and the ICB Strategic Transformation Quality Improvement Committee, ensuring ICS-wide visibility of safeguarding risks and assurances.

Child Protection – Information Sharing (CP-IS) Phase 2

Working alongside Primary Care colleagues and Digital Leads, the safeguarding team coordinated the NHS England priority to launch CP-IS Phase 2 from March 2025 and remains on target.

Violence Against Women and Girls (VAWG)

The safeguarding team provided system leadership for the VAWG agenda, with a particular focus on strengthening commissioning arrangements for domestic abuse. HSCP established the Children and Young People Domestic Abuse Board in response to learning from the Joint Targeted Area Inspection (JTAI). The ICB led innovative practice, including:

- Launch of the Hertfordshire Domestic Abuse Conversation Tool for primary care.
- Strengthening GP practice assurance through the domestic abuse toolkit.
- Enhancing the ICB reviewer process, with recommendations to NHS England that are now integrated nationally to strengthen the voice of the child in Domestic Homicide Reviews.
- Maintaining the Memorandum of Understanding for the Joined-up Advocacy commissioning arrangements.

Child Exploitation

In response to the National Audit on Group-Based Child Sexual Exploitation and Abuse, led by Baroness Casey (2025) the safeguarding team held a roundtable discussion to develop the ICB response to the key recommendations. The ICB and Primary Care partners participated in multi-agency audits and learning events focused on child exploitation. These learning activities strengthened the application of professional curiosity and improved confidence in tackling difficult safeguarding conversations.

Child Death

Across Hertfordshire and Essex, the ICS launched the Reducing Sudden Unexpected Death in Infancy (SUDI) campaign, highlighting safer sleep, maternal smoking and maternal obesity. There has been a small but continued rise in child suicide deaths; the safeguarding team has provided leadership for multi-agency reviews and thematic analyses to understand how best to reduce risk. The ICB has also contributed to strengthened support for vulnerable adults with complex needs as part of the Child Death Review process with the introduction of representation from Adult Mental health services. Outcomes from the Essex SUDI thematic review introduced a Safer Sleeping tool for use across the multiagency system.

System Learning

Learning events were expanded to include both system and regional audiences to maximise impact and support sustainable improvement linked to the recommendations arising from statutory reviews.

Children in Care and Care Experienced

The Designated Professionals in both ICS's supported the thematic analysis of reviews to inform the strategic deliverables for commissioned services for children in care and care leavers. Hertfordshire is a pathfinder for supporting Care Experienced young people through The Care Leavers Deed of Covenant. The Covenant is crucial in addressing health and social inequalities for this cohort in accessing employment, education, and successful transition to adulthood. CIC can access timely dental care and treatment through specialist contractual arrangements. A Government statement in December 2025 shared the intention for all care leavers to receive free prescriptions, dental and eye care up to the age of 25, as well as opportunities within the NHS for paid internships.

Transformation within the safeguarding team continued with the drive towards the All-Age Model with a focus on a strategic and collaborative approach in preparedness for the new ICB blueprint and achieving the NHS 10-year plan.

These safeguarding activities demonstrates how the safeguarding team ensure that the ICB discharged its statutory duties set out under the Children Act 1989/2004; the domestic abuse Act 2022; the Care Act 2015 and the mental capacity Act, 2005.

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. An overall ICS Green Plan was planned for summer 2025 but paused due to reorganisation of ICBs.

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

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

Task force on climate-related financial disclosures (TCFD)

The Department of Health and Social Care (DHSC) Group Accounting Manual (GAM) set out a phased approach to incorporating the recommended 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 the 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, were to be implemented in sustainability reporting requirements on a phased basis up to the 2025-26 financial year.

The phased approach incorporates the disclosure requirements by the following listed 'pillars': Governance, Strategy, Risk management, and Metrics and targets. These disclosures were not completed by year end as a result of internal capacity issues and subsequent cessation of the ICB.

The Climate Change Risk Assessment (CCRA) tool can support development of TCFD disclosures. This can be found on Future NHS.

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 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

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**

A summary of ICB activities in 2025/26 is given below

Governance and Planning	Meetings between the three merging ICB sustainability leads with a view to ensuring significant progress made in Bedfordshire, Luton and Milton Keynes ICB and Cambridge and Peterborough ICB are embedded in Central East ICB once established
Public Engagement and Behaviour Change	The ICB have run an 'Only order what you need' engagement campaign to reduce medicines waste
Supply chain and procurement	Tenders include questions on breaches of environmental waste and pollution regulations, Carbon Reduction Plans and Net Zero Commitments (PPN006/25), and set questions for Social Value commitments that always include an environmental consideration.
	The ICB raised awareness of the online short course Building a Net Zero NHS for staff.
	The ICB shared information for staff and public linked to national environmental awareness days, and activities to live more sustainably (car sharing is promoted, recycling, reducing use of consumables, switching off equipment)
	The ICB further consolidated its office footprint, relinquishing Charter House office, which closed in July 2025.
	Ongoing advice, support, check and challenge to Trusts and Primary Care organisations to progress sustainability workstreams.

We will continue to input to major strategies and consultations, to ensure an environmental sustainability thread is woven through same. Working the transition period has included:

- Environmental Policy for Central East
- Environmental Impact Assessment process for Central East Commissioning intentions

Metrics and 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. Given the planned closure of Charter House, the ICB's main office, in July 2025 targets for these elements were not specified but reduced the utilities impact to zero in addition to impacts on waste and paper usage.

The Green Plan refresh for the Herts and West Essex system was put on hold given the ICB reorganisation which will result in Central East ICB being responsible for a larger footprint. 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.

The ICB is not fully compliant with TCFD requirements: it has a governance structure, risk management, a programme of activities being carried out, and key metrics being monitored; additionally, its main strategy and Joint Forward Plan incorporated environmental sustainability as a driver and core programme. However, there are some gaps in compliance as follows:

- the ICB was not directly quantifying its own corporate contributions to global warming and environmental degradation, although it was carrying out activities to reduce its impact. NHS England advises individual NHS organisations not to calculate their own carbon footprints.
- supporting ICB plans, strategies, and policies have not yet been updated to specifically incorporate risks to the business and its intended outcomes from climate change. This was due to the announcement, in March 2025, that ICBs were to reduce in size and change function, and the subsequent decision to create the new Central East ICB.

Rectifying both non-compliance issues are considered as recommendations for the successor organisation, Central East ICB. As part of the new ICB, a clear suite of metrics will be assessed which will help to demonstrate how risks can be measured.

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, remained 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) has been aligned to the National Quality Board's 'A shared commitment to quality,' and included 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 been updated on levels of quality assurance and risk via the bi-monthly System Transformation and Quality Improvement Committee.

This Committee brought together quality, performance and transformation and sought assurance the ICB was delivering its functions in a way that secured continuous quality improvement, against each of the dimensions of quality set out in the National Quality Board guidance.

Looking ahead following the formation of the Central East ICB from April 2026 the Utilisation Management and Quality Improvement Committee will be responsible for quality oversight across Central East including Hertfordshire.

During 2025-26 the Nursing and Quality Team have identified and progressed work related to key opportunities in enhancing quality assurance and oversight. Examples of this included:

- 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
- enhancing the quality oversight and support to primary care medical services,

- developments to the system quality dashboard; and
- a strong alignment to areas underpinned by equality and diversity.

These have included partnership and quality improvement workstreams linked to benchmarking compliance around statutory functions such as a robust focus on Children and Young People aligned to Special Educational Needs and Disability (SEND) services. During 2025-26 there has been positive acknowledgement from the Care Quality Commission (CQC) and Ofsted regarding key improvement actions that have been taken collaboratively by the ICB and Hertfordshire County Council to improve the quality of SEND service provision since the initial inspection in 2023.

Approaches regarding how these will be taken forward in 2026-27 will be explored and agreed once the Central East ICB has been established.

In line with previous years' priorities, we have maintained our joint work in partnership with providers, overseeing a range of contractual quality responsibilities. This included 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.

Quality Strategy

The 3-year ICS Quality Strategy was co-developed with system partners and members of our population and implemented in 2023. It is available on the ICS website via the following link: <https://hertsandwestessexics.org.uk/work/ics-quality-strategy/14>

The Strategy sets out five system-agreed Quality Principles for Hertfordshire and West Essex, aligned to the National Quality Board's principles and tailored to local need:

- Delivering and co-designing person-centred services
- Collaborating effectively across organisations to continuously improve care
- Creating a positive and healthy environment for our population and workforce
- Using information and technology effectively
- Ensuring services are accessible and available to all

Throughout the lifetime of the Strategy, the ICS has worked collectively to deliver the agreed measures for each principle and to monitor performance, learning, and opportunities for further improvement.

Over the past three years, a range of significant measures have been delivered to enhance the quality, safety, and experience of services for the population of Hertfordshire and West Essex. These developments demonstrate the tangible impact of implementing the Quality Strategy and below provides a snapshot of the progress achieved to date:

- The development and system-wide rollout of a refreshed Quality Partnership Visit Framework across the ICS, supporting the identification of good practice, promoting shared learning, and enabling consistent quality improvement across partner organisations.
- The full implementation and embedding of the Medical Examiner statutory requirements, ensuring that all non-coronial community deaths are reviewed. This has strengthened clinical governance, improved transparency, and enhanced learning to support safer care.
- The development and delivery of an Experience of Care report focused on frailty services, capturing patient and carer feedback to highlight areas of excellence and identify opportunities for improvement. The findings from this work directly inform the design and development of new and enhanced services.

- The rollout of the Autism Project across all three maternity units, improving access, experience, and outcomes for autistic people during pregnancy, birth, and the postnatal period through more inclusive and responsive care.
- The delivery of a 12-month pilot programme for integrated, person-centred care during transitions, supporting individuals with complex needs and improving outcomes and experiences when moving between specialist and acute care settings.

Patient Safety

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.

We have focused on supporting the implementation of the Primary Care Safety Strategy this year (published in September 2024) with our GP practices.

Progress this year includes.

- Developed a process to ensure learning from incidents is shared widely across our system – ensuring relevant learning is shared across all sectors, including dental, pharmacy and optometry where relevant.
- Presentations on the Strategy, Patient Safety Incident Response Framework (PSIRF) and Learning from Patient Safety Events (LFPSE) delivered to various forums, including Primary Care Lead Nurse Forum, Community Pharmacy Network, and Locality Practice Manager forums and plans in place for a Protected Time to Learn session with GPs.
- Bespoke support to several independent and smaller providers to develop their PSIRP plans, and ongoing work with main providers to review and approve their updated plans and priorities.
- Continued work within the ICB to support a patient safety culture, including encouraging the uptake of Level 1 & 2 Patient Safety Training among colleagues, promoting World Patient safety Day, and supporting patient safety in various workstreams.
- Establishment of a Patient Safety Partner Network across the system – to better understand the role and challenges within different providers – and encourage joint working on common themes and issues.
- Ongoing development of the Patient Safety Network in HWE, which now also includes those working in patient safety across our independent and smaller providers. There is regular sharing of learning, resources and best practice across providers and joint working on common issues.
- Ongoing development of the ICB's System-wide Learning from Deaths forum, reviewing data and themes from mortality reviews and Prevention of Future Deaths Reports to facilitate conversations and focus across system workstreams.
- Continued to support GP practices with individual patient safety incidents, working with ICB colleagues to ensure appropriate reporting, investigation, and relevant learning is shared appropriately.

Patient Safety: Serious Incidents and Never Event Data

Hertfordshire and West Essex ICB received three Serious Incidents reported in the 2025-26 reporting year under the older framework – these were reported by GP practices who have not yet adopted the PSIRF approach.

In addition, 34 Patient Safety Incident Investigations (PSIIs) were reported in 2025-26 by those organisations who are working within the PSIRF framework. The ICB is notified of incidents,

and requests copies of the Learning Responses produced.

Of these incidents, 5 (15%) have been classified as Never Events. The ICB continued to maintain oversight of Never Events, with reports being reviewed by ICB colleagues.

Complaints Data

The ICB Patient Experience Team have received 3030 enquiries during 2025-26

The team worked across the ICB in order that no patient or family experienced a “wrong door” with their concerns.

The majority of queries, 2414, have been managed by the team as informal concerns/queries (patient advice and liaison queries) some of the queries are complex, the team supported the patient and the provider with gaining resolution.

The team recorded 332 formal complaints, however 38% 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 worked 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 received 255 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 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 accessing services in primary and secondary care. The ICB worked 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 asked people who raised 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.

Engaging people and communities

Maternity and neonatal services

The Three-year delivery plan for maternity and neonatal services recognises that listening and responding to all women and families was 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.

The Local Maternity and Neonatal System (LMNS) commission Maternity and Neonatal Voice Partnerships (MNVP) within each of the local hospitals in accordance with the Maternity and Neonatal Voices Partnership Guidance (NHS England 2023). The MNVP Leads have been embedded into ICB and trust governance processes, providing a service user feedback lens within safety and service improvement discussions.

This year the LMNS have developed the support offer for the MNVP Leads, to include a handbook and a training programme to support with attendance at Perinatal Mortality reviews.

Reporting of feedback trends from local families has been strengthened alongside increased attendance at events within the community as well as within the hospital wards. The MNVPs have focused on engaging with increased numbers of families who have been bereaved, or who have had children in neonatal care. They have also held events and visits targeted within communities who are more at risk of adverse outcomes including Black and Asian mothers and parents, families from Gypsy, Roma and Traveller backgrounds and families living in government accommodation whilst seeking asylum.

Supported by service user feedback, a hub based neonatal psychology role has been implemented within the three neonatal units, giving families whose babies are receiving neonatal care timely access to a psychologist, an improved pathway for readmission for babies with jaundice at Princess Alexandra hospital, an improved support for deaf service users has been rolled out at Watford Hospital and a new Induction of Labour pathway has been co-produced at Lister hospital.

Reducing health inequalities

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

While much of our population enjoys good health and has 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 was a feature of all ICS Transformation Programmes with a Population Health Management approach enabling this transformational work through tools which segment populations and stratify individuals based on several intersectional characteristics, where outcomes can be improved.

An example of how these tools had been 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.

Our work focuses on delivering practical, place-based actions aligned to local priorities, with particular emphasis on reducing inequalities in cardiovascular disease (CVD) outcomes, strengthening community engagement, and embedding lived experience and Voluntary, Community, Faith and Social Enterprise organisations (VCFSE) partnership working across system programmes. Work during this period balanced direct delivery, system leadership, and enabling activity, supporting both immediate population health impact and longer-term system change.

Key Areas of Action and Impact

Reducing Inequalities in Cardiovascular Disease (CVD)

A significant focus of activity was targeted CVD prevention and early detection in underserved communities. This included the distribution of blood pressure monitors to community and faith-based organisations, delivery of blood pressure training to volunteers and frontline staff, and partnership working with local authorities and VCFSE partners to support outreach events. These actions directly supported the ICB Medium Term Plan priority on inequalities in CVD outcomes and contributed to increased screening, earlier identification of hypertension, and improved access to follow-up care.

Community-Led Innovation and Health Improvement

Through the Innovation in Health Improvement Programme, work was delivered in partnership with Health Innovation East and One Vision, focusing on communities at higher risk of poor cardiovascular outcomes. The programme generated demonstrable clinical and social value, with strong early outcomes including high screening uptake, appropriate signposting to primary care, and evidence of medication initiation or optimisation for individuals identified with raised blood pressure.

Research Engagement and Inclusion

The Research Engagement Network (REN) programme continued to strengthen inclusive research participation, particularly among communities traditionally under-represented in health research. Activity aligned with the ICB Research Strategy and supported recruitment into multiple studies in partnership with primary care, regional research delivery networks, and VCFSE organisations. This work helped to embed community trust, improve awareness of research opportunities, and ensure research activity better reflects population diversity.

System Collaboration and Workforce Support

Health inequalities leadership was provided across multiple system groups, including the Health Inequalities Community of Practice, Patient Engagement Forum, Personalised Care Collaborative, and wider ICS networks. These spaces supported shared learning, workforce connection, and alignment across social prescribing, care coordination, and community engagement roles.

Partnership and Social Value

Partnership with the VCFSE sector remained central throughout the year, enabling culturally appropriate delivery, trusted community access, and strong social value. Investment during this period demonstrated a significant return in both social and clinical value, reinforcing the importance of community-anchored approaches to tackling health inequalities.

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 would be measured and a small number of key strategic priorities for action, where there was 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 was to 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 worked 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 2026-2029](#) identifies four key overarching priority areas:

- improving life chances for children and young people
- helping more people get jobs and stay in work
- building healthy, resilient and connected communities
- creating opportunities to improve health and reduce the impact of poor 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 demonstrated 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 Health and Wellbeing Board in summer 2026.

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

- **Prevention** – increasing the number of people undertaking blood pressure checks, with targeted approaches in areas where health inequalities are prevalent. Referrals into the National Digital Weight management programme have increased and we launched a new tier 2 and tier 3 weight management service for adults.
- **Smoking Cessation** - We have implemented the national Tobacco Dependency Programme pathways, in maternity, acute inpatient (in limited) but high impact specialities; community inpatient and mental health inpatient settings
- **Dementia Strategy** - Implementation of the Hertfordshire Dementia Strategy 2023-2028 has continued across health, care and voluntary and community partners.
- **Care Closer to Home** - We continue to develop our model to support a greater proportion of the frail, older population to receive health services closer to home and shift more care from acute reactive services to more proactive and preventative care delivered by community or primary care. Respiratory hubs have been rolled out by PCNs across the ICB.
- **Mental Health** - the Mental Health Urgent Care Centre (UCC) was launched to support those experiencing mental health crisis.
- **All-Age Autism Strategy** - The ICB continues to support the delivery of a coordinated, life-course
- **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 under the Civil Contingencies Act 2002 ([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 Emergency Preparedness, Resilience and Response process.

In 2025-26 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	SUBSTANTIAL 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	SUBSTANTIAL COMPLIANCE
Overall rating	SUBSTANTIALLY COMPLIANT

In 2025/26 the ICB has focused on:

- Continued management of new and ongoing incidents, e.g. industrial action, extreme health system pressures, various power outages, severe weather conditions.
- Horizon scanning and ensuring preparedness for potential emerging risks, e.g. flu epidemic and other infectious diseases. Reviewing current risk management processes in conjunction with the Local Resilience Forum to ensure that these are more robust.
- Continued development of the System Co-ordination Centre (SCC) in line with best practice in other areas and evolving NHSE requirements
- Completion of exercise plans for 2025/26 including severe weather, marauding terrorist attack, lithium battery fire, chemical release into a canal, winter system pressures, failure of a care home provider and communications exercises, as well as a national flu pandemic exercise.
- Continued business continuity planning, including plans for any potential national power outage or infectious disease outbreak and preparedness for the switch off of the Public Switched Telephone Network (PSTN) in 2027
- The completion of detailed Equality Impact Assessments for a number of emergency plans
- Introduction of a new "Lessons Learned Strategy."
- Participation in the Essex and Hertfordshire Local Resilience Forums and attendance at various subgroups, e.g. multi-agency exercise and training and Risk Intelligence Groups
- Completion of the 2025/26 NHSE Core Standards for EPRR assurance process
- Facilitation of an external audit in relation to emergency planning and business continuity management
- 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. The ICB is now also delivering more of the training in-house, therefore reducing the reliance on external trainers.
- Ongoing timely annual review of all EPRR policies and plans
- Whole health system working group set up to review P3 (Patient Community and Rest Centre) arrangements
- Transition plans for the SCC and EPRR functions to transfer from HWE ICB to the Central Eastern Cluster with effect from 1 April 2026.

In 2026/27 the ICB's priorities will be:

- Progressing the Central Eastern Transition plan to ensure a smooth transition from HWE ICB to the Central Eastern Cluster
- Transitioning the HWE ICB System Co-ordination Centre (SCC) to a Central Eastern Cluster SCC and ensuring that this continues to align with the purpose, key deliverables and the minimum operating requirements outlined by NHSE.
- Maintaining 24/7 on-call functions across the Central Eastern Cluster
- Continuing to review business continuity arrangements, aligning to new structures and staffing arrangements within Central Eastern Cluster
- Ensuring that all HWE ICB EPRR plans/policies/arrangements transition to Central Eastern Cluster plans/policies/arrangements and continue to align to the NHSE EPRR framework
- Overseeing and managing clinical risks within the Central Eastern Cluster with specific reference to UEC Demand and Capacity
- Continuing to consider how EPRR is managed in Primary Care; ensuring GP practices are aware of their EPRR and business continuity responsibilities; preparing for the future roll out of annual core standards assurance to all practices within Primary Care.
- Ensuring that appropriate training and exercise arrangements are in place within the Central Eastern Cluster
- Finalising new P3 (Patient and Community Rest Centres) which would be set up to treat the walking injured during a mass casualty incident and implementing any necessary changes
- Continuing to work with the Herts Local Resilience Forum to establish Community Hubs which could be set up in the event of a National Power Outage.
- Working towards full compliance with NHSE Core Standards for EPRR within Central Eastern Cluster and supporting system partners to improve their compliance against these standards too.

THE WORK OF HBL ICT SHARED SERVICES

Hosted by Hertfordshire and West Essex ICB, HBL ICT provide IT services to the four member organisations forming the HBL Partnership. 2025 has been a year of significant change within the NHS as member organisations look to digital to enable them to deliver greater efficiencies and automated services to our population. HBL ICT have taken pride in being an ICT service provider, delivering a cost-effective service that delivers without compromising on quality.

As an ICT Service provider, HBL look to develop and innovate services to meet the demands of the ICB. During 2025, HBL made significant investments in cyber defences, successfully deploying MS Win11 operating system to all end user devices across the enterprise, prior to the Microsoft deadline of October 2025. In addition, HBL entered into a partnership with a new Robotic Process Automation (RPA) service provider (JifJaff) to provide RPA at scale within Primary Care. This will improve digital services, freeing up the scarce clinical resource time at the point of care.

Customer is given priority and ongoing improvements have been made in-year to communication channels, including ongoing development of virtual agent and chat facilities to make our technicians more accessible to support customers.

This year ICB completed a redesign of its core infrastructure relocation, replacing the on-premise data centre with a new commercial site in Enfield and replacing core technology stacks via a leasing model in partnership with HPE as a strategic supplier. This strategic digital shift will deliver a more sustainable technology model with greater flexibility and reduce the cost of ownership, making technology more accessible, adaptable and affordable to the partnership. In 2025/26 HBL received praise and recognition across all of its functional areas which was further endorsed by its six-monthly customer survey results. This demonstrated the value placed upon the organisation as a well led, quality driven, integrated ICT service provider.

Looking ahead, HBL ICT will focus on delivering a 5-year business and digital strategy 'Digital Once.' focusing 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 the strategy will be to progress with RPA and generative AI technologies to further drive efficiencies.

HBL ICT Staff

HBL ICT have continued to invest in several key initiatives concerning its staff. This includes management development initiatives, a comprehensive staff training programme and the ongoing development inclusion champions' within HBL ICT, which provides a confidential support channel for all of its staff.

Financial position

At the end of 2025/26, HBL ICT met the control total specified by the Partnership Board. Service charges to partner organisations based upon an 'Activity Based Costing' model incorporating inflation and cost improvement targets, resulted in a small surplus at the financial at the end of the fiscal year.

Cyber Security

Cyber security continued to dominate daily operations. To that extent, HBL ICT has published its first cyber security strategy. The strategy focuses on key strategic objectives to further strengthen the position across cyber security domains such as user awareness and culture, threat detection and prevention, defence in depth, and response and recovery.

Cyber security continues to be a significant threat globally, which needs to be constantly managed to protect business and patient data. However, due to the investments in developing a highly secure, resilient and robust IT infrastructure, underpinned by tight control processes and patching regime, the HBL Partnership continues to deliver a highly available service

Financial review

Introduction

This section of the Annual Report sets out a summary of the ICB's financial performance for the 2025/26 financial year.

The Annual Accounts have been prepared under directions issued by NHS England and the DHSC Group Accounting Manual (GAM). Further details on ICB's financial performance can be found in ICB's Accounts at the end of this Annual Report

Financial performance

ICBs have a statutory duty to contain expenditure within the limits directed by NHS England, with a requirement to deliver system financial balance. NHS England may make directions about ICB's management or use of financial or other resources. NHS England may also set joint financial objectives for ICBs, and their partner NHS Trusts and NHS Foundation Trusts. ICBs and partner NHS Trusts and NHS Foundation Trusts must exercise their functions with a view to ensuring that limits specified by a direction by NHS England are not exceeded.

ICBs have the following statutory financial duties. The performance of the ICB in 2025/26 is set out in the following table. Further details are provided in the annual accounts which commence on page **X**

Matter	Target	Actual	Achieved
	£000s	£000s	

Maximum revenue resource use The revenue resource use for each Integrated Care Board in 2025/26 shall not exceed the amount specified.	4,190,067	4,190,055	Yes
Maximum revenue resource attributable to matters relating to administration The revenue resource use for each Integrated Care Board attributable to matters relating to administration in 2025/26 shall not exceed the amount specified.	42,108	40,313	Yes
Maximum capital resource use The capital resource use for each Integrated Care Board in 2025/26 shall not exceed the amount specified.	0	0	Yes

The funding allocation to Hertfordshire and West Essex ICB for the period 1 April 2025 to 31 March 2026 is set out in the table below. The total authorised allocation for spending by the ICB was £ 4.190 bn.

The ICB's Control Total, the targeted amount of spending NHS England sets for the ICB, was to deliver breakeven position in 2025/26. The ICB worked within the financial allocations set by NHS England.

Description of Allocation	Allocation for the ICB £'000
Programme Costs	3,256,999
Primary Care Delegated Functions	487,398
Specialised Commissioning Costs	403,562
Administration Costs	42,108
Total Funding	4,190,067

The ICB's other financial duties include controlling the amount of spend on the administration function of the organisation. In 2025/26, the ICB spent £40.3 million in this area, which is within the planned spending target.

Mental Health Investment Standard

An important planning requirement is the delivery of the Mental Health Investment Standard (MHIS). The standard requires Integrated Care Boards to increase investment in mental health services at a higher percentage than their overall rise in allocation from NHS England each year.

Achievement of the Standard is measured by comparing expenditure in 2025/26 to that in the previous financial year. This is after considering any mental health specific recurrent or non-recurrent allocations received 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 our general allocation. Spending on learning disability and dementia services is currently excluded from the MHIS calculation. ICBs are required to publish a formal declaration as to whether their spending met the Standard. This statement will be subject to audit assurance through the ICB's auditor.

In 2025/26 the ICB was required to increase its mental health spending by a minimum 4.93%. Subject to confirmation through independent audit, the ICB has met the Mental Health Investment Standard (MHIS) in 2025/26. The MHIS expenditure as a proportion of total operating expenditure increased from 6.32% to 6.66% in 2025/26

	2025-26 £'000	2024-25 £'000
Minimum expenditure in mental health services to meet the Mental Health Investment Standard as notified by NHS England	282,162	247,623
Eligible mental health expenditure	282,610	247,958
Mental health expenditure above minimum investment required	449	335
Mental health expenditure as a proportion of total operating expenditure	6.66%	6.32%

2026/27 Planning Guidance and Financial Outlook

NHS England has shifted from annual cycles to a multi-year planning framework covering 2026/27 to 2028/29, with aligned capital guidance to 2029/30. This is anchored in the NHS 10-Year Health Plan and the move toward prevention, digital transformation and community-based care. The move from single-year planning to a medium-term approach has been enabled by the 3-year revenue settlement from the Spending Review 2025, and 4-year capital settlement. As part of this, revenue spending will increase by 3% in real terms over the course of the spending review period to 2028/29. However, to manage within the funding available, while delivering national and local priorities, the ICB will need to deliver stretching efficiency and productivity requirements.

From 2026/27 both ICBs and NHS Trusts / NHS Foundation Trusts will be required to deliver a breakeven revenue position as individual bodies, which reflects a change from the 2025/26 business rules where ICBs and NHS Trusts were required to support the delivery of breakeven in aggregate across the system. However, ICBs and Trusts must continue to collaborate to support the delivery of locally agreed priorities. As part of this, ICBs and Trusts will be required to work together to agree plans that address the healthcare needs of the populations they serve, in accordance with national and local priorities, and ensure that resources are used effectively and efficiently in support of this. This includes each organisation taking proactive steps to ensure that plans are mutually aligned.

The financial duties of ICBs for the next three financial years are set out below:

Duty or Requirement	Description of Duty
ICB breakeven duty	Statutory duty to act with a view to ensuring expenditure does not exceed funding received.
ICB revenue resource use limit	Statutory duty to comply with the limit set by NHS England.
ICB administration limit	Statutory duty to comply with the limit set by NHS England (referred to as ICB running cost allowance).
Better Care Fund (BCF)	Requirement to comply with the ICB funding conditions set by DHSC.
Mental Health Investment Standard (MHIS)	Requirement to comply with the ICB MHIS values set by NHS England.
Dental services ringfence	Requirement to comply with the ICB dental services ringfence values set by NHS England.

Payment System Reform

Work is underway to deconstruct block contracts with NHS providers and reform the NHS Payment Scheme. For 2026/27, a new payment model is being introduced for urgent and emergency care (UEC) comprising a fixed element (based on cost x activity) and a variable element (roughly 20% of total payment).

New best practice tariffs on day cases, outpatients and more efficient ways of working will also be proposed as part of the 2026/27 NHS Payment Scheme. The UEC payment model will be further developed to incentivise shifting more care out of hospitals and into community settings, to be trialed with pilot sites in 2026/27.

A Fairer Distribution of Funding

A review of the NHS funding formula is underway which will seek to return system allocations to their corresponding fair share of resources. The pace of implementation will be balanced with ensuring finances are not destabilised in the short term.

NHS England are also reviewing the Carr-Hill formula for GP funding - another major component of NHS resource distribution. This review is intended to improve fairness by ensuring resource allocation reflects deprivation, population need and workload.

Organisational Change

During 2025/26 the ICB has operated within a period of significant national restructuring, culminating in the confirmed abolition of NHS Hertfordshire and West Essex ICB with effect from 1 April 2026 and establishment of the NHS Central East ICB which will assume all commissioning functions across Hertfordshire, Bedfordshire, Luton and Milton Keynes, and Cambridgeshire & Peterborough. The ICB has focused significant capacity during the year on transition planning, ensuring continuity of commissioning, safe transfer of financial and contractual obligations and maintaining organisational stability during a period of unprecedented structural change. The assets and liabilities of the HWE ICB will transfer to the new Central East ICB as a transfer by absorption. The Hertfordshire element of the assets and liabilities of HWE ICB will transfer to NHS Central East ICB and the West Essex element will transfer to NHS Essex ICB. The expected date for the transfer was 1 April 2026.

In March 2025, the Secretary of State for Health and Social Care announced the abolition of NHS England – ‘Over the next 2 years, NHS England will be brought into the department entirely’. Commissioning responsibility for vaccination and screening will move to ICBs, likely from April 2027, subject to the passage of legislation. In 2026/27, NHS England will develop a commissioning and contracting framework covering these new responsibilities.

It is currently unclear what will happen to the remaining services that are currently commissioned by NHS England, this includes the remaining highly specialised services, some public health functions including national screening and immunisation programmes, health & justice and armed forces commissioning. It is possible that responsibility for commissioning these services will be delegated to Integrated Care Boards in the future.

Joint Capital Resource Plan

As required under the National Health Service Act 2006 (as amended by the Health and Care Act 2022), Central East ICB has, in partnership with its NHS Trusts and Foundation Trusts, prepared a Joint Capital Resource Plan (JRCP) ahead of the 2026/27 financial year. This plan sets out the system's agreed approach to capital resource use, ensuring alignment with the multi-year capital framework introduced through the Spending Review 2025 and the wider 10-Year Health Plan, which emphasises a more transparent, devolved and integrated model of capital planning across the NHS.

The JCRP supports strategic investment decisions that underpin local priorities, including modernisation of estate, digital transformation, diagnostics capacity and community-based service developments, while operating within the national Capital Departmental Expenditure Limit (CDEL). In line with statutory requirements, the plan will be shared with the local Health and Wellbeing Boards and NHS England, and the ICB will report progress against. The Plan is published on the ICB website here. [Joint Capital Use Resource Plan - Herts and West Essex ICS](#)

Delivery against the joint capital use resource plan has been monitored through the ICB Strategic Finance and Commissioning committee, as part of the finance function. Providers also report delivery of their strategic capital programmes through their own governance arrangements, with provider funding making up most of the System Capital Departmental Expenditure Limit (CDEL) allocations in 2025/26. For 2026/27, arrangements for the distribution and oversight of capital has changed, with ICBs no longer having system CDEL responsibilities.

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 2025 to 31 March 2026 including membership and organisation of our governance structures and how they supported the achievement of our objectives.

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

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

Corporate Governance Report

Governance Statement

Introduction and context

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

The 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 people for the purposes of the health service in England. The ICB is 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 2025 and 31 March 2026, the ICB was not subject to any directions from NHS England issued under Section 14Z61 of the National Health Service Act 2006 (as amended).

From 1 October 2025 to 31 March 2026 the ICB, working in partnership with Bedfordshire Luton and Milton Keynes ICB and Cambridge and Peterborough ICB, operated transitional governance arrangements which were approved by the Boards of all three organisations. The arrangements required changes to both the ICB's Constitution, which was approved by NHS England, and the ICB's Governance Handbook which was approved by the ICB Board.

These changes brought together the ICB Boards and Committees of each ICB, whilst maintaining the statutory obligations as independent legal entities. From October 2026, we operated Boards and Committees in *Common or as Joint Committees. Whilst statutory Committees were retained, the Board established a number of new Joint Committees. These transitional arrangements have been reflected within this Annual Governance Statement.

** A committee in-Common is where two or more organisations meet in the same place at the same time, have separate agendas but the same items on them and may reach the same conclusions – but the individual organisations remain distinct.*

Statement of Accountable Officer's Responsibilities

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

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

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 NHS Hertfordshire and West Essex ICB and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

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

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

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

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

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

Governance Arrangements and Effectiveness

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

The ICB Board met six times during 2025-2026 as follows:

27 June 2025
26 September 2025
17 October 2025 (in Common)
28 November 2025 (in Common)
6 February 2026 (in Common)
27 March 2026 (in Common)

There was good attendance from all ICB Board Members. Attendance is recorded within the minutes for each meeting. The minutes of the meetings held in public are available on the ICB website - [Board Meetings and Papers | HWEICB Website](#)

The ICB Board was served by the following Committees throughout this period:

From 1 April 2025 to 30 September 2025

Audit & Risk Committee (Statutory Committee) – Chaired by a Non-Executive Member, the Audit & Risk Committee is accountable to the board and provides it with an independent and objective view of the ICB's financial systems, financial information and compliance with laws, regulations and directions governing the ICB as far as they relate discharging their statutory duties. The Committee ensures that there is an effective system of internal control and provide an objective review of systems and reports presented by Internal and External Audit and provides the Board with an assurance that the ICB's governance, including financial assurance and risk management processes are conducted within best practice guidelines set out in the Audit Committee Handbook published by the Healthcare Financial Management Association.

Remuneration Committee (Statutory Committee) – Chaired by a Non-Executive Member, the Remuneration Committee 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.

System Transformation and Quality Improvement Committee (Non-Statutory Committee) – Chaired by a Non-Executive Member, the System Transformation and Quality Improvement Committee provides assurance to the Board on delivery of 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.

People Board (Non-Statutory Committee) – Chaired by a Non-Executive Member, the People Board contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the ICB on delivery of the ten people functions, building on the enduring ambitions set out in the People Plan and the People Promise, ensuring a one workforce approach within the ICB. The duties of the committee were be driven by the local, regional, and national priorities and risks.

Strategic Finance and Commissioning Committee (Non-Statutory Committee) Chaired by a Non-Executive Member, the committee is responsible for: Providing oversight and assurance on the delivery of the ICS strategy, system wide transformation and improvement schemes

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.

Strategy Committee (Non-Statutory Committee) Chaired by a Non-Executive Member, the Strategy 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. Following the announcement surrounding the realignment of ICBs in March 2025, this Committee did not sit in 2025/2026.

Name	Role/Job Title/Organisation (ICB Roles held between 1 April 2025 to 1 October 2025 unless otherwise stated)	A&R	SFCC	SC	PC	PCCC	REM	ST&QI
Paul Burstow	Chair							
Gurch Randhawa	Deputy Chair/Non-Executive Member	✓	✓					✓
Dr Jane Halpin	Chief Executive Officer	✓						
Alan Pond	Chief Finance Officer (to 18 July 2025)		✓				✓	
Jonathan Wilson	Chief Finance Officer (from 18 July 2025)	✓	✓				✓	
Natalie Hammond	Director of Nursing and Quality	✓						✓
Dr Rachel Joyce	Medical Director			✓		✓		✓
Tania Marcus	Director of People				✓			
Beverley Flowers	Director of Strategy			✓				
Matthew Coats	Senior Responsible Officer South West Herts HCP		✓					
Elliot Howard-Jones	Board Partner Member – NHS Trusts and Foundation Trusts, Senior Responsible Officer East and North Herts HCP		✓					
Thom Lafferty	Senior Responsible Officer West Essex HCP		✓					
Karen Taylor	Senior Responsible Officer Mental Health & Learning Disabilities & Autism HCP		✓					
Adam Sewell-Jones	Joint Senior Responsible Officer East and North Herts HCP, Board Partner Member – NHS Trusts and Foundation Trusts		✓					
Dr Prag Moodley	Partner member, Primary Medical Services		✓					
Dr Ian Perry	Partner member, Primary Medical Services							
Dr Trevor Fernandes	Partner member, Primary Medical Services							✓

Christopher Martin	Partner member, Local Authority, ECC (Interim)		✓					
Angie Ridgwell	Partner member, Local Authority, HCC		✓					
Ruth Bailey	Non-Executive Member (to 30 June 2025)				✓			✓
Thelma Stober	Non-Executive Member	✓						✓
Nick Moberly	Non-Executive Member		✓		✓			
Joanna Marovitch	VCFSE Alliance Board Member (to 22 May 2025)							
Mark Hanna	VCFSE Alliance Board Member		✓					

1 October 2025 to 31 March 2026

Audit & Risk Committee (Statutory) – Chaired by a Non-Executive Member. The Committee's purpose is to provide independent assurance on governance, risk management, internal control, and financial reporting. Key responsibilities of the Committee are to oversee internal and external audit processes; monitor risk management frameworks including deep dives on system-wide risks; review financial statements and governance reports; ensure compliance with statutory and regulatory requirements [Information Governance, Cyber Security, EPRR, Annual Report & Annual Accounts including Annual Governance Statement, Freedom to Speak Up], provide Integrated Care Partnership assurance.

Remuneration & Workforce Committee (Statutory [Remuneration]) – Chaired by a Non-Executive Member, the Committee's purpose is to oversee Executive and Director (VSM) pay, performance, and workforce strategy aligned with NHS People Plan. Key responsibilities of the Committee are to set remuneration and terms for senior executives; monitor workforce planning, recruitment, and wellbeing; compliance with the Fit and Proper Persons Test (FPPT); promote equality, diversity and, inclusion and compliance with Workforce Race Equality Standards (WRES)/Workforce Disability Equality Standard (WDES).

Finance Planning and Payer Function Committee (Non-Statutory) – Chaired by a Non-Executive Member. The Committee's purpose is to ensure financial sustainability and value-based commissioning aligned with population health needs. Key responsibilities of the Committee are to oversee the payer function; oversee financial planning, budget setting and monitoring financial performance; approve major investments and business cases; monitor commissioning outcomes and contract performance; align resources with strategic priorities; approve Health Care Partnership assurance investment; oversee utilisation of research opportunities. Post October 2025, this Committee met in common with the joint NHS Cambridge & Peterborough (C&P) ICB and NHS Bedfordshire, Luton & Milton Keynes (BLMK) *Finance Planning & Payer Function Committee (FPPFC)*

System Transformation and Quality Improvement Committee (Non-Statutory Committee) – Chaired by a Non-Executive Member, the System Transformation and Quality Improvement Committee provides assurance to the Board on delivery of 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. Post October 2025, this Committee met in common with the joint NHS Cambridge & Peterborough (C&P) ICB and NHS Bedfordshire, Luton & Milton Keynes (BLMK) *Utilisation Management and Quality Improvement Committee (UMQIC)*.

Management Executive Committee – Chaired by the ICB Chief Executive (CEO) (Non-Statutory). The Joint Committee's purpose is to be responsible for the operational leadership and delivery of the ICB's strategic objectives. It ensures effective coordination across executive

functions and supports the CEO in discharging their responsibilities to the Board. The Committee provides executive leadership and oversight of day-to-day operations including performance, finance, workforce, and quality metrics; ensures delivery of the ICB's strategic and operational plans; coordinates cross-functional initiatives and transformation programmes; supports the development of Committee/Board papers and assurance reports; oversees the Board Assurance Framework (BAF) and Corporate Risk Register and ensures alignment with NHS priorities and statutory obligations.

Joint Transition Committee – In line with NHSE Guidance, the Boards of Hertfordshire and West Essex ICB, Bedfordshire Luton & Milton Keynes ICB, and Cambridgeshire & Peterborough ICB, established a Joint Transition Committee which met from August 2025. The purpose of the Committee was to oversee the transitional arrangements, close down of three ICBs alongside the development of the new Central East ICB which is anticipated to be established from 1 April 2026.

Name	Role/Job Title/Organisation (ICB Roles unless otherwise stated)	A&R	FPPF/SFCC	ME	REM	UMQ/STQIC
Jan Thomas	Chief Executive Officer		✓	✓		
Poi Toner	Director of Safeguarding and Complex Care			✓		✓
Kate Vaughton	Executive Director Neighbourhood Health, Places & Partnerships		✓	✓		
Maria Wogan	Director of Neighbourhood Health Places and Partnerships BLMK			✓		
Karen Barker	Transition Director & Executive Director of Corporate Services		✓	✓		
Thelma Stober	Non-Executive Member	✓	✓		✓	✓
Prof Gurch Randhawa	Deputy Chair	✓	✓			✓
Nick Moberly	Non-Executive Member		✓			✓
Stacie Coburn	Director of Contracts and Performance			✓		
Marcel Coffait	Chief Executive, Central Bedfordshire Council					
Elizabeth Disney	Director of Strategic Planning and Commissioning			✓		
Beverly Flowers	Director of Strategic Planning and Commissioning (Until 31.12.2025)			✓		
Pam Green	Director of Neighbourhood Health Places and Partnerships for Cambridge & Peterborough			✓		
Sarah Griffiths	Executive Director of Finance, Resources and Contracting		✓	✓		
Prof Natalie Hammond	Director of Safeguarding & Complex Care (Until 22.03.2026)			✓		✓
Dr Fiona Head	Executive Clinical Director Utilisation Management (Medical Director) & Caldicott Guardian		✓	✓		✓
Sarah Hughes	Non-Executive Member				✓	✓
Louis Kamfer	Executive Director of Strategy, Planning and Evaluation		✓	✓		✓
Ed Knowles	Director of Neighbourhood, Place and Partnerships for Hertfordshire			✓		
Emma Kriehn-Morris	Director of Finance			✓		
Prag Moodley	GP (Primary Medical Services)		✓			
Ian Perry	GP (Primary Medical Services)					
Trevor Fernandes	GP (Primary Medical Services)					✓
Tania Marcus	Director of People and Culture			✓		✓
Andrew Palmer	Director of Population Health, Analytics and Evaluation			✓		
Robin Porter*	Chair				✓	

Matthew Coats	Senior Responsible Officer South West Herts HCP		✓			
Elliot Howard-Jones	Board Partner Member – NHS Trusts and Foundation Trusts, Senior Responsible Officer East and North Herts HCP		✓			
Thom Lafferty	Senior Responsible Officer West Essex HCP		✓			
Karen Taylor	Senior Responsible Officer Mental Health & Learning Disabilities & Autism HCP		✓			
Adam Sewell-Jones	Joint Senior Responsible Officer East and North Herts HCP, Board Partner Member – NHS Trusts and Foundation Trusts		✓			

The ICB's Constitution was approved by NHSE and came into force on 1 July 2022. It is published on the [our website](#).

The Committee structure was supported by the [ICB's Governance Handbook](#) which was last approved by the ICB Board in February 2026, and which is also published on the website.

Member practices forming the membership body of the ICB can be found on page 91 of the [ICB's Governance Handbook](#).

The composition and named membership of the ICB Board and its committees, throughout the financial year, are set out in the corporate governance section from page 36. There was good attendance at all ICB committee meetings which is recorded within the minutes of each meeting.

The gender distribution of the board, senior managers and all other employees is set out in the staff report section on page 68

UK Code of Corporate Governance

NHS bodies are not required to comply with the UK Code of Corporate Governance. Whilst the detailed provisions of the UK corporate governance code are not mandatory for public sector bodies, compliance is considered good practice.

In line with the UK corporate governance code, we conducted a committee effectiveness survey in Quarter 4 of 2025/26. This was based on the transitional governance arrangements described above which were in place from 1 October 2025. Key outcomes from the survey are set out below:

- Strategic focus and leadership – Boards and Statutory Committees demonstrate strong strategic intent and leadership, with recognised need for sufficient time to explore complex and high-risk issues in depth.
- Governance roles and clarity – Governance arrangements are broadly understood, with some ongoing need for clarity around roles, responsibilities as decision-making arrangements continue to evolve.
- Papers and agenda management – The volume timing and length of papers can limit effective scrutiny across Boards and Committees with members seeking more concise, purpose-drive reporting.
- Culture, challenges, and relationships – Culture is generally seen as open and respectful, though the size of meetings held in common and the pace of changes can affect consistent participation and challenge.
- Governance development and maturity – There is strong support for structured development to build shared understanding, role clarity and effective challenge as arrangements move forward to a single ICB.

The outcomes of the effectiveness survey will be reported to the Committees and the Board during the first quarter of the Central East ICB's Committee cycle.

Regular review of the new Governance Framework and continuing effectiveness monitoring will continue to be a priority for the new ICB. Board Development will be incorporated into the overall new Central East ICB Organisational Development Programme. The Organisational Development & Delivery Team is responsible for building organisational capability, culture and performance structures to keep promises and sustain delivery and will be responsible for taking forward the ICB's organisational development programme, including Board Development. Specific focus for the Board will include ensuring mandatory Board training is undertaken, recognising the new ICB's statutory responsibilities, as well Board oversight and involvement on the delivery of Central East ICBs Strategy 'Our Way'. There will be strong focus on effective appraisals for all staff, Executive and Non-Executive Directors. The new ICB will also embark on a series of Orientation Days for all those appointed to the new ICB. These will commence in May/June 2026.

Discharge of Statutory Functions

The ICB has reviewed all the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that the ICB is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a Chief Officer within the ICB Executive Team. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all the ICB's statutory duties.

Modern Slavery Act

NHS Herts and West Essex 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.

Risk management arrangements and effectiveness

Within the ICB, risk management is demonstrated by:

- Adopting an integrated approach to risk management, whether the risk relates to clinical, organisational, health and safety, or financial risk, through the processes and structures detailed in the ICB's Risk Management Policy.
- Managing risk as part of the routine line management responsibilities and consideration of funding to address 'risk' issues (based on a risk assessment) as part of the normal business planning process.
- Undertaking risk assessments on existing, new, and proposed activities to ensure that:
 - Significant risks are identified in accordance with the Risk Management Policy which provides full details on what constitutes a risk, and how it should be identified and assessed,
 - Assessments are made of their potential frequency and severity,
 - Control measures are implemented in accordance with the Risk Management Policy,
 - Risks are always assessed and reduced or minimised where possible,
 - Strategic risks are recorded on the Board Assurance Framework (BAF) in line with the Risk Scoring Matrix,

- A Transition Risk Register is in place monitored by the Joint Transition Committee

Staff at all levels of the organisation contribute to the identification and assessment of risk and at the main provider meetings and contract and clinical quality review meetings. The risk management actions that have been taken this year include:

- Maintenance of the ICB's Board Assurance Framework and Corporate Risk Register,
- Establishment of a Transition Risk Register,
- Compliance with NHS England's Emergency Preparedness Resilience and Response (EPRR) Framework and subsequent delivery against the annual EPRR Core Standards self-assessment. For 2025, the ICB declared full compliance against these standards,
- Compliance against the Data Security and Protection Toolkit, overseen by a Joint IG Steering Group chaired by the ICB's Senior Information Risk Owner.

The ICB delivered an effective Impact Assessment process for completion of the impact assessments to support business case development, project management, and service transformation/reductions requiring public consultation, where these documents form part of the overall process.

The control environment is supported by regular review of our ICB Constitution, including Standing Orders, Scheme of Delegation and Standing Financial Instructions, directions on fraud, programme of Internal Audit, budgetary control systems, and information to support performance and risk monitoring processes.

Capacity to Handle Risk

The ICB Board provides leadership to ensure that risk management is embedded within the organisation. This includes continuous development of the BAF which identifies the key objectives and related risks.

As Accountable Officer, I ensure that sufficient resources are invested in managing risk and I am supported in this task by the Caldicott Guardian (Chief Nurse until 30 September 2025 and Executive Clinical Director from 1 October 2025) who holds ICB board level responsibility for clinical risks. The ICB Executive Team (until 30 September 2025) and the Management Executive Committee (from 1 October 2025) take executive level responsibility for non-clinical risks supported by the Corporate Governance Team led by the Director of Governance. The Chief Finance Officer (until 30 September 2025) and the Executive Director of Strategy, Planning and Evaluation (from 1 October 2025) is the ICB's Senior Information Risk Owner (SIRO).

Leadership across the organisation is given to the risk management process through the ICB Executive Team, Senior Leadership Team and ICB board members via the committees of the ICB Board. Each Committee regularly reviews strategic risks set out in the BAF.

Risk registers are maintained at a directorate level and all staff are required to adhere to the ICB's Risk Management Policy which requires them to assess, identify and manage risks in a way that is appropriate to their authority and duties. Guidance is provided to staff by the Corporate Governance Team who provide templates on how to undertake risk assessments, produce risk registers and business continuity plans, and embed risk management in the activity of the organisation. The Corporate Risk Register (CRR) has been developed further this year and brings together escalated risks from the Directorate Risk Registers (DRRs) alongside corporate risks identified by the ICB Executive Team.

Risk Assessment

The BAF identifies the ICB's strategic objectives and risks, the controls that are currently in place to minimise the risk, and the sources of assurance to those controls. The system of regular review of the BAF by the ICB board provides evidence to the Annual Governance Statement. The ICB board has overseen regular assessment of the risks associated with achieving the ICB's strategic objectives and risks, has reviewed gaps in key controls and assurance to address those risks, and monitored management actions to address the gaps. The BAF assesses the likelihood of an event occurring combined with the possible consequences to provide a standard approach to the assessment of risk. Calculating the risk supports the prioritisation of action plans and the reduction of risks is therefore managed through this process. Organisational risks are included in Directorate Risks Registers and escalated to the Corporate Risk Register.

The internal audit review of the BAF and our risk management processes was completed in March 2026. Reasonable Assurance was received.

The BAF is regularly reviewed by the key committees of the ICB board. It is also scrutinised at each Audit & Risk Committee and presented to the ICB board meeting in public throughout the year.

The BAF is reviewed by the Board and key Committees of the ICB at each meeting, including scrutiny by the Audit & Risk Committee, which also looks for assurance around the risk management framework. At Board level, there is strong representation from the wider NHS, through our Partner Members, as well as our Local Authority members and public stakeholders such as Healthwatch. All members are able to contribute to the discussion around the management of risk and assurance on mitigations.

The BAF identified several risks to achieving our strategic aims which are being managed through actions linked to the BAF to mitigate these risks. These are as follows as of Board meeting held on 27 March 2026: The risk scoring matrix can be found on page 17 of the [HWE ICB Risk Management Policy](#). The same risk scoring matrix features in the Risk Management Policy that has been developed for the new Central East ICB.

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.

ID	Description	Current risk score	Controls
755	IF local EPRR functions are removed as part of upcoming restructures THEN this could RESULT IN detrimental impacts on health care resilience and business continuity through loss of local knowledge of the health systems, geography, local Incident Co-ordination Centres and insufficient staffing to be able to meet statutory responsibilities as defined within the Civil Contingencies Act. Furthermore, the proposed UK Government Devolution plans anticipate improved local responsiveness and localised decision making and the potential removal or loss of local health systems EPRR functions would conflict with these intentions.	16	Communication From National Leadership: 01 April 25: Jim Mackay's letter to ICBs Strategic Planning Documentation: 02 May 25: Draft ICB Blueprint Operational Response Frameworks: Existing On Call and Incident response structures Risk Management Processes: Ongoing Modelling and Scenario Planning: Staff Wellbeing Support: Staff Engagement and Updates: Mental Health and Wellbeing Signposting: Organisational Integration Measures: Transition Guidance (Pending Confirmation): Workstream Rationalisation (Pending Confirmation): No changes to this risk over the period
745	IF healthcare systems {inc ICBs, NHSE & UKHSA} lose EPRR staff due to current uncertainty around future posts THEN the wider health care systems ability to maintain current structures during the forthcoming transition period will be compromised RESULTING IN detrimental impacts on these systems resilience and business continuity of service delivery through loss of local knowledge of the health systems, geography and insufficient staffing to be able to meet statutory responsibilities as Category 1 & 2 responders as defined within the Civil Contingencies Act, this includes a 24/7 on call function.	16	Communication From National Leadership: 01 April 25: Jim Mackay's letter to ICBs Strategic Planning Documentation: 02 May 25: Draft ICB Blueprint Operational Response Frameworks: Existing On Call and Incident response structures Risk Management Processes: Risk identified, added to register and subject to regular review. Ongoing Modelling and Scenario Planning: Ongoing national and local modelling / discussions Staff Wellbeing Support: Employee Assistance Programme Staff Engagement and Updates: Regular touchpoints to update staff on progress Mental Health and Wellbeing Signposting: Support signposted to help staff manage mental health / anxieties / concerns / queries Organisational Integration Measures: Integration of NHSE into DHSC Transition Guidance (Pending Confirmation): Transition Team Guidance (Await further advice regarding if this is NHSE key control). Workstream Rationalisation (Pending Confirmation): Rationalisation of workstreams (Await further advice regarding whether this is an NHSE key control.) No changes to this risk over the period

752	IF women choose to birth outside their local hospital catchment, either across HWE or externally, without interoperable maternity records, shared or known pathways or aligned policies or procedures THEN women may not be referred for their antenatal care in a timely manner and maternity teams may lack access to vital clinical information and may follow inconsistent care practices, RESULTING in safety risks for women and babies, suboptimal or missed care, limited birth choices and poor experiences and adverse maternal and neonatal outcomes	16	Digital: Shared drives phased rollout of shared care record, and CMW training by ShCR team. Reciprocal Care: Model active in one HWE hospital. Cross Border Hub: Policies and contacts on Shared Futures page. Information: ENH provides leaflets/web info; others discuss risks at booking. Safety Reviews: Incidents analysed for cross-border issues. Appointments: ENH offers 16- and 36-week checks for catchment women birthing in Bedford. Collaboration: Monthly Cross Border Group reviews progress and challenges. The LMNS Partnership Board has been overseeing the progress against this risk with key workstreams underway relating to: - The cross border hub and associated information for women - Shared Care Records - The reciprocal care model The LMNS Partnership Board has now formally closed, requesting that this risk sits on individual trust and regional risk registers. We have not yet received confirmation from region or trusts that they have added or reviewed the cross border risk onto their own risk register. The Central East Board should consider retaining this risk on the new corporate risk register.
722	If the CHC team remains understaffed, with high vacancy, sickness rates and leavers and lacks the in-house knowledge, skills, and experience to respond effectively, THEN the team's ability to deliver safe and compliant care will be compromised, RESULTING IN backlogs in casework and failure to meet national standards and efficiency targets.	16	Vacancy rate of 22% in July 2025 Whole team (19.05 clinical posts /5 Non clinical posts). Sickness rate of 9.7% (upward trend) 3.80 Business as usual clinical agency workers recruited to commencing 1st September 2025 to mitigate risk. 5.00 WTE Clinical leavers in August 2025 Local induction in development to support retention. Competency framework drafted to support developmental needs across the service in September 2025

698	IF there is no clear pathway, process, and resources in place to deliver the work for individuals who meet the acid test and lack Court of Protection Deprivation of Liberty Safeguard orders (CoPDOLS), THEN vulnerable CHC patients may be unlawfully deprived of their liberty, RESULTING IN potential legal challenges against the ICB due to breaches of individuals' Article 5 rights under the European Convention on Human Rights.	16	As mitigation business case with options outlined to Board and Execs agreed with 'bronze' option approved meaning minimum level of workforce approved to work on the highest of Red, Amber, Green (RAG) rated cases. Recruitment underway with agency staff 'infill' until fuller substantive recruitment can be completed or clustering of ICB's concluded with agreement from cluster as to levels of workforce and establishment make up needed to address Risk needs to remain at current level due to lack of dedicated workforce to the workstream. Business As Usual (BAU) team supporting where they can and are able with the casework already generated from previous project team, however this is slowing progress and impacting on
649	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	Ongoing site visits to assess urgent estate needs. Limited mutual aid under discussion within the ICS and with NHSE. System reviews: QI/assurance reviews with providers; NHSE desktop reviews completed for PAH and HCT. Governance: Weekly ICB escalation meetings and monthly system audiology meetings chaired by the Director of Nursing. Pathways: Hearing aid, 0–3, 3–5, and over-5 pathways now open and operational. Estates: Lister works completed; 0–3 estates plan moving to Lister with NHSE approval. Demand & capacity modelling completed; regional/national reporting in place. Equity: System discussions on levelling up care across sites. Oversight: Fortnightly ENHT meetings and regular reporting to ICB and NHSE bodies. Performance: Jumbo clinics delivered for over-5s, reducing waiting lists. March 2026 Risk score remains the same, this is likely to be the case until ENHT estates for 0-3s is resolved. Some progress with ENHT pathways with hearing aid and Auditory Brainstem Response (ABR) pathways open, however significant backlog and risk of harm remains due to size and length of waits within the waiting list. Discussions ongoing re mutual aid, with HCT providing limited mutual aid and agreement in principle for PAH to provide limited mutual aid from January 2026. Additional risk (which balances progress) around ABR reviews, with HCT commencing full 5 year look back and PAH triggering the full 5 year look back in December 2025. Progress is being hampered by lack of national SME availability.

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 65 week-waits (ww). 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 constitutional standards for 18 weeks are not being met. Plans to meet 65ww target of 0 by end December 2024 were not met although there has been significant improvement of long waits. The 65ww forecast for end of August is 50. The overall Patient Tracking List (PTL) has been on a steadily decreasing trend since March 2024. 6-week wait diagnostic performance across the ICS decreased in May and has remained static in June reaching 63.3% (target of 95% by March 2026)
608	Failure to meet Urgent and Emergency Care (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.	16	Performance Oversight: UEC performance reviewed at regular place-based, system, and ICB forums with escalation through the UEC Board and Performance Committee. Alignment: Linked to Operations Directorate plans, BAF metrics, and improvement trajectories, referencing ENH, SWH, and WE mitigations. Quality & Safety: Risks such as ambulance handovers, mental health delays, and corridor care monitored via Quality Meetings and PSIRF, with minimal harm identified. The risk score remains at 16 since being reduced in April 2025. Current performance is on plan for the recovery trajectory of the four-hour standard (recovery target is 78% by March 2026) HWE target for July was 77.9% and 79.1% was achieved. Cat 2 Ambulance response times have remained static since March 2025. Currently they are on target with July reaching c.35 with a target of 35 minutes in July. The target for end of year was 30 minutes.

Through the assessment of these risks, the BAF sets out the gaps in controls and the management actions that are required to mitigate the risk. Where risks remain high, additional scrutiny is set out below:

- Continued review of finance, patient safety, quality, and performance risks through the Integrated Performance Report (IPR) presented to the Quality Performance & Finance Committee until 30 September 2024⁵ and the Finance Planning and Payer Function Committee and Utilisation Management & Quality Improvement Committee (from 1 October 2025).
- Review of governance risks via the Audit & Risk Committee and associated sub-groups of the Quality Performance & Finance Committee (until 30 September 2025) and the Joint Transition Committee from 1 October 2025.
- Review of workforce risks via the People Board (until 30 September 2025) and the Joint Transition Committee (from 1 October 2025).
- The BAF is reviewed six times per year, ahead of each board meeting by the Executive Team of the ICB.

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.

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.

Other Sources of Assurance

Internal Control Framework

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

The system of Internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness. The internal audit plan is agreed annually by the Audit & Risk Committee and combines a range of internal audit reviews to meet national requirements and local areas identified by the executive. This provides the basis of assurance to the Audit & Risk Committee.

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 December 2024 and supporting national e-learning module for managing conflicts of interest in ICBs which is mandated for all ICB staff to undertake. The revised statutory guidance on managing conflicts of interest ordinarily expects commissioners - although not a specified requirement - to carry out an annual internal audit review of conflicts of interest management. The Internal Audit Review of the ICB's conflicts of interest arrangements was last conducted in 2024/25. Due to the prioritised transitional arrangements and after discussion with our internal auditors it was agreed not to undertake a specific Audit in-year. The ICB did however work with its Local Counter Fraud Service provider to populate the NHS Counter Fraud Authority (NHSCFA) Conflict of Interest checklist.

The ICB has internal 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.

From 2024/25 ICBs were required to measure and publish their performance against the Cyber Assurance Framework aligned DSPT. The ICB has achieved Standards Met in March 2026. 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 Director of Strategy, Planning and Organisation 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 Chief Medical Officer 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 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 published by NHS Digital for admitted patient care, outpatients, A&E/Emergency Care and Maternity in acute hospitals. 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 when they send 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 to inform the Board is acceptable.

Nationally Outsourced Services

The ICB receives some administrative services from nationally commissioned organisations, the systems of internal control are audited by their independent auditors and are reported through the International Standard on Assurance Engagements (ISAE) 3402 Performance Assurance Service Auditor Reports. In 2025/26 these reports reviewed by the ICB show:

- **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) Ltd** – *No exceptions were noted across the control objectives*
- **Dental payments by NHS Business Services Authority (BSA) Ltd** – *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 4 out of 14 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 Ltd
– No exceptions were noted across the control objective

Control issues

- Set out in the table below are the significant control issues and pressures that were identified by the ICB within the Month 9 Governance Statement submitted in January 2026, together with the remedial action that has been undertaken or is in progress. An update on the current progress is included.

Control Issue	Finance, Governance and Control – Finance and Procurement	Finance, Governance and Control - Other
M9 Position (23 January 2026)	The transition to the new NHS financial system, Integrated Single Financial Environment (ISFE2) in Autumn 2025 has been challenging. HWEICB, in common with other ICBs, have experienced a challenging go-live period. The ICB has experienced payment issues impacting providers (with potential Better Payment Practice Code (BPPC) compliance impacts) and issues with some ISFE2 functionality and reporting. The ICB is working with NHS SBS to support improvements.	The ICB has been asked to reduce its running costs to £19 per head of population from April 2026. Accordingly, the ICB is currently undertaking both voluntary and compulsory redundancy schemes. This will result in a significant number of staff leaving the organisation in the coming months. The ICB considers there is a risk as due to the number of staff leaving in a short space of time and the impact this could have on the business of the ICB, whilst all staff are re-organised. The ICB has mitigations in place with regard to this risk which include clear timelines and handover processes for staff who are leaving. The ICB also has its senior management team in place who are not affected by this change, having already been re-organised during 2025.
Position at 31 March 2026	The transition to the new NHS financial system (ISFE2) in Autumn 2025 was challenging. HWEICB, in common with other ICBs, experienced a difficult go-live period. The ICB experienced delays in making payments to Providers and issues with some ISFE2 functionality and reporting. Although some improvements have been seen, there remain a number of issues still to be resolved. The ICB continues to work with NHS SBS and NHS England to support improvements.	As at 31 March 2026 and the dissolution of HWEICB, the organisational reconfiguration continues into the new Central East ICB. The ICB is currently continuing to recruit to the new structure, with slotting in finalised and interviews for competitive slot ins taking place over the next few weeks. An Assessment Centre is in place to manage to the next stages of the reconfiguration. Voluntary redundancy arrangements have commenced and the ICB will be in a better position to understand the number of compulsory redundancies that will be required by the end of Quarter 1. The new Central East ICB will continue to have mitigations in place to manage the business which includes clear timelines and handover processes for staff that are leaving.

Review of Economy, Efficiency, and Effectiveness of the Use of Resources

The ICB Board is accountable for ensuring that the ICB has mechanisms in place to ensure that the organisation uses its resources economically, efficiently, and effectively. The ICB Board approved the ICB's Financial Plan and associated Savings Plan on an annual basis. The responsibility for monitoring this has been delegated to the Finance Investment and

Commissioning Committee (to 30 September 2025) and the Finance Planning and Payer Function Committee (from 1 October 2025). This Committee also provided scrutiny of the ICB's financial planning, in year performance monitoring, and central running costs.

The Finance Investment and Commissioning Committee oversaw the ICB's financial risks and reviewed the risks on the BAF at each meeting to 30 September 2025) and the Finance Planning and Payer Function Committee (from 1 October 2025). The Committee reported to the ICB Board at each meeting, where an overview of committee business was provided, alongside the Integrated Performance Report (IPR), which provided a comprehensive suite of data covering quality, finance, contract, activity, complex cases, project management office, population outcomes and other performance data into a single accessible source.

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 2025/26 reporting period. To the best of the ICB leadership's knowledge, all delegated services were commissioned in accordance with 2025/26 delegation agreements and national service specifications.

The ICB leadership is able to provide the necessary evidence of compliance with the delegation agreements, any associated developmental requirements and national service specifications, and to show how effectively the delegated function is operating 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 (to 30 September 2025) and the Executive Director of Finance, Resources & Contracts (from 1 October 2025) 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 218 of The ICBs [Integrated Governance Handbook](#) for the ICBs 'whistleblowing' procedures.

Head of Internal Audit opinion

Following completion of the planned audit work for 2025/26 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
Emergency Preparedness, Resilience and Response	Reasonable Assurance
Financial Management	Reasonable Assurance
Primary Care – Workforce	Reasonable Assurance
Risk Management	Reasonable Assurance
Cyber Assessment Framework aligned Data Security and Protection Toolkit (DSPT) Independent Assessment, March 2026	High Confidence, Very Low Risk
Continuing Healthcare and Personal Health Budgets	Partial Assurance
Transition – Contract Registers	Minimal Assurance

For Continuing Healthcare and Personal Health Budgets audit:

Issues leading to conclusion:

The ICB was committed to ensuring they provided the right care for their patients and believed that PHBs were a fundamental entitlement to those patients that were deemed eligible to have this offering. The ICB was securing more resources to ensure that they were strengthening their capabilities within the existing team. At the time of this review, the ICB was demonstrating partial assurance in backlog management, Personal Health Budget documentation, policy finalisation, provider oversight, digital systems, and review processes, however with the new arrangements taking place and the strengthening of the core team the ICB should improve the robustness of their arrangements.

Action plans agreed:

Target dates for eight actions have been agreed 30 September 2026 to allow sufficient time for stabilisation and full embedding of improvements. Delays in implementation have been largely due to ongoing workforce shortages and the wider organisational transition.

For Transition – Contract register audit:

Issues leading to conclusion: The ICB had some underlying issues following the implementation of the Atamis contract register in achieving a complete register of all contracts with some statutory and operational agreements partially recorded or held outside of the Atamis contract register with teams using separate systems. This is noted to limit central oversight and the ICBs ability to maintain a reliable view of contractual commitments. Work is underway to improve the accuracy and compliance to processes

Review of the Effectiveness of Governance, Risk Management, and Internal Control

As the Accountable Officer my review of the effectiveness of the system of internal control is informed by the work of the Internal Audit, Executive Directors, and Clinical Leads within the ICB who have the responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me.

The BAF itself provides me with the evidence that the effectiveness of controls that manage the risks to the organisation achieving its corporate objectives have been reviewed. My review is also informed by internal and external audit. I have been advised of the implications of the result of my review of the effectiveness of the system of internal control by the ICB Board and the Audit & Risk Committee. A plan to address weaknesses and ensure continuous improvements

of the system of internal control will be put in place. The ICB Board and its associated committees, together with internal audit, maintain a regular review of the effectiveness of the process of internal control.

My review is also informed by:

- The Data Security and Protection Toolkit,
- Our Research Governance Framework,
- Any external reviews,
- My attendance at key governance meetings,
- Reports from internal audit and the head of internal audit opinion,
- NHS Resolution Membership and Risk Management Assessment,
- Full Compliance against the Emergency Preparedness Resilience and Response (EPRR) core standards for 2025,
- External audit's assessment of the ICB's arrangements for economy, efficiency, and effectiveness in the use of its resources,
- Regular meetings with NHSE including touchpoint and quarterly oversight meetings.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the following:

- The ICB Board, which had responsibility for setting the overall direction, agreeing the ICB's strategic aims, corporate objectives, assessing and managing strategic risks to the delivery of those objectives, and monitoring progress through regular performance monitoring reports at each ICB Board meeting in public,
- Scrutiny and assurance provided by the ICB's committees:
 - The Audit & Risk Committee (Joint from 1 October 2025) which works to a well-developed audit plan and provides assurance to the ICB Board,
 - The Remuneration Committee (Joint from 1 October 2025), which is responsible for recommending Very Senior Managers' pay to the ICB Board,
 - The Primary Care Commissioning Sub Committee reporting to the Finance Investment and Commissioning Committee (to 30 September 2025) and the Finance Planning and Payer Function Committee from 1 October 2025 which oversees delegated commissioning of primary care services in line with the Delegation Agreement with NHS England East of England,
 - The Quality Performance & Finance Committee (to 30 September 2025) and the Utilisation Management & Quality Improvement Committee) from 1 October 2025) which provides scrutiny of delivery of quality, finance (to 30 September), performance, and contracts management including activity,
 - The People Committee (to 30 September 2025), which contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the ICB on delivery of the ten people functions, building on the enduring ambitions set out in the People Plan and the People Promise, ensuring a one workforce approach within the ICS.
 - The Finance Investment and Commissioning Committee to 30 September 2025) and the Finance Planning and Payer Function Committee from 1 October 2025 which provides assurance to the board on the delivery of the objectives set out in improvement and reform plans as approved by the management executive and laid out within the workstream plans within the ICB.
 - Joint Transition Committee which provides assurance to the three ICBs which provides assurance on transitional arrangements, ICB close down and establishment of the new Central ICB.
- ICB Board Members, Executive Directors and associated Senior Managers (Associate Directors/Deputy Directors) who lead on specific areas of responsibility,
- The ICB Executive Team which meets weekly to support delivery of the Operational Plan, Strategic Plan, and deals with day-to-day risk,
- The command, control and co-ordination structures established to support the incident response in line with our duties under the Civil Contingencies Act 2004,

- Internal audit has reviewed the effectiveness of the design and operation of the controls in the areas covered by its risk-based Operational Plan. As described above, the Head of Internal Audit Opinion 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.
- Any weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk, and this will be addressed via management action plans agreed between internal audit and executive director leads for each area. The Audit & Risk Committee reviews progress against implementation of all internal audit recommendations.

Conclusion

The ICB has continued to face a number of challenges during 2025/26 but has also made some significant improvements to enhance the care we provide to our local population, as well as maintaining strong and effective governance which is reflected in the Internal Audit Review outcomes and the Head of Internal Audit Opinion.

2025/2026 was a challenge financially to manage the continued impact of industrial action, rising inflation and prescribing pressures but the ICB delivered a break-even position and more importantly the ICS which constitutes over £3.3bn of services delivered a system break-even position for the third year in a row. This has been achieved through increased robust grip and control measures on areas of identified pressure alongside assured delivery of the efficiency plans, and additional efficiencies being identified.

The context for health and care delivery has presented several new challenges in recovering and improving services in 2025/2026. Timely access to urgent and emergency care remains a challenge across our area. We have taken pro-active steps to invest in primary and community care, as well as other acute alternatives to the Emergency Department to keep as many people well and supported in their own homes as possible.

2025/26 has also seen the transition to the new NHS financial system (ISFE2) in Autumn 2025. HWEICB, in common with other ICBs, has experienced a challenging go-live period. The ICB has experienced payment issues impacting providers (with potential BPPC compliance impacts) and issues with some ISFE2 functionality and reporting. The ICB continues to work NHS SBS to support improvements.

2025/26 has also been the year when the ICB has been asked to reduce its running costs to £19 per head of population in preparation for 1 April 2026. Accordingly, the ICB embarked on a significant reconfiguration programme during this year, and as we move into the new financial year, and the creation of a new Central East ICB, we are concluding the outcomes of the staff consultation and the creation of a new organisational structure. This has/will resulted in a significant number of staff leaving the organisation as we conclude the end of the financial year and move into 2026/2027. The ICB considers there is a risk as due to the number of staff leaving in a short space of time and the impact this could have on the business of the ICB, whilst all staff are re-organised. The ICB has mitigations in place with regard to this risk which include clear timelines and handover processes for staff who are leaving. The ICB also has its Executive Management Team in place who are not affected by this change, having already been re-organised during 2025.

As I conclude our Annual Governance Statement for 2025/26, I recognise that this will be the last one for Hertfordshire and West Essex ICB. During times of significant change, staff have continued to maintain focus on maintaining effective governance arrangements, delivering our Operational Plan and our Strategic Commissioning Plan, which will ensure that the local health and care system partnership remains responsive to the needs of our local population.

Accountable Officer
Organisation
Signature

Jan Thomas, Chief Executive
NHS Hertfordshire & West Essex Integrated Care Board

Date

23 June 2026

Remuneration and Staff Report

Remuneration Report

Membership of the ICB's Remuneration Committee can be found at page 46 of this report

2025/26 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 2025-26. 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 2025-26 was £255K to £260K (£245k to 250k in 2024-25). This was 4.52 times the median remuneration of the workforce, which was £56,908.

YEAR	Total remuneration ratio	Median total remuneration ratio	75 th Percentile total remuneration ratio
2025-26	257,500:39,686	257,500:56,908	257,500:70,247
	6.49	4.52	3.67
YEAR	25 th Percentile total remuneration	Median total remuneration ratio	75 th Percentile total remuneration ratio
2024-25	247,500:38,307	247,500:53,342	247,500:64,337
	6.46	4.64	3.85

The change from the previous year in respect of average employee salary and allowances, (2025-26 £58,444 : 2024-25 £55,275) is due to Agenda for change pay awards and a change in the grade profile of staff.

Average employee salary and allowances in 2025/26 was £58,444. In 2025-26 one of employee received remuneration in excess of the highest paid director, this was due to the Executive team sharing arrangement. Remuneration ranged from £4,171 to £271,032. 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 2025-26	£ 58,444.41	Performance pay and bonuses in 2025-26	£0.00
Average salary in 2024-25	£ 55,275.00	Performance pay and bonuses in 2024-25	£0.00
Percentage increase	5.73%	Percentage increase	0%

Highest paid Director banding 2025-26	£255k-£260k	Performance pay and bonuses in 2025-26	£0.00
Highest paid Director banding 2024-25	£245-250k	Performance pay and bonuses in 2024-25	£0.00
Percentage increase	4.04%	Percentage increase	0%

As a number of Director posts included in the fair pay disclosure above were shared across three ICBs,

for transparency if the disclosure had been based on the total salary for those directors, disclosure would have been as follows:

YEAR	25 th Percentile total remuneration	Median total remuneration ratio	75 th Percentile total remuneration ratio
2025-26	272,500:39,686	272,500:56,908	272,500:70,247
	6.87	4.79	3.88
YEAR	25 th Percentile total remuneration	Median total remuneration ratio	75 th Percentile total remuneration ratio
2024-25	247,500:38,307	247,500:53,342	247,500:64,337
	6.46	4.64	3.85

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 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	2025-26 Permanent Employees £'000	Other £'000
Salaries and wages	42,122	41,108	1,014
Social security costs	5,730	5,730	0
Employer Contributions to NHS Pension scheme	8,562	8,562	0
Other pension costs	33	5	28
Apprenticeship Levy	196	196	0
Termination benefits	20,656	20,656	0
Total employee benefits expenditure	77,299	76,257	1,042

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

Average number of people employed (subject to audit)

	Total Number	2025-26 Permanently employed Number	Other Number
Total for ICB	695.7	675.8	19.9
	Total Number	2024-25 Permanently employed Number	Other Number
Total for ICB	740.9	717.7	23.2

HERTFORDSHIRE & WEST ESSEX ICB

Policy on the remuneration of senior managers

Remuneration payments made to the Lay Members and GP Board Members are proposed to the Board by the ICB's Remuneration Committee, taking into consideration relevant Conflicts of Interests. The Committee reviews benchmarking data from other ICBs to support any proposed changes to remuneration of these members. No remuneration was waived by members and no compensation was paid for loss of office. No payments were made to co-opted members and no payments were made for golden hellos.

Where individual national review bodies govern salaries, then the national rates of increase have been applied. Where national review bodies do not cover staff, then increases have been in line with the percentage notified by the NHS Chief Executive and approved by the Remuneration Committee. For 2025/26 this was 0% (2024/25 0%). Any increases above that limit have been on the basis of increased responsibilities or promotion.

The cost of a session paid to a GP for attendance at a meeting remained unchanged at £285 (2024/25 0% increase).

Remuneration for members of the Board - Salaries and allowances April 2025 - March 2026

Table 1: Single total figure (Subject to Audit)

Name	Role	Note	2025-26						
			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 (to 30 September 2025)	1,5	125-130	200	0	0	0	0	125-130
Janine Thomas	Chief Executive Officer (from 1 October 2025)	3,7	45-50	0	0	0	0	10-12.5	55-60
Paul Burrows	ICB Chair (to 17 October 2025)	1	35-40	0	0	0	0	0	35-40
Robin Porter	Chair (from 4 November 2025)	3,7	10-15	0	0	0	0	0-2.5	10-15
Alan Pond	Chief Finance Officer (to 18 July 2025)	1	55-60	0	0	0	0	0	55-60
Jonathan Wilson	Chief Finance Officer (from 1 Aug 2025 to 30 Sept 2025)	9	25-30	0	0	0	0	112.5-115	140-145
Sarah Griffiths	Executive Director of Finance, Resources & Contracts (from 1 October 2025)	3,7	25-30	300	0	0	0	5-7.5	35-40
Dr Rachel Joyce	Medical Director (to 30 September 2025)		85-90	0	0	0	0	45-47.5	130-135
Dr Fiona Head	Executive Clinical Director of Utilisation Management (from 1 October 2025)	3,7	25-30	0	0	0	0	7.5-10	35-40
Natalie Hammond	Director of Nursing & Quality (to 30 September 2025)	8	90-95	0	0	0	0	0	90-95
Natalie Hammond	Director of Safeguarding and Complex Care (from 1 October 2025 to 22 March 2026) 33.3%	3	25-30	0	0	0	0	0	25-30
Sarah Stanley	Clinical director of Total Quality management (from 1 October 2025)	3,7	25-30	0	0	0	0	0	25-30
Beverley Flowers	Director of Strategy (to 30 September 2025)		80-85	0	0	0	0	40-42.5	125-130
Beverley Flowers	Director of Strategy Planning and Commissioning (1 October 2025 to 31 December 2025) 33.3%	3	10-15	0	0	0	0	5-7.5	20-25
Louis Kamfer	Executive Director of Strategy, Planning & Commissioning (from 1 October 2025)	3,7	25-30	300	0	0	0	5-7.5	30-35
Katherine Vaughton	Executive Director of Neighbourhood Health Places & Partnerships (from 1 October 2025)	3,7	25-30	0	0	0	0	12.5-15	40-45
Adam Lavington	Director of Digital Transformation (to 30 September 2025)		65-70	100	0	0	0	20-22.5	85-90
Tania Marcus	Chief People Officer (to 30 September 2025)		75-80	100	0	0	0	22.5-25	95-100
Tania Marcus	Director of People and Culture (from 1 October 2025) 33.3%	3	25-30	0	0	0	0	7.5-10	30-35
Karen Barker	Executive Director Corporate Services (from 1 October 2025)	3	25-30	0	0	0	0	15-17.5	40-45
Avni Shah	Director of Primary Care Transformation (to 30 September 2025)		70-75	800	0	0	0	25-27.5	95-100
Frances Shatlock	Director of Performance (to 30 September 2025)		75-80	0	0	0	0	20-22.5	95-100
Toni Coles	Managing Director (WE) (to 30 September 2025)	1	70-75	0	0	0	0	0	70-75
Sham Elton	Managing Director (ENH) (to 30 September 2025)	5	70-75	100	0	0	0	30-32.5	105-110
Matthew Webb	Managing Director (BWH) (to 30 September 2025)	5	70-75	100	0	0	0	-	70-75
Michael Watson	Chief of Staff (to 30 September 2025)		60-65	0	0	0	0	17.5-20	80-85
Dr Prag Moodley	Partner Member-Primary Medical Services	2	65-70	0	0	0	0	0	65-70
Dr Ian Perry	Partner Member-Primary Medical Services	2	50-55	0	0	0	0	0	50-55
Dr Trevor Fernandes	Partner Member-Primary Medical Services	2	50-55	0	0	0	0	0	50-55
Ruth Bailey	Lay Member (to 31 January 2026)	4	20-25	0	0	0	0	0	20-25
Professor Gurh Randhawa	Lay Member	4,6	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 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 "Fractioner 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 - Upon appointment to the Central East ICB Executive Team, the member's remuneration has been apportioned across the three legacy ICB's and only that relating to Herts and West Essex ICB has been disclosed above, based on 33.3% of their total remuneration. For transparency the member's total remuneration across the legacy organisations is disclosed in the table below (pension benefits of those not employed by Herts and West Essex ICB are disclosed in the Remuneration Reports of Cambridge and Peterborough ICB, or Beds, Luton and Milton Keynes ICB's).

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

Note 5 - 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 6 - Professor Guruch Randhawa was acting chair during the period 17 October 2025 to 4 November 2025, no additional remuneration was received by Professor Randhawa for this role.

Note 7 - The senior managers Pension related benefits are disclosed in full within the Remuneration Reports of the employing bodies, Cambridge and Peterborough ICB or Beds, Luton and Milton Keynes ICB.

Note 8 - Due to an inconsistency in the information provided by the pensions agency the numbers are not provided here.

Note 9 - The notable rise in pension benefits for the member in the 2025/26 financial year is attributable to the part Year ICB employment duration.

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

Thomas Lafferty - Chief Executive, Princess Alexandra Hospital NHST.

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 VCFSE Alliant board Member (to 22 May 2025)

Mark Hanna VCFSE Alliant board Member (from 23 May 2025)

Following is the salary for Executive Team members during their joint board tenure.

Name	Role	Salary (bands of £5,000)
		£000
Janine Thomas	Chief Executive Officer (from 1 October 2025)	135-140
Robin Porter	Chair (from 4 November 2025)	35-40
Sarah Griffiths	Executive Director of Finance, Resources & Contracts (from 1 October 2025)	80-85
Dr Fiona Head	Executive Clinical Director of Utilisation Management (from 1 October 2025)	80-85
Natalie Hammond	Director of Safeguarding and Complex Care	175-180
Beverley Flowers	Director of Strategy Planning and Commissioning (to 31 December 2025)	125-130
Tania Marcus	Director of People and Culture	150-155
Sarah Stanley	Clinical director of Total Quality management (from 1 October 2025)	85-85
Karen Barker	Executive Director Corporate Services (from 1 October 2025)	80-85
Louis Kamfer	Executive Director of Strategy, Planning & Commissioning (from 1 October 2025)	80-85
Katherine Vaughton	Executive Director of Neighbourhood Health Places & Partnerships (from 1 October 2025)	80-85

Payments for loss of office

These values are not included in the salaries table above. NHS redundancy pay is calculated either under the Agenda for Change contractual scheme or the UK statutory scheme.

Name	Description	Payment
Jonathan Wilson	Payment in lieu of notice	£45,000
Dr Rachel Joyce	Payment in lieu of notice	£43,674
Adam Lavington	Redundancy	£53,333
Toni Coles	Redundancy	£55,275
Toni Coles	Payment in lieu of notice	£35,174
Matthew Webb	Redundancy	£33,333
Matthew Webb	Payment in lieu of notice	£11,725

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

Name	Role	Note	2024-25						
			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
Sham 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 Gurh 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 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 "Practitioner 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 - 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, Princess Alexandra Hospital NHST, replaced Lance McCarty 4 November 2024.

Karen Taylor - Chief Executive, Hertfordshire Partnership University NHS FT

Angie Ridgwell - 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

HERTFORDSHIRE & WEST ESSEX ICB
Table 2: Pensions Benefits (Subject to Audit)

Table 2: Pension Benefits April 2025 - March 2028

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 2028 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2028 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2025	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2028	Employer's contribution to stakeholder pension
			£000	£000	£000	£000	£000	£000	£000	£000
Jane Halpin	Accountable Officer (to 30 September 2025)	1	0	0	0	0	0	0	0	0
Janine Thomas	Chief executive Officer (from 1 October 2025)	9	0-2.5	0-2.5	45-50	25-30	880	8	784	0
Paul Burstow	ICB Chair (to 17 October 2025)	1	0	0	0	0	0	0	0	0
Robin Porter	ICB Chair (from 4 November 2025)	9	0-2.5	0	0-5	0	0	1	18	0
Alan Pond	Chief Finance Officer (to 18 July 2025)	1	0	0	0	0	0	0	0	0
Jonathan Wilson	Chief Finance Officer (from 30 August 2025 to 30 September 2025)		6-7.5	12.5-15	30-35	85-90	0	91	688	0
Sarah Griffiths	Executive Director Finance, Resources and Contracts (from 1 October 2025)	9	0-2.5	0	10-15	0	123	3	185	0
Rachel Joyce	Medical Director (to 30 September 2025)		2.5-5	0	10-15	0	113	38	215	0
Fiona Head	Executive Clinical Director Utilisation Management (from 1 October 2025)	9	0-2.5	0-2.5	55-60	135-140	1225	11	1328	0
Natalie Hammond	Director of safeguarding and complex Care (to 22 March 2028)	10	0	0	10-15	0	2488	0	178	0
Sarah Stanley	Clinical director of Total Quality management (from 1 October 2025)	9	0-2.5	0	60-65	130-135	1137	0	1170	0
Beverley Flowers	Director of Strategy (to 31 December 2025)	10	2.5-5	0-2.5	95-70	165-170	1508	54	1,845	0
Louis Kamfer	Executive Director Strategy Planning and Evaluation (from 1 October 2025)	9	0-2.5	0	35-40	0	488	8	528	0
Katherine Vaughton	Executive Director Neighbourhood Place and Partnerships (from 1 October 2025)	9	0-2.5	0-2.5	45-50	110-115	874	11	874	0
Adam Lavington	Director of Digital Transformation (to 30 September 2025)	5	0-2.5	0	25-30	0	378	14	428	0
Tania Marous	Chief People Officer	10	0-2.5	0-2.5	35-40	75-80	718	31	798	0
Karen Barker	Executive Director Corporate Services (from 1 October 2025)	9	0-2.5	0	35-40	0	412	12	503	0
Avni Shah	Director of Primary Care Transformation (to 30 September 2025)		0-2.5	0-2.5	60-55	115-120	955	27	1043	0
Francis Shatlock	Director of Performance (to 30 September 2025)	5	0-2.5	0	10-15	0	188	14	217	0
Toni Coles	Managing Director (WE) (to 30 September 2025)	1	0	0	0	0	0	0	0	0
Sharn Elton	Managing Director (ENH) (to 30 September 2025)		0-2.5	0-2.5	75-80	180-185	1,880	38	1,784	0
Michael Watson	Chief of staff (to 30 September 2025)	5	0-2.5	0	15-20	0	148	8	185	0
Matthew Webb	Managing Director (SWH) (to 30 September 2025)		0	0	50-55	120-125	1138	0	1142	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	3	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 Guruh 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 2026.

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 2016 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 2016 Scheme or 2008 Section

Note 6 - NHS employees contribute towards their pension benefits. In 2025/26 contribution rates were based on actual pensionable earnings. Employee contribution rates were 12.5% where individuals earned in excess of £82,825.

Note 9 - Members who were part of the joint executive team, but employed by partner legacy ICB's. The members pension has been apportioned across the 3 legacy ICB organisations and only that relating to Herts and West Essex ICB has been disclosed, based on 33.3% of their pension values.

Note 10 - Members who were employed by Herts and West Essex ICB but formed part of the joint executive team from 1 October 2025. The members pension real increase has been apportioned across the 3 legacy ICB organisations for the second half of the year based on 33.3%.

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

Note 11 - 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.

Note 13 - 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).

Payments to past members (subject to audit)

No payments were made in 2025-26 to any individual who had previously been a director of the ICB.

The pension disclosures for the Joint Executive Directors named below are disclosed in full within the Remuneration Report produced by NHS Cambridgeshire & Peterborough ICB.

Janine Thomas	Joint Chief Executive Officer (from 1st October 2025)
Dr Fiona Head	Joint Executive Clinical Director Utilisation Management (from 1st October 2025)
Sarah Griffiths	Joint Executive Director Finance, Resources and Contracts (from 1st October 2025)
Katherine Vaughton	Joint Executive Director Neighbourhood Health Place & Partnerships (from 1st October 2025)
Louis Kamfer	Joint Executive Director Strategy Planning and Evaluation (from 1st October 2025)
Karen Barker	Joint Executive Director - Corporate Services (from 1st October 2025)

The pension disclosures for the Joint Executive Directors named below are disclosed in full within the Remuneration Report produced by NHS Beds Luton and Milton Keynes ICB.

Sarah Stanley	Chief Nurse (to 30th September 2025) Joint Executive Clinical Director Total Quality Management (from 1st October 2025)
Robin Porter	Chair (from 1st May 2025 to 30th September 2025) Joint Chair (from 1st October 2025)

Table 2: Pension Benefits April 2024 - March 2026

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 £2,500)	Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £2,500)	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 Burdow	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
Racheal Joyoe	Medical Director	5	0	0	5-10	0	0	0	113	0
Natalie Hammond	Director of Nursing & Quality	8	30-32.5	86-87.5	106-110	290-295	1825	750	2499	0
Elizabeth Disney	Director of Operations (to 30 August 2024)		0-2.5	0	16-20	5-10	189	5	242	0
Beverley Flowers	Director of Strategy		0-2.5	0	80-85	180-185	1384	31	1,608	0
Adam Lavington	Director of Digital Transformation	5	0-2.5	0	25-30	0	322	18	378	0
Tania Marous	Chief People Officer		0-2.5	0	30-35	75-80	835	23	719	0
Avni Shah	Director of Primary Care Transformation		0-2.5	0	46-50	116-120	868	23	965	0
Francis Shattock	Director of Performance	5	2.5-5	0	10-15	0	117	24	188	0
Toni Coles	Managing Director (WE)	1	0	0	0	0	0	0	0	0
Sham Elton	Managing Director (ENH)		2.5-5	0-2.5	70-75	185-190	1,480	63	1,880	0
Mihael Watson	Chief of staff (from 1 October 2024)	5	0-2.5	0	10-15	0	111	82	148	0
Matthew Webb	Managing Director (SWH)		0-2.5	0	60-65	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 Guroh 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 £82,925.

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

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme.

They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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.

Staff Report

As at 31 March 2026, Hertfordshire and West Essex ICB employed a total of 678 staff (631.25 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 2026).

Agenda for change band	Headcount	FTE
8a	117	107.48
8b	98	94.2
8c	37	34.6
8d	27	25.57
9	11	11
Very Senior Manager (VSM)	7	7
Medical & Dental (M&D) ^[1]	12	5.88

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 2025/26, Hertfordshire and West Essex ICB engagement approach was fully cognisant of this duty. The new ICBs will continue to promote equality of opportunity for the population of Hertfordshire and West Essex in the context of all its commissioning engagement activities. The ICB met statutory responsibilities around data publication and will review our data and equality and diversity work to 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. The ICB's profile for staff-declared ethnicity appears in the table below (at 31 March 2026).

Staff composition

Gender	Headcount	%
Male	175	25.81
Female	503	74.19

Unknown		
Disability Status		
Disabled	54	7.96
Non-disabled	611	90.12
Prefer Not To Answer	3	0.44
Unknown	10	1.47
Ethnicity		
White	453	67.01
BAME	214	31.66
Unspecified/Not Stated	9	1.33
Age Band		
Under 20	1	0.15
21 to 40	169	24.93
41 to 50	204	30.09
51 to 65	280	39.97
66 +	24	3.54
Religion		
Atheism	108	16.10%
Buddhism	6	0.89%
Christianity	286	42.62%
Hinduism	42	6.26%
I do not wish to disclose my religion/belief	119	17.73%
Islam	35	5.22%
Jainism	7	1.04%
Judaism	8	1.19%
Other	51	7.60%
Sikhism	9	1.34%
Undeclared/Unknown	0	0.00%
Sexual Orientation		
Bisexual	10	1.49
Gay or Lesbian	12	1.78
Heterosexual	572	84.99
Other	4	0.59
Undecided	2	0.30
Not Stated	73	10.85
Unknown		
Marital Status		
Married / Civil Partnership	419	61.98
Single	167	24.70
Separated	5	0.74
Divorced	56	8.28
Widowed	11	1.63
Unknown	18	2.66

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 gap 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 2026, the mean gender pay gap was 16.4% which is a decrease on the 2025 figure of 17.9%. 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 2026, the median gender pay gap was 4.07%. This means that typically men are paid 12.39% more in the ICB than women.

Pay Band by Gender – 31 March 2026

An employer must publish six calculations showing their:

- Average gender pay gap as a mean average; Average gender pay gap as a median average;
- Proportion of males and females when divided into four groups (quartiles) ordered from lowest to highest pay;
- Average bonus gender pay gap as a mean; Average bonus gender pay gap as a median; and
- Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment

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. This is our preferred measure of any gender pay gap.

Mean & Median Hourly Rates

Gender	Mean Hourly Rate	Median Hourly Rate
Male	39.0808	33.1799
Female	32.6632	29.1030
Difference	6.4176	4.0769
Pay Gap %	16.4213	12.3872

Proportion of employees | Q1 = Low, Q4 = High (Males make up 25.6% of the workforce)

Quartile	Female Headcount	Male Headcount	Female %	Male %
1	128	43	74.85	25.15
2	147	47	75.77	24.23
3	120	44	73.01	26.99
4	124	88	59.90	40.10

Bonus Payments – Clinical Excellence payments are considered a bonus for gender pay gap reporting. As only one bonus payment was made in the year mean and median calculations cannot be made.

Gender	Employees Paid Bonuses	% of total relevant employees.
Female	1	0.18
Male	0	0

Equality and Diversity Action Planning and the NHS Equality Delivery System (EDS)

The Equality Delivery System (EDS) is the foundation of equality improvement within the NHS. It is an accountable improvement tool for NHS organisations in England, used in active conversations with patients, public, staff, staff networks and trade unions. It encourages NHS organisations to review and develop their services, workforces, and leadership. It is driven by evidence and insight.

The EDS comprises eleven outcomes spread across three Domains, which are:

1. Commissioned or provided services
2. Workforce health and well-being
3. Inclusive leadership.

The outcomes are evaluated, scored, and rated using available evidence and insight.

ICB's have a dual role of providing support and assurance to NHS providers and to complete EDS for their own organisation.

Given the substantial organisational changes, the ICB did not complete a full EDS assessment for 2025/6. The ICB will continue to work with providers to support and provide the assurance required under domain 1 but did not assess against domains 2 and 3. EDS will continue to be a core part of the work of the new Central East ICB and a commitment has been made to the following:

- To continue to provide support, assurance and partnership working with NHS providers who are required to complete EDS. This will be through liaison at both ICB and Neighbourhood level.
- To put in place the processes and tools required to support workforce health and wellbeing. This will include opportunities for effective staff feedback and assessment of the outcomes to support EDS grading in the future.
- Ensure that equality, diversity and inclusion and compliance with relevant equality and health inequality legislation (and NHS requirements, such as EDS), is built into the governance processes of the ICB and that the Governing Body and Executive are aware of their responsibilities.

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](#) 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 was developed to implement a consistent framework of leadership development for colleagues from across the ICS for equality groups currently underrepresented in leadership roles; to support career progression. The programme included the completion of a service improvement project within the participants work area that aimed to improve patient outcomes, improved system performance and personal/professional learning.

The ICB ran 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 2026, approximately 90% of staff have declared they have no disability, with approximately 8% declaring a disability, increase of 2% on 2025 figures and the remaining 2% 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 its 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:	5,390.40 (equivalent calendar days)
Total absence (FTE)	5,439.63 Days out of a total of 250,568.23 available FTE days
Average absences per employee:	7.95 Days (average of total days lost by ICB employee headcount) note calendar days, not working days
Of total days lost, long term absence episodes:	45
Long term days total:	3,421.10 days (included in total days lost)

Staff engagement percentages

As existing ICB staff transfer into two new organisations from 1st April 2026, the ICB did not engage in the NHS staff survey due to the challenges of new, merged organisations responding to survey results. The ICB held fortnightly online briefings for all staff, responding to feedback in real time, publishing regular response updates on the staff intranet. The full reports can be viewed here: [NHS Staff Survey dashboard](#)

The ICB has created action plans through 'The Big 5' campaign, which will take place across 5 months (May to September 2025) with 5 themes with one Executive lead sponsoring each month.

Staff policies

The ICB 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 met regularly throughout the year providing a forum 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 to support the workforce. These include:

- 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.

Expenditure on consultancy

The total spend on consultants in 2025/26 is shown on Note 4 of the Annual accounts.

Off-payroll engagements

Table 1: Length of all highly paid off payroll engagements

For all off-payroll engagements as of 31 March 2026, for more than £245(1) per day:

	Number
Number of existing engagements as of 31 March 2026	86
Of which, the number that have existed:	
for less than one year at the time of reporting	34
for between one and two years at the time of reporting	29
for between 2 and 3 years at the time of reporting	21
for between 3 and 4 years at the time of reporting	2
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 2025 and 31 March 2026, greater than £245 per day:

	Number
off-payroll workers engaged between 1 April 2025 and 31 March 2026	92
Of which:	
No. not subject to off-payroll legislation	0
No. subject to off-payroll legislation and determined as in-scope of IR35 (1)	92
No. subject to off-payroll legislation and determined as out of scope of IR35 (1)	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

Note

(1) 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.

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 2025 and 31 March 2026:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility during the reporting period	0
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	30

Note

(1) There should only be a very small number of off-payroll engagements of board members and/or senior officials with significant financial responsibility, permitted only in exceptional circumstances and for no more than six months

(2) As both on payroll and off-payroll engagements are included in the total figure, no entries here should be blank or zero

In any cases where individuals are included within the first row of this table the department should set out:

- Details of the exceptional circumstances that led to each of these engagements.
- Details of the length of time each of these exceptional engagements lasted.

*Exit packages, including special (non-contractual) payments

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

	2025-26 Compulsory redundancies		2025-26 Other agreed departures		2025-26 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	14	103,284	14	103,284
£10,001 to £25,000	1	20,000	51	919,562	52	939,562
£25,001 to £50,000	4	185,621	43	1,625,771	47	1,811,392
£50,001 to £100,000	3	185,163	64	4,749,530	67	4,934,693
£100,001 to £150,000	2	245,667	40	4,804,193	42	5,049,860
£150,001 to £200,000	0	0	11	1,832,148	11	1,832,148
Total	10	636,451	223	14,034,488	233	14,670,939

	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

Exit packages are significant in the 2025-26 financial year as a result of the Government's direction to ICBs across the country to reduce running costs by 50%. This ICB has therefore offered a mutually agreed resignation scheme (MARS) to its employees to allow employees to leave their post by mutual agreement in return for severance payments. In addition, the ICB has also implemented a voluntary redundancy scheme which enables employees to apply for redundancy as part of organisational changes, alongside a compulsory redundancy scheme. The above table shows the total of such arrangements which are agreed as at 31 March 2026. As at the publication date of these financial statements, further compulsory redundancy agreements have not yet been finalised and as such, have been excluded from the table above. The total of termination costs (agreed and not agreed) can be seen on note 3.1 of the Annual Accounts.

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

	2025-26		2024-25	
	Other agreed departures		Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	200	13,428,590	1	79,405
Mutually agreed resignations (MARS) contractual costs	23	605,898	0	0
Total	223	14,034,488	1	79,405

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 xxx.

An audit certificate and report is also included in this Annual Report at page 78.

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF NHS CENTRAL EAST INTEGRATED CARE BOARD IN RESPECT OF NHS HERTFORDSHIRE AND WEST ESSEX INTEGRATED CARE BOARD

Report on the audit of the financial statements

Opinion

In our opinion, the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2026 and of its expenditure, income and cash flows for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2025-26; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Care Act 2022.

We have audited the financial statements of NHS Hertfordshire and West Essex Integrated Care Board ("the ICB") for the year ended 31 March 2026, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and notes to the financial statements, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and UK-adopted International Financial Reporting Standards as adapted and interpreted by the Government Financial Reporting Manual 2025-26 as contained in the Department of Health and Social Care Group Accounting Manual 2025-26 and the Accounts Direction issued by NHS England with the approval of the Secretary of State as relevant to Integrated Care Boards in England.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), the Code of Audit Practice prepared by the Comptroller and Auditor General and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Independence

We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

Emphasis of matter - basis of preparation of financial statements

We draw attention to Note 13 Events after the end of the reporting period, which describes the disestablishment of the ICB and the transfer of its functions, services, duties, assets and liabilities to NHS Central East ICB and NHS Essex ICB from 1 April 2026. Our opinion is not modified in respect of this matter.

Conclusions relating to going concern

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

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on continuation of the ICB's services by NHS Central East ICB and NHS Essex ICB for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

The going concern basis of accounting for the ICB is in accordance with the expectation set out in the Department of Health and Social Care Group Accounting Manual 2025-26 that entities prepare their accounts on a going concern basis where it is anticipated that the services they perform will continue to be provided into the future. In reaching our conclusions relating to going concern, we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024) issued by the Public Audit Forum on the application of ISA (UK) 570 Going Concern to public sector entities and to Supplementary Guidance Note 01 issued by the Comptroller and Auditor General in November 2024.

Other information

The Accountable Officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon. Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements, or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on regularity

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

Basis for opinion on regularity

We are responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General. We carried out our work on regularity in accordance with Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024) issued by the Public Audit Forum. We believe the evidence obtained from this work, in conjunction with the evidence we have obtained in our audit of the financial statements, is sufficient and appropriate to provide a basis for our opinion on regularity.

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2025-26, and
- the other information published together with the audited financial statements is consistent with the financial statements.

Matters on which we are required to report by exception

Use of resources

We are required to report to you if, in our opinion, we have not been to satisfy ourselves that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026.

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in March 2026, we have identified the following significant weakness in the ICB's arrangements for the year ended 31 March 2026:

Significant weakness in arrangements	Recommendations
We identified weaknesses in the ICB's arrangements for delivering Continuing Healthcare (CHC) services, including: - ongoing cost pressures not being effectively mitigated; - delays in implementing agreed actions from internal audit's review of CHC services, with eight out of ten internal audit actions outstanding at year end, of which two were high risk; - ongoing workforce capacity constraints, including high vacancy and sickness levels, and reliance on agency staff as a short-term measure; - inadequate mitigation of known risks on the ICB's risk register, including those relating to Personal Health Budgets; - underperformance against national standards, with only 60% of eligibility decisions made within 28 days against a target of 100%; and - a significant increase in the CHC appeals provision, indicating weaknesses in the eligibility assessment process and a corresponding increase in disputed decisions. These matters are evidence of a significant weakness in the ICB's governance arrangements.	We recommended that the successor organisation (NHS Central East ICB) should: - ensure that the action plan for CHC services includes clear mechanisms to address outstanding reviews and backlog cases, particularly within the Hertfordshire geographical area. The effectiveness of these arrangements should be regularly monitored to ensure timely delivery and achievement of intended outcomes; - ensure that contracts relating to Personal Health Budgets and care home placements are agreed and finalised in advance of the financial year; - prioritise maintaining robust oversight of commitments that remain outstanding as a result of the organisational transition, including: - a comprehensive backlog recovery plan for the Central East area should be finalised and implemented by the revised target date of 30 September 2026. Progress against this plan should be subject to regular monitoring and review; and - workforce-related risks within the CHC function should be addressed through the implementation of sustainable staffing solutions, including the recruitment and retention of personnel with appropriate skills, knowledge, and experience.

Other matters on which we report by exception

We are required report to you if:

- the Governance Statement is materially inconsistent with the financial statements, or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the ICB under section 24 of the Local Audit and Accountability Act 2014.

We are not required to consider, nor have we considered, whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in respect of these matters.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's responsibilities, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accountable Officer has been informed by the relevant national body of their intention to dissolve the ICB without transfer of its services or functions to another entity.

The Accountable Officer is responsible for ensuring that value for money is achieved from the resources available to the ICB. The Accountable Officer is also responsible for the propriety and regularity of the public finances for which the Accountable Officer is answerable.

Auditor's responsibilities for the audit of the financial statements

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

However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the ICB and management.

Extent to which the audit was capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

Non-compliance with laws and regulations

Based on:

- Our understanding of the ICB and the industry in which it operates;
- Discussion with management, and those charged with governance; and
- Obtaining and understanding of the ICB's policies and procedures regarding compliance with laws and regulations

we considered the significant laws and regulations to be the applicable accounting framework and the National Health Service Act 2006, as amended by the Health and Care Act 2022.

The ICB is also subject to laws and regulations where the consequence of non-compliance could have a material effect on the amount or disclosures in the financial statements, for example through the imposition of fines or litigations. We identified such laws and regulations to be the Data Protection Act 2018, Bribery Act 2010 and Economic Crime and Corporate Transparency Act 2023.

Our procedures in respect of the above included:

- Enquires of management regarding any litigations and claims ongoing during the year;
- Review of minutes of meetings of those charged with governance for any instances of non-compliance with laws and regulations;

- Review of correspondence with regulatory authorities for any instances of non-compliance with laws and regulations;
- Review of financial statement disclosures and agreeing to supporting documentation; and
- Review of legal expenditure accounts to understand the nature of expenditure incurred.

Fraud

We assessed the susceptibility of the financial statements to material misstatement, including fraud. Our risk assessment procedures included:

- Enquiry with management, the ICB's head of internal audit, the ICB's local counter fraud specialist and those charged with governance regarding any known or suspected instances of fraud;
- Obtaining an understanding of the ICB's policies and procedures relating to:
 - Detecting and responding to the risks of fraud; and
 - Internal controls established to mitigate risks related to fraud.
- Review of minutes of meeting of those charged with governance for any known or suspected instances of fraud;
- Discussion amongst the engagement team as to how and where fraud might occur in the financial statements;
- Performing analytical procedures to identify any unusual or unexpected relationships that may indicate risks of material misstatement due to fraud; and
- Considering remuneration incentive schemes and performance targets and the related financial statement areas impacted by these.

Based on our risk assessment, we considered the areas most susceptible to fraud to be expenditure accruals, classification of administration expenditure, special severance payments, the ledger transfer and the override of controls by management.

Our procedures in respect of the above included:

- Testing a sample of journal entries throughout the year, which met defined risk criteria, by agreeing to supporting documentation;
- Testing accruals to supporting evidence to confirm that a liability existed at period end;
- Testing a sample of payments and invoices for March 2026 to check that goods or services were received by the ICB or provided to patients;
- Assessing the outcome of the NHS Agreement of Balances exercise on the ICB's expenditure and accruals, including considering disputed balances with other NHS bodies;
- Assessing estimated accruals made by management for bias by considering the reasonableness of assumptions made and supporting evidence for figures used in the estimation;
- Reviewing the journals reclassifying administrative expenditure to programme within our risk criteria and determining whether the reclassification was within the normal course of business;
- Confirming appropriate approvals were obtained by the ICB for special severance payments as per NHS England and/or HM Treasury guidance and reviewing minutes of Remuneration committee meetings to confirm completeness of disclosure of special severance payments
- Testing the reconciliation of the data migration in the ledger system.

We also communicated relevant identified laws and regulations and potential fraud risks to all engagement team members who were all deemed to have appropriate competence and capabilities and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

Our audit procedures were designed to respond to risks of material misstatement in the financial statements, recognising that the risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery, misrepresentations or through collusion. There are inherent limitations in the audit procedures performed and the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely we are to become aware of it.

A further description of our responsibilities is available on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required under section 21 of the Local Audit and Accountability Act 2014 to satisfy ourselves that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our work in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General, having regard to the Auditor Guidance Notes prepared and published by the National Audit Office on behalf of the Comptroller and Auditor General.

Certificate - delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for NHS Hertfordshire and West Essex Integrated Care Board for the year ended 31 March 2026 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have received confirmation from the National Audit Office that the Department of Health and Social Care group audit has been certified by the Comptroller & Auditor General and therefore no further work is required to be undertaken in order to discharge the auditor's duties in relation to consolidation returns under the Code of Audit Practice. We are satisfied that this work does not have a material effect on the financial statements.

Use of our report

This report is made solely to the Members of NHS Central East Integrated Care Board, as a body, in respect of NHS Hertfordshire and West Essex Integrated Care Board, in accordance with part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of NHS Central East Integrated Care Board those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of NHS Central East Integrated Care Board, as a body, for our audit work, for this report, or for the opinions we have formed.

Rachel Brittain
Key Audit Partner

23 June 2026

BDO LLP is a limited liability partnership registered in England and Wales (with registered number OC305127).

ANNUAL ACCOUNTS

**Statement of Comprehensive Net Expenditure for the year ended
31 March 2026**

	Note	2025-26 £'000	2024-25 £'000
Income from contracts with customers	2	(54,785)	(52,509)
Other operating income	2	(1,713)	(1,481)
Total operating income		(56,498)	(53,990)
Staff costs	3.1	77,299	57,364
Purchase of goods and services	4	4,158,202	3,858,658
Depreciation	4	411	662
Provision expense	4	8,407	4,302
Other operating expenditure	4	2,231	1,706
Total operating expenditure		4,246,550	3,922,692
Net Operating Expenditure		4,190,052	3,868,702
Finance expense		21	65
Other gains and losses		(18)	0
Net expenditure for the year		4,190,055	3,868,767
Total Comprehensive Expenditure for the year ended 31 March 2026		4,190,055	3,868,767

The notes on pages 88 to 98 form part of this statement.

**Statement of Financial Position as at
31 March 2026**

	Note	31 March 2026 £'000	31 March 2025 £'000
Non-current assets			
Property, plant and equipment		0	235
Right-of-use assets		100	1,552
Total non-current assets		100	1,787
Current assets			
Trade and other receivables	6	19,489	17,009
Cash	7	0	24
Total current assets		19,489	17,033
Total assets		19,589	18,820
Current liabilities			
Trade and other payables	8	(212,467)	(163,340)
Lease liabilities		(96)	(514)
Borrowings	7	(5,042)	0
Provisions		(10,653)	(5,489)
Total Current Liabilities		(228,258)	(169,343)
Total Assets less Current Liabilities		(208,669)	(150,523)
Non-current Liabilities			
Lease Liabilities		0	(1,097)
Provisions		(451)	(2,393)
Total non-current liabilities		(451)	(3,490)
Assets less Liabilities		(209,120)	(154,013)
Financed by Taxpayers' Equity			
General fund		(209,120)	(154,013)
Total taxpayers' equity		(209,120)	(154,013)

The notes on pages 88 to 98 form part of this statement.

The financial statements on pages 84 to 87 were approved by the Audit and Risk Committee (on behalf of the Board) on 16 June 2026 and signed on its behalf by:

Jan Thomas
Accountable Officer
23 June 2026

**Statement of Changes In Taxpayers' Equity for the year ended
31 March 2026**

	General fund £'000
Changes in taxpayers' equity for 2025-26	
Balance at 1 April 2025	(154,013)
Changes in NHS Integrated Care Board taxpayers' equity for 2025-26	
Net operating expenditure for the financial year	(4,190,055)
Net funding	<u>4,134,948</u>
Balance at 31 March 2026	<u>(209,120)</u>
	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	<u>3,899,945</u>
Balance at 31 March 2025	<u>(154,013)</u>

**Statement of Cash Flows for the year ended
31 March 2026**

	Note	2025-26 £'000	2024-25 £'000
Cash Flows from Operating Activities			
Net operating expenditure	SOCNE	(4,190,055)	(3,868,702)
Depreciation	4	411	662
Interest paid		21	0
Other Gains & Losses		(18)	0
Movement in trade & other receivables	6	(2,480)	(874)
Movement in trade & other payables	8	49,127	(34,579)
Provisions utilised		(5,185)	(1,187)
Increase in provisions		8,408	4,302
Net Cash Outflow used in Operating Activities and before Financing		(4,139,771)	(3,900,378)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		4,134,948	3,899,945
Repayment of lease liabilities		(243)	(489)
Net Cash Inflow from Financing Activities		4,134,705	3,899,456
Net (Decrease) in Cash & Cash Equivalents	7	(5,066)	(922)
Cash at the Beginning of the Financial Period	7	24	946
Cash at the End of the Financial Period		(5,042)	24

The notes on pages 88 to 98 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 2025-26 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.

Where an organisation ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided, the financial statements are prepared on the going concern basis.

NHS Hertfordshire and West Essex ICB (HWE) along with NHS Bedfordshire, Luton and Milton Keynes ICB (BLMK) and Cambridgeshire and Peterborough ICB (C&P), were disestablished on 31 March 2026. From 1 April 2026, all services, functions and duties of HWE were divided and transferred between two new entity ICBs - the Hertfordshire element to NHS Central East ICB and the West Essex element to NHS Essex ICB. At the same time, all services, functions and duties of BLMK and C&P ICBs were also transferred to the new NHS Central East ICB. Accordingly, the financial statements for HWE are prepared on a going concern basis as the services will continue to be provided in the future by NHS Central East ICB and NHS Essex ICB.

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.

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.

1.5.3 Termination Benefit Costs

Termination benefits are only those benefits where the event giving rise to the benefit is the termination of the employment by the employer, or by the employee deciding to accept the employer's offer of benefits in exchange for termination. This can include redundancy costs, termination gratuities and pension enhancements on termination. Benefits that are conditional on future service by an employee are not termination benefits.

Termination benefits are recognised at the earlier of when the entity can no longer withdraw the offer of those benefits, and when the entity recognises costs for a restructuring that is within the scope of IAS 37 and involves the payment of termination benefits.

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

1.8 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 derecognised 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 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.

2 Operating Income

	2025-26 Total £'000	2024-25 Total £'000
Revenue from contracts with customers		
Non-patient care services to other bodies	11,232	10,808
Prescription fees and charges	17,833	17,287
Dental fees and charges	24,629	24,234
Other revenue	1,091	180
Total Income from sale of goods and services	54,785	52,509
Other operating income		
Non cash apprenticeship training grants revenue	68	51
Other non contract revenue	1,645	1,430
Total Other operating income	1,713	1,481
Total Operating Income	56,498	53,990

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

	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
2025-26						
Source of Revenue						
NHS	0	11,227	0	0	22	11,249
Non NHS	0	5	17,833	24,629	1,069	43,536
Total	0	11,232	17,833	24,629	1,091	54,785
	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
2024-25						
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

3. Employee benefits**3.1 Employee benefits**

	2025-26 Total £'000	2024-25 Total £'000
Salaries and wages	42,122	43,591
Social security costs	5,730	4,823
Employer Contributions to NHS Pension scheme	8,562	8,640
Other pension costs	33	6
Apprenticeship Levy	196	202
Termination benefits	20,656	102
Gross employee benefits expenditure	77,299	57,364

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 two ill health retirements totalling £75k in 2025-26 (Nil for 2024-25).

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 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 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

	2025-26	2024-25
	Total	Total
	£'000	£'000
Purchase of goods and services		
Services from other ICBs and NHS England	1,107	408
Services from foundation trusts	748,270	650,965
Services from other NHS trusts	1,846,875	1,783,376
Services from other WGA bodies	154	0
Purchase of healthcare from non-NHS bodies	669,631	610,906
Purchase of social care	49,119	44,131
General Dental services and personal dental services	99,134	96,686
Prescribing costs	243,904	242,694
Pharmaceutical services	56,422	52,878
General Ophthalmic services	15,443	14,554
GP Primary Care Services	329,763	304,592
Supplies and services – clinical	1,423	106
Supplies and services – general	73,166	31,639
Consultancy services	0	479
Establishment	15,191	13,825
Transport	3,971	3,450
Premises	2,061	3,961
Audit fees (Note 1)	359	221
Other non statutory audit expenditure		
· Other services (Note 2)	32	35
Other professional fees (Note 3)	580	735
Legal Fees	369	1,689
Education and training	1,160	1,278
Non cash apprenticeship training grants	68	50
Total Purchase of goods and services	4,158,202	3,858,658
Depreciation		
Depreciation	411	662
Total Depreciation	411	662
Provision expense		
Provisions	8,407	4,302
Total Provision expense	8,407	4,302
Other Operating Expenditure		
Chair and Non Executive Members	117	163
Grants to Other bodies	150	559
Expected credit (gain) on receivables	(4)	0
Other expenditure	1,968	984
Total Other Operating Expenditure	2,231	1,706
Total operating expenses (excluding employee benefits)	4,169,251	3,865,328

Note 1

Audit fee is shown inclusive of VAT and the net amount was £299k (£183.9k 2024-25).

Limitation on auditor's liability for external audit work carried out for 2025-26 is £1million (£1m 2024-25)

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 £28k (£28.8k 2024-25).

Note 3

Other professional fees includes the sum of £107k for Internal Audit Fees (£107k 2024-25). Internal audit fees is shown net of VAT.

5 Better Payment Practice Code**Measure of compliance**

	2025-26 Number	2025-26 £'000	2024-25 Number	2024-25 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	58,151	1,175,323	62,550	1,117,156
Total Non-NHS Trade Invoices paid within target	57,792	1,152,511	61,825	1,106,915
Percentage of Non-NHS Trade invoices paid within target	99.38%	98.06%	98.84%	99.08%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,540	2,658,477	2,630	2,512,084
Total NHS Trade Invoices Paid within target	2,503	2,654,568	2,533	2,500,711
Percentage of NHS Trade Invoices paid within target	98.54%	99.85%	96.31%	99.55%

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 2026 £'000	Current 31 March 2025 £'000
NHS receivables: Revenue	2,126	4,232
NHS prepayments	11	85
NHS accrued income	277	0
Non-NHS and Other WGA receivables: Revenue	3,870	1,261
Non-NHS and Other WGA prepayments	11,389	9,482
Non-NHS and Other WGA accrued income	0	13
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	0	0
VAT	1,796	1,900
Other receivables and accruals	20	36
Total Trade and Other Receivables	19,489	17,009

7 Cash

	2025-26 £'000	2024-25 £'000
Balance at start of the period	24	946
Net change in the period	(5,066)	(922)
Balance at 31 March 2026	(5,042)	24
Made up of:		
Cash with the Government Banking Service at 31 March	0	24
Bank overdraft: Government Banking Service	(5,042)	0
Balance at 31 March 2026	(5,042)	24

The overdraft position is the result of the last BACS payment of the financial year clearing into the following month.

8 Trade and other payables

	Current 31 March 2026 £'000	Current 31 March 2025 £'000
NHS payables: revenue	12,061	6,638
NHS accruals	34,699	22,426
Non-NHS and Other WGA payables: Revenue	28,793	24,357
Non-NHS and Other WGA accruals	126,735	98,501
Non-NHS and Other WGA deferred income	3,838	2,810
Social security costs	637	586
Tax	669	631
Other payables and accruals	5,035	7,391
Total Trade and Other Payables	212,467	163,340

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.

9.1.1 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 2026 £'000	Financial Assets measured at amortised cost 31 March 2025 £'000
Trade and other receivables with NHSE bodies	862	4,010
Trade and other receivables with other DHSC group bodies	1,540	222
Trade and other receivables with external bodies	3,891	1,316
Cash and cash equivalents	0	24
Total at 31 March	6,293	5,572

9.3 Financial liabilities

	Financial Liabilities measured at amortised cost 31 March 2026 £'000	Financial Liabilities measured at amortised cost 31 March 2025 £'000
Trade and other payables with NHSE bodies	488	1,548
Trade and other payables with other DHSC group bodies	46,273	28,289
Trade and other payables with external bodies	160,658	131,086
Other financial liabilities (note 7)	5,042	0
Total at 31 March	212,461	160,923

10 Operating segments

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

	2025-26 £'000	2024-25 £'000
Commissioning of healthcare services	4,190,055	3,868,767

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:

2025-26	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	458,113	261,847	8,271	3,999	7,646	2,673	33,497	33,497	302,016
Expenditure	458,774	262,515	7,306	3,533	7,646	2,673	31,505	33,497	302,218
Total Variance	(661)	(668)	965	466	0	0	1,992	0	(202)

2024-25	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	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)

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	1,568	0	2	0
Stanmore Medical Group - Dr. P Moodley	7,654	0	0	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	2,642	0	0	41
Stevenage North PCN - Dr. P Moodley	2,077	0	0	0

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

NHS Bedfordshire Luton and Milton Keynes ICB	850	0	0	0
NHS Cambridgeshire and Peterborough ICB	1,113	0	0	0
Haverfield Surgery	621	0	0	0
King George Surgery	3,983	0	0	0
NHS Property Services	3,786	0	480	0
St Andrews Healthcare	922	0	36	0
Stellar Healthcare	3,293	33	654	0
Herts Mind Network	52	0	0	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
 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
 Essex County Council
 NHS Suffolk and North East Essex ICB
 Accurx Ltd

12a Related party transactions (2024-25)

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

13 Events after the end of the reporting period

From 1 April 2026 NHS Hertfordshire and West Essex ICB (HWE) was disestablished with all functions, services and duties being divided and transferred by Establishment Order between two new ICBs - the Hertfordshire element going to NHS Central East ICB and the West Essex element going to NHS Essex ICB. The two new ICBs will take on the commissioning function of HWE. The assets and liabilities of HWE were transferred to the new ICBs as transfers by absorption. The date for the transfer was 1 April 2026.

It is classified as a non-adjusting event as it is an event that arose after the end of the reporting period and therefore does not result in adjustment to the financial statements. It is disclosed for completeness, to support the users of the financial statements to reach a proper understanding of the financial position of the ICB; the disclosure supplements the Going Concern disclosure note.

There are no other adjusting events after the reporting period which will have a material effect on the financial statements of this ICB.

14 Losses and special payments

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

Losses	2025-26 Total Number of Cases Number	2025-26 Total Value of Cases £'000	2024-25 Total Number of Cases Number	2024-25 Total Value of Cases £'000
Fruitless payments	1	0 *	1	1
Claims abandoned	0	0	1	1
Total	1	0	2	2

* Actual amount was £200

Special Payments	2025-26 Total Number of Cases Number	2025-26 Total Value of Cases £'000	2024-25 Total Number of Cases Number	2024-25 Total Value of Cases £'000
Ex Gratia Payments	1	850	0	0
Total	1	850	0	0

The ex gratia payment related to a full and final settlement agreement in respect of a procurement challenge made against the former Clinical Commissioning Groups which are now part of this ICB.

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:

	2025-26 Target £'000	2025-26 Performance £'000	2025-26 Duties Achieved?	2024-25 Target £'000	2024-25 Performance £'000	2024-25 Duties Achieved?
Expenditure not to exceed income	4,246,565	4,246,553	Yes	3,929,957	3,922,757	Yes
Capital resource use does not exceed the amount specified in Directions	0	0	Yes	0	0	Yes
Revenue resource use does not exceed the amount specified in Directions	4,190,067	4,190,055	Yes	3,875,967	3,868,767	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	42,108	40,314	Yes	29,449	28,815	Yes
Revenue administration resource pay award for agenda for change staff for 2022-23 does not exceed the amount specified in Directions						

16 Mental Health Expenditure

	2025-26 £'000	2024-25 £'000
Minimum expenditure in mental health services to meet the Mental Health Investment Standard as notified by NHS England	282,162	247,623
Eligible mental health expenditure	282,610	247,958
Mental health expenditure above minimum investment required	449	335
Mental health expenditure as a proportion of total operating expenditure	6.66%	6.32%

In 2025-26 the ICB was required to increase its mental health spending by a minimum 4.93%. Subject to confirmation through independent audit, the ICB has met the Mental Health Investment Standard (MHIS) in 2025-26. The MHIS expenditure as a proportion of total operating expenditure increased from 6.32% to 6.66% in 2025-26.

17 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, with a trial date set for October 2027.