NHS South East London

NHS South East London Integrated Care Board

Annual Report and Annual Accounts 2024/25

(01 April 2024 - 31 March 2025)

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1. Welcome and Introduction

Welcome to the NHS South East London Integrated Care Board annual report and accounts, covering the period 1 April 2024 to 31 March 2025.

The purpose of this report is to show how we have discharged our functions and statutory duties in the last financial year.

Our operational performance improved in 2024/25 on most key metrics compared with the previous year. But it is still nowhere near where we would all wish it to be. Waiting times improved broadly in line with plans, but only 59% (54% in 2023/24) of patients are receiving elective care within 18 weeks with the NHS standard of 92%. 74% (72% in 2023/24) of patients waited four hours or less in A&E compared with the NHS standard of 95%. Our cancer work has focused on improving performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 as part of achieving the 80% ambition by March 2026, and improving performance against the 62-day referral/upgrade to treatment target to 70%. We are on track on both of these metrics. For mental health, we have seen consistent improvement in performance, particularly relating to children and young people and access to community services.

Our financial position remains difficult but is improving. As a health system, we spent a total of £4,886m in 2024-25. We are the most over-target system in the country in terms of our fair share of resources and received funding outside normal allocations of £100 million to cover the deficit at King's College Hospital NHS Foundation Trust. For these reasons, we cannot expect our financial issues to be resolved through additional income, as our allocation will grow at less than the average for the NHS for the foreseeable future. In 2024/25 we met all our financial duties but did this in a manner consistent with our long-term financial strategy of ensuring financial sustainability while re-balancing spending from physical to mental health, from hospital to community and from cure to prevention.

Both operational and financial performance were affected in 2024/25 by industrial action across the NHS and specifically in south east London by a cyberattack on our main pathology provider.

It is important that we do not just focus on in-year performance – important though this is – and this report also aims to show how we are working with our partners to improve health and care in the future through our Integrated Care Strategy and other work focused on long-term sustainability and transformation.

2025/26 will be a year of both continuity and change.

Continuity, as we press on with our programme of work to improve operational performance and financial sustainability supported by the government's three shifts: from hospital to community; cure to prevention and; analogue to digital.

Change, as we respond to the planned refocusing of ICBs and associated reductions in our management costs announced by the government.

In south east London, we believe we are well placed to respond to the challenges and opportunities created by these changes and look forward to continuing our work to improve the health and care of all our population.

Sir Richard Douglas, Chair
Andrew Bland, Chief Executive

2. Who we are

2.1 Introduction to NHS South East London ICB and our role within the wider health system in South East London

NHS South East London Integrated Care Board is the body responsible for the provision of healthcare for the residents of south east London. This area covers the boroughs of: Bexley; Bromley; Greenwich; Lambeth; Lewisham and Southwark.

We are part of the South East London Integrated Care System (ICS). The ICS is a collection of health and social care providers within the six South East London boroughs who work in partnership to drive the four purposes of the ICS:

- improve outcomes in south east London population health and health and care services;
- tackle inequalities in outcomes, experience and access experienced by the residents of south east London;
- enhance productivity and value for money in the use of health and care resources in south east London; and
- support broader social and economic development

We make decisions on allocating NHS resources and planning services and enable improvement. In addition we are accountable for ensuring that the ICB and the NHS providers headquartered within south east London manage within resources provided.

2.2 Our Duties

Our main powers and duties are to arrange certain health services for the population of our boroughs. These provisions are supplemented by other statutory powers and duties as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).

2.3 Our Population

South east London has a diverse population of two million people with complex health and care needs. The population is predicted to increase by nearly 10% by 2029, with a particularly high rate of growth in the older population.

The proportion of people from black and minority ethnic backgrounds also differs across our boroughs, from 60% in Lambeth to 19% in Bromley.

We have a higher-than-average proportion of local people identifying as LGBTQI+. For example, Lambeth and Southwark have the second and third largest lesbian, gay and bisexual communities in the country.

We also have a large prison population of over 3,500 adult men and young adults across four prisons in Greenwich and Lambeth.

There is wide variation in health, both within and across our six boroughs. Life expectancy at birth can vary by up to nine years between the most and least deprived areas, even within a single borough. Many things affect health – such as deprivation, the local environment, housing, crime, education, employment, social isolation and lifestyle choices.

One in five children in south east London lives in a low-income home. Greenwich, Lambeth, Lewisham and Southwark rank among the 15% most deprived local authority areas in the country.

2.4 Working in partnership across South East London

The ICS is built on the principles of:

- partnership: working together
- subsidiarity: allowing local decisions and action
- accountability: being open and taking responsibility.

We have embedded a truly collaborative approach involving NHS organisations, local authorities, patient groups and the voluntary, community and social enterprise (VCSE) sector through a “system of systems” approach.

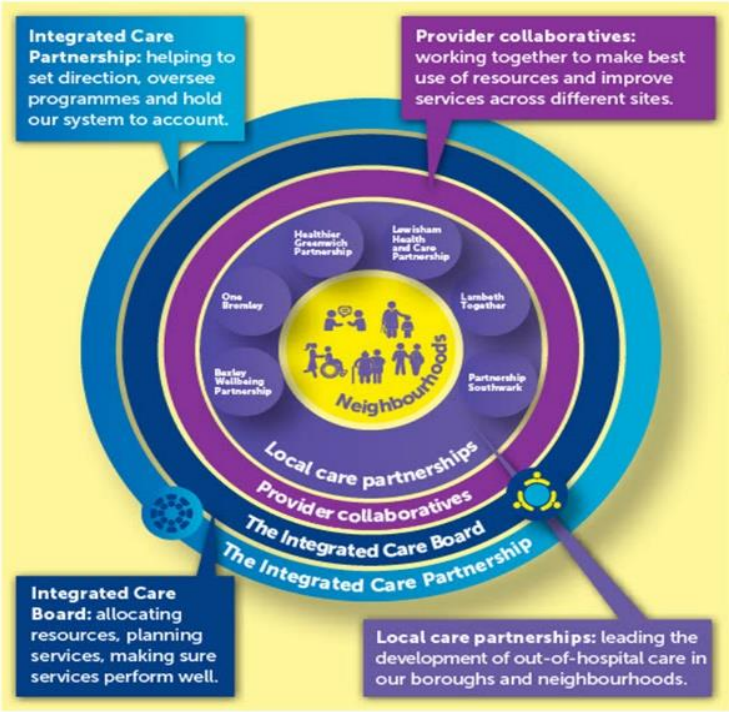


Fig 1: SEL "system of systems"

Integrated Care Partnership (ICP)

The Integrated Care Partnership (ICP) is a broad alliance of leaders who set strategic direction, provide leadership and support of key south east London-wide programmes. The ICP also ensure governance is in place to enable us to hold each other to account for the delivery of the ICB's priorities.

The ICP is made up of:

- representatives from the six south east London local authorities
- the Chairs of our biggest health provider organisations
- Directors of public health, adult social care and children's services
- a representative from Kings Health Partners, primary care, the VCSE sector, and Healthwatch.

Provider Collaboratives and Networks

Provider collaboratives and networks operate across each of acute care, mental health services and community services, bringing together similar providers to jointly plan and deliver key aspects of care. The objectives are to:

- drive the standardisation of care planning and outcomes
- make the best use of our available capacity through taking a system approach rather than an individual organisational one, and
- enable best practice.

Embedding the work of our Provider Collaboratives in our system of systems means that we are able to join up our integrated care. We can also make sure that plans and outcomes are driven by both operational imperatives and health needs.

Local Care Partnerships

Borough based **Local Care Partnerships** (LCPs) bring together NHS, Local Authority, other statutory and voluntary sector partners, to plan and deliver healthcare at a local level.

This is driven by the local Joint Strategic Needs Assessment and associated Health and Wellbeing Plans. Our LCPs focus on developing integrated community-based services. These services should be designed to meet the needs of the population in a way that is clearly in line with the core purposes of an ICS.

Integrated Neighbourhood Teams

At an even more local level, we are developing Integrated Neighbourhood Teams, to bring together services with local communities within LCPs. Our aim is to transform how services work together at a local level by:

- Improving co-ordination of care
- Improving access to care
- Reducing pressure on hospitals
- Tackling health inequalities

To achieve this, Integrated Neighbourhood Teams will initially focus on three key groups where we believe we have the greatest opportunity for improvement:

- people with three or more long term conditions
- frailty and end-of-life care, and
- children with complex needs.

2.5 Key risks and influences

We want to reduce health inequalities. We know that, as a care system, we need to deliver healthcare at the right time, in the right place, and in the most efficient, effective and sustainable way that we can.

This is against a backdrop of:

- increased demand on our services,
- high levels of serious illness,
- an ageing and expanding population that has increasingly complex health needs,
- risks around: workforce recruitment and retention, capacity of services and demand for them,

- challenges in how we move people through departments and services (or ‘flow’)
- financial constraints.

We are continuing to work with our system partners to address these issues. Central to our plans is our desire to:

- co-produce and co-design our services with the communities that we serve
- make sure we understand and address the priorities of our local communities
- improve underlying health, health outcomes and inequalities, and
- meet the expectations of the NHS.

These are broad and complex areas. We have sought to mitigate the risk that we do not deliver by making sure that we:

- are clear about our planned actions and their expected impact,
- are able to track delivery,
- have prioritised our work to ensure an ambitious but achievable set of delivery expectations.

There is more information on how we manage and monitor risks in the governance section of this report.

3. Performance Summary

This section provides summary information on our performance against the national performance standards for 2024/25. It looks at how we have delivered our operational plans.

3.1 2024-25 Performance in summary

In 2024/25 we continued to focus on the recovery of our core services from the impact of the Covid-19 pandemic. We put emphasis on improving the overall quality and safety of our services. This has included:

- improving A&E waiting times, by working to avoid unnecessary hospital admissions, and to discharge people from hospital who no longer need to be there,
- reducing long waits for planned surgery and treatment,
- improving performance against standards for cancer and diagnosis,
- making it easier for people to access community and primary care services, and
- improving access to mental health services so that more people of all ages receive the treatment they need.

We aimed to build on the progress made over 2023/24. Our targets had to take into account the ongoing legacy of the pandemic, the demand for services, and the capacity of those services. We aimed to be realistic in how quickly we could improve, in transforming care pathways and improving productivity and efficiency.

We have continued to make collaboration and innovation central to how we work, including:

- Embedding ‘population health management’ approaches into how we plan and deliver services. This means that we understand better the needs of our population and respond to them more effectively. It enables us to focus on reducing health inequalities, as well as meeting overall performance targets.
- Encouraging and embedding collaborative approaches to the delivery and improvement of services. We have worked more to use our service capacity on a system-wide basis, rather than on an individual provider basis. We have also strengthened our approaches to mutual aid.
- Digital transformation, for example:
    - increased development of online or telephone appointments for primary care and outpatients,
    - more use of technology and remote health monitoring, and
    - moving to remote consultations across general practice, which enables the most effective use of NHS people and places.

We have also been working to improve care pathways. This includes:

- Continuing to build community-based care, to avoid unnecessary visits and admissions to hospital, and to provide care closer to home, with:
    - continued development of our urgent community response and reablement services
    - the roll-out and adoption of virtual wards and remote monitoring, and
    - on-going improvement of community services for mental health.
- Action to expand capacity and improve productivity and efficiency. This will help us meet demand for services including diagnostics, planned treatments and surgery, urgent and emergency care, mental health community teams and crisis services, as well as increasing the number of available beds.
- We have increased capacity in: community diagnostic centres, operating theatres and elective hubs, and made more beds available in two of our most pressured acute sites.
- Working to make sure we are meeting best practice and using evidence-based guidelines across our services. For example, our Clinical Effectiveness South East London (CESEL) team has been working with general practice to deliver clinical guides, clinical templates, education events and facilitation visits to individual practices, focusing on long-term conditions such as diabetes and hypertension. CESEL's evidence-based approach to quality improvement has also attracted funding.
- Our urgent and emergency care system partners have worked together to embed the SEL 111 service within wider integrated urgent care, to roll out Same Day Emergency Care, and improve our hospital discharge planning processes, in line with best practice.
- For planned surgery and treatments, we have commissioned and expanded new community-based alternatives, so that patients are seen in the right place, first time. This is helping to improve community-based care. We have also produced guidelines for how people with key conditions are referred to the right service. This also helps us to manage demand for those services.

2024/25 was a difficult year for us and the whole of the NHS because of ongoing industrial action. Also, in June 2024 the largest pathology provider in south east London was the victim of a criminal cyber-attack. This affected pathology services for all but one of our Trusts and over 200 general practices. This led to delays and cancellations, particularly in the first couple of weeks after the incident. Pathology services have been back to normal since September 2024, but the backlog caused by the attack affected performance for the rest of the year.

Alongside this, multiple factors affected our performance, including levels of demand for services and the capacity of those services, workforce and financial pressures, and operational demands impacting our ability to deliver the productivity and efficiency gains we need to.

As a result we ended the year with levels of performance that fell below national standards for some areas.

Despite this, we did achieve some successes in delivering our plans for improvement. These included:

- delivering an improved position for the three main metrics for measuring cancer performance in acute settings (hospitals),
- a greater proportion of people waiting less than four hours in A&E,
- improvement against the majority of the key mental health performance indicators, and
- a significant reduction in the number of people waiting over a year for treatment.

3.2 Forward view

At the time of writing we have almost finished our operational plans and Joint Forward Plan refresh for 2025/26. These include commitments we are making on health improvement, service delivery, performance, finance and productivity.

We have two overarching priorities: reducing health inequalities and improving the sustainability of our care system.

To meet these objectives, we will have to address the government's three shifts for the NHS: from hospital to community; cure to prevention and; analogue to digital.

We will focus both on quick wins and longer-term planning.

We launched a system sustainability programme in 2024/25. Its purpose is to identify, assess and then implement improvements to our care system that will enable us to move away from implementing changes at an organisational and tactical level, and be more strategic.

We are also working with colleagues in south west London to develop strategic plans for specialised services.

4. Our Strategy and Performance

This section describes the planning framework we have used to deliver our statutory duties. It also provides more detail on our performance this year.

4.1 Planning Framework

4.1.1 Our Operational Plan

Our Operational Plan for 2024-25 was agreed with NHS England at the start of the year. It set out our ambitions for improving operational performance across our providers and reducing our financial deficit.

4.1.2 Our Integrated Care Strategy

We identified five strategic priorities for our care system. These are areas where there are significant opportunities to work together to improve health outcomes, reduce health inequalities and join up care. We identified these opportunities by working with local people, our local authorities and the local care partnerships.

The five priorities are:

Prevention and Wellbeing: preventing ill health and helping people in south east London stay healthy and well.

Early Years: making sure that children get a good start in life by providing effective support for mothers, babies and families both before and after birth.

Children's and Young People's mental health: making sure children and young people have quick access to effective support for common mental health needs.

Adults' mental health: making sure adults have quick access to early support, to prevent mental health challenges from getting worse.

Primary care and people with long term conditions: providing convenient access to high-quality primary care and improving support and care for people with long-term conditions.

You can find more detail on our priorities on our website.

4.1.3 Our Joint Forward Plan

Our Joint Forward Plan contains our medium-term objectives and our plans to make sure that we are developing a service for residents that:

- Meets their needs,

- Demonstrates real progress in delivering the core priorities of our care system,
- Delivers national priorities, all of which are relevant to south east London,
- Meets our statutory requirements.

2025/26 will be the third year of our five-year Joint Forward Plan. We have refreshed our plan this year, and focused on how it supports delivery of our two major priorities:

- **Improving population health and reducing inequalities** in access, experience and outcomes; and
- **Improving system sustainability** over the short, medium and long term.

4.2 Our Performance in 2024-25

This section provides a summary of our performance in 2024-25, covering specifically:
- *operational performance in 4.2.1*
- *quality and patient experience in 4.2.2*
- *health inequalities in 4.2.3, and*
- *finance in 4.2.4*

4.2.1 Operational Performance

4.2.1.1 Acute Hospitals

The following table provides information on our performance against the national performance standards shown in aggregate across our three acute Trusts: Guy's & St Thomas' NHS Foundation Trust (GSTT), King's College Hospital NHS Foundation Trust (KCH) and Lewisham & Greenwich NHS Trust (LGT).

Metric	Standard	SEL 2024/25 Plan	Period	2024/25	2023/24
RTT 18 week wait performance	92%	-	March 2025	58.7%	54.2%
RTT 52 week wait performance	0	-	March 2025	6,439	13,803
RTT 65 week wait performance	0	0	March 2025	366	2,548
RTT 78 week wait performance	0	0	March 2025	32	269
RTT 104 week wait performance	0	0	March 2025	2	11
Diagnostics 6 week waits	<1%		March 2025	32.9%	38.9%
A&E 4-hour performance*	95%	78.0%	March 2025	75.7%	72.2%

A&E 12-hour waits	**0**	**0**	**March 2025**	**1,851**	**1,554**
Cancer 28 day waits (faster diagnosis standard)	**75%**	**77.0%**	**March 2025**	**78.6%**	**75.1%**
Cancer 31 day decision to treat to treatment	**96%**	**-**	**March 2025**	**92.2%**	**87.3%**
Cancer 62 day referral/upgrade to first treatment	**85%**	**68.8%**	**March 2025**	**61.9%**	**58.2%**

* whole system position which includes standalone urgent care centre data

Definitions
Elective care - Referral to Treatment (RTT) waiting times: The percentage of referral to treatment (RTT) incomplete pathways (patients yet to start treatment) within 18 weeks. Elective care - Referral to Treatment (RTT) 52 week waits: The number of pathways for which patients have been waiting more than 52 weeks from referral. Elective care - Referral to Treatment (RTT) 65 week waits: The number of pathways for which patients have been waiting more than 65 weeks from referral. Not reported in 2022/23 so comparative performance is not available. Elective care - Referral to Treatment (RTT) 78 week waits: The number of pathways for which patients have been waiting more than 78 weeks from referral. Elective care - Referral to Treatment (RTT) 104 week waits: The number of pathways for which patients have been waiting more than 104 weeks from referral. Diagnostic waits: The percentage of patients waiting six weeks or more for a diagnostic test. A&E 4-hour waits: Percentage of A&E attendances where the patient spent four hours or less in A&E from arrival to transfer, admission or discharge as measured against the pre pandemic NHS constitutional standard of 95% of patients being seen and discharged or admitted within 4 hours of arrival. A&E 12-hour waits: Total number of patients who have waited over 12 hours in A&E from decision to admit to discharge or admission. Cancer 28 day waits (faster diagnosis standard): Percentage of patients receiving a communication of diagnosis for cancer or a ruling out of cancer, or a decision to treat if made before a communication of diagnosis within 28 days following an urgent referral for suspected cancer; a referral for breast symptoms where cancer was not initially suspected or secondary care professional; or an urgent referral from an NHS Cancer Screening Service Cancer 31 day decision to treatment: Percentage of patients receiving treatment within a maximum of 31 days from decisions to treat/earliest clinically appropriate date to treatment of cancer. Cancer referral/upgrade to first treatment standard (62-day standard): Percentage of patients receiving a first definitive treatment for cancer within 62 days of receipt of: an urgent GP (or other referrer) referral for urgent suspected cancer; a breast symptomatic referral; an urgent screening referral; or consultant upgrade.

4.2.1.2 Elective care

In 2024-25 the national priority was reducing/eliminating long waiting times with a requirement to eliminate waits of over 65 weeks for elective care as soon as possible; recognising that we cannot continue to reduce long waits without also reducing overall numbers of people waiting and improving productivity.

In 2024/25, we reduced the number of people waiting 104, 78, 65 and 52 weeks for elective care. However, we did not deliver our plan to end all 65 week waits.

As we have already seen, our performance was affected by a major cyber-attack, industrial action and other factors. We took action during the year to help improve performance, including:

- supporting the acute provider collaborative in developing south east London-wide waiting lists.
- updating waiting lists on a weekly basis, which allows detailed review of how planned care is matched to patient demand, and actionable reports to be provided to the various elective recovery workstreams.
- the roll out of patient-initiated follow-up across a wide range of specialties. The three Trusts are working together to share learning, care pathways and other resources to ensure a consistent approach.
- promoting the use of advice and guidance across south east London, improving patient experience and referral management.

4.2.1.3 Diagnostics

In 2024/25, the national target was to increase the percentage of patients receiving a diagnostic test within six weeks to a minimum of 95% in March 2025. Implementation of a new patient record system in two of our providers in 2023/24 caused data quality issues. Coupled with changes in ways of working, this led to deterioration in performance.

We prioritised access to diagnostics for cancer and emergencies. Although this helped reduce how long people stayed in hospital, and had a positive impact on 4-hour waits in A&E and cancer waiting times, it did have a negative impact on the diagnostic 6-week wait target.

The Acute Provider Collaborative has led on delivery of improvements in diagnostics delivery, including demand management, optimisation of available capacity and initiatives to improve how that capacity is used. We continue to deliver some additional diagnostic activity through the independent sector and outsourcing capacity is in place for imaging.

4.2.1.4 Urgent and emergency care (UEC)

We planned for an improvement in A&E waiting times compared to 2023/24, with a minimum of 78% of patients seen within four hours in March 2025.

In practice, urgent and emergency demand and associated performance remained a problem for us. High mental health attendances in acute emergency departments have, in particular, affected the number of people waiting for a long time, and this is reflected in the growth in 12-hour waits.

During the year, we continued to focus on improving performance and how we move people through hospitals. We implemented system-level recovery plans with priority

areas including: same day emergency care. inpatient hospital flow, transfer of care hubs, and virtual wards.

Discharging people effectively remains key to how we move people through hospitals, and to our ability to admit patients from emergency departments. Our Discharge Solutions Improvement Group has worked to improve performance while ensuring that patients are discharged safely.

4.2.1.5 Cancer

Our 2024-25 plans focused on improving performance against the 28-day faster diagnosis standard to 77% by March 2025 as part of achieving the 80% ambition by March 2026, and improving performance against the 62-day referral / upgrade to treatment target to 68.8%.

We achieved the 28-day faster diagnosis standard, but we did not achieve the 62-day target in March 2025.

We still face significant difficulties. In particular, these relate to transfers, which are a critical focus for us to improve performance. This particularly impacts our performance because the main tertiary provider for lung pathways for the south east of England is in south east London. This provider receives referrals from other acute hospitals for patients who need specialist care. These are usually complex patients and pathways. Our Cancer Alliance is working with the trusts and referring providers and systems to improve pathways.

4.2.1.6 Mental health performance

Metric	2024/25 Plan/Target	Period	2024/25	2023/24
Talking Therapies: Number discharged*	2,119	March 2025	**1,845**	**-**
Talking Therapies: Reliable recovery*	48%	March 2025	**48%**	**-**
Talking Therapies: Reliable improvement*	67%	March 2025	**68%**	**-**
Dementia diagnosis date	66.7%	March 2025	**70%**	**69.7%**
SMI physical health checks	70%	March 2025	**60%**	**65%**
CYP access through NHS funded MH services	24,017	March 2025	**22,980**	**20,905**
CYP eating disorder wait times – routine	95%	March 2025	**95%**	**50%**
CYP eating disorder wait times – urgent**	95%	March 2025	**100%**	**-**
Access to transformed community MH services	12,864	March 2025	**24,500**	**11,385**

Contact with Perinatal MH services	1,703	March 2025	**1,720**	**1,595**

*New metric for 2024/25. 2023/24 performance is not available
**Performance not reported for 2023/24 due to number of patients being fewer than 5

Definitions
Talking Therapies Number discharged: Number of patients discharged having received at least 2 treatment appointments in the reporting period. Talking Therapies reliable recovery: Reliable recovery rate for those completing a course of treatment and meeting caseness Talking Therapies: reliable improvement: Reliable improvement rate for those completing a course of treatment. Dementia diagnosis: Diagnosis rate for people with dementia, expressed as a percentage of the estimated prevalence. SMI physical health checks: The proportion of people on the GP serious mental illness (SMI) registers who have received a comprehensive physical health assessment in the 12 months to the end of the reporting period. CYP access: Number of people aged 0-17 supported through NHS funded mental health services receiving at least one contact in the previous 12 months. CYP eating disorder wait times – routine: The proportion of Children and Young People (CYP) with eating disorders (routine cases) that wait four weeks or less from referral to start of NICE-approved treatment in previous 3 months CYP eating disorder wait times – urgent: The proportion of Children and Young People (CYP) with eating disorders (urgent cases) that wait one week or less from referral to start of NICE-approved treatment in previous 3 months. Access to transformed community MH services: Number of people who receive two or more contacts from transformed NHS or NHS commissioned community mental health services (in transformed PCNs) for adults and older adults with severe mental illnesses Contact with Perinatal MH services: Number of women accessing (1+ contact) specialist community PMH and MMHS services in the previous 12 months

We agreed performance and activity plans for 2024/25 across a range of key mental health areas. We achieved significant improvements (or continued to meet national standards) across the majority of the metrics associated with these. However, difficulties relating to workforce, demand, capacity and high numbers of emergencies remain, and were key drivers of underperformance in some areas.

New national performance metrics for Talking Therapies were introduced for 2024/25. These measure the number of patients discharged after receiving at least two treatment appointments with the service, and the percentage of patients moving to “reliable improvement and recovery”. This means that these patients are assessed as no longer requiring clinical treatment based on a questionnaire that is tailored to their specific condition.

We have achieved reliable improvement and recovery targets at a south east London level, but performance varies across individual services. Activity has been lower than planned. Referral levels are lower than we expected. Providers have continued to take action to raise awareness of the service, including leaflet drops, bus campaigns and greater engagement with GPs.

We consistently achieved the national dementia diagnosis rate target in 2024/25. While there is variation, we are meeting this target regularly in four out of six boroughs.

We consistently met the target for children and young people accessing NHS-funded mental health services during the first three quarters of the year. However, there was a fall in performance after January and we did not meet the target in the final quarter of

the year. This is due to a change in the coding of ADHD and ASD activity which is no longer counted against this metric.

Delivery of waiting time targets for children and young people accessing eating disorder services fell at the start of 2024/25. Since then, there has been further improvement, and we are now consistently meeting the target for urgent cases. There has also been significant improvement in delivery of the target for routine cases, and performance met the national target in March 2025.

We did not achieve the planned improvement in the percentage of people with severe mental illness receiving an annual physical health check. Delays in blood tests as a result of the cyberattack affected delivery at the start of the year. Local improvement plans were in place and performance improved in the following quarters.

We have met the target for the number of people accessing specialist community mental health and maternal mental health services. We significantly exceeded the target for the number of people accessing transformed community mental health services. These services are locally designed, person-centred and holistic integrated models of care that support patients to live well in their communities.

4.2.1.7 Learning Disability and autism

Our learning disability and autism (LDA) programme focused on priority actions, such as reducing reliance on inpatient care and delivering annual health checks.

By the end of March 2024, the number of adults, children and young people receiving care in mental health hospitals was higher than planned, as a result of an increase in the identification and diagnosis of autism in our population. Despite this, during 2024/25 several people who had experienced long stays in hospital were successfully discharged into the community. By the end of March 2025, we had achieved the target number of inpatient discharges.

We completed 7,469 annual health checks for people with learning disability between April 2024 and March 2025. This is approximately 85% of the number of people registered with a learning disability in south east London. The target was 75%.

2024/25 was the second year of implementing these priority actions in the Joint Forward Plan 2023-28:

1. In addition to further reducing the number of inpatients, the focus will be on ensuring appropriate admissions, reducing length of stay, repatriating people to south London and improving the quality of inpatient and community services.
2. Reducing health inequalities in terms of improving outcomes and access for people with a learning disability and autism, in both hospital and community settings.

3. Significantly reducing the waiting times and the number of people on waiting lists for autism diagnostic assessment across all ages and developing post-diagnostic support for people with an autism-only diagnosis.
4. Developing community alternatives to hospital admission to meet the needs of current inpatients, as well as preventing admission by providing safe and effective care and support in the community.

Key deliverables and improvements during 2024/25 included:

- Expansion of the South East London Education Care and Treatment (SELECT) Keyworking Service to meet need and demand. Everyone under the age of 18 who is an inpatient or is at high or medium risk of admission to hospital and is on the Dynamic Support Register (DSR) are offered a SELECT Keyworker.
- Full implementation of care education treatment reviews and DSR guidance and support for staff. There is now a more consistent approach to how DSRs are approached across all boroughs, as well as a move to a digital system.
- During 2024, LeDeR (Learning form the Lives and Deaths of people with a Learning Disability and Autistic people) became a standing agenda item on the SEL ICS Learning From Deaths group. During 2023/24 (the most recent year for which finalised data is available) there were 82 LeDeR notifications and 54 reviews completed. Of the 54 reviews completed, 56% were “initial” (basic) and 44% “focused” (in depth). There continues to be underreporting of autistic people’s deaths, which echoes London and England data.
- Development and implementation of our core offer for our children and young people’s autism assessment pathway.
- Implementation of LDA pathway strategy and panel in partnership with the mental health and Community Provider Collaborative.
- Development of FIND (Forensic Intellectual and Neurodevelopmental Disabilities) service to meet needs in the community by increasing capacity and capability.
- Implementation of local LDA steering groups in all six boroughs to support SEL-wide and borough-based initiatives.
- Development of a comprehensive autism data reporting dashboard to support planning and commissioning of services.
- Implemented pilots for the Partnership for Inclusion of Neurodiversity in Schools programme and autism support through the Emotionally Based School Non-Attendance project.
- Establishment of a new Special Educational Needs and Disabilities network to support delivery of the SEL SEND work plan and priority actions.
- Delivery across our care system of Oliver McGowan training on learning disability and autism.

4.2.2 Quality

4.2.2.1 Quality of commissioned care services

The new NHS Patient Safety Incident Response Framework came into effect from April 2024. This proposes a co-ordinated and data-driven response to patient safety incidents and aims for a significant cultural shift towards systematic patient safety management. As part of the rollout, we reviewed provider patient safety incident response plans to understand their key patient safety priorities and focused improvement work plan. We plan to complete a pilot rollout at five primary care providers by April 2025.

Two newly established quality staff committees, 'Themes & Concerns' and 'Learning from Deaths', provide a mechanism to triangulate concerns and work on system-wide improvement. Both groups report into the System Quality Group, which is made up of representatives from across the south east London care system. These groups have supported a variety of reviews to support cross-system learning and improvements to pathways and stakeholder communications.

When the quality of healthcare within a service raises concerns, there is a process in place for escalation to NHS England through the Regional Quality Group. This group reviews known concerns in healthcare providers. Members of the group can co-ordinate support to drive forward improvements and ensure learning happens across the region.

The quality alert process is fully embedded in our day-to-day operations. We received 1,540 alerts in 2024 from our providers, mainly GPs. Appointment and referral issues, treatment delays and communication were among the top themes of quality alerts reported, all of which are being monitored with focused improvement work through a group led by our Medical Director. We are currently reviewing the quality alert process to align it with the principles of the patient safety strategy.

Numbers of Quality Alerts reported by quarter

Quality Alerts	Q1	Q2	Q3	Q4	Total
2021/2022	288	278	333	346	1,245
2022/2023	320	333	363	355	1,371
2023/2024	669	503	578	511	2,259
2024/2025	492	490	558	494	2,034

Numbers of Serious Incidents and Patient Safety Events by quarter

Serious Incidents	Q1	Q2	Q3	Q4	Total
2021/2022	136	164	162	139	601
2022/2023	165	126	142	138	571
2023/2024	128	104	69	49	350
2024/2025	39	35	27	34	135
Never Events	Q1	Q2	Q3	Q4	Total
2021/2022	4	4	4	7	19
2022/2023	3	1	8	2	14
2023/2024	6	4	1	5	16
2024/2025	0	8	3	4	15
Patient Safety Events	Q1	Q2	Q3	Q4	Total
2021/2022	0	0	0	0	0
2022/2023	0	0	0	0	0
2023/2024	0	1	7	2	10
2024/2025	11	29	42	26	108

Key themes arising from patient safety incidents within hospitals, social care and community settings were: treatment delays, self-harm and discharge. Delay in treatment and delayed diagnosis are recurring themes across the trusts.

The System Quality Group also commissioned the Local Maternity and Neonatal System (LMNS) to set up a task & finish group to review never events in maternity.

4.2.2.2 Local Maternity and Neonatal Services

Our LMNS operates as a collaborative network with membership from care providers, commissioners, service users and other key stakeholders. It oversees work on improving the quality and safety of services. This collaboration enables knowledge sharing and cross-system learning and implementation of improvements, with the aim of reducing unwarranted variation in the care that women receive.

The LMNS has a number of different workstreams, including:

- collaboration with community organisations and women and birthing people, especially those who are under-represented, to explore how we can reduce the inequities they face. This is part of the LMNS Equality and Equity action plan.
- Improving the relationship between women and birthing people and their maternity healthcare providers by providing relational care before and after a birth.

- Delivery of the Maternal Medicine Network care pathway, which provides a multi-disciplinary service for women and birthing people with complex medical conditions, to make sure they receive the right care in the right place.
- Delivery of the Perinatal Pelvic Health Service, a specialist midwifery and physiotherapy pathway for those who have experienced pelvic health complications due to childbirth, plus education for women and staff.
- Optimisation of newborn pathways that help reduce mortality and illness, including the right place of birth for premature infants.
- Specific improvement initiatives for infants who are not premature, for example:
    - Providing more neonatal care within postnatal ward settings to reduce separation of babies and their parents as part of 'Transitional Care'.
    - Working on improving and standardising community jaundice pathways to make sure there is easy access to care when needed.
    - Ensuring babies (particularly those born prematurely), are given the best start possible with interventions such delayed umbilical cord clamping, close monitoring of temperature and promoting early breast milk.
    - Promoting robust sharing of learning across the system from the Avoiding Term Admissions into the Neonatal Intensive Care Unit (ATAIN) programme and identifying opportunities for care pathway development.
- Delivery of preconception health education and support across south east London as part of the women's and girls' health hubs, with a focus on planning for a healthy pregnancy and raising awareness of how to optimise preconception health.
- Oversight of maternity and neonatal quality and safety, working with the services to share and learn from incidents and make sustainable improvements when themes or concerns arise, and to reduce mortality and illness.

4.2.2.3 Infection Prevention and Control

Our Infection Prevention and Control (IPC) group meets monthly to provide a platform for organisations to share learning, identify risks and implement guidance in a consistent way.

The IPC team produce surveillance reports detailing our position against specific measures, which we act on as appropriate, where infection counts go above agreed thresholds.

The South East London Forum for Antimicrobial Stewardship, made up of both primary and secondary care members, also met regularly throughout the year. A key development was the rollout of the Microguide app as part of our strategy to improve antibiotic use and to fight antibiotic resistance. The app helps standardise best practices, gives prescribers easy access to treatment guidelines, and includes a decision support tool. It also collects prescribing data to support monitoring and compliance.

The IPC team worked closely with local health protection teams, the UK Health Security Agency (UKHSA), and primary care partners to manage outbreaks of measles, invasive group A strep (iGAS), and norovirus. We also continued our work on local infection risks supporting care homes and colleagues in social care. We kept our yearly audit programme for primary care practices.

4.2.2.4 Safeguarding

Legislation, statutory guidance and national directives inform our responsibilities for safeguarding children and adults at risk. We are statutorily responsible for making sure that the organisations we commission services from provide a system that safeguards vulnerable adults and children at risk of abuse or neglect. This includes specific responsibilities for looked-after children, and the child death overview process. These duties include:

- a clear line of accountability for safeguarding, properly reflected in our governance arrangements, i.e. having a named executive lead to take overall leadership responsibility for the organisation's safeguarding arrangements.
- making sure that the health providers we commission services from (both public and independent sector) have comprehensive and effective single and multi-agency safeguarding arrangements in place
- putting in place clear policies setting out our approach to safeguarding, including: children and adults safeguarding; domestic abuse staff support; safeguarding supervision policy, safer recruitment practices, and arrangements for dealing with allegations against people who work with children or adults
- making sure that staff reach a level of safeguarding competence that is appropriate to their role, in accordance with the respective children, looked after children, and adult intercollegiate competency documents which detail what training should be in place for staff.

During 2024/25, our safeguarding team continued to promote compliance with these responsibilities and respond to national and local developments and priorities. Key achievements, developments and opportunities are set out within the ICBs Safeguarding Annual Report.

Our safeguarding teams are represented at all stages of a statutory case review process. This includes completing chronologies and Individual Management Reviews, as required, and the sharing of learning to the wider care system.

We have implemented the NHSE safeguarding case review tracker, which is a national portal to record statutory reviews and provide themed reports, to support learning and improvement.

Statutory reviews include:

- safeguarding adult reviews
- domestic homicide reviews

- rapid reviews
- child safeguarding practice reviews
- child death reviews

Looked after children

National and local trends show a rise in the number of children in care due to increased placements and longer stays. Our teams focus on improving compliance with statutory initial and review health assessments and working with partners to improve the experiences and outcomes for children in care.

Mental Capacity Act and deprivation of liberty

The Mental Capacity Act can be complex and difficult for health and social care staff, as shown by reviews into the lives and deaths of people with a learning disability and through Safeguarding Adult Reviews. We support staff by providing expert advice, information and training around the Act.

Special Education Needs and Disability (SEND) individuals (0-25 years):

SEND governance and function has changed in 2024/25 to align with the learning disability and autism programme. Our work programme outlines priorities and actions to achieve strategic goals in this area, including the delivery of the statutory duties for SEND, improving the access to, and quality of, health provision for children and young people and young adults with SEND.

We have established a local SEND network with membership from across health, education and care to support delivery of our priority actions:

- strengthening governance
- sharing learning
- strategic commissioning
- workforce capacity, and
- data and intelligence.

All Age Continuing Care (AACC)

AACC is a national programme of reform focused on the policy areas of NHS Continuing Healthcare (NHS CHC) and Children and Young People's Continuing Care (CYPCC) services. The programme focuses on improved experience and transparency, and the reduction of unwarranted variation across all forms of continuing care.

Governance and oversight will be a key priority within the national operating model to

ensure compliance with the statutory duties and national guidance set out in the National Framework for NHS Continuing Healthcare and NHS funded Nursing Care July 2022 (Revised) and the National Framework for Children and Young People's Continuing Care (2016).

Regional oversight will continue to focus on monitoring of performance indicators and metrics, standards of practice, Independent Review Panels (IRPs), finance assurance relating to quality improvement, Personal Health Budgets (PHBs) and new metrics for Children and Young People's Continuing Care.

We led one of the transformational AACC Pioneer projects, designed to support delivery of the vision. SEL developed a digital capability assessment tool, now adopted and published (August 2024) as the national AACC Digital Capability Assessment Tool (AACC DCAT) following regional and national endorsement.

4.2.3 Patient Experience and Complaints

In 2024/ /25, we received a total of 685 formal complaints. Of these, 57 related to issues we are responsible for investigating and responding to. We also received 299 complaints relating to issues which we are not directly responsible for, and which we forwarded to the appropriate organisation for investigation and response. We received a further 329 complaints relating to primary care services.

The areas that we received the most complaints about, and that were within our remit, were:

- Continuing healthcare (assessment for eligibility process, payment)
- Mental health commissioning (access to services, availability and funding)

The most common themes of complaints about primary care services were:

- Access / appointments
- Prescribing
- Aspects of clinical care and treatment
- Attitude of staff

We aim to resolve all complaints at a local level. Sometimes, however, people who complain are unhappy with the outcome of their concern and go to the Health Service Ombudsman for a review. Six out of 664 complaints were referred to the Parliamentary and Health Service Ombudsman in 2024/25.

Patient Advice and Liaison Services (PALS) and MP enquiries

We listen carefully to concerns raised by our patients and local residents and advise them on the best way forward. While we cannot always resolve a concern to their

satisfaction, we can give people information about support services and voluntary organisations that may be able to help. The PALS service helps reduce anxiety for people who use our services and helps them to navigate the health and care system. It also helps reduce the number of issues that go on to become formal complaints.

In 2024/25, we received and responded to 3,098 PALS enquiries from members of the public. Key themes were:

- Advice and signposting.
- Primary care access – GP appointments and access to dentistry.
- Commissioning decisions – individual funding requests and lack of access to over-the-counter medications on prescription.
- Delays in complaint handling by providers we commission.

In the same period, we received a total of 208 enquiries from local MPs. This represents a 55% increase on the previous year.

The most common areas of service MPs enquired about were:

- Primary care access and prescribing
- Continuing healthcare
- Commissioning decisions
- Synnovis cyberattack.

Further detailed analysis about complaints and patient experience data will be available in the SEL ICB Annual Complaints Report 2024/25.

4.2.4 Financial Performance

This section describes our performance against our main financial duties and responsibilities:

- *containing our spending within our allocation in the year;*
- *ensuring that we live within our management cost limit;*
- *delivering total spending across the ICB and its providers within the control total set by NHS England*
- *delivering total capital spending across the ICB and its providers within the control total set by NHS England*
- *meeting the mental health investment standard.*

We are required to achieve specific financial targets and fulfil certain duties each year. A summary of our performance against each of these is in the table below:

		2024/25 target (£'000's)	2024/25 actual (£'000's)	
Delivery of statutory financial duties	Agreed Surplus	-	87	Achieved
	Expenditure not to exceed income	4,947,140	4,947,053	Achieved
	Operate Under Resource Revenue Limit	4,885,531	4,885,444	Achieved
	Not to exceed Running Cost Allowance	35,908	31,750	Achieved
	Operate under Capital Resource Limit	554	554	Achieved
Deliver administrative duty under the better payments practice	95% of NHS creditor payments within 30 days	95.0%	100.0%	Achieved
	95% of non-NHS creditor payments within 30 days	95.0%	99.1%	Achieved

We are pleased to confirm that we achieved all of our financial performance targets for 2024/25.

Key points to note are:

- our overall financial allocation (revenue resource limit) was £4,886m. We achieved an overall surplus of £87,000.
- our running cost allocation was £35.9m. We underspent this by £4.2m.
- we achieved all targets under the Better Payment Practice code; which means that we pay our invoices in a timely manner.

We have appropriate controls in place for both limiting the use of agency staff and, where agency staff are used, ensuring that rates of pay do not exceed the agreed NHS capped rates. All agency staff are subject to approval by our vacancy review panel and our Chief Executive. They only approve agency staff when they are both business critical and where the rates of pay are within the capped rates. Our draft statutory accounts for the 2024/25 report that spend on agency staff was £0.957m. Equivalent spend for 2023/24 was £1.063m.

In 2024/25, we received a number of largely non-recurrent funding allocations for specific purposes. Material examples include funding for:

- cancer alliance (£10.2m)
- Pharmacy First (£3.8m)
- adult community mental health services (£17.6m)
- additional discharge (£16.2m), and
- bed capacity (£25.4m).

We account separately for each of these allocations and produce specific financial reports. Any spending related to this funding has been for the purposes specified.

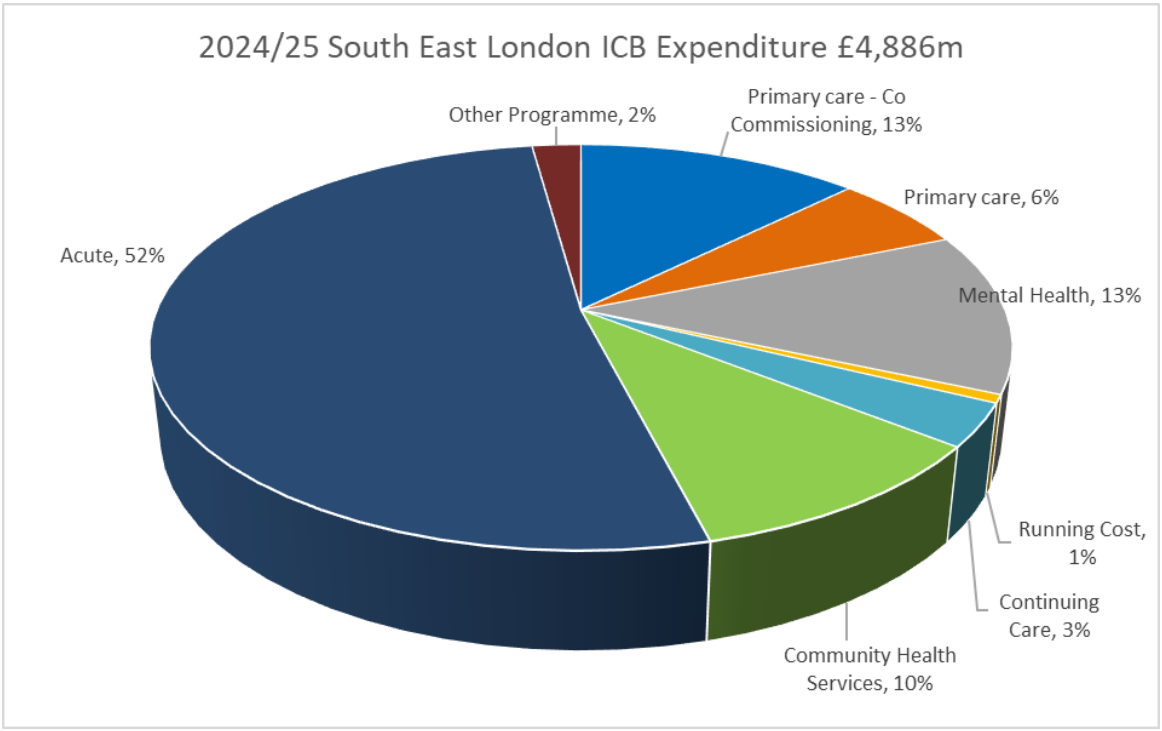
How we spent our 2024-25 Financial Allocation

We commission healthcare services to meet the needs and improve the health of the population of south east London. Our main NHS providers are:

- Lewisham and Greenwich NHS Trust,
- Guy's and St. Thomas's NHS Foundation Trust,
- Kings College Hospital NHS Foundation Trust,
- South London and Maudsley NHS Foundation Trust and
- Oxleas NHS Foundation Trust.

In addition, we fund the prescribing costs of GP practices and hold delegated responsibility, from NHS England, for commissioning primary care, dental, pharmacy and ophthalmic services within south east London.

The total financial allocation available to us in 2024-25 was £4,886m. The following pie chart summarises how we spent our budget in 2024-25:



Financial performance against the Mental Health Investment Standard (MHIS)

We met the requirements of the MHIS with an increase in spend in 2023/24 of 7.24% compared to the target increase of 6.85%.

The proportion of mental health spend has shown a slight increase as a percentage of the overall recurrent programme allocation.

Financial Years	2023/24 (£000's)	2024/25 (£000's)
Mental Health Spend	439,678	471,495
ICB Programme Allocation	4,108,899	4,388,890
Mental Health Spend as a proportion of ICB Programme Allocation	10.70%	10.74%

We achieved the MHIS for 2023/24. This has been confirmed by independent review. Note that there was a slight change in the MHIS value as previously reported because of data improvements made during the mental health data review in September 2024. The 2023/24 value was £439.9m.

Disclosure of external audit remuneration

We paid £270,800 (excluding non-recoverable VAT) to Grant Thornton, who are the external auditors, in relation to ICB audit work for 2024/25. In addition, we paid £37,000 (excluding non-recoverable VAT) to the external auditors for the review of our compliance with the MHIS for 2023/24. We have complied with HM Treasury's guidance on setting charges for release of information.

2024/25 annual accounts

The full annual accounts for 2024/25, together with the Statement of Accountable Officer's responsibilities and Independent Auditors Report are included in Section 8.

Financial outlook for future years

We have completed budget-setting and financial planning for 2025/26. In common with other NHS organisations, we have significant underlying financial and operational pressures to manage as we leave the current year. We will continue to focus on sustained improvement in services, efficient use of resources, and additional investment in primary care, community and mental health services.

NHS England have said that all ICBs will be required to significantly reduce their running and programme corporate costs, with implementation during the third quarter of 2025/26. This will be a significant challenge for us, and all ICBs.

4.2.5 Reducing health inequalities

One of the core purposes of our ICS is to tackle inequalities in outcomes, experience and access experienced by the residents of south east London.

Our plans recognise the role prevention can play in this. This includes:

- embedding a systematic, evidence-based approach to the prevention of key population risk factors affecting adults, children and young people,
- enabling access to vaccinations and immunisations, and
- delivery of Vital 5 checks to enable health promotion, and prevention, self-management, and proactive management of illness.

We recognise that delivery of any scheme to reduce health inequalities requires us – and our partners – to build trust and confidence with our communities. So we have a strong focus on long-term partnerships with voluntary and community sector organisations.

Health inequalities statement; and managing health inequalities
Health inequalities are systematic, unfair and avoidable differences in health across the population and between different groups within society. They arise because of the conditions in which people are born, grow, live, work and age. Within the wider context, health inequalities are also driven by inequalities in the access people have to health services, their experience of and outcomes of healthcare.

Our Health Inequalities statement for 2023/24 is available on our website, and we will publish the statement for 2024/25 in September 2025.

We need good quality data to understand more about the populations we serve, and to identify people who are most at risk of poor access to healthcare, poor experiences of healthcare services, or poor outcomes. Good quality data will also help us to deliver targeted action to reduce health inequalities.

We have a well-established local Core20PLUS5 data reporting dashboard in place for adults. The Core20PLUS5 is the most deprived 20% of the population, as identified by the national Index of Multiple Deprivation, and the groups most likely to experience health inequalities (our ‘plus’/health inclusion groups). This has enabled us to identify the population groups and communities who are most likely to experience inequalities. In 2024/25, we also developed a dashboard for children and young people and,

working in collaboration with our local authority partners, we will now be able to use this to identify where we need to build stronger relationships with children and their families to improve outcomes of care.

In September 2024, we published our first Health Inequalities Report. We had already identified some of the inequalities highlighted in this report, and we had ongoing partnership and improvement work in place to address them. This annual report includes two specific case studies where this is the case: vaccinations (covid and flu) and rates of total mental health act detentions (see below).

Our Health Inequalities Report also identified some lesser-known inequalities. For example, we found a marked difference between male and female patients in face-to-face and virtual (telephone) outpatient appointments, with women attending at a much higher rate. We are currently investigating these areas, to build our understanding and to provide an opportunity for learning and redesigning our approach.

We will refresh our Health Inequalities Report early in 2025/26, analysing the latest data available for 2024/25, and publish it in September 2025.

4.2.5.1 Uptake of Winter Vaccinations

Our Health Inequalities Report shows that:

- For both Covid and flu: there was a correlation between deprivation and uptake. Less deprived people have a higher vaccine uptake.
- For flu: there is a marked imbalance in flu vaccine uptake. The only group whose uptake is above the south east London average is the White ethnicity group (24.2%). All other ethnic groups are below the average.

Developing trust and confidence with communities requires honest, open and consistent dialogue over a long period of time. For some communities, grassroots community groups and voluntary sector organisations are in a unique position to develop and maintain these dialogues, to build relationships.

We continue to build engagement and information-sharing with people who have either declined a flu and covid vaccination or have not engaged with any programme. This has resulted in targeted and meaningful discussions, often with small groups, to share information, answer questions and discuss concerns. We have also continued to move away from providing these sessions in a healthcare environment, which can be a barrier for some people. Boroughs have made use of community locations including family hubs, children's centres, places of worship and community hubs – ensuring that the service goes out to people, rather than people needing to travel to the service.

Borough vaccination teams and borough-based vaccination champions have also taken opportunities to attend local community events, to share information and answer questions from residents. Through very local borough-based relationships, the teams

have worked with local councillors and elected members to ensure that they are kept informed of the latest information and data on vaccine take-up and hesitancy. This enables them to signpost any resident who may have a query.

Through the development of our women's and girls' health hubs, various outreach engagement events have taken place to gain insights and experiences from women and girls across south east London. The team have taken the opportunity to ensure that information is available on a range of different types of prevention activity. This has included flu and covid vaccinations as well as screening and lifestyle advice.

As we move into 2025/26 we are working with the South East London Community and Voluntary Sector Alliance. We will commission grassroots organisations to continue to build trust and confidence in NHS services across a three-year period, including vaccinations and immunisations.

4.2.5.2 Rates of total Mental Health Act detentions

The Mental Health Act is a law that details the rights of people with a mental health disorder, and how they can be treated. Being detained (also known as being sectioned) under the Mental Health Act is when a person is made to stay in hospital for assessment or treatment. Under the Mental Health Act people can be detained and treated in hospital even if they do not want to be.

Our 2023-24 Health Inequalities Report shows that:

- There is a marked difference in the rate of Mental Health Act detentions between age groups, with the highest rates seen in the 18-24, 35-49 and 50-64 age cohorts.
- There is a strong correlation between deprivation and the rate of Mental Health Act detention; the more deprived people are, the more likely they are to be detained.
- There are marked inequalities in the rates of Mental Health Act detentions between ethnic groups, and in particular for those of Black ethnicity. Rates of detention per 100,000 population were 263 for Black ethnicity, 213.4 for "other" ethnicity, 77 for White and 70.5 for Asian.

These differences are similar to the national picture with regards to Mental Health Act detentions. We have been working in a number of ways with ICS partners, and the mental health trusts in particular, to address these inequalities:

- **Transformation of community mental health services for working age adults** to provide earlier intervention and prevention, and a more holistic approach to care. This has included significant investment into community mental health services, to expand service provision and develop neighbourhood-based community mental health teams. These teams bring

together primary and secondary care, voluntary and community sector services and local authority-based services, including employment support.

The voice of people with lived experience has been key to this transformation, and particularly for those from our Black, Asian and other ethnic minority communities. The transformation programme has tested and embedded peer support worker roles and dedicated outreach worker roles, to reach and build trust with these communities and enable access to services.

In 2024/25, South London and Maudsley NHS Foundation Trust was selected by NHS England as one of the national pilot sites to provide 24/7 community care building on the existing transformation to date in Lewisham. As we move into 2025/26, our priority is to embed the learning from the transformation programme so far, and continue to test and learn new approaches, including any national guidance and evidence.

- **Increasing our focus on children and young people's mental health.** National statistics indicate that 50% of mental health problems are established by the age of 14 and 75% by the age of 24. Intervening early in life is therefore a key area of focus for us, with the aim of reducing the number of detentions under the Mental Health Act for adults in the longer term.

  In 2024/25, this has included a focus on increasing access to community child and adolescent mental health services, through reducing waiting times and expanding mental health support in schools. This focus will remain as we move into 2025/26.

  There has also been some targeted work to support particular cohorts of children and young people, under the wider programme auspices of NHS England's national connectors programme. In 2023/24 and 2024/25 we commissioned Black Thrive to work with a select number of schools in Key Stage 2 to engage with children, their parents/care givers and teachers, to co-produce solutions and initiatives to improve mental health and emotional wellbeing. We are currently in the process of implementing the findings from the engagement and co-production work, and we will continue with the expansion of the connectors programme in 2025/26.

5. Supporting the delivery of healthcare

This section covers the work we do to support delivery of healthcare:

- *engagement with local communities (section 5.1);*
- *digital (section 5.2);*
- *support for work on supporting diversity, equality and inclusion (section 5.3);*
- *sustainability work (section 5.4); and*
- *support for our staff (section 5.5).*

5.1 Engagement with people and communities

Engagement – working with people and communities – is a priority for us and we are committed to keeping patients and the public at the heart of what we do.

Our senior leadership champion the importance of engagement. Our Engagement Assurance Committee is a well established part of our governance and assurance on engagement, and the majority of the committee are members of the public. The committee also includes a non-executive director of the ICB (who chairs the committee), the Medical Director and the Chief of Staff, along with the Director of communications and engagement, the Director of South East London Healthwatch and the Director of voluntary sector collaboration and partnerships. Key areas, engagement projects and work that the committee has provided assurance on in the last year include:

- NHS 111
- women's and girls' health hubs
- the development of a new guide to healthcare
- the engagement workplan
- the refresh of the ICS engagement toolkit
- the developing approach to recognising involvement and
- the findings from the refresh of the SEL People's Panel.

The committee also receives regular reports from SEL Healthwatch and the Voluntary, Community and Social Enterprise Sector (VCSE) Alliance, including their work on widening participation in the health care workforce for under-represented groups.

A key focus in 2024/25 was listening to women and girls from diverse communities across south east London, to understand their needs and how they wish to access healthcare. This was to inform the development of women's and girls' health hubs, whose purpose is to provide more accessible, integrated care in our communities. This is part of the implementation of the Women's Health Strategy.

We were keen to hear from people about:

- What health services and support are most important to women and girls
- How we can deliver these services so they are easier to access
- How can we ensure women and girls across our diverse communities have access to knowledge and information about their health and wellbeing - including how to know and where to go if they might need support from a healthcare professional
- What the barriers are that women and girls face in relation to health
- What we could do to remove these barriers so that everyone can access the care and support they need, regardless of where they live or their situation.

We invited feedback from local women and girls through an online survey and a conversation forum. We promoted the survey and forum through diverse channels, including a social media campaign. We received 1,434 responses.

In addition to collecting online feedback, we attended several face-to-face community events to complement this insight.

These sessions allowed us to hear from over 250 local women and girls. We focused on listening to young women (16-25) and women and girls from communities facing barriers to care and experiencing health inequalities, including South Asian, Black African, Black Caribbean, and Latin American communities.

We also held two online focus groups to gain further detailed insight to contribute to the co-design of the women's and girls' health hub. These sessions were a good opportunity to continue the conversations and allowed us to test proposed solutions.

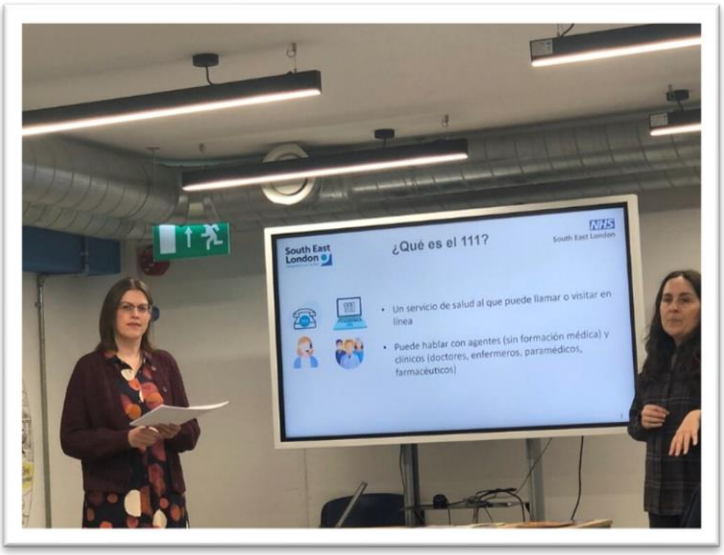
Participants shared their experiences, highlighting the need for better diagnosis and treatment for issues like menstrual health and pelvic floor issues. Participants also raised problems such as limited appointments for services like contraception, menopause support and pelvic floor care. The discussions also showed a strong need for more accessible and personalised care.

There is more information on our Let's talk health and care engagement platform.

Another key project was to gain views and insight to inform the redesign of the NHS 111 service in south east London as part of a re-procurement process. We listened to local people through a survey, outreach sessions and community events to understand what works well and what needs improvement.

We promoted the survey to members of the public in south east London, as well as to over 1,000 members of the South East London People's Panel. Over 400 people shared their experiences through the survey, highlighting the value of NHS 111, and pointing out areas for improvement such as callbacks, waiting times and accessibility barriers. In addition, we carried out targeted outreach with diverse communities which helped us to collect further insights.

The key findings and the full report is available on the project page on our Let's talk health and care platform.



Over summer 2024 we organised a series of face-to-face outreach sessions, aimed at connecting with groups and communities that have been identified as not accessing the NHS 111 service, facing barriers in accessing the service, or who access the service much more than the general population. We visited various community events and groups, gathering insight from from over 100 individuals.

We supported the national conversation on Change NHS to inform the development of the 10 Year Plan by promoting the national on-line portal and hosting two on-line webinars in January and February 2025 with 74 members of the public These focused on the government's three shifts :

- from hospitals to communities
- from analogue to digital
- from cure to prevention

The word cloud below represents the words people used in the second workshop to describe how the NHS will feel in the future if the 10 Year Plan is a success.

Key topics that people identified included:

- welcoming of the use of technology that works for both staff and patients. But concerns were raised about confidentiality and security and the potential for exacerbating health inequalities for those who are digitally excluded
- general positive response to moving more care out of hospital and into community settings or at home, but with the acknowledgement that social care is a key partner in this shift area. There was also the caveat that not everyone's home environment is suitable for receiving care, and that good public transport links and parking are required for care staff; and
- recognition of the importance of prevention. Some participants highlighted the need to focus on children and young people's mental health, and to address wider determinants of health such as air quality, worklessness, housing, access to healthy food, and transport.

We also worked with South London Listens and Citizens UK who held two face-to-face roundtable discussions with their community leaders. The south east London session took place in January 2025.

You can read more, including local people's views from the webinars, at Change NHS: help build a health service fit for the future | Let's Talk Health and Care south east London.

We continue to develop and have good engagement with our on-line engagement platform, Let's talk health and care in south east London. We have published 11 new projects in the last year and continue to update on-going projects. Since April 2024 we have had 41,000 visits to the site with just over 18,000 informed visits (such as people clicking through and downloading documents) and nearly 10,000 engaged visits (people responding to a survey or chat forum).

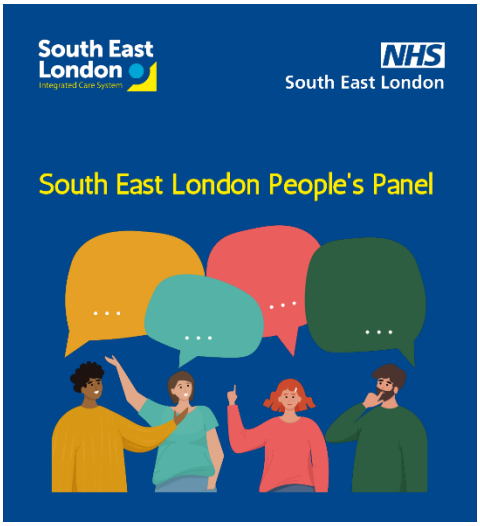
We promote all our projects as well as those of partner organisations in our monthly Get Involved newsletter. This has a combined circulation across south east London of over 2,000 people with partners also sending it on to their mailing lists. You can read and sign up to our Get Involved newsletter at Engagement newsletter - sign up | South East London ICS.

We have further developed our insight library on the ICS website. It contains insight from people and communities across partners and programmes. Its aim is to maximise the value of engagement, avoid duplication and engagement fatigue and enable programmes to focus engagement activity on working with people and communities to identify solutions to issues raised, rather than gaining further insight.

We worked with Mabadiliko CIC, a local Black-led organisation, to develop and share a range of insight from people from Black African and Caribbean, South Asian and economically disadvantaged communities. The report synthesises insight gained from seven distinct programmes, previously carried out by Mabadiliko CIC across south east London, and it identifies recurring themes and insights across three key areas:

- individual and community factors: including health knowledge, personal beliefs, and the impact of social circles on health behaviours
- relationships with healthcare professionals and local services: exploring trust, communication, and experiences of care
- impact of wider system and societal influences: examining systemic issues, including racism in healthcare and the effects of service digitalisation.

Mabadiliko presented the key findings at the ICB's Equalities Sub Committee and the SEL Themes and Concerns Group. You can read the report and other insight we have gained and shared at What we've heard from local people and communities - South East London ICS.



In the autumn, we worked with Jungle Green, a market research agency, to refresh the South East London People's Panel. We focused on people from communities who are often underserved and marginalised.

A final report of the survey findings which formed part of the recruitment is available at South East London People's Panel survey 4 report | Let's Talk Health and Care South East London.

The south east London engagement team continues to organise and facilitate the ICS Engagement Practitioners' Network. It meets on a bi-monthly basis to share insight, align engagement and share good practice and learning across partnerships and place with engagement leads and practitioners from health and care partner organisations including Healthwatch and VCSE representatives. The engagement team also organises and facilitates a regular bi-monthly meeting of co-ordinators of the community champions schemes acrossour boroughs. These networks are key forums for sharing learning and insight as we continue to develop a more aligned approach to working with our people and communities.

5.2 Digital developments, innovation and research

The Digital team has developed a new strategy for the future of digital, data and system intelligence for south east London. Delivering digital transformation requires partnership working and we have sought to work more closely with, and develop closer relationships between, digital directorates and colleagues across London. We held an innovation day and developed a London-wide framework for the safe and effective use of AI in health and care.

The Innovation day was delivered in partnership with South West London ICB, Health Innovation Network and Digital Health London. Expert panels and breakout sessions delved into critical topics such as digital transformation, patient-centred care, and the integration of new technologies into existing healthcare frameworks. These discussions demonstrated the importance of a unified approach in advancing healthcare delivery and were showcased to the more than 200 healthcare professionals, technology experts, industry leaders, and innovators who attended.

We also led the development of a London-wide framework for the safe and effective use of AI in health and care, through a series of collaborative events. The purpose of this framework is to outline an approach for the implementation, use and maintenance

of AI within the London health and care system. Our proposed approach agrees a collaborative methodology, where providers share information about their plans and outcomes, and where projects follow a level of consistency in approach so that we can harness opportunities to spread and scale.

In June, the team supported the system-wide response to a large cyberattack, including working to quickly establish mutual aid arrangements with partners. The cooperation and transfer of resources to support south east London helped to reduce the impact of the attack on people and communities across our six boroughs.

This is all alongside the day-to-day support offered by the directorate. Across primary care and NHS South East London, our IT team supports over 9,000 users, 14,800 smartcards and 7,500 devices.

Our new digital, data and system intelligence strategy outlines six programmes to enable the delivery of high quality care for the people of south east London through digital innovation and data-driven intelligence. The strategy covers:

- empowering our people through digital and data, including: increasing use of the NHS App; reducing digital exclusion; supporting care in the community and improving triage tools.
- digital solutions for connected care, including: transition to a single ordering system for GP pathology; increasing access to the London Care Record to social care, care homes and community pharmacy; and simplification of information for GP practices
- delivery of data driven insights. In particular, leading delivery of the London Data Service building on the success of the London Care Record to provide a data infrastructure that supports teams to deliver the best possible health and care for all Londoners.
- ensuring resilience and cyber security. This has included not just the response to the cyberattack but developing a comprehensive cyber security and resilience strategy.
- driving continuous improvement and innovation. This year our work was shortlisted for an HSJ Award in the ‘driving efficiency through technology’ category. This recognises our efforts, and those of practices and partners, to improve access for people and communities across south east London.
- supporting our workforce to embrace digital.

5.3 Our Work on Equality Diversity and Inclusion

We place a high priority on equality, diversity and inclusion, not just because of our statutory duties under general and NHS-specific legislation; but because this is good for our population and good for us as an organisation.

This section covers:

- our public sector equality duty (section 5.3.1)
- our equality objectives, governance and monitoring (section 5.3.2)
- workforce standards and staff networks (section 5.3.3)

Public Sector Equality Duty

The Public Sector Equality Duty requires public authorities to demonstrate 'due regard' in their operations. This means they must actively consider the following for both their workforce and communities:

- eliminating unlawful discrimination, harassment, and victimisation
- advancing equality of opportunity between people who share a protected characteristic and those who do not
- encouraging good relations between people who share a protected characteristic and those who do not.

We publish our annual Public Sector Equality Duty report in March each year, outlining how we are addressing equalities and health inequalities. The 2024/25 report is available here.

Equality Objectives, Governance and monitoring

As an ICB, we are required to establish equality objectives: clear and measurable commitments set by the Board, regularly monitored and reviewed, and updated at least every four years.

Our current equality objectives are:

1. Embed equality analysis across all functions and demonstrate accountability with the Equality Act 2010.
2. Cultivate an organisation that is inclusive; free from discrimination, with all able to fulfil their potential.
3. Board members and senior leaders demonstrate commitment to equality, diversity and inclusion in the development of SEL ICB vision, values, strategies and culture. Building assurance and accountability for progress.
4. Build strong relationships with our diverse communities, better understand the needs and experiences of the population across south east London and adjust our approaches accordingly.

We are reviewing these and will update them in 2025/26. Our governance is overseen directly by the Board and through the Equalities sub-committee, chaired by the Chief of Staff and Equalities senior responsible officer.

We established the Equalities sub-committee to drive meaningful improvements in equality, diversity and inclusion, both within the organisation and for the people and communities we work for. In September 2024, we conducted a review to enhance the

committee's effectiveness. As a result, we updated the membership to bring together leaders from across the organisation and our wider care system.

We monitor our performance through a combination of our internal governance, standard NHS systems, external reviews and audits, and the use of external standards. These include EDS (Equality Delivery System) 22, a generic system designed for both NHS providers and health care planners. In 2023/24, we completed our first report and achieved a rating of 'Developing'. Building on this foundation through 2024/25, we saw a strong improvement, to 'Achieving'. The EDS report for 2024/25 is available here.

Equality Impact Assessments (EIA) help analyse new or changing policy, processes, services or developments. In 2024/25, the EIA process underwent an extensive redesign to make sure it was easy to use; it included a comprehensive toolkit, a new screening form aligned with the organisation's risk matrix, and a dedicated intranet space for the workforce to access. This has been very well received. We are planning further work on training, which will substantially improve the effectiveness of EIAs.

We also use external reviews to assess our equalities work. We were pleased to see that the SEL Anti Racism strategy was highlighted as a case study in Sir Michael Marmot's Structural Racism, Ethnicity and Health Inequalities in London report, published in October 2024 by the Institute of Health Equity. We were also approached by the Race Equality Foundation to participate in a pilot programme called the 'Race Equality Maturity Index.'

Workforce Equality Standards, Gender Pay Gap and Staff Networks

We measure ourselves against three workforce equality standards: race, disability and sexual orientation.

The Workforce Race Equality Standard (WRES) was developed to ensure employees from a Global Majority background have equal access to career opportunities and receive fair treatment in the workplace. The findings of the 2024/25 report show that we have made improvements in representation, but that further work is required on all indicators. This is underway, with the support of the Embracing Race and Diversity staff network. The WRES report for 2024/25 is available here .

The Workforce Disability Equality Standard (WDES) is a set of ten metrics enabling NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. We have used the data to develop an action plan. The results for the 2024/25 report show improvements, but further work is required on all metrics. This is underway with the support of the Age & Ability staff network. The WDES report for 2024/25 is available here.

The Workforce Sexual Orientation Equality Standard (WSOES) is a framework to improve workplace equality for LGBTQ+ staff in the NHS. Using eight metrics, we use

the framework to identify and address disparities in recruitment, progression and staff experiences. 2024/25 is the first time we have used the framework. The WSOES report for 2024/25 is available here .

The gender pay gap is the difference in average earnings between men and women, typically expressed as a percentage of men's earnings. It reflects various factors, including differences in job roles, working hours, career progression, and discrimination. There are two main types:

- mean gender pay gap; the average difference in pay across all employees
- median gender pay gap; the difference between the middle-earning man and the middle-earning woman.

All UK organisations with more than 250 employees are required to publish details of their gender pay gap as part of the Equality Act 2010 Act. As at 31 March 2024, we employed 629 people, 69% (434) women and 31% (195) men. Our mean gender pay gap for hourly pay is 5% (compared to 12.7% on 31 March 2023) and our median gender pay gap is 4.4% (compared to 2.43% on 31 March 2023). The full Gender Pay Gap report for 2024/25 is available here.

We have four staff networks: Age and Ability; Embracing Race and Diversity; LGBTQ+ and; Women, Parent and Carers. These networks ensure that staff voices are at the heart of our workforce activities. The networks receive direct support from the Executive team and engagement is high, resulting in consistently well-attended and effective meetings.

5.4 Supporting sustainability

This section describes our approach, including:
- *our current Green Plan and progress*
- *our current priorities and*
- *governance.*

In October 2020, the NHS became the first national health system in the world to commit to delivering a net zero system. This means improving healthcare while reducing harmful carbon emissions and investing in efforts that remove greenhouse gases from the atmosphere. The NHS England report Delivering a ‘Net Zero’ National Health Service sets two clear targets for:

- The NHS Carbon Footprint: for the emissions we control directly, to be net zero by 2040
- The NHS Carbon Footprint Plus: for the emissions we can influence, to be net zero by 2045.

5.4.1 Our Green Plan

To support the net NHS ambition we developed a Green Plan which we published in April 2022. The plan sets out aims, objectives and delivery plans for carbon reduction. The plan contains a total of 122 objectives for delivery over the three-year cycle, across eleven areas of focus:

- **Workforce and system leadership** – making sustainability part of our core business.
- **Air quality** – working collaboratively improve air quality in south east London.
- **Travel and transport** – reduction and decarbonisation of our travel and transport.
- **Estates and facilities** – optimising resource use and reduce emissions from our estate.
- **Sustainable models of care** – developing models of care to reduce their environmental impact and improve social value.
- **Digital transformation** – using digital transformation to improve the sustainability of healthcare without compromising quality.
- **Medicines** – reducing the environmental impact of medicines prescribing optimisation.
- **Supply chain and procurement** – using supplies more efficiently and collaborating on the decarbonisation of our suppliers
- **Food and nutrition** – providing patients in hospital with healthy food and reducing waste
- **Adaptation** – mitigating the impact of climate change and events on our services.
- **Green/blue space and biodiversity** – improving green spaces (areas with plants) and blue spaces (areas with water).

The latest bi-annual assurance assessment in September 2024 confirmed that we have delivered 90 of 122 objectives.

5.4.2 Our current priorities

We are required by NHS England to produce refreshed Green Plans setting out the key actions we will take to deliver emissions reductions and support resilience to climate impacts over a minimum of the next three years (at least 2025-28, following the previous three-year cycle of 2022-25). Our plans must strike an appropriate balance between immediate emissions reductions in some areas, alongside strategic development of capability in others.

We have started work on the refresh and an external party will support us in this.

5.4.3 Sustainability Governance

The Green Plan is delivered through a sustainability programme, which has an agreed governance structure and representation from Trust operational sustainability leads and Executive Board leads across all contributor organisations. Our Chief of Staff is the Senior Responsible Officer (SRO) for the ICS Green Plan. The programme governance structure is led by three key committees:

- The **Greener SEL Oversight Committee,** providing system-level leadership and oversight; attended by board-level executive leads from the ICS, each of the Trusts and primary care.
- The **Primary Care Sustainability Steering Group**, chaired by the ICB Deputy Medical Director and attended by representatives from each of the six boroughs and representatives from ICB workstreams relevant to primary care (e.g. estates, medicines, digital transformation)
- The **SEL Sustainability Network**; attended by the operational leads from south east London provider Trusts. The network group receives updates on progress against delivery of the Green Plan, while also providing a forum to share best practice.

We report Green Plan progress to the Greener SEL Oversight Committee bi-annually, and to the ICB Board typically twice a year as per the Board's rotating agenda. Progress reports provide a quantified delivery summary and a narrative to provide oversight on delivery of actions relating to climate.

The ICB Board received a full update from the Programme SRO in late 2024 and members provided feedback on Green Plan objectives which will inform the Green Plan refresh in 2025. Additionally, we include Green Plan updates typically twice a year in the Chief Executive's report.

An emerging priority for 2025 – climate adaptation

Adaptation refers to adjustments in processes, practices and structures to mitigate risks and impacts associated with climate change and severe climate events (most commonly extremes of temperature, flood and drought) or even to benefit from opportunities associated with them. It should not be confused with emergency response to climate events as it is a separate discipline.

Climate adaptation is of increasing importance and has been given a higher profile through the London Climate Resilience Review (to which the ICS submitted evidence in 2023) and the forthcoming UKHSA Health and Climate Adaptation Report (to which the ICS contributed via a London Roundtable in September). The final report of the London Climate Resilience Review concludes that London is not well prepared enough

for severe climate events. It has made recommendations for the NHS, including for ICBs to “Work with their organisations to collaboratively agree an approach to adaptation risk assessment and planning. Coordinating support required for providers and work with partners to set system level adaptation plan.”

Greener NHS has recognised climate adaptation as a new London priority, and so will establish a pan-London climate adaptation workstream, which we have agreed to participate in. The ICB will use this additional expertise and capacity to support and advice ICS partners, and to ensure that climate adaptation is set appropriately in refreshed Green Plans and recognised appropriately as an emerging priority.

Task force on climate-related financial disclosures

The Department of Health and Social Care General Accounting Manual has adopted a phased approach to incorporating the recommended Taskforce on Climate-related Financial Disclosures (TCFD), as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury’s TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures, as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025-26 financial year. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

The phased approach incorporates the disclosure requirements of the governance, risk management and metrics and targets pillars for 2024-25. We are providing these disclosures below where they are not accessible either elsewhere in this annual report, on in our Green Plan which is available on our website at https://www.selondonics.org/who-we-are/sustainability/our-green-plan/ .

Programme governance

The wider ICS sustainability governance arrangements (detailed above) support climate adaptation. In addition, we are an active participant in the London Climate Resilience Task and Finish group. This is a London-wide group established and led by London Greener NHS to respond to the recommendations of the London Climate Resilience Review and to lead to the establishment of climate adaptation plans across London NHS organisations. Partnership working with the Greater London Authority (GLA) also enables public health input and the exploration of approaches and frameworks to support climate risk identification and adaptation planning.

Oversight and assurance

The SEL Sustainability Network has agreed to compare and pool key climate risks in a SEL climate risk register, to present an aligned syetm-wide view of ICS-wide climate risks.

Escalation and oversight is via the Greener SEL Oversight Committee, with an aligned register of ICS-wide climate risks presented to the Oversight Committee as a standing business item together with Green Plan progress. The ICB Board typically receives an update twice per year as per the Board's rotating agenda. Additionally, Green Plan updates are included typically twice a year in the Chief Executive's Report. All Green Plan updates include the position on climate-related actions, challenges and opportunities.

We are required to report a RAG-rated position on Green Plan delivery, along with summary details of achievements, risks and support requirement to Greener NHS, bi-annually. The Greener SEL Oversight Committee reviews and signs off the assurance submission.

Risk management

We recognise the risks presented by the global impact of climate change and specifically the impact on health provision for our residents. Adaptation plans are under development across NHS organisations in south east London, and our visibility at Borough Resilience Forums enables engagement with borough risk registers which include climate related risks.

We maintain two risks on our corporate risk register; one relating to overall delivery and monitoring of the Green Plan (including climate-related objectives) and a second recognising potential climate impacts to our estate, utilities, staff, infrastructure and therefore productivity. We review and update these monthly as part of our general risk management processes. This ensures that climate change is recognised on the risk register; however given the current residual risk scores assigned are within the tolerable risk range, they do not feature as a principal risk or a Board Assurance Framework risk.

We hold a record of natural hazards and their associated risks, which we compile from the risk registers of the six south east London councils. Impacts include

- travel disruption / increased traffic (and resultant impact on infrastructure including supply chain and public goods deliveries),
- risk to property and life by fire, high winds, tremors or flood waters,
- impacts to the health of elderly and vulnerable populations from excess heat, cold, snow or flooding,
- disruptions to power supply and communications links (including data networks and GPS systems),
- increased incidence of waterborne disease,
- increased incidence and / or exacerbations of respiratory and cardiovascular conditions from changes in air quality,
- disruptions to / closures of health and social care services,
- overall impact (of any/all of the above) on mental health and potential (in extreme cases) for public disorder.

The whole south east London population could be affected by any combination of the above, but we recognise there are a number of groups where the impacts and effects may be greater. This includes our elderly population, vulnerable adults and children, our disabled population and residents in areas identified as suffering from social and health inequalities. Our primary focus is on the impact on the health of our residents and patients - particularly those vulnerable and most exposed to health inequalities – and their ability to access our healthcare services.

5.5 Support for our staff

This section:

- *summarises the results of our staff survey and how we use this to inform our development and training offers (section 5.5.1);*
- *outlines our work on organisational development (section 5.5.2); and*
- *summarises our training offers to staff (5.5.3).*

As at the end of March 2025, we employed a total of 633 whole time equivalent staff across six boroughs. During 2024/25 we made around 60 staff redundant as part of our planned programme of management cost reductions. Other reductions were achieved through staff turnover.

As we have reduced our size, we place even greater emphasis on supporting and developing our staff.

Our 2024 staff survey

We launched the staff survey in October 2024. This was a challenging time for staff, being in the middle of our management cost reduction programme. We received the survey results in January 2025.

In headline, we saw:

- a response rate of 62%. This was slightly up on the previous year (58%) but below the median for similar organisations (74%)
- compared with ourselves last year, a statistically significant improvement in scores under the people promise, relating to compassionate culture, health and safety, morale and staff engagement
- compared with other similar organisations, 23 scores are in the top 20%; 77 scores are in the intermediate 60% and seven in the bottom 20%.

The full results are available here.

We are currently engaging staff and the Executive team on how we respond to the results, and we are working with staff networks to understand better the data related to protected characteristics. We will develop a series of recommendations and act on

them in early 2025. We will share a ‘you said, we did’ document with staff ahead of the 2025 survey, to demonstrate that staff have been listened to and their comments have been acted on, wherever possible.

Organisational Development

Given the scale of change taking place through our management cost reduction programme, our focus in 2024/25 was on supporting staff through these changes. This is both those leaving the organisation and those remaining, and how they work differently with fewer staff in the organisation.

Our 2024/25 priorities centred on learning, wellbeing and employee experience, as key drivers for engagement, career and leadership development and effectiveness. We aligned our four-pillar workplan to national workforce strategies for the NHS. The four pillars are: culture, new ways of working, talent and development, and staff engagement and experience.

The organisational development plan for 2025/26 will focus on the recommendations from the 2024 staff survey, as well as supporting staff through the government-mandated NHS directives, in which ICBs will see a further reduction in their costs.

Training

We continue to offer, and our staff continue to request, training, both mandatory and personal / team development. During the year we digitised the request process, making it easier for staff to complete and enabling us better to capture the data around staff who are requesting training. Highlights of the training offer are below.

New Ways of Working

We have held a series of workshops and team training sessions to support the new ways of working required following the management cost reductions. These have covered, among other areas: finance; medicines management; continuing care and primary care.

Oliver McGowan training on learning disability and autism

With our partners, we have been buying-in Oliver McGowan mandatory training from an external training provider since August 2024, using funding from NHS England. During this time, 3,244 NHS staff have been trained in Tier 1 (20% of eligible NHS staff) and 5,583 NHS staff have been trained in Tier 2 (11% of eligible NHS staff).

While the training currently uses an external provider, we are working to develop a more sustainable, localised model as NHS England funding ended in March 2025.

Statutory and mandatory training

We have maintained a compliance rate of 80% on all statutory and mandatory training. Our online corporate induction, which we launched through the learning management

system at the end of 2023/24, has maintained steady growth with current compliance at 88%.

Inclusive recruitment training

In quarters two and three, we offered inclusive recruitment training sessions to staff across the system. More than 235 staff learnt the fundamental skills and knowledge to create fair and equitable recruitment processes.

Pension seminars

More than 172 staff accessed 12 pension seminars in 2024/25 in the wake of the management cost reduction.

Clinical and Care Professional Leads (CCPLs)

Clinical and care professional leadership is central to our approach. CCPLs are clinical and care professionals who take up leadership roles within our care system, to improve healthcare delivery.

Following extensive engagement, we agreed a new structure and recruited to more than 100 posts. Two face-to-face welcome and induction events took place in September, which were an opportunity for our clinical and care professional leaders to learn more about their roles, our ICB and the broader system.

Following feedback, we established a development programme. Key parts of this included:

- a CCPL forum: the first session took place on 13 November. The aim was to bring together senior programme and place leads, representing other CCPLs in their teams for regular check-ins and an opportunity to share best practice.
- webinars: to give colleagues the opportunity to hear important updates as well as more in-depth discussions around subjects including planning, finance, VCSE programmes.
- networking events for CCPLs to build relationships with each other and with colleagues across the system, and provide a platform to collaborate. The first event took place on 15 January. The network was well attended and feedback was positive.
- a CCPL newsletter which aims to raise the profiles of CCPLs across south east London by sharing updates, information and best practice. The first issue of the CCPL newsletter went out in early February and plans for the second issue are underway.

Andrew Bland
Chief Executive & Accountable Officer
19 June 2025

6. Accountability Report

6.1 Corporate Governance Report

6.1.1 Members Report

6.1.1.1 Composition of the ICB Board

The ICB Board comprises the following members:

- Sir Richard Douglas, ICB Chair
- Andrew Bland, ICB Chief Executive
- Anu Singh, non-executive member
- Paul Najsarek, non-executive member
- Peter Matthew, non-executive member
- Georgina Fekete, non-executive member (from 1 December 2024) *
- Mike Fox, Chief Finance Officer
- Paul Larrisey, Acting Chief Nurse
- Dr Toby Garrood, Medical Director
- Professor Clive Kay, partner member, acute services
- David Bradley, partner member, mental health services
- Dr Ify Okocha, partner member, community services
- Dr George Verghese, partner member, primary care services
- Debbie Warren, partner member, local government
- Diana Braithwaite, Place Executive Lead, Bexley
- Dr Angela Bhan, Place Executive Lead, Bromley
- Sarah McClinton, Place Executive Lead, Greenwich (to 31 December 2024)
- Andrew Eyres, Place Executive Lead, Lambeth
- Ceri Jacob, Place Executive Lead, Lewisham
- Darren Summers, Place Executive Lead, Southwark (since 3 June 2024) *

** Appointments made part way through the year*

6.1.1.2 Committees of the Board

The Board is supported in delivering its obligations through a number of committees, as detailed below.

Committee	Chair
Audit & Risk Committee	Peter Matthew
Executive Committee	Andrew Bland
Quality and Safeguarding Committee	Anu Singh
Integrated Performance Committee	Paul Najsarek
Remuneration Committee	Anu Singh

People Committee	Dr Ify Okocha
Digital Committee	David Bradley

Local Care Partnerships	
Bexley Wellbeing Partnership Board	Dr Siddarth Deshmukh
One Bromley LCP	Cllr Colin Smith and Dr Andrew Parson (joint chairs)
Healthier Greenwich Partnership	Dr Nayan Patel
Lambeth Together Care Partnership Board	Cllr Jim Dickson & Dr Di Aitken (Joint chairs)
Lewisham LCP	Dr Pinaki Ghoshal
Partnership Southwark	Cllr Evelyn Akoto and Dr Nancy Kuchemann (joint chairs)

The Greenwich Charitable Funds Committee also reports directly into the Board, and is a committee set up to specifically manage legacy charitable funds available for Greenwich borough specific projects.

The Audit and Risk Committee comprises four members, being:

Peter Matthew	Non-executive member and Chair of the committee
Paul Najsarek	Non-executive member and vice-Chair of the committee
Debbie Warren	ICB partner member
Dr Ify Okocha	ICB partner member

Further information on the membership of the other ICB committees is provided in the Governance Statement section of this report.

6.1.1.3 Register of Interests

The register of interests for our Board is available on the ICB's website here. A register of interests for all staff is maintained by the governance team and is available on request.

6.1.1.4 Personal data related incidents

There has been one data incident this year that has met the threshold of being reportable to the Information Commissioner's Office (ICO).

6.1.1.5 Modern Slavery Act

NHS South East London ICB fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the period 1 April 2024 to 31 March 2025 is published on our website.

Andrew Bland
Chief Executive & ICB Accountable Officer
19 June 2025

6.1.2 Statement of Accountable Officer's Responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of NHS South East London 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 Andrew Bland to be the Accountable Officer of NHS South East London 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 NHS South East London ICB's 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 NHS South East London 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.

Andrew Bland
Chief Executive & ICB Accountable Officer
19 June 2025

6.1.3 Governance Statement

6.1.3.1 Introduction and context

NHS South East London ICB is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended).

NHS South East London ICB's statutory functions are set out under the National Health Service Act 2006 (as amended). The ICB's general function is arranging the provision of services for persons for the purposes of the health service in England. The ICB is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population.

Between 1 April 2024 and 31 March 2025, the Integrated Care Board was not subject to any directions from NHS England issued under Section 14Z61 of the National Health Service Act 2006 (as amended).

Scope of responsibility

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

I am responsible for ensuring that NHS South East London 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 clinical commissioning group as set out in this governance statement.

6.1.3.2 Governance arrangements and effectiveness

The main function of the 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 arrangements to achieve this for NHS South East London ICB are detailed below.

Governance Framework

The governance arrangements for the ICB are set out in line with the ICB Constitution, which details how the ICB will exercise its statutory functions, and the ICB Governance Handbook, which is available on the ICB website.

Board meetings

The ICB Board is comprised of ICB non-executive directors, executive directors and partner members, to ensure all parts of the Integrated Care System are represented. The Board meets on a monthly basis, with quarterly meetings held in public, and with meeting dates and venues openly published on the ICB website which members of the public are welcomed to attend to observe the meetings either in person or virtually.

Four Board meetings have been held in public between 1 April 2024 and 31 March 2025, with attendance as follows:

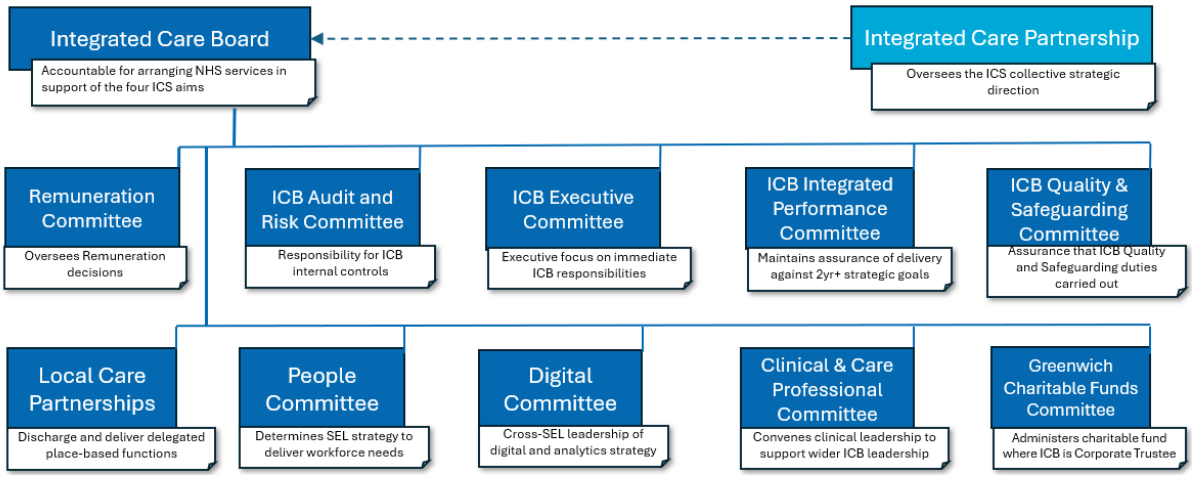
Member	Role in ICB	No of meetings attended
Sir Richard Douglas	ICB Chair	4/4
Paul Najsarek	Non-Executive Member	3/4
Peter Matthew	Non-Executive Member	3/4
Anu Singh	Non-Executive Member	3/4
Georgina Fekete	Non-Executive Member (from 1 December 2024)	1/1
Andrew Bland	Chief Executive Officer	4/4
Mike Fox	Chief Finance Officer	4/4
Dr Toby Garrood	Medical Director	4/4
Paul Larrisey	Acting Chief Nurse	4/4
Diana Braithwaite	Place Executive Lead (Bexley)	3/4
Dr Angela Bhan	Place Executive Lead (Bromley)	3/4
Sarah McClinton	Place Executive Lead (Greenwich) (to 31 December 2024)	2/3
Andrew Eyres	Place Executive Lead (Lambeth)	2/4
Ceri Jacob	Place Executive Lead (Lewisham)	4/4
Darren Summers	Place Executive Lead (Southwark) (from 3 June 2024)	3/3
Martin Wilkinson	Acting Place Executive Lead (Southwark) (to 31 May 2024)	1/1
Professor Clive Kay	Partner Member, Acute Services	4/4
David Bradley	Partner Member, Mental Health Services	3/4

Dr Ify Okocha	Partner Member, Community Health Services	4/4
Dr George Verghese	Partner Member, Primary Care Services	4/4
Debbie Warren	Partner Member, Local Authority	1/4

Committees of the ICB

The Board is supported in ensuring delivery of the ICB objectives by the following committees, who have delegated authority from the Board as specified in their Terms of Reference. The ICB undertook a review of its governance arrangements in the year, and as a result, dis-established the Planning & Finance Committee and Quality & Performance Committee, and constituted two new committees with revised remits – the Integrated Performance Committee and Quality & Safeguarding Committee.

The revised structure, approved by the Board on 16 October 2024, is shown below:



Membership attendance from members and executive directors on the ICB Board is detailed below.

NB: Executive directors “in attendance” at the Board (with no Board voting rights) are shown with an asterisk.

Planning & Finance Committee – meeting monthly from 1 April 2024 until 28 August 2024 (five meetings in this period)

Member	Role in ICB	No of meetings attended
Dr George Verghese	Partner Member & Committee Chair	5/5
Sir Richard Douglas	ICB Chair	5/5
Anu Singh	Non-Executive Member	4/5
Andrew Bland	ICB Chief Executive Officer	3/5

Mike Fox	Chief Finance Officer	5/5
Dr Toby Garrood	Medical Director	4/5
Diana Braithwaite	Place Executive Lead – Bexley	0/5
Dr Angela Bhan	Place Executive Lead – Bromley	3/5
Sarah McClinton	Place Executive Lead – Greenwich (to 31.12.24)	0/5
Andrew Eyres	Place Executive Lead – Lambeth	0/5
Ceri Jacob	Place Executive Lead – Lewisham	4/5
Darren Summers	Place Executive Lead – Southwark	3/3
Sarah Cottingham *	Executive Director of Planning	4/5
Tosca Fairchild *	Chief of Staff	2/5

Quality & Safeguarding Committee – meeting quarterly w.e.f 16 October 2024 (two meetings have taken place up to 31 March 2025)

Member	Role in ICB	No of meetings attended
Anu Singh	Non-Executive Member & Committee Chair	2/2
Dr Toby Garrood	Medical Director	1/2
Paul Larrisey	Acting Chief Nurse	2/2
Dr Angela Bhan	Place Executive Lead – Bromley	2/2
Tosca Fairchild *	Chief of Staff	1/2

Integrated Performance Committee – meeting every two months w.e.f 16 October 2024 (three meetings this year)

Member	Role in ICB	No of meetings attended
Paul Najsarek	Non-Executive Member & Committee Chair	3/3
Sir Richard Douglas	ICB Chair	1/3
Andrew Bland	ICB Chief Executive Officer	3/3
Mike Fox	Chief Finance Officer	3/3
Dr Toby Garrood	Medical Director	1/3

Paul Larrisey	Acting Chief Nurse	0/3
Ceri Jacob	Place Executive Lead – Lewisham	3/3
Dr Ify Okocha	Partner member – Community Services	2/3
Dr George Verghese	Partner member – Primary Care Services	2/3
Sarah Cottingham *	Executive Director of Planning	3/3
Tosca Fairchild *	Chief of Staff	3/3

For several of the above members, representatives attended on their behalf where they were unable to attend in person.

Audit & Risk Committee – meeting quarterly (five meetings since 1 April 2024)

Member	Role in ICB	No of meetings attended
Peter Matthew	Non-Executive Member & Committee Chair	5/5
Paul Najsarek	Non-Executive Director	5/5
Debbie Warren	Partner Member	3/5
Dr Ify Okocha	Partner Member	4/5

Remuneration Committee – (two meetings since 1 April 2024)
To note: other decisions have been made virtually due to time restrictions.

Member	Role in ICB	No of meetings attended
Anu Singh	Non-Executive Member & Committee Chair	2/2
Richard Douglas	ICB Chair	1/2
David Bradley	Partner Member – Mental Health Services	1/2
Dr George Verghese	Partner Member – Primary Care Services	2/2

Clinical & Care Professional Committee (two meetings since 1 April 2024)

Member	Role in ICB	No of meetings attended
Dr Toby Garrood	Medical Director & Committee Chair	2/2
Paul Larrisey	Acting Chief Nurse	1/2

In addition, the Committee has membership representation for the medical directors and chief nurses of each of the South East London Trusts and Bromley Healthcare, primary care and borough clinical leads, Public Health, local authorities, and allied healthcare professionals.

People Committee – meeting every other month (five meetings since 1 April 2024)

Member	Role in ICB	No of meetings attended
Dr Ify Okocha	Partner Member & Committee Chair	3/5
Paul Larrisey	Acting Chief Nurse	1/5
Tosca Fairchild *	Chief of Staff	5/5

The committee membership also includes Trust and other ICS partner representatives from across providers, local authorities and the voluntary and third sector.

Executive Committee – meeting fortnightly (23 meetings since 1 April 2024)

Member	Role in ICB	No of meetings attended
Andrew Bland	ICB Chief Executive Officer & Committee Chair	21/23
Mike Fox	Chief Finance Officer	14/23
Dr Toby Garrood	Medical Director	21/23
Paul Larrisey	Acting Chief Nurse	16/23
Sarah Cottingham *	Executive Director of Planning	21/23
Tosca Fairchild *	Chief of Staff	20/23
Diana Braithwaite	Place Executive Lead (Bexley)	19/23

Dr Angela Bhan	Place Executive Lead (Bromley)	20/23
Sarah McClinton	Place Executive Lead (Greenwich)	11/17
Andrew Eyres	Place Executive Lead (Lambeth)	16/23
Ceri Jacob	Place Executive Lead (Lewisham)	18/23
Darren Summers	Place Executive Lead (Southwark) (from 3 June 2024)	18/19
Martin Wilkinson	Acting Place Executive Lead (Southwark) (to 31 May 2024)	4/4
Meera Nair *	Chief People Officer (to 28 February 2025)	18/20
Crystal Akass *	Chief People Officer (from 1 March 2025)	3/3
Ranjeet Kaile *	Director of Communications & Engagement	15/23
Philippa Kirkpatrick *	Chief Digital Information Officer	18/23
Dr George Verghese	Partner Member – Primary Care Services	20/23

For the majority of the above members, representatives attended on their behalf where they were unable to attend in person.

Local Care Partnerships meet every other month in public and are attended by partners from across the borough.

6.1.3.3 UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance. However, we have reported on our Corporate Governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code that we consider to be relevant to the ICB and best practice.

This Governance Statement is intended to demonstrate how the ICB has regard for the principles set out in the code as considered appropriate for ICB's for the financial year ended 31 March 2025.

6.1.3.4 Discharge of Statutory Functions

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

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the clinical commissioning group's statutory duties.

6.1.3.5 Risk management arrangements and effectiveness

NHS South East London ICB's approach to risk management and board assurance is completed in accordance with legislation, national and local guidance. It seeks to embed recognised best practice through a process of on-going review and improvement and underpins the production of the Annual Governance Statement.

The Risk Management Framework for the ICB has been established to ensure that the principles, processes and procedures for best practice in risk management are enacted in a consistent way across the organisation. The processes are designed to enable the Board to be effectively appraised on key risks to delivery of the ICB's main responsibilities and objectives and the actions taken to manage and mitigate these risks.

The framework describes the ICB's risk management duties and responsibilities for staff at different levels in the organisation. Its aim is to support proactive risk management in support of the ICB achieving its agreed objectives and other responsibilities.

The ICB seeks to embed risk management at all levels within the organisation, empowering and encouraging all staff to identify risks and take action to mitigate them.

In addition to identifying South East London-wide risks, risk registers are maintained at 'place' and directorate level, each with assigned risk sponsors and risk owners who account for monitoring and managing those risks. These risks are included on registers which are reviewed at the ICB's Executive Committee and, where relevant to their areas of delegated responsibility, by place Local Care Partnership senior management teams and their boards. Risks are reviewed on a regular basis, and the Board Assurance Framework (BAF) is reported quarterly at each ICB Board meeting held in public.

The ICB has continued to ensure risk processes fully support the Board engagement on the ICB's operational management of risk as well as setting and overseeing the strategic approach to risk. The Risk and Assurance Team has continued to manage the ICB's BAF and risk register, working with risk owners and sponsors throughout the year to ensure content is accurate, clear and succinctly described.

The ICB's risk-appetite approach to the management and escalation of risk is designed in alignment with the organisation's scheme of delegation and agreed accountabilities. In support of this, the responsibility for detailed assurance and oversight of risk has been distributed for in-scope risks to the ICB's Executive Committee, and Audit and Risk Committee, and, for risk relating to ICB activities delegated to place, to the six Local Care Partnership Boards. The ICB Board has retained oversight of all BAF risks following their

consideration by these committees.

In this the ICB has benefitted from its inclusion of partner members on key committees and each committee has taken steps to increasingly consider the main risks that impact the broader ICS system as well as local ‘place’ systems.

Developing the ICB’s approach to risk management in 24/25

Progressing arrangements for ‘system risk management’ across the SEL ICS

The ICB Board made a commitment in 2024 to the ICB leading the development of an approach to the management of system risk (i.e. to collaborative management of common areas of risk, and risks to the delivery of shared ICS objectives that impact upon and are influenced by multiple ICS partners and the ICB).

In common with the vast majority of ICS areas in England, SEL began 2024/25 in the early stages of development of an approach to system risk. Initial thinking was shaped by the NHS England guide on system risk; learnings from the experience of a handful of ‘early adopter’ areas; and work to grow an understanding of commonality and difference in the local risk management processes, informed by a stock take of risks on ICB and ICS partner BAFs.

The ICB Board recognised the benefits of adopting a system risk management approach would include the breaking down of organisational barriers to problem-solving; the strengthening of coordination in response to risk; enhanced accountabilities and oversight; a collective focus on hard-to-crack problems; a reduction in duplication of activities / streamlining of management processes. As such the ICB has taken action to make substantial progress over the course of 2024/25.

Following engagement with colleagues across the ICS, an ICS System Risk Leaders Group has been established with representatives from GSTT, KCH, SLaM, Oxleas, LGT, and SEL ICB. The System Risk Leaders Group has met four times in 2024 – July, September, November 2024, and in February 2025. A set of aims and objectives of the group has been developed, and terms of reference has been agreed by partners.

At each meeting, the group has undertaken regular review and discussion of all risks on partner BAFs with the aim of sharing knowledge and approaches and learning from each other. Partners have identified a consistency in the types of risks being recorded, with all ICS partners’ BAFs including a proportion of risks that relate to the wider system as well as more clearly bounded organisational risks. The group collectively reviews partners’ assessed risks in seven key areas: finance and finance related risks; sustainability and estates; demand, capacity and operational performance; quality of care; IT and digital; and workforce.

Changes and new/emerging risks are highlighted by all partners at each group meeting, and partners have been given regular sight on all BAF risks across the ICB and each of the NHS

partner trusts, which has helped improve awareness of potential risks across the partnership.

The group's work has also provided opportunity for ICS risk leaders to undertake 'test and challenge' approach in considering areas of BAF risks, risk score ratings and changes, and different organisations' rationale for changes to their BAFs. This has resulted in improvement in collaboration and supports a better-informed analysis of major system risks.

Continued analysis of the ICS BAF risks in this way will support review the major ICS' strategic objectives and thinking about how to reflect the major risks to achieving these in a consistent (though organisationally relevant) way, across the BAFs and risk registers of all NHS ICS partners.

The group has also achieved the following benefits in 2024/25:

- Shared best-practice online risk training modules for staff, across the partnership.
- Completed deep-dive review of areas of common risk, including those related to quality of care, environmental sustainability and delivery of net zero plans. This work represents an example of how the group has sought to collaborate and learn from partners' approach to a shared area of risk. Future deep dives are scheduled on cyber security, planned care, and a further review of more specific commitments to improve safety across the ICS system.

The group committed to undertake further development work in 2025/26 to identify common risks against the delivery of ICS shared strategic objectives and ensure these are consistently considered. In addition, the group will examine how partners align on the management of risks identified at pan-ICS groups (e.g. via ICS quality and safety governance) and via ICS procedures and policies for the identification and management of system risk – e.g. learning from the Patient Safety Incident Response Framework (PSIRF).

Development and roll-out of staff mandatory and enhanced risk management training modules

The ICB Assurance and Risk Team designed and developed two bespoke risk-management e-training modules, which were tested and launched in 2024/25. The first part of the training has been incorporated into staff mandatory training and is designed to inform all staff on important components of risk management including risk categories and appetite, and reporting of risks within the ICB's governance arrangements. The second module is targeted at all staff at band 8A and above and is designed for actual and potential ICB risk owners and sponsors in their understanding of the ICB's Risk Management Framework. It provides all the information they need to manage and record risks as per the policy.

Modules were launched in April 2024, with an ambition to achieve a 100% completion rate by April 2025. As at 1 March 2025, an uptake rate of 78% for part 1, and a 71% completion rate for part 2, had been achieved with an aim of achieving full compliance by year end.

The e-training modules have been shared with risk leaders across the ICS as an example of good practice.

Counter fraud arrangements
NHS South East London ICB has a nominated Local Counter Fraud Specialist and has a risk-based work plan in place to identify and respond to fraud risk.

The Chief Finance Officer is the Executive Lead for counter fraud and the organisation's Counter Fraud Champion.

NHS South East London ICB has an Anti-Bribery, Fraud and Corruption Policy in place to support the ICB's stance of zero tolerance to fraud and corruption. The ICB's counter fraud activities are informed by best practice guidance provided by the NHS Counter Fraud Authority. NHS South East London ICB is compliant with the Bribery Act 2010.

The ICB's Audit & Risk Committee receives on an annual basis a report against each of the Standards for Commissioners and has a report from the Local Counter Fraud Specialist as a standard agenda item for every Audit & Risk Committee meeting.

6.1.3.6 Identification and evaluation of risk

The risks to which the ICB is exposed are identified by:

- internal methods – such as audits, evaluating the ICB's operational and strategic plans, productivity and efficiency plans, programme plans and related documents, patient satisfaction surveys, whistle-blowing, complaints, engagement with primary care, and monitoring the quality of commissioned services
- external methods - such as CQC inspections, media, national reports, new legislation, reports from assessments/inspections by external bodies, reviews of partnership working.

For the year 2024/25 NHS South East London ICB has followed the risk standards set out in the HM Government's *The Orange Book Management of Risk – Principles and Concepts.* The framework uses a 5 x 5 scoring matrix of likelihood of occurrence against impact to identify the scale of risk. Extreme risks are those that attract the highest scores and therefore warrant immediate attention by the Board, committees and risk owners.

			Likelihood				
			1	2	3	4	5
			Rare	Unlikely	Possible	Likely	Almost certain
Severity	5	Catastrophic	5	10	15	20	25
	4	Major	4	8	12	16	20
	3	Moderate	3	6	9	12	15
	2	Minor	2	4	6	8	10
	1	Negligible	1	2	3	4	5

As at 31 March 2025, the ICB Board Assurance Framework risks which exceeded tolerance and are therefore of most focus are:

Risk Category	Risk ID	Risk title / summary of risk	Max tolerance score	Residual risk score
Finance	**543**	ICS revenue financial plan 2024/25	12	25
Data and Information Management	**435**	SEL will not meet the AACC (All Age Continuing Care) Data Set submission due to variation in digitalisation across the six boroughs by the deadline of 1st April 2025.	9	12
Strategic commitments and delivery priorities: Implementation of ICB strategic commitments, approved plans, and delivery priorities	**384**	Delivering successful elective care transformation programmes to support the delivery of elective recovery and waiting times objectives.	12	16
	385	Competing priorities for non-admitted and admitted capacity, resulting in a negative impact on elective recovery across the ICB/its providers, with a consequence increase in waiting times for diagnosis and treatment.		16
	386	Ongoing pressures across SEL UEC services		16
	504	Cancer performance targets		16
Clinical, Quality and Safety	**391**	Increased waiting times for autism diagnostics assessments	9	16
	404	New and emerging High Consequence Infections Diseases (HCID) & pandemics		12

	437	Disruption to IT/ Digital systems across provider settings due to external factors		15
	468	Risk of variation in performance across SEL with FNC (funded nursing care) reviews		12
	528	Access to primary care services		12
	561	Increase in vaccine preventable diseases due to not reaching herd immunity coverage across the population - Seasonal Vaccinations		12

Prevention of risk is viewed as a key element of risk management and is embedded within the ICB through:

- Key policies to support risk management, such as Information Governance, Anti-Bribery and Counter Fraud, Standards of Business Conduct, Safeguarding, and Incident Reporting policies.

- Robust plans to manage risk areas around emergency planning and incident response.

- Mandatory training for all staff, which includes areas such as risk management, conflicts of interest, anti-bribery and counter fraud, equality and diversity in the workplace, health and safety, information governance, safeguarding and PREVENT.

- Completion of Equality Impact Assessments for all policies and service design

- Stakeholder engagement to promote patient and public voices in our decision-making and service development.

Emergency Planning and Business Continuity

The Health and Social Care Act 2022 has designated Integrated Care Boards as Category 1 responders under the definitions within the Civil Contingencies Act 2004. This means that the ICB is considered to be an organisation at the core of emergency response and subject to the full set of civil protection duties.

The ICB is required to identify an Accountable Emergency Officer to assume executive responsibility for Emergency Preparedness, Resilience and Response (EPRR) matters, and this role is held by the Chief of Staff. The ICB has robust response plans in place for a range of incidents and regularly tests these plans both internally and by participation in local and regional exercises. The ICB is an active member of all six South East London Borough

Resilience Forums and liaises regularly with the regional NHS England EPRR team. South East London also operates a sector-based Local Health Resilience Partnership (LHRP) as a sub-group of the London LHRP. The SEL LHRP has been in operation since September 2023 and is jointly chaired by the SEL ICB Chair of Staff and a Director of Public Health.

The risk that the ICB is not prepared to respond to any incidents is mitigated through the appointment of experienced EPRR practitioners in the organisation, regular testing and exercising of plans and processes, and annual assurance review by NHS England. In 2024, the ICB was assessed as providing a **fully compliant** level of assurance against NHS England core standards for emergency planning.

Conflicts of Interest

The ICB has put in place numerous controls to manage the conflicts of interest risks involved in the course of its commissioning duties. In addition to reviewing its policies, it has a Conflicts of Interest (CoI) panel and is guided by the Conflicts of Interest Guardian, the non-executive member who chairs the Audit and Risk Committee.

Conflicts of interest Module 1 is part of mandatory training for all staff, Board members and relevant individuals participating in ICB committees and sub-committees. Module 2 and 3 has recently been released by NHS England and the ICB is in the process of assessing which cadres of staff need to complete the relevant learning and assessment.

An online system for declaration of interests is in place across the ICB to make it easier for staff and committee members to declare and review their declarations of interests, gifts and hospitality. Registers of interests, gifts and hospitality and procurement decisions are published on the ICB website.

PREVENT Awareness

The ICB has a PREVENT programme lead who is also the Head of Safeguarding Adults and Children. All ICB staff are required to complete the PREVENT training as part of annual mandatory training.

Whistleblowing arrangements/ Freedom to Speak Up

The ICB has appointed a Freedom to Speak Up (FTSU) Guardian and has borough Freedom to Speak Up (FTSU) Champions, who are supported in the execution of their roles by the Chief of Staff as executive lead for FTSU, and a non-executive member.

Our team of FTSU Guardians and Champions comprises of individuals from diverse backgrounds in terms of sex, age, ethnicity and professional experience both at work and in their personal lives. The aim of having diversity in the team is to ensure that staff have choice in the guardian they approach for any concerns they might have.

The ICB also has a Freedom to Speak Up/ Whistleblowing Policy to comply with national guidance and requirements.

The ICB has registered five Freedom to Speak Up concerns raised in the year, principally concerning either primary care issues or staff management.

6.1.3.7 Capacity to Handle Risk

Leadership of the risk management process is provided by the Board, its various committees and the directors managing teams and departments.

The Board is responsible for setting the strategic direction for risk management and overseeing the arrangements for identifying and managing risk across their organisation. It regularly reviews and challenges the contents of the Board Assurance Framework, and, recognising the benefits of using the subject matter expertise within its committees and sub-committees, obtains assurance from these fora on the operational risks associated to their areas through a regular committees' report.

Place risks registers are considered by the LCPs in their meetings held in public, to ensure partnership contributions to the recognition, prioritisation and mitigation of local risks is encouraged.

An annual audit of the ICBs' risk management processes is carried out with any management actions identified assigned to individuals within the organisation who are held to account for their completion.

The risk management framework document is available to all staff to explain the process and governance of our risk management approaches, and all staff are provided with training in risk management and incident reporting.

The ICB Chief of Staff chairs a monthly Risk Forum comprising senior governance staff and executives from across the organisation to provide a forum for cross-departmental and 'place' challenge, standardisation of risk assessment and scoring, sharing of information on potential risks and consideration of best practice.

6.1.3.8 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 Board is supported in maintaining oversight of the ICBs control environment through the implementation of a suite of policies, processes and reporting procedures, such as the Scheme of Reservation and Delegation and the ICBs Standing Financial Instructions, together with a robust set of governance principles to support the operation of various committees and sub-committees.

Data Quality

The data provided to the Board and its committees is generated from a variety of sources and is reported internally and externally through monthly reports and a summary of the year-end performance data is included in this report.

There are processes in place to ensure that all data provided to the Board has been sourced from credible sources, considered as fit for purpose, discussed, analysed and minuted at committee meetings prior to being submitted for discussion or noting or for a formal decision at the Board.

Board papers are made publicly available through the ICB website.

Information Governance

The NHS Information Governance (IG) 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 Data Security and Protection Toolkit (DSPT) and the annual submission process provides assurances to the ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

There is a complex legal framework governing the way in which the NHS handles information about patients and employees, including personal confidential data. This includes the NHS Act 2006, the Health and Social Care Act 2012, the Data Protection Act 2018, UK General Data Protection Regulation, and the Human Rights Act. The DSPT allows organisations to measure their performance against the National Data Guardian's ten data security standards. For the 2024-25 period the ICB is required to submit their DSPT by 30 June 2025. The IG team are continuing to work through the organisation's DSPT workplan that has been developed to gather the required evidence for submission.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have developed information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and continuously update staff information governance guidance on the staff intranet to ensure staff are aware of their information governance roles, responsibilities, and best practice.

We have assigned the roles of Senior Information Risk Owner, Caldicott Guardian, and Data Protection Officer to staff members who attend the Information Governance Sub Committee (IGSC) meetings to monitor IG compliance within the ICB.

There are processes and polices in place for incident reporting and investigation of serious incidents within the ICB. Information governance risks are recorded on the corporate risk register, which are reviewed and updated monthly at the IGSC meetings to ensure appropriate mitigation plans are in place for each risk. We have established a framework and policies for information governance, and for the security, management and quality of information. Information Governance and Cyber Security training is mandatory for all ICB staff, whether permanent or temporary.

Business Critical Models
NHS England recognises the importance of quality assurance across the full range of its analytical work. In partnership with analysts in the Department of Health we have developed an approach that is fully consistent with the recommendations in Sir Nicholas Macpherson's review of quality assurance of government models. The framework includes a programme of mandatory workshops for NHS England analysts, which highlights the importance of quality assurance across the full range of analytical work.

The Macpherson Report on the review of quality assurance (QA) of Government Analytical Models set out the components of best practice in QA making eight key recommendations.

Third party assurances
Where the ICB obtains services via a service organisation, assurance on the effectiveness and adequacy of the third party control environment is sought from Service Auditor Reports. The outcomes of these reports are considered by the ICB Audit & Risk Committee as part of its year end audit assurance process.

6.1.3.9 Control Issues

The main risks currently facing the ICB are captured in the Board Assurance Framework (BAF) which is updated every month. Following an extensive review of the ICBs Risk Management Framework in the year, the BAF reflects any risks held either at SEL-wide or borough level where the risk score is in excess of the agreed risk threshold for that type of risk.

Principal risks arise in the areas of financial sustainability for the SEL System as a whole, and operational capacity and demand challenges. This in turn impacts the risk in achieving performance and access targets and delivery of recovery plans. From an operational perspective, the benefits of working collectively as a system to address and mitigate the risk is well recognised with a number of system wide forums in place to agree actions and

monitor activity. The ICB has created a system sustainability team with a focus on financial recovery to support provider Trusts with system-wide projects.

Delivery against targets and improvement plans is regularly reported to the Integrated Performance Committee within the ICB, which feeds updates to each Board meeting.

6.1.3.10 Review of economy, efficiency & effectiveness of the use of resources

The ICB ensures that resources are used economically, efficiently and effectively, through:

- a clear governance framework which is set out in the Scheme of Delegation,
- a strong focus on effective use of resources from ICB committees,
- a clearly defined strategic planning process where jointly agreed commissioning intentions underpin strategic programmes which determine investment and implementation plan,
- a system approach through the Integrated Care Partnership Board, to adopt collective responsibility for achieving financial targets and ensuring the delivery of plans at scale and at borough level, transforming services and achieving the benefits of collaborative projects,
- an annual mandated external auditors assessment of achievement of value for money.

6.1.3.11 Head of Internal Audit Opinion

1. FINAL HEAD OF INTERNAL AUDIT OPINION

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

This document provides our final annual internal audit opinion for 2024/25.

1.1 The final head of internal audit opinion

For the year ended 31 March 2025, our final head of internal audit opinion for South East London Integrated Care Board, is as follows:

Final Head of Internal Audit Annual opinion	Factors influencing our opinion
	The factors which are considered when influencing our opinion are: • inherent risk in the area being audited; • limitations in the individual audit assignments; • the adequacy and effectiveness of the risk management and / or governance control framework; • the impact of weaknesses identified; • the level of risk exposure; and • the response to management actions and timeliness of actions taken.

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

1.2 Scope and limitations of our work

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

- the final opinion does not imply that internal audit has reviewed all risks and assurances relating to the organisation;
- the final opinion is substantially derived from the conduct of risk-based plans generated from the ICB assurance framework. As such, the assurance framework is one component that the board takes into account in making its annual governance statement (AGS);
- the final opinion is based on the findings and conclusions from the work undertaken, the scope of which has been agreed with the lead individual;
- the final opinion is based on the testing we have undertaken, which was limited to the area being audited, as detailed in the agreed audit scope;
- where strong levels of control have been identified, there are still instances where these may not always be effective. This may be due to human error, incorrect management judgement, management override, controls being by-passed or a reduction in compliance;
- due to the limited scope of our audits, there may be weaknesses in the control system which we are not aware of, or which were not brought to our attention; and
- it remains management's responsibility to develop and maintain a sound system of risk management, internal control and governance, and for the prevention and detection of material errors, loss or fraud. The work of internal audit should not be seen as a substitute for management's responsibilities around the design and effective operation of these systems.

1.3 Factors and findings which have informed our final opinion

Substantial Assurance and Reasonable Assurance

We issued the following Substantial Assurance and Reasonable Assurance opinions in 2024/25:

- Data Security and Protection Toolkit – 2023.24 Submission (Substantial Assurance)
- Freedom to Speak Up - Whistleblowing (Reasonable Assurance)
- Prescribing - Medicines Optimisation (Reasonable Assurance)
- Local Authority Engagement – Better Care Fund (BCF) (Reasonable Assurance)
- Data Quality (Reasonable Assurance)
- Cost Improvement Programme (CIPs) (Reasonable Assurance)
- Board Assurance Framework and Risk Management (Reasonable Assurance)

In the audits shown as providing Substantial Assurance and Reasonable Assurance, we have identified some areas where enhancements are required and in each of these cases management actions have been agreed, the implementation of which will improve the control environment.

Partial Assurance / Little Progress

We also issued the following Partial Assurance / Little Progress opinions in 2024/25:

- Continuing Healthcare – Follow Up (Little Progress)
- Procurement – Single Tender Waivers and Grants (Partial Assurance)

The control issues from these opinions were as follows:

Continuing Healthcare – Follow Up

We undertook a follow up exercise on progress made by SEL ICB to implement previously agreed management actions from the Continuing Healthcare (CHC) audit from 2022/23. Since the 2022/23 review, seven medium actions had been presented as implemented to Audit Committee, and progress had been made towards implementing the two remaining actions. In our opinion the ICB had continued to demonstrate little progress in implementing the agreed management actions, attributable largely to the delays in clearing the CHC reviews backlog as the high action remained open. The action for the drafting of policies had been superseded, as a subsequent action to approve the policies in the governance structure was raised. Revised dates were agreed and we continued to follow up on implementation for the Audit Committee.

At the time of this opinion, the high action remains in progress. We will continue to follow this up and report on progress to the Audit Committee.

Procurement – Single Tender Waivers and Grants

We completed a review of Procurement, focussing on single tender waivers, grants awarding, and supplier contract management at the ICB. We agreed on six medium and three low priority actions with management. Key areas identified for improvement included having a robust and effective process of flagging contracts that are nearing expiry so that preparations for formal procurement and tendering process can begin on time to avoid continuous use of STWs; reporting on grants awarded; exercising greater control of grant allocations across the ICB; ensuring that grants are approved by the CFO, following approval by place leads, in line with the ICB Schedule of Delegated Matters; and ensuring the organisation has a clear roadmap for rolling out the Atamis Contract management system.

At the time of this opinion, one medium management action was implemented and the remaining five medium and three low management actions were not yet due.

Advisory

We undertook three advisory reviews / exercises to support management with areas under development or those that required a deep dive.

Primary Care Services - Delegated Duties

We undertook an advisory review of the Dentistry, Optometry and Pharmacy Services (DOPs) at SEL ICB following the delegation of commissioning from NHSE to ICBs from 1 April 2023. Through discussion with management and review of supporting evidence, we were able to consider the roles and responsibilities of SEL, the assurances that SEL receive from the Commissioning Team hosted by NEL ICB on behalf of all London ICBs, the opportunities that delegation affords the ICB, and the governance and reporting structure that supports delivery of DOPs services.

We confirmed that at the time of this review, SEL ICB were satisfied with the assurances provided and there were suitable arrangements in place for SEL to perform their responsibilities. Five advisory considerations were agreed to enhance the control framework regarding oversight over investment opportunities with the ringfence around dental and how the Hub can provide SEL with more targeted information based on local needs.

Cyber Assurance Framework Data Security and Protection Toolkit (DSPT) Pre-Implementation

The ICB had implemented some well-designed controls to ensure alignment with Objective E of the CAF-aligned DSPT framework, including reference to relevant legislations such as GDPR within privacy policies, the presence of an Information Governance Incident Management Policy, the existence of a subject access request register and procedure, and a comprehensive data sharing agreement. However, there were areas where further enhancement were required. These issues primarily relate to inconsistencies between privacy notices, a lack of a well-structured data processing document, absence of policy approvals, and insufficient notification of policies to users. These issues increase the risk of non-compliance with data protection regulations and data governance inefficiencies. As a result, we agreed ten medium and one low-priority actions with management.

Assurance Map

The assurance map provides the ICB with a visual representation of the assurances over key areas of the organisation, enabling an improved ability to understand and confirm that they have suitable and sufficient assurance over key controls or where control gaps exist, whether actions are in place to address those risks.

The exercise identified areas where management assurances (i.e. opinions) changed since the January 2024 iteration developed by RSM, with all areas rated by management as either reasonable or substantial assurance. Management highlighted changes to the first line assurances, notably around Emergency Planning, suggesting that assurances across all types were now being received. Similarly, Medicines Management and Prescribing were combined and saw additional assurances being added across first and second lines. The assurance map should be updated on an ongoing basis by management as assurances change at the organisation.

Follow Up

During the year, we have followed up on 111 actions in 2024/25. Of these, 78 (four high, 30 medium, 36 low and eight advisory) have been confirmed as implemented or superseded, and 21 actions (16 medium, three low and two advisory) are not yet due. There are 12 actions (one high, three medium, one low and seven advisory) confirmed as in progress with revised due dates.

Service Auditor Reports

NHS Shared Business Services – ISAE 3402

We reviewed the service auditors report ISAE 3402 for NHS Shared Business Services for its provision of Finance and Accounting Services. The opinion was qualified on the basis of three

controls where exceptions were identified in testing. However, these are not considered sufficiently significant to impact on the ICB's Head of IA Opinion.

NHS Business Services Authority: Electronic Staff Record (ESR) –Type II ISAE 3000

We reviewed the service auditors report ISAE 3000 for NHS Business Services Authority for its provision and maintenance of the Electronic Staff Record system. No exceptions were noted.

NHS Business Service Authority: Dental Payments Process – Type II ISAE 3402

We reviewed the service auditors report ISAE 3402 for NHS Business Services Authority for its Dental Payments Process system. No exceptions were noted.

NHS Business Service Authority: Prescription Payments Process – Type II ISAE 3402

We reviewed the service auditors report ISAE 3402 for NHS Business Services Authority for its Prescription Payments Process system. No exceptions were noted.

Capita: Primary Care Support England - Type II ISAE 3402

We reviewed the service auditors report ISAE 3402 for Capita for the Primary Care Support England (PCSE) services for processing GP, Ophthalmic and Pharmacy payments and pensions administration, operated on behalf of NHS England. The opinion was qualified based on one control objective where exceptions were identified in testing however, this is not considered sufficiently significant to impact on the ICB's Head of IA Opinion.

NHS CSU Service Auditor Report (Type II) for Finance, Payroll and Non-Clinical Procurement

We reviewed the Type II Service Auditor Report, covering Finance, Payroll and Non-Clinical Procurement services provided by the four NHS CSUs for the period 1 April 2024 to 31 March 2025. For the ICB the Report covers the Payroll service NECSU provided to the ICB during the period.

One opinion was given for this report covering all four CSUs. The opinion was qualified based on two control objectives where exceptions were identified in testing, relating to the Accounts Receivable areas of sales order requests and credit notes. These are not services provided to the ICB and therefore do not impact on the ICB's Head of IA Opinion.

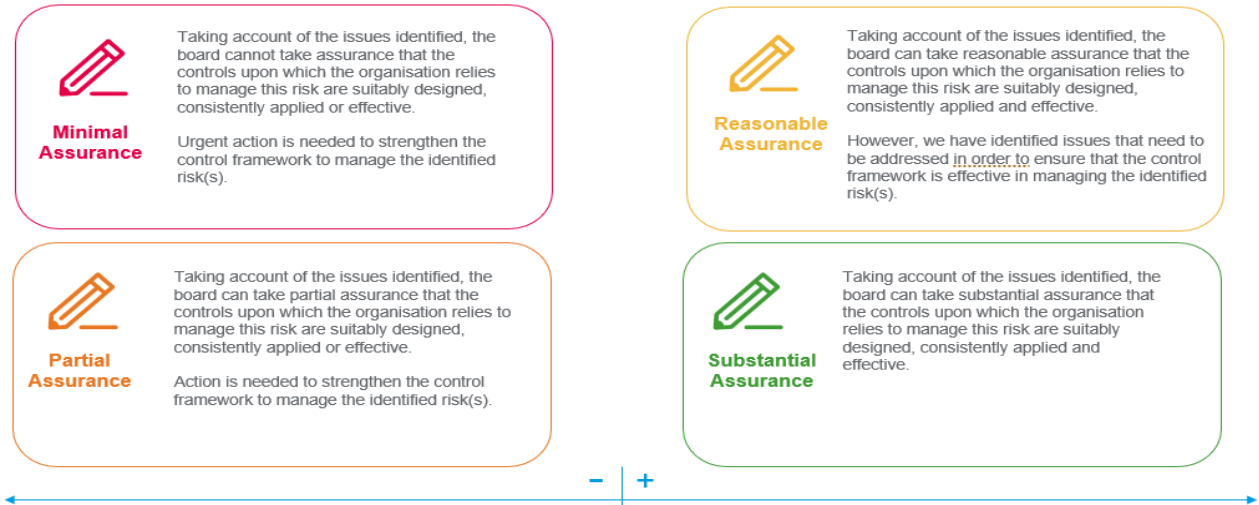
1.4 Topics judged relevant for consideration as part of the annual governance statement

Based on the work we have undertaken on the ICB's system on internal control, Management should consider whether there are any issues that need to be flagged as significant control issues within the Annual Governance Statement (AGS). Specifically, consideration may be given to some of the issues identified within the reviews on Continuing Healthcare (Follow Up) and Procurement – Single Tender Waivers and Grants.

The ICB may also wish to consider whether any other issues have arisen, including the results of any external reviews for potential inclusion in the Annual Governance Statement.

APPENDIX A: ANNUAL OPINIONS

The following shows the full range of opinions available to us within our internal audit methodology to provide you with context regarding your annual internal audit opinion.



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

“My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the ICB who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the ICB achieving its principal objectives have been reviewed.

I have been advised on the implications of the result of this review by the Board, the audit committee, Board committees, and internal audit outcomes, and a plan to address weaknesses and ensure continuous improvement of the system is in place.”

6.1.3.13 Conclusion

There were no significant internal control issues identified.

Andrew Bland
Chief Executive & ICB Accountable Officer
19 June 2025

6.2 Remuneration and Staff Report

6.2.1 Remuneration Report

6.2.1.1 Remuneration Committee

The Remuneration Committee is comprised of four members and has met twice during the past year, supplemented by four other instances where decisions were agreed electronically (via email approval) due to time constraints on the decisions being made.

Committee members are listed below, with further details of attendance included in section 6.1.3.2.

Name	Role
Anu Singh	Non-Executive Director and chair of committee
Sir Richard Douglas	ICB Chair
David Bradley	Partner Member, Mental Health Services
Dr George Verghese	Partner Member, Primary Care Services

6.2.1.2 Policy on the remuneration of senior managers

The Committee's deliberations are carried out within the context of national pay and remuneration guidelines, local comparability and taking account of independent advice regarding pay structures. There are no arrangements in place for additional payments or allowances to staff, at any level, outside of national regulations. The future remuneration policy is not expected to change.

6.2.1.3 Remuneration of Very Senior Managers

All ICB staff members of the Board, plus those "in attendance", are deemed to be individuals with significant financial responsibility during the financial year and are therefore regarded as 'senior managers'.

Senior Manager Remuneration, including salary and pension entitlements (audited)

Name	Title	Salary	Expense Payments (taxable)	Performance pay and Bonuses	Long term Performance pay and bonuses	All Pension-Related Benefits	Total
		(bands of £5000)	Disclosed in £ to the nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2,500)	(bands of £5000)
		£000	£	£000	£000	£000	£000
Andrew Bland	Chief Executive Officer	245 - 250	1300	0	0	0	250 - 255
Richard Douglas	Chair	60 - 65	0	0	0	0	60 - 65
Mike Fox	Chief Finance Officer	170 - 175	300	0	0	25 - 27.5	195 - 200
Dr Toby Garrood (5)	Medical Director	200-205	0	0	0	0	200 - 205
Paul Larrisey	Acting Chief Nurse	155 - 160	0	0	0	0	155 - 160
Diana Braithwaite	Bexley Place Executive Director	160 - 165	0	0	0	127.5-130	290 - 295
Angela Bhan	Bromley Place Executive Director	120 - 125	0	0	0	17.5 - 20	140 - 145
Sarah McClinton (3)(5)	Greenwich Place Executive Director	55 - 60	0	0	0	0	55 - 60
Andrew Eyres (3)	Lambeth Place Executive Director	80 - 85	0	0	0	7.5 - 10	90 - 95
Ceri Jacob (3)	Lewisham Place Executive Director	80 - 85	0	0	0	0	80 - 85
Martin Wilkinson	Southwark Acting Place Executive (4)	20 - 25	0	0	0	2.5 - 5	25 - 30
Darren Summers	Southwark Place Executive Director (4)	70 - 75	0	0	0	10 - 12.5	80 - 85
Sarah Cottingham	Executive Director of Planning	175 - 180	0	0	0	22.5-25	200 - 205
Ranjeet Kaile (5)	Director of Communications and Engagement	100-105	0	0	0	0	100-105
Tosca Fairchild	Chief of Staff	155 - 160	0	0	0	25 - 27.5	180 - 185
Philippa Kirkpatrick	Chief Digital Information Officer	120 - 125	3600	0	0	32.5-35	160 - 165
Anu Singh	Non Executive Director	15 - 20	0	0	0	0	15 - 20
Paul Najsarek	Non Executive Director	20 - 25	0	0	0	0	20 - 25
Peter Matthew	Non Executive Director	10 - 15	0	0	0	0	10 - 15
Georgina Fekete	Non Executive Director	0 - 5	0	0	0	0	0 - 5
Dr. George Verghese	Partner Member (Primary Care)	45 - 50	0	0	0	0	45 - 50

Notes

1. The following members of the Board are employees of other NHS organisations and therefore did not receive any salary payments from the ICB:
   Meera Nair – Chief People Officer
   Professor Clive Kay – partner member (acute services)
   David Bradley – partner member (mental health services)
   Dr Ify Okocha – partner member (community services)

Debbie Warren – partner member (local authority)

2. Where the ICB shares the cost of the senior managers salary with another organisation, it is only the element of the cost incurred by the ICB that is recognised within the ICB's remuneration report.
3. The total salary for Andrew Eyres was £165k to £170k, and for Ceri Jacobs £160k to £165k. For the remaining Place Executive Leads where there are joint costs, the total salaries are disclosed in the annual reports of their employing organisations. This is the Royal Borough of Greenwich for Sarah McClinton.
4. Martin Wilkinson held the role of acting Southwark Place Executive Lead until the end of May 2024 when Darren Summers became the substantive Southwark Place Executive Lead from June 2024.
5. For these pay costs, the ICB receive a recharge from the employing organisation and so these costs include on-costs as the costs are not broken down into the constituent elements to enable us to report net costs.
6. All Pension Related Benefits are the cash value of payments (whether in cash or otherwise) in lieu of retirement benefits, and all benefits in year from participating in pension schemes.

Financial Year 2023-24 (audited)

Name	Title	Salary	Expense Payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	Total
		bands of £5,000	Disclosed in £ to the nearest £100	bands of £5,000	bands of £5,000	bands of £2,500	bands of £5,000
Andrew Bland	Chief Executive	235-240	400	0	0	0	235-240
Richard Douglas	Chair	60-65	0	0	0	0	60-65
Mike Fox	Chief Finance Officer	165-170	0	0	0	2.5-5	170-175
Dr Jonty Heaversedge (5)	Joint Medical Director	70-75	0	0	0	0	70-75
Angela Helleur (4)	Chief Nursing Officer	140-145	0	0	0	0	140-145
Paul Larrisey (4)	Acting Chief Nursing Officer	60-65	0	0	0	0	60-65
Stuart Rowbotham (2)(3)	Bexley Place Executive Lead	70-75	0	0	0	0	70-75
Angela Bhan	Bromley Place Executive Lead	115-120	0	0	0	30-32.5	145-150
Sarah McClinton (2) (3)	Greenwich Place Executive Lead	60-65	0	0	0	0	60-65
Andrew Eyres (2)(3)	Lambeth Place Executive Lead	75-80	0	0	0	0	75-80
Ceri Jacob (2)(3)	Lewisham Place Executive Lead	75-80	0	0	0	0	75-80
James Lowell (2)(3) (6)	Southwark Place Executive Lead	30-35	0	0	0	0	30-35

Martin Wilkinson (6)	Acting Southwark Place Executive Lead	135-140	1,100	0	0	0	135-140
Sarah Cottingham	Executive Director of Planning	165-170	0	0	0	0	165-170
Tosca Fairchild	Chief of Staff	150-155	0	0	0	40-42.5	190-195
Anu Singh	Non-executive director	15-20	0	0	0	0	15-20
Paul Najsarek	Non-executive director	15-20	0	0	0	0	15-20
Peter Matthew	Non-executive director	10-15	0	0	0	0	10-15
Dr George Verghese	Partner member (primary care)	35-40	0	0	0	0	35-40

Notes

1. The following members of the Board are employees of other NHS organisations and therefore did not receive any salary payments from the ICB:
   Dr Toby Garrood – joint medical director
   Ranjeet Kaile – director of communications and engagement
   Julie Screaton – Chief People Officer (to 31 December 2023)
   Meera Nair – Chief People Officer (from 1 January 2024)
   Beverley Bryant – Chief Digital Officer
   Professor Clive Kay – partner member (acute services)
   David Bradley – partner member (mental health services)
   Dr Ify Okocha – partner member (community services)
   Debbie Warren – partner member (local authority)
2. Where the ICB shares the cost of the senior managers salary with another organisation, it is only the element of the cost incurred by the ICB that is recognised within the ICB's remuneration report.
3. The total salary for Andrew Eyres was £160k to £165k, and for Ceri Jacobs £150k to £155k. For the remaining Place Executive Leads, the total salaries are disclosed in the annual reports of their employing organisations. These are the Royal Borough of Greenwich for Sarah McClinton, the London Borough of Bexley for Stuart Rowbotham, and South London and Maudsley NHS Foundation Trust for James Lowell.
4. Angela Helleur was on secondment to Kings College Hospital NHS Foundation Trust from 18 September 2023 but left ICB service in January 2024. Her salary payments reflect the period to January 2024. Paul Larrisey is the Acting Chief Nurse following Angela's secondment.
5. Dr. Jonty Heaversedge left the ICB on 30 November 2023.
6. James Lowell left the ICB in September 2023, Martin Wilkinson became the acting Southwark Place Executive Lead from that point.
7. All Pension Related Benefits are the cash value of payments (whether in cash or otherwise) in lieu of retirement benefits, and all benefits in year from participating in pension schemes.

Pension Benefits 2024-25 (audited)

Name	Real Increase in pension at pension age (bands of £2,500)	Real Increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2025 (bands of £5,000)	Lump Sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000)	Cash equivalent Transfer Value at 1 April 2024 (to nearest £1,000)	Real increase in cash equivalent transfer value (to nearest £1,000)	Cash equivalent transfer value at 31 March 2025 (to nearest £1,000)	Employer contribution to stakeholder pension
	£'000s	**£'000s**	**£'000s**	**£'000s**	**£'000s**	**£'000s**	**£'000s**	**£'000s**
Sarah Cottingham – Executive Director of Planning	2.5 - 5	0	70 - 75	205 - 210	1,762	41	1,957	0
Andrew Eyres – Lambeth Place Executive Lead	0 - 2.5	0	80 - 85	220 - 225	101	35	164	0
Mike Fox - Chief Finance Officer	2.5 - 5	0	55 - 60	145 - 150	1,082	24	1,200	0
Diana Braithwaite – Bexley Place Executive Lead	5 - 7.5	10 - 12.5	45 - 50	115 - 120	865	135	1,078	0
Philippa Kirkpatrick - Chief Digital Information Officer	2.5 - 5	0	0 - 5	0	26	19	64	0
Darren Summers – Southwark Place Executive Lead	0 - 2.5	0	40 - 45	95 - 100	885	23	985	0
Tosca Fairchild - Chief of Staff	0 - 2.5	0	15 - 20	30 - 35	275	17	331	0
Dr Angela Bhan - Bromley Place Executive Lead	0 - 2.5	0	0 - 5	0	40	18	76	0
Martin Wilkinson - Acting Southwark Place Executive Lead (April-May 24)	0 - 2.5	0	55 - 60	150 - 155	1,221	22	1,343	0

Notes:

Andrew Bland chose not to be covered by the pension arrangements during the 2024/25 financial reporting year.

Pension Benefits 2023-24 (audited)

Name	Real Increase in pension at pension age (bands of £2,500)	Real Increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2024 (bands of £5,000)	Lump Sum at pension age related to accrued pension at 31 March 2024 (bands of £5,000)	Cash equivalent Transfer Value at 1 April 2023 (to nearest £1,000)	Real increase in cash equivalent transfer value (to nearest £1,000)	Cash equivalent transfer value at 31 March 2024 (to nearest £1,000)	Employer contribution to stakeholder pension
	£'000s	**£'000s**	**£'000s**	**£'000s**	**£'000s**	**£'000s**	**£'000s**	**£'000s**
Mike Fox – Chief Finance Officer	0 - 2.5	42.5 - 45	50 – 55	140 - 145	745	239	1,082	-
Dr Jonty Heaversedge – Joint Medical Director	0 - 2.5	0 - 2.5	15 – 20	35 - 40	298	-	339	-

Andrew Eyres – Lambeth Place Executive Lead	0 - 2.5	10 - 12.5	75 – 80	205 - 210	1,666	-	101	-
Sarah Cottingham – Executive Director of Planning	0 - 2.5	42.5 - 45	70 – 75	190 - 195	1,356	232	1,762	-
Tosca Fairchild - Chief of Staff	2.5 - 5	-	10 – 15	30 - 35	209	29	275	-
Angela Bhan - Bromley Place Executive Lead	0 - 2.5	-	0 – 5	-	-	28	40	-
Martin Wilkinson - Southwark Place Executive Lead	0 - 2.5	27.5 - 30	50 – 55	140 - 145	996	105	1,221	-

Notes:

The real increase in cash equivalent transfer value zero return for Andrew Eyres is due to being over NRA (Normal Retirement Age) in the existing scheme – therefore a CETV calculation not being applicable for current year, resulting in negative figure. The zero return for Jonty Heaversedge represents a negative figure after inflation effects.

Andrew Bland chose not to be covered by the pension arrangements during either the 2023/24 or 2024/25 financial reporting years.

6.2.1.4 Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the members 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 the 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.

6.2.1.5 Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

6.2.1.6 Pay multiples (audited)

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. Total remuneration is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

The banded remuneration of the highest paid member of the Board in NHS South East London ICB in financial year 2024/25 was £245k-£250k, a 5% increase from 2023/24 (£235k-£240k).

Percentage change in remuneration of highest paid director

	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	5%	0
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	5%	0

The average pay of the organisation also increased by 5% reflecting the impact of an NHS Pay Award and of career progression pay increments.
The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Year	25th Percentile Total remuneration ratio	25th Percentile Salary	Median Total remuneration ratio	Median salary	75th Percentile Total Remuneration ratio	75th Percentile Salary
2024-25	4.56	54,261	3.55	69,641	2.31	106,996
2023-24	4.94	48,054	4.05	58,698	3.04	78,163

During the reporting period 2024/25, no employees received remuneration in excess of the highest-paid director/ member. Remuneration ranged from £24k to £249k.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments, employer pension contributions and the cash equivalent transfer value of pensions. In calculating the relationship between the highest paid person in the organisation and the median remuneration, the ICB has to remove VAT and an estimate

of agency premiums from the payments for all contractors and treat all appointments and employments as if they were full-time and for twelve months.

Additional guidance for this disclosure requirement is available at Section 2 of the ARM which cites the Hutton review of Fair Pay – Implementation Guidance. This guidance has been revised in 2023/24 to reflect updates to fair pay disclosures.

6.2.2 Staff Report

6.2.2.1 Number of senior managers

Taking this to be Very Senior Managers (VSM) this is a total of 20 individuals of which 12 are female and 8 are male. See tables at 6.2.2.2 and 6.2.2.3.

6.2.2.2 Staff numbers and costs (audited)

The table below shows the composition of the ICBs workforce together with their annualised pay costs.

Gender	Pay Band	Headcount	FTE	Basic Annual Pay
Female	Band 3	7	6.00	176,512
	Band 4	24	21.30	670,312
	Band 5	41	37.03	1,410,976
	Band 6	79	71.81	3,224,540
	Band 7	71	66.19	3,524,371
	Band 8A	85	81.50	4,876,909
	Band 8B	82	73.85	5,460,401
	Band 8C	38	35.75	3,060,543
	Band 8D	34	31.80	3,284,106
	Band 9	15	14.30	1,720,576
	VSM	12	11.75	1,770,990
Female Total		**488**	**451.28**	**29,180,236**
Male	Band 3	0	0	0
	Band 4	6	5.75	161,764
	Band 5	20	20.00	667,433
	Band 6	18	17.10	711,492
	Band 7	28	27.80	1,362,551
	Band 8A	22	21.80	1,246,047

	Band 8B	29	27.70	1,927,184
	Band 8C	19	18.30	1,515,568
	Band 8D	28	27.92	2,728,080
	Band 9	7	7.00	839,366
	VSM	8	8.00	1,359,737
Male Total		**185**	**181.37**	**12,519,222**
Grand Total		**673**	**632.65**	**41,699,458**

6.2.2.3 Staff composition

The ICB's workforce as of 31 March 2025 is set out below by overall employee group and then broken down by male and female, of which the split is 27.37%/72.63% respectively.

Headcount by role	Female	Male	Grand Total
Clinical Lead	102	35	137
Board	3	5	8
Board non-executives (inc Chair)	2	3	5
Borough Lay members	5	2	7
Very Senior Managers (VSM grade)	9	3	12
Employee	476	177	653
Grand Total	**597**	**225**	**822**

Approximately 17.2% of the ICB's workforce are on part-time contracts, broken down as below.

Employee Category	Headcount	FTE
Full Time	557	557.00
Part Time	116	75.65
Grand Total	**673**	**632.65**

All the above have either permanent or fixed term contracts of employment.

Staff numbers are analysed by category as follows:

Category	Headcount	FTE	Actual pay cost
A Ambulance Staff	0	0	0
G Administration and Estates staff	535	510.89	33,064,908
H Health care assistants and other support staff	0	0	0
M Medical and dental staff	0	0	0
N Nursing, midwifery and health visiting staff	78	67.04	4,638,791
P Nursing, midwifery and health visiting learners	0	0	0
S Scientific, therapeutic and technical staff	60	54.72	3,995,759
U Healthcare science	0	0	0
Z General payments	0	0	0
Grand Total	**673**	**632.65**	**41,699,458**

The tables below show the ICB's workforce broken down by other protected characteristics.

Disability

Disability	Headcount	%	FTE
No	584	86.78	550.65
Not Declared	10	1.49	9.10
Prefer Not To Answer	9	1.34	7.80
Unspecified	7	1.04	6.00
Yes	63	9.36	59.10
Grand Total	**673**	**100.00**	**632.65**

Gender

Gender	Headcount	%	FTE
Female	488	72.51	451.28
Male	185	27.49	181.37
Grand Total	**673**	**100.00**	**632.65**

Sexual Orientation

Sexual Orientation	Headcount	%	FTE
Bisexual	12	1.78	11.20
Gay or Lesbian	19	2.82	18.85
Heterosexual or Straight	585	86.92	550.53
Not Disclosed	54	8.02	49.07
Other sexual orientation not listed	3	0.45	3.00
Grand Total	**673**	**100.00**	**632.65**

Ethnicity

Ethnic Group	Headcount	%	FTE
A White - British	303	45.02	282.58
B White - Irish	14	2.08	13.40
C White - Any other White background	34	5.05	32.20
CA White English	2	0.30	2.00
CB White Scottish	1	0.15	1.00
CC White Welsh	2	0.30	1.30
CF White Greek	1	0.15	1.00
CJ White Turkish Cypriot	1	0.15	1.00
CK White Italian	1	0.15	1.00
CP White Polish	1	0.15	1.00
CX White mixed	3	0.45	2.85
CY White Other European	4	0.59	3.80
D Mixed – White & Black Caribbean	3	0.45	3.00
E Mixed - White & Black African	4	0.59	3.80
F Mixed - White & Asian	5	0.74	4.71
G Mixed - Any other mixed background	7	1.04	6.91
GD Mixed – Chinese & White	1	0.15	1.00
GE Mixed – Asian & Chinese	1	0.15	1.00

H Asian or Asian British - Indian	46	6.84	42.37
J Asian or Asian British - Pakistani	11	1.63	10.60
K Asian or Asian British - Bangladeshi	9	1.34	8.65
L Asian or Asian British - Any other Asian background	12	1.78	12.00
LE Asian Sri Lankan	1	0.15	1.00
M Black or Black British - Caribbean	45	6.69	42.19
N Black or Black British - African	111	16.49	106.51
P Black or Black British - Any other Black background	8	1.19	7.75
PB Black Mixed	1	0.15	1.00
PC Black Nigerian	5	0.74	5.00
PD Black British	5	0.74	4.50
R Chinese	11	1.63	9.40
S Any Other Ethnic Group	7	1.04	6.29
SA Vietnamese	2	0.30	1.82
SD Malaysian	1	0.15	1.00
SE Other Specified	2	0.30	2.00
Z Not Stated	8	1.19	7.01
Grand Total	**673**	**100.00**	**632.65**

Religion

Religious Belief	Headcount	%	FTE
Atheism	119	17.68	113.49
Buddhism	6	0.89	4.92
Christianity	300	44.58	281.03
Hinduism	29	4.31	26.07
Islam	36	5.35	34.95
Jainism	1	0.15	1.00
Judaism	3	0.45	3.00

Not Disclosed	122	18.13	113.61
Other	46	6.84	44.28
Sikhism	11	1.63	10.30
Grand Total	**673**	**100.00**	**632.65**

Age Band

Age Band	Headcount	%	FTE
<=20 Years	0	0	0
21-25	10	1.49	10.00
26-30	57	8.47	55.40
31-35	82	12.18	79.35
36-40	93	13.82	89.17
41-45	101	15.01	96.07
46-50	93	13.82	88.46
51-55	73	10.85	69.55
56-60	100	14.86	91.37
61-65	54	8.02	44.77
66-70	9	1.34	8.00
>=71 Years	1	0.15	0.50
Grand Total	**673**	**100.00**	**632.65**

Marital Status

Marital Status	Headcount	%	FTE
Civil Partnership	6	0.89	5.91
Divorced	30	4.46	28.40
Legally Separated	8	1.19	7.60
Married	299	44.43	274.19
Single	257	38.19	247.10
Unknown	69	10.25	65.46
Widowed	4	0.59	4.00
Grand Total	**673**	**100.00**	**632.65**

6.2.2.4 Sickness absence data

NHS sickness absence and the absence cost is always calculated on a rolling 12-month basis and is for substantive staff only. The table below shows the sickness absence rates and cost for the year to 31 March 2025.

Absence FTE %	Absence FTE	Available FTE
2.71%	**6,345.74**	**234,008**

6.2.2.5 Staff turnover percentages

Based on Permanent Employees in substantive posts

The monthly turnover for those in substantive posts is shown below.

	April 24	May 24	June 24	July 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	March 25
Headcount	665	661	670	736	744	776	790	811	777	776	778	780
FTE	605.77	601.57	610.45	628.40	634.30	654.71	666.12	683.67	654.44	655.37	659.13	660.13
Leavers Headcount	16	7	5	8	9	5	5	8	43	20	6	8
Leavers FTE	13.60	5.60	4.00	5.50	7.70	4.60	4.10	6.50	36.84	16.64	4.80	6.40
Starters Headcount	8	5	15	33	20	31	19	31	7	17	11	6
Starters FTE	6.39	3.20	12.91	11.85	16.10	22.68	15.00	26.96	6.20	14.30	9.50	5.30
Turnover Rate (Headcount)	2.14%	0.88%	0.63%	0.86%	1.21%	0.72%	0.64%	1.02%	5.79%	2.61%	0.75%	1.01%

6.2.2.6 Staff engagement percentages

The ICB participates in the annual national NHS staff survey. For this year's survey the ICB obtained an engagement rate of 62%.

6.2.2.7 Staff policies

Following the establishment of the ICB in July 2022, the full suite of HR policies was reviewed and refreshed to reflect ICB practices. A light touch review of policies has been completed to ensure all HR policies that are currently live have either been updated to ensure they reflect current requirements from either legislation or national guidance or remain in publication with no change.

The ICB has a robust set of recruitment practices to ensure interview panels are diverse in relation to gender and ethnicity as a minimum and has continued its work on reasonable adjustments to ensures staff with specific requirements are supported in the recruitment process and throughout their employment.

The ICB strives to support its workforce during the ongoing workforce reduction period with a focus on good communications and information sharing, appropriate investment in staff training and development, and good internal organisational development support to teams with interventions anchored in the pillars of the NHS People Plan. More information on the ICBs organisational development work is included in section at 5.5.

6.2.2.8 Trade Union Facility Time Reporting Requirements

The ICB has a Staff Partnership Forum in place which meets regularly and is attended by the Chief of Staff (or deputy). There are no full-time officers within the ICB. Our recognised trade unions are the Royal College of Nursing, the British Medical Association, UNITE, UNISON, GMB and MiP.

6.2.2.9 Other employee matters

The ICB has continued to provide regular health and wellbeing support and guidance to staff, which includes signposting to financial health and wellbeing advice and provision of an employee assistance programme. Regular written communications, updates and staff briefings also continue, with briefings and events taking place either virtually or in person.

The ICB continues to make progress against its equality delivery plan objectives. Details of this can be found in our public sector equality duty (PSED) report for this year.

The ICB's staff networks have built on the good progress from last year and are well received by attendees, covering a diverse range of subjects which matter to staff. Staff continue to access training and development opportunities and the demographic split of these is monitored and reported to the Equalities Sub-Committee.

6.2.2.10 Expenditure on consultancy

A total of £378k was spent on consultancy between 1 April 2024 and 31 March 2025. This mainly relates to work commissioned on behalf of the ICS in proactively participating in NHS England's Investigation and Improvement programme to ensure that our health system could benefit from the external support available and also some work on sustainability more generally. Some expenditure was also incurred relating to the successful challenge and recovery of overpayment of primary care rates.

6.2.2.11 Off-payroll engagements

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

	Number
Number of existing engagements as of 31 March 2024	5
Of which, the number that have existed:	
for less than one year at the time of reporting	5
for between one and two years at the time of reporting	0

for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

All existing off-payroll engagements, outlined above, have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

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

For all off-payroll engagements for the year to 31 March 2025, for

more than £245[1] per day:	**Number**
No. of temporary off-payroll workers engaged between 1 April 2023 and 31 March 2024	15
Of which:	
No. not subject to off-payroll legislation[2]	0
No. subject to off-payroll legislation and determined as in-scope of IR35[2]	15
No. subject to off-payroll legislation and determined as out of scope of IR35[2]	0
the number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: no. of engagements that saw a change to IR35 status following review	0

[1] The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

[2] A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, for the year to 31 March 2025:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during 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 should include both on payroll and off-payroll engagements. (1)	20

6.2.2.12 Exit packages, including special (non-contractual) payments (audited)

Table 1: Exit Packages

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	4	20,843	0	0	0	0	0	0
£10,000 - £25,000	5	77,158	0	0	0	0	0	0
£25,001 - £50,000	11	423,193	0	0	0	0	0	0
£50,001 - £100,000	15	1,214,039	0	0	0	0	0	0
£100,001 - £150,000	8	1,041,783	0	0	0	0	0	0
£150,001 – £200,000	3	480,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
TOTALS	**46**	**3,257,015**	**0**	**0**	**0**	**0**	**0**	**0**

Redundancy and other departure cost have been paid in accordance with the provisions of Agenda for Change Terms and Conditions. Exit costs in this note are accounted for in full in the year of departure. Where NHS SEL ICB has agreed early retirements, the additional costs are met by NHS SEL ICB and not by the NHS Pensions Scheme.

Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table. In the year, one ICB staff member left service under ill health retirement at a cost of £9,051.

Table 2: Analysis of Other Departures

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice*	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval**	0	0
TOTAL	0	0

No non-contractual payments were made to individuals where the payment value was more than 12 months of their annual salary.

The Remuneration Report includes disclosure of exit packages payable to individuals named in that Report.

No payments have been made to past directors or for loss of office in the reporting period.

I hereby sign off the Remuneration Report element of the NHS South East London ICB Annual Report 2024/25.

Andrew Bland

Chief Executive & ICB Accountable Officer

19 June 2025

7. Parliamentary Accountability and Audit Report

NHS South East London Integrated Care Board is not required to produce a Parliamentary Accountability and Audit Report. There are no contingent liabilities to report.

A summary of the Head of Internal Audit Opinion is included in this Annual Report on Page 78.

Andrew Bland

Chief Executive & ICB Accountable Officer

19 June 2025

8. Annual accounts

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Independent auditor's report to the members of the Board of NHS South East London Integrated Care Board

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS South East London Integrated Care Board (the 'ICB') for the year ended 31 March 2025, 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 international accounting standards in conformity with the requirements of Schedule 1B of the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2025 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25; 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.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2024) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the ICB's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the ICB to cease to continue as a going concern.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2024-25 that the ICB's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the ICB. In doing so we have 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) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the ICB and the ICB's disclosures over the going concern period.

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

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern 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.

Other information

The other information comprises the information included in the annual report and annual accounts, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report and annual accounts. 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 audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in November 2024 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the requirements of the Department of Health and Social Care Group Accounting Manual 2024-25 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2024-25; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the period for which the financial statements are prepared is consistent with the financial statements.

Opinion on regularity of income and expenditure required by the Code of Audit Practice

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.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; 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 make a written recommendation to the ICB under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

Statement of Accounting Officer's Responsibility

As explained more fully in the Statement of Accountable Officer's responsibilities, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, 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 they have been informed by the relevant national body of the intention to dissolve the ICB without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

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.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the ICB and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25).
- We enquired of management and the audit and risk committee, concerning the ICB's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the audit and risk committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the ICB's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and the risk of fraud and error in expenditure recognition. We determined that the principal risks were in relation to:
  - High risk unusual journal entries including consideration of closing entries, entries posted after year-end, and other unusual journal entries meeting other determined risk factors.
  - Consideration of potential management bias in accounting estimates and other significant transactions with related parties which could give rise to an indication of management override.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud.
  - journal entry testing, with a focus on unusual journal entries using criteria based on our knowledge of the entity and other risk factors identified.
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of the prescribing accrual and continuing healthcare accrual.
  - Completeness of expenditure and associated liabilities testing, with focus on post year end invoices and payments accounting.
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further

removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.

- We communicated relevant laws and regulations and potential fraud risks to all engagement team members, including the potential of fraud in expenditure recognition, and the significant accounting estimates related to prescribing and continuing healthcare accrual. We remained alert to any indications of non-compliance with laws and regulations, including fraud, throughout the audit.
- The engagement partner's assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the ICB operates
  - understanding of the legal and regulatory requirements specific to the ICB including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The ICB's operations, including the nature of its other operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The ICB's control environment, including the policies and procedures implemented by the ICB to ensure compliance with the requirements of the financial reporting framework.

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

Report on other legal and regulatory requirements – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able 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 2025.

We have nothing to report in respect of the above matter.

Responsibilities of the Accountable Officer

As explained in the Governance Statement, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the ICB's resources.

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

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. 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 review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in November 2024. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the ICB plans and manages its resources to ensure it can continue to deliver its services;

- Governance: how the ICB ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the ICB uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the ICB has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for NHS South East London Integrated Care Board for the year ended 31 March 2025 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed the work necessary in relation to the ICB's consolidation schedules, and we have received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete for the year ended 31 March 2025. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2025.

Use of our report

This report is made solely to the members of the Board of the ICB, as a body, 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 the Board of the ICB those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the ICB and the members of the Board of the ICB as a body, for our audit work, for this report, or for the opinions we have formed.

Matthew Dean

Matthew Dean, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

London
19 June 2025

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

	Note	2024-25 £'000	2023-24 £'000
Income from sale of goods and services	2	(61,609)	(64,547)
Other operating income	2	-	-
Total operating income		**(61,609)**	**(64,547)**
Staff costs	4	53,525	59,781
Purchase of goods and services	5	4,887,757	4,485,553
Depreciation and impairment charges	5	223	429
Provision expense	5	3,877	(2,415)
Other operating expenditure	5	1,650	1,396
Total operating expenditure		**4,947,032**	**4,544,743**
Net Operating Expenditure		**4,885,423**	**4,480,196**
Finance expense	7	21	29
Net expenditure for the Year		**4,885,444**	**4,480,225**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**4,885,444**	**4,480,225**
Comprehensive Expenditure for the year		**4,885,444**	**4,480,225**

The notes on pages 113 to 142 form part of this statement

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

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2024-25		
Balance at 01 April 2024	(248,571)	(248,571)
Adjusted NHS Integrated Care Board balance at 31 March 2024	**(248,571)**	**(248,571)**
Changes in NHS Integrated Care Board taxpayers' equity for 2024-25		
Net operating expenditure for the financial year	(4,885,444)	**(4,885,444)**
Net Recognised NHS Integrated Care Board Expenditure for the Financial year	**(4,885,444)**	**(4,885,444)**
Net funding	4,843,363	**4,843,363**
Balance at 31 March 2025	**(290,652)**	**(290,652)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2023-24		
Balance at 01 April 2023	(212,741)	**(212,741)**
Adjusted NHS Integrated Care Board balance at 31 March 2024	**(212,741)**	**(212,741)**
Changes in NHS Integrated Care Board taxpayers' equity for 2023-24		
Net operating costs for the financial year	(4,480,225)	(4,480,225)
Net Recognised NHS Integrated Care Board Expenditure for the Financial Year	**(4,480,225)**	**(4,480,225)**
Net funding	4,444,395	4,444,395
Balance at 31 March 2024	**(248,571)**	**(248,571)**

The notes on pages 113 to 142 form part of this statement

Statement of Financial Position as at 31 March 2025

	Note	2024-25 £'000	2023-24 £'000
Non-current assets:			
Right-of-use assets	8	838	508
Total non-current assets		**838**	508
Current assets:			
Trade and other receivables	9	5,898	7,606
Cash and cash equivalents	10	834	1,997
Total current assets		**6,732**	**9,603**
Total assets		**7,570**	10,111
Current liabilities			
Trade and other payables	11	(291,103)	(244,023)
Lease liabilities	8	(208)	(528)
Provisions	12	(5,109)	(14,131)
Total current liabilities		**(296,420)**	(258,682)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(288,850)**	(248,571)
Non-current liabilities			
Lease liabilities	8	(640)	-
Provisions	12	(1,162)	-
Total non-current liabilities		**(1,802)**	**-**
Assets less Liabilities		**(290,652)**	(248,571)
Financed by Taxpayers' Equity			
General fund		(290,652)	(248,571)
Total taxpayers' equity:		**(290,652)**	(248,571)

The notes on pages 113 to 142 form part of this statement

The financial statements on pages 109 to 112 were approved by the Audit Committee on 19 June and signed on its behalf by:

Andrew Bland
Chief Accountable Officer
19 June 2025

Statement of Cash Flows for the year ended 31 March 2025

	Note	**2024-25 £'000**	2023-24 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(4,885,444)	(4,480,225)
Depreciation and amortisation	5	223	429
Interest paid / received		22	29
(Increase)/decrease in trade & other receivables	9	1,708	2,852
Increase/(decrease) in trade & other payables	11	47,080	29,971
Provisions utilised	12	(9,182)	(175)
Increase/(decrease) in provisions	12	1,321	4,908
Net Cash Inflow (Outflow) from Operating Activities		**(4,844,272)**	(4,442,211)
Cash Flows from Investing Activities			
Net Cash Inflow (Outflow) from Investing Activities		**-**	0
Net Cash Inflow (Outflow) before Financing		**(4,844,272)**	(4,442,211)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		4,843,363	4,444,395
Repayment of lease liabilities	8	(255)	(456)
Net Cash Inflow (Outflow) from Financing Activities		**4,843,109**	4,443,939
Net Increase (Decrease) in Cash & Cash Equivalents	10	**(1,163)**	1,728
Cash & Cash Equivalents at the Beginning of the Financial Year		**1,997**	269
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		-	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**834**	1,997

The notes on pages 113 to 142 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. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2024-25 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the 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 a going concern basis.

On 13 March 2025 the government announced NHS England and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of ICBs is currently unchanged.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. If services will continue to be provided in the public sector the financial statements should be prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2025, on a going concern basis.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 Movement of Assets within the Department of Health and Social Care Group

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Pooled Budgets

Arrangements over which the ICB has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture. A joint venture is a joint operation whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method. A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the ICB is a joint operator, it recognises its share of the assets, liabilities, income and expenses in its own accounts.

The ICB has entered into a pooled budget arrangement with each of the 6 local boroughs, namely Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark in accordance with section 75 of the NHS Act 2006. Under the arrangements, funds are pooled for Better Care Funds for each borough plus additional non material items and Note 17 provides details of the income and expenditure. The arrangements for each scheme within the respective Better Care Fund have been reviewed to determine the appropriate accounting treatment by the ICB and the respective council. Control of the commissioning arrangements has been kept to determining the nature of each scheme within the fund.

Some of the pools are hosted by NHS SEL ICB and some by the individual Local Authorities, the details are provided in Note 17. The substance of the arrangement, however, is that individual members continue to contract with individual providers without reference to other members and continue to use their own resources of funding. In substance, these are neither joint operations nor lead commissioner transactions and not a vehicle for joint commissioning. This conclusion has been reached as both parties have retained the financial risks associated with each of the schemes which existed before the fund was set up and in accordance with the pooled budget agreements.

1.5 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the ICB. NHS SEL ICB only has one reporting segment, namely, Commissioning of Healthcare Services.

Notes to the financial statements

1.6 Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:
• As per paragraph 121 of the Standard, the ICB will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
• The ICB is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the ICB to reflect the aggregate effect of all contracts modified before the date of initial application.
The main source of funding for the ICBs is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.
Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.
Payment terms are standard reflecting cross government principles.
The value of the benefit received when the ICB accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.7 Employee Benefits

1.7.1 Short-term Employee Benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.7.2 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.

Local Government Pensions

Some employees within the ICB's Borough Integrated Commissioning teams work across NHS SEL ICB and the relevant London Borough. Some of these employees are also members of the Local Government Pension Scheme which is a defined benefit pension scheme and have a contract of employment with relevant London Borough. The scheme assets and liabilities attributable to those employees cannot be identified and are not recognised in the ICB accounts, however they form part of the disclosure within the accounts of the relevant London Boroughs.

1.8 Other Expenses

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.9 Grants Payable

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the ICB recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

Notes to the financial statements

1.10 Leases

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration.
The ICB assesses whether a contract is or contains a lease, at inception of the contract.

1.10.1 The ICB as Lessee

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.
The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.
The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.
The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.
Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.
For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

Notes to the financial statements

1.11 Cash & Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

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

1.12 Provisions

Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

• A nominal short-term rate of 4.03% (2023-24: 4.26%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

• A nominal medium-term rate of 4.07% (2023-24: 4.03%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

• A nominal long-term rate of 4.81% (2023-24: 4.72%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

• A nominal very long-term rate of 4.55% (2023-24: 4.40%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the ICB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.13 Clinical Negligence Costs

NHS Resolution operates a risk pooling scheme under which the ICB pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with ICB.

1.14 Non-clinical Risk Pooling

The ICB participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the ICB pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.15 Contingent liabilities and contingent assets

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence of non-occurrence of one or more uncertain future events not wholly within the control of the ICB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

Notes to the financial statements

1.16 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.

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.16.1 Financial Assets at Amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial

1.16.2 Financial assets at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the ICB elected to measure an equity instrument in this category on initial recognition.

1.16.3 Financial assets at fair value through profit and loss

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

1.16.4 Impairment of financial assets

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets or assets measured at fair value through other comprehensive income, the ICB recognises a loss allowance representing the expected credit losses on the financial asset.

The ICB adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The ICB therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the ICB does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

Notes to the financial statements

1.17 Financial Liabilities

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

1.17.1 Other Financial Liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.18 Value Added Tax

Most of the activities of the ICB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 Losses & Special Payments

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

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).

Notes to the financial statements

1.20 Critical accounting judgements and key sources of estimation uncertainty

In the application of the ICB's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.20.1 Critical accounting judgements in applying accounting policies

The following are the judgements, apart from those involving estimations, that management has made in the process of applying the ICB's accounting policies and that have the most significant effect on the amounts recognised in the financial statements. The ICB has none to declare.

1.20.2 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year. The ICB has no material items to declare.

1.21 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.22 New and revised IFRS Standards in issue but not yet effective

IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2025: early adoption is not therefore permitted. No material impact is expected on the ICB's accounts by the adoption of this standard.

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 implications of this new standard is currently unknown.

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. The implications of this new standard is currently unknown.

2 Other Operating Revenue

	2024-25 Total £'000	2023-24 Total £'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	**17,103**	23,296
Prescription fees and charges	**16,429**	15,601
Dental fees and charges	**22,471**	21,856
Other Contract income	**5,606**	3,795
Total Income from sale of goods and services	**61,609**	**64,547**
Total Operating Income	**61,609**	**64,547**

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

	2024-25				
	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income	Total income
	£'000	£'000	£'000	£'000	£'000
Source of Revenue					
NHS	-	-	-	1,139	1,139
Non NHS	17,103	16,429	22,471	4,467	60,470
Total	**17,103**	**16,429**	**22,471**	**5,606**	**61,609**

	2024-25				
	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income	Total income
	£'000	£'000	£'000	£'000	£'000
Timing of Revenue					
Point in time	3,471	16,429	22,471	4,795	47,166
Over time	13,632	-	-	811	14,443
Total	**17,103**	**16,429**	**22,471**	**5,606**	**61,609**

	2023-24				
	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income	Total income
	£'000	£'000	£'000	£'000	£'000
Source of Revenue					
NHS	25	-	-	2,020	2,045
Non NHS	23,271	15,601	21,856	1,775	62,503
Total	**23,296**	**15,601**	**21,856**	**3,795**	**64,548**

	2023-24				
	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income	Total income
	£'000	£'000	£'000	£'000	£'000
Timing of Revenue					
Point in time	4,015	15,601	21,856	3,770	45,242
Over time	19,281	-	-	25	19,306
Total	**23,296**	**15,601**	**21,856**	**3,795**	**64,548**

4. Employee benefits and staff numbers

4.1.1 Employee benefits	Total		2024-25
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	37,133	957	**38,090**
Social security costs	5,209	-	**5,209**
Employer Contributions to NHS Pension scheme	9,306	-	**9,306**
Apprenticeship Levy	218	-	**218**
Termination benefits	701	-	**701**
Gross employee benefits expenditure	**52,568**	**957**	**53,525**
Less recoveries in respect of employee benefits (note 4.1.2)	-	-	**-**
Total - Net admin employee benefits including capitalised costs	**52,568**	**957**	**53,525**
Less: Employee costs capitalised	-	-	**-**
Net employee benefits excluding capitalised costs	**52,568**	**957**	**53,525**

4.1.1 Employee benefits	Total		2023-24
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	38,896	1,063	**39,959**
Social security costs	4,816	-	**4,816**
Employer Contributions to NHS Pension scheme	7,467	-	**7,467**
Apprenticeship Levy	215	-	**215**
Termination benefits	7,323	-	**7,323**
Gross employee benefits expenditure	58,718	1,063	**59,781**
Less recoveries in respect of employee benefits (note 4.1.2)	-	-	**-**
Total - Net admin employee benefits including capitalised costs	58,718	1,063	**59,781**
Less: Employee costs capitalised	-	-	**-**
Net employee benefits excluding capitalised costs	**58,718**	**1,063**	**59,781**

4.2 Average number of people employed

	2024-25			2023-24		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**610.51**	**13.41**	**623.92**	**612.00**	**14.13**	**626.13**
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4.3 Exit packages agreed in the financial year

	2024-25 Compulsory redundancies		2024-25 Other agreed departures		2024-25 Total	
	Number	£	Number	£	Number	£
Less than £10,000	4	20,843	-	-	4	20,843
£10,001 to £25,000	5	77,158	-	-	5	77,158
£25,001 to £50,000	11	423,193	-	-	11	423,193
£50,001 to £100,000	15	1,214,038	-	-	15	1,214,038
£100,001 to £150,000	8	1,041,783	-	-	8	1,041,783
£150,001 to £200,000	3	480,000	-	-	3	480,000
Over £200,001	-	-	-	-	-	-
Total	**46**	**3,257,015**	**-**	**-**	**46**	**3,257,015**

	2023-24 Compulsory redundancies		2023-24 Other agreed departures		2023-24 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	1	11,857	-	-	1	11,857
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	1	146,767	-	-	1	146,767
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**2**	**158,624**	**-**	**-**	**2**	**158,624**

	2024-25 Departures where special payments have been made		2023-24 Departures where special payments have been made	
	Number	£	Number	£
Less than £10,000	-	-	-	-
£10,001 to £25,000	-	-	-	-
£25,001 to £50,000	-	-	-	-
£50,001 to £100,000	-	-	-	-
£100,001 to £150,000	-	-	-	-
£150,001 to £200,000	-	-	-	-
Over £200,001	-	-	-	-
Total	**-**	**-**	**-**	**-**

Analysis of Other Agreed Departures

	2024-25 Other agreed departures		2023-24 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval*	-	-	-	-
Total	**-**	**-**	**-**	**-**

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of Agenda for Change.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

Where **entities** has agreed early retirements, the additional costs are met by NHS **Entities** and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

4.4 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:

4.4.1 Accounting valuation

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

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

4.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (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.

5. Operating expenses

	2024-25 Total £'000	2023-24 Total £'000
Purchase of goods and services		
Services from other ICBs and NHS England	660	1,038
Services from foundation trusts	2,415,044	2,202,951
Services from other NHS trusts	988,201	908,951
Purchase of healthcare from non-NHS bodies	585,418	517,066
Purchase of social care	5,002	3,920
General Dental services and personal dental services	129,475	126,274
Prescribing costs	254,336	247,876
Pharmaceutical services	53,281	47,573
General Ophthalmic services	20,178	19,668
GPMS/APMS and PCTMS	403,084	378,816
Supplies and services – clinical	798	685
Supplies and services – general	10,763	5,543
Consultancy services	378	387
Establishment	5,064	6,264
Premises	7,992	8,317
Audit fees	271	271
Other non statutory audit expenditure		
· Internal audit services	212	191
· Other services	37	35
Other professional fees	6,331	8,546
Legal fees	472	596
Education, training and conferences	762	587
Total Purchase of goods and services	**4,887,757**	**4,485,553**
Depreciation and impairment charges		
Depreciation	223	429
Total Depreciation and impairment charges	**223**	**429**
Provision expense		
Provisions	3,877	(2,415)
Total Provision expense	**3,877**	**(2,415)**
Other Operating Expenditure		
Chair and Non Executive Members	270	223
Clinical negligence	17	21
Expected credit loss on receivables	20	(6)
Other expenditure	1,343	1,157
Total Other Operating Expenditure	**1,650**	**1,396**
Total operating expenditure	**4,893,507**	**4,484,962**

In accordance with S1 2008 NO.489, The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, the Integrated Commissioning Board is required to disclose the liability of Grant Thornton, its members, partners and staff (whether in contract, negligence, or otherwise) shall in no circumstances exceed £1m, aside from where the liability cannot be limited by law. This is in aggregate in respect of all services. The audit fees above excluding VAT is £270,800 and the fee for the Mental Health Investment Standard audit is £37,000 excluding VAT and is shown on the other services line.

6 Payment Compliance Reporting

6.1 Better Payment Practice Code

Measure of compliance	2024-25 Number	2024-25 £'000	2023-24 Number	2023-24 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	71,378	1,048,728	60,860	963,603
Total Non-NHS Trade Invoices paid within target	70,939	1,039,806	60,026	950,999
Percentage of Non-NHS Trade invoices paid within target	**99.38%**	**99.15%**	**98.63%**	**98.69%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	6,337	3,427,590	2,590	3,597,905
Total NHS Trade Invoices Paid within target	6,329	3,427,520	2,571	3,597,448
Percentage of NHS Trade Invoices paid within target	**99.87%**	**99.99%**	**99.27%**	**99.99%**

7 Finance costs

	2024-25 £'000	2023-24 £'000
Interest		
Interest on lease liabilities	21	29
Total interest	**21**	**29**
Other finance costs	-	-
Provisions: unwinding of discount	-	-
Total finance costs	**21**	**29**

8 Leases

8.1 Right-of-use assets

2024-25	Buildings excluding dwellings £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2024	1,409	64	1,473
Additions	554	-	554
Cost/Valuation at 31 March 2025	**1,962**	**64**	**2,026**
Depreciation 01 April 2024	923	42	965
Charged during the year	203	21	223
Depreciation at 31 March 2025	**1,126**	**62**	**1,188**
Net Book Value at 31 March 2025	**836**	**2**	**838**

8 Leases cont'd

8.2 Lease liabilities

2024-25	**2024-25 £'000**	2023-24 £'000
Lease liabilities at 01 April 2024	(528)	(955)
Additions purchased	(554)	-
Interest expense relating to lease liabilities	(21)	(29)
Repayment of lease liabilities (including interest)	255	456
Lease liabilities at 31 March 2025	**(848)**	**(528)**

8.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2024-25 £'000	**Of which: leased from DHSC group bodies £000**	2023-24 £'000	Of which: leased from DHSC group bodies £000
Within one year	(241)	-	(334)	-
Between one and five years	(606)	-	(434)	-
After five years	(102)	-	-	-
Balance at 31 March 2025	**(949)**	**-**	**(768)**	**-**
Effect of discounting	101	-	240	-
Included in:				
Current lease liabilities	(208)	-	(528)	-
Non-current lease liabilities	(640)	-	-	-
Total	**(848)**	**-**	**(528)**	**-**

8 Leases cont'd

8.4 Amounts recognised in Statement of Comprehensive Net Expenditure

2024-25	**2024-25 £'000**	2023-24 £'000
Depreciation expense on right-of-use assets	223	429
Interest expense on lease liabilities	21	29

8.5 Amounts recognised in Statement of Cash Flows

	2024-25 £'000	2023-24 £'000
Total cash outflow on leases under IFRS 16	255	456

9.1 Trade and other receivables

	Current 2024-25 £'000	**Non-current 2024-25 £'000**	Current 2023-24 £'000	Non-current 2023-24 £'000
NHS receivables: Revenue	553	-	1,421	-
NHS prepayments	-	-	400	-
Non-NHS and Other WGA receivables: Revenue	1,646	-	1,555	-
Non-NHS and Other WGA prepayments	2,383	-	2,831	-
Non-NHS and Other WGA accrued income	-	-	804	-
Expected credit loss allowance-receivables	(37)	-	(17)	-
VAT	1,351	-	609	-
Other receivables and accruals	2	-	4	-
Total Trade & other receivables	**5,898**	**-**	**7,606**	**-**
Total current and non current	**5,898**		**7,606**	
Included above:				
Prepaid pensions contributions	-		-	

9.2 Receivables past their due date but not impaired

	2024-25 DHSC Group Bodies £'000	**2024-25 Non DHSC Group Bodies £'000**	2023-24 DHSC Group Bodies £'000	2023-24 Non DHSC Group Bodies £'000
By up to three months	72	995	467	1,024
By three to six months	-	-	-	-
By more than six months	-	1	58	-
Total	**72**	**996**	**525**	**1,024**

9.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies	**Other financial assets**	**Total**
	£'000	**£'000**	**£'000**
Balance at 01 April 2024	**(17)**	**-**	**(17)**
Lifetime expected credit losses on trade and other receivables-Stage 2	(20)	-	**(20)**
Total	**(37)**	**-**	**(37)**

10 Cash and cash equivalents

	2024-25	2023-24
	£'000	£'000
Balance at 01 April 2024	1,997	269
Net change in year	(1,163)	1,728
Balance at 31 March 2025	**834**	**1,997**
Made up of:		
Cash with the Government Banking Service	834	1,997
Cash and cash equivalents as in statement of financial position	**834**	**1,997**
Balance at 31 March 2025	**834**	**1,997**
Patients' money held by the integrated care board, not included above	-	-

11 Trade and other payables	Current 2024-25 £'000	Non-current 2024-25 £'000	Current 2023-24 £'000	Non-current 2023-24 £'000
NHS payables: Revenue	2,725	-	2,952	-
NHS accruals	10,297	-	128	-
Non-NHS and Other WGA payables: Revenue	54,667	-	24,281	-
Non-NHS and Other WGA accruals	137,918	-	149,604	-
Social security costs	639	-	640	-
Tax	790	-	686	-
Other payables and accruals	84,067	-	65,732	-
Total Trade & Other Payables	**291,103**	**-**	**244,023**	**-**
Total current and non-current	**291,103**		**244,023**	

Other payables include £3,336k outstanding pension contributions at 31 March 2025

12 Provisions

	Current 2024-25 £'000	**Non-current 2024-25 £'000**	Current 2023-24 £'000	Non-current 2023-24 £'000
Redundancy	3,025	-	8,935	-
Continuing care	2,084	1,162	5,192	-
Other	-	-	5	-
Total	**5,109**	**1,162**	**14,131**	**-**
Total current and non-current	**6,270**		**14,131**	

	Redundancy £'000	**Continuing Care £'000**	**Other £'000**	**Total £'000**
Balance at 01 April 2024	**8,935**	**5,192**	**5**	**14,131**
Arising during the year	-	3,877	-	**3,877**
Utilised during the year	(3,354)	(5,823)	(5)	**(9,182)**
Reversed unused	(2,556)	-	-	**(2,556)**
Unwinding of discount	-	-	-	**-**
Change in discount rate	-	-	-	**-**
Transfer (to) from other public sector body	-	-	-	**-**
Transfer (to) from other public sector body under absorption	-	-	-	**-**
Balance at 31 March 2025	**3,025**	**3,246**	**-**	**6,270**
Expected timing of cash flows:				
Within one year	3,025	2,084	-	**5,109**
Between one and five years	-	1,162	-	**1,162**
After five years	-	-	-	**-**
Balance at 31 March 2025	**3,025**	**3,246**	**-**	**6,270**

The redundancy provision has arisen due to the implementation of the Management Cost Reduction programme which has not yet been completed for some staff.
Legal claims are calculated from the number of claims currently lodged with the NHS Resolution and the probabilities provided by them.
The CHC provision comprises of claims in respect of retrospective reviews and also PuPoC (Previously Unassessed Period of Care) claims which were transferred from NHS England.

13 Contingencies

NHS SE London does not have any contingent liabilities or contingent assets in 2024/25 nor did it in 2023/24.

14 Commitments

NHS SE London ICB does not have any capital commitments or other financial commitments.

15 Financial instruments

15.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS SE London integrated care board 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 NHS SE London integrated care board 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 NHS SE London integrated care board in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS SE London integrated care board standing financial instructions and policies agreed by the Board. Treasury activity is subject to review by the NHS SE London integrated care board and internal auditors.

15.1.1 Currency risk

The NHS SE London integrated care board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS SE London integrated care board has no overseas operations and therefore has low exposure to currency rate fluctuations.

15.1.2 Interest rate risk

The NHS SE London integrated care board borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The NHS SE London integrated care board therefore has low exposure to interest rate fluctuations.

15.1.3 Credit risk

Because the majority of the NHS SE London integrated care board revenue comes parliamentary funding, NHS integrated care board has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

15.1.4 Liquidity risk

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

15.1.5 Financial Instruments

As the cash requirements of NHS SE London integrated care board are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS SE London integrated care board's expected purchase and usage requirements and NHS SE London integrated care board is therefore exposed to little credit, liquidity or market risk.

15 Financial instruments cont'd

15.2 Financial assets

	Financial Assets measured at amortised cost 2024-25 £'000	Equity Instruments designated at FVOCI 2024-25 £'000	Total 2024-25 £'000	Total 2023-24 £'000
Trade and other receivables with NHSE bodies	357		357	1,233
Trade and other receivables with other DHSC group bodies	196		196	187
Trade and other receivables with external bodies	1,648		1,648	2362
Cash and cash equivalents	834		834	1997
Total at 31 March 2025	**3,035**	**-**	**3,035**	5780

15.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2024-25 £'000	Other 2024-25 £'000	Total 2024-25 £'000	Total 2023-24 £'000
Trade and other payables with NHSE bodies	1,756		**1,756**	737
Trade and other payables with other DHSC group bodies	11,288		**11,288**	3007
Trade and other payables with external bodies	276,630		**276,630**	239478
Private Finance Initiative and finance lease obligations	848		**848**	0
Total at 31 March 2025	**290,522**	**-**	**290,522**	243223

16 Operating segments

The ICB has one operating segment, the commissioning of healthcare services.

17 Joint arrangements and Pooled Budgets

ICBs should disclose information in relation to pooled budgets.

17.1 Pooled Budgets

			Amounts recognised in Entities books ONLY 2024-25				Amounts recognised in Entities books ONLY 2023-24			
Name of arrangement	Parties to the arrangement	Description of principal activities	Assets	Liabilities	Income	Expenditure	Assets	Liabilities	Income	Expenditure
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Better Care Fund	South East London ICB & London Borough of Bexley	Provision of Integrated Health & Social Care Services in Bexley	0	0	0	51,125	0	0	0	49,633
Better Care Fund	South East London ICB & London Borough of Bromley	Health and Social Care	0	0	0	31,308	0	0	0	28,495
Pooled Budget	South East London ICB & Royal Borough of Greenwich	Better Care Fund	0	0	0	29,094	0	0	0	27,138
Better Care Fund	South East London ICB & London Borough of Lambeth	Better Care Fund	0	0	0	35,168	0	0	0	33,135
Living Well Network Alliance	South East London ICB & London Borough of Lambeth, South London and Maudsley NHS FT, Certitude, Thamesreach	Provision of Adult Mental Health Services	0	0	0	90,570	0	0	0	84,667
Better Care Fund	South East London ICB & London Borough of Lewisham	Pooled Budgets	0	0	0	31,878	0	0	0	29,032
Better Care Fund	South East London ICB & London Borough of Southwark	Health and Social Care	0	0	0	34,179	0	0	0	31,727

18 Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Relating to interests declared by the Governing Body members				
WATERLOO HEALTH CENTRE - Dr George Verghese	2,817	-	13	-
ROYAL BOROUGH OF GREENWICH - Debbie Warren	30,994	(2,978)	2,896	-
BOLTON NHS FOUNDATION TRUST - Tosca Fairchild	17	-	-	-
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST - Professor Clive Kay	844,802	-	1,168	-
OXLEAS NHS FOUNDATION TRUST - Dr Iffy Okocha	279,341	(10)	156	-
LONDON BOROUGH OF LAMBETH - Andrew Eyres	51,681	(15,971)	(3,998)	-
NHS NORTH CENTRAL LONDON ICB - Paul Najsarek	72	(1,286)	(6)	-
SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST - David Bradley	395,386	(207)	(1,427)	-
GUYS & ST THOMAS HOSPITAL NHS FOUNDATION TRUST - Dr Toby Garrood	884,730	(315)	6,902	-

The Department of Health is regarded as a related party. During the year the ICB has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

- NHS England
- NHS ICBs
- NHS Trusts and NHS Foundation Trusts
- NHS Property Services
- NHS Community Health Partnership

The NHS organisations listed below are those where transactions over the year 2024-25 have exceeded £2m:

BARTS HEALTH NHS TRUST
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST
CROYDON HEALTH SERVICES NHS TRUST
DARTFORD & GRAVESHAM NHS TRUST
EPSOM & ST HELIER UNIVERSITY HOSPITALS NHS TRUST
GUYS & ST THOMAS HOSPITAL NHS FOUNDATION TRUST
IMPERIAL COLLEGE HEALTHCARE NHS TRUST
KING`S COLLEGE HOSPITAL NHS FOUNDATION TRUST
LEWISHAM & GREENWICH NHS TRUST
LONDON AMBULANCE SERVICE NHS TRUST
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST
MEDWAY NHS FOUNDATION TRUST
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
OXLEAS NHS FOUNDATION TRUST
ROYAL FREE LONDON NHS FOUNDATION TRUST
ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST
SOUTH LONDON & MAUDSLEY NHS FOUNDATION TRUST
ST GEORGES UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST
THE ROYAL MARSDEN NHS FOUNDATION TRUST

Local Authorities

LONDON BOROUGH OF BEXLEY
LONDON BOROUGH OF BROMLEY
LONDON BOROUGH OF GREENWICH
LONDON BOROUGH OF LAMBETH
LONDON BOROUGH OF LEWISHAM
LONDON BOROUGH OF SOUTHWARK

2023-24

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000

GUYS & ST THOMAS HOSPITAL NHS FOUNDATION TRUST (Dr. Toby Garrood)	753,418	(347)	(4,157)	-
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST (Prof. Clive Kay)	799,468	(213)	(923)	-
ROYAL BOROUGH OF GREENWICH (Debbie Warren & Sarah McClinton)	30,197	(2,549)	(1,467)	-
WATERLOO HEALTH CENTRE (George Verghese)	3,547	-	806	-
ROYAL BOLTON NHS FOUNDATION TRUST (Tosca Fairchild)	14	-	-	-
LONDON BOROUGH OF BEXLEY (Stuart Rowbotham)	17,345	(7,866)	(809)	-
LONDON BOROUGH OF LAMBETH (Andrew Eyres)	36,011	(17,214)	3,054	-
OXLEAS NHS FOUNDATION TRUST (Dr Ify Okocha)	237,084	(220)	(807)	-
SOUTH LONDON & MAUDSLEY NHS FOUNDATION TRUST (David Bradley)	318,385	(264)	-	-
Total	**2,195,469**	**(28,673)**	**(4,304)**	**-**

The Department of Health is regarded as a related party. During the year the ICB has had a significant number of material transactions with entities for

- NHS England
- NHS ICBs
- NHS Trusts and NHS Foundation Trusts
- NHS Property Services
- NHS Community Health Partnership

The NHS organisations listed below are those where transactions over the year 2023-24 have exceeded £2m:

BARTS HEALTH NHS TRUST
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST
CROYDON HEALTH SERVICES NHS TRUST
DARTFORD & GRAVESHAM NHS TRUST
EPSOM & ST HELIER UNIVERSITY HOSPITALS NHS TRUST
GUYS & ST THOMAS HOSPITAL NHS FOUNDATION TRUST
IMPERIAL COLLEGE HEALTHCARE NHS TRUST
KING`S COLLEGE HOSPITAL NHS FOUNDATION TRUST
LEWISHAM & GREENWICH NHS TRUST
LONDON AMBULANCE SERVICE NHS TRUST
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST
MEDWAY NHS FOUNDATION TRUST
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
NHS COMMUNITY HEALTH PARTNERSHIP
NHS PROPERTY SERVICES
OXLEAS NHS FOUNDATION TRUST
ROYAL FREE LONDON NHS FOUNDATION TRUST
ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST
SOUTH LONDON & MAUDSLEY NHS FOUNDATION TRUST
ST GEORGES UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST
THE ROYAL MARSDEN NHS FOUNDATION TRUST

Local Authorities

LONDON BOROUGH OF BEXLEY
LONDON BOROUGH OF BROMLEY
LONDON BOROUGH OF GREENWICH
LONDON BOROUGH OF LAMBETH
LONDON BOROUGH OF LEWISHAM
LONDON BOROUGH OF SOUTHWARK

19 Events after the end of the reporting period

On 13 March 2025 the government announced NHS England and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of ICBs is currently unchanged but they have been tasked with significant reductions in their cost base. Discussions are ongoing on the impact of these and the impact of staffing reductions, together with the costs and approvals of any exit arrangements. ICBs are currently being asked to implement any plans during quarter 3 of the 2025/26 financial year.

20 Third party assets

NHS SE London ICB does not have any third party assets.

21 Financial performance targets

NHS Integrated Care Board have a number of financial duties under the NHS Act 2006 (as amended).
NHS Integrated Care Board performance against those duties was as follows:

	2024-25 Target	**2024-25 Performance**	**2024-25 Target Achieved?**	2023-24 Target	2023-24 Performance	2023-24 Target Achieved?
Expenditure not to exceed income	4,947,694	4,947,607	**Yes**	4,544,818	4,544,772	Yes
Capital resource use does not exceed the amount specified in Directions	554	554	**Yes**	-	-	Yes
Revenue resource use does not exceed the amount specified in Directions	4,885,531	4,885,444	**Yes**	4,480,271	4,480,225	Yes
Revenue administration resource use does not exceed the amount specified in Directions	35,908	31,750	**Yes**	39,433	35,523	Yes