NHS
Central London
Community Healthcare
NHS Trust

Annual Report 2018/19

Section 1 – Performance report

Section 2 – Accountability report

Section 3 – Financial statements

1.1 Overview

The purpose of the annual report is to provide details on the performance of CLCH for the year 2018/19.

Included in the report is a summary of the Trust's performance alongside a statement of the key issues and risks that could affect the Trust in the delivery of its objectives as we move into the 2019/20 financial year.

1.2 Foreword

This year the NHS reached its 70th year and we were delighted to join in the nationwide celebrations marking this important milestone. For us, this was an opportunity to recognise the incredible contributions of our staff and volunteers in improving the lives of millions of patients across London and Hertfordshire.

In 2018/19 we were proud to win Organisation of the Year at the Health Service Journal (HSJ) Patient Safety Awards. This was for our work on our Quality Strategy, *Simply the Best, Every Time* and clear testament to our on-going commitment to providing the best quality care.

Through the launch of our Academy programme, we've provided new opportunities for education and training, enabling community and primary care professionals to learn together. We are also supporting new roles and ways of working through the Apprentice Nursing Associates scheme as well as enabling rotations for staff across community and primary care to build their experience.

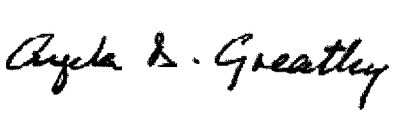
Our Quality Development Unit initiative and shared governance approach are both examples of how we're now enabling our front line staff to demonstrate their excellence in practice whilst also empowering them to drive improvements to their services.

Fifteen quality councils have been set up across our four divisions which are chaired by junior members of staff. Councils identify improvement projects and work together with patient representatives to deliver changes that benefit patients and staff.

We are pleased to have welcomed new services to the Trust in 2018/19, including 0-19 services in Ealing and school nursing in Wandsworth. In January 2019, we were awarded the contract to provide adult community services in Hertfordshire, which will take effect in October 2019, and involve 650 staff joining us.

Cultivating strong partnerships with GPs, other NHS Trusts, social care and voluntary sector partners, continues to be a major priority for the Trust as we work towards integrating care across all areas in line with the Five Year Forward plan.

We would once again like to credit our health visiting teams based at Colville health centre in Westminster for their ongoing resilience throughout the past year. Their dedication to building and maintaining trusting relationships with families means that the new Grenfell team that is now in place can continue the crucial support to those that were affected by the fire in 2017.



Angela Greatley, OBE
Chair

Andrew Ridley
Chief executive

1.3 About us

This section outlines the purpose and activities of the Trust. Central London Community Healthcare NHS Trust (CLCH) provides more than 70 different community healthcare services in London and Hertfordshire. We employ approximately 3,500 staff who care for more than two million patients. We help people to stay well, manage their own health and avoid unnecessary trips to, or long stays in, hospital. We provide care and support for people through every stage of their lives from health visiting for new-born babies through to community nursing and palliative care for people towards the end of their lives.

In 2018/19 we provided a broad range of services in eleven different London boroughs and Hertfordshire. We were established in 2008 as a provider of community services for Hammersmith and Fulham, Kensington and Chelsea and Westminster. We now provide services across Hertfordshire and each of the additional following boroughs: Richmond, Merton, Wandsworth, Brent, Barnet, Harrow, Hounslow, and Ealing.

We continue to focus on developing integrated community services, working closely with physical and mental health providers, social care and the voluntary sector. In this way we can bring greater benefits to the patients, families and communities facing increasingly complex health conditions.

Our range of services includes:

- Adult community nursing including district nursing, community matrons and case management.
- Children and family services including health visiting, school nursing, community nursing, speech and language therapy, blood disorders and occupational therapy.
- End of life care supporting people to make decisions and receive the care they need at the end of their life.
- Long-term condition management supporting people with complex ongoing health needs caused by disability or chronic illness.
- Rehabilitation and therapies including physiotherapy, occupational therapy, foot care, and speech and language therapy.
- Specialist services including delivering care for people living with diabetes, heart conditions, Parkinson's,, homeless health services, community dental services, sexual health and contraceptive services.
- Walk-in and urgent care centres providing care for over 220,000 people with minor illnesses and injuries and providing a range of health advice and information.

Many of our services are open seven-days-a-week and our community nursing and inpatient rehabilitation and palliative care units offer 24 hour care.

Our vision is to deliver: great care closer to home.

Our mission is: working together to give children a better start and adults greater independence.

We have four core values, providing a reference point for all our staff on how we should conduct ourselves when working with patients, colleagues and partners.

- Quality: we put quality at the heart of everything we do
- Relationships: we value our relationships with others
- Delivery: we deliver services we are proud of
- Community: we make a positive difference in our communities.

We operate in four Sustainability and Transformation Partnerships (STPs): North Central London, North West London, South West London and Hertfordshire and West Essex. The STPs bring organisations together to take collective responsibility and to plan improvements. Working within these STPs is a complex challenge and to be an effective partner in each STP we need to be able to focus and commit time and resources.

In our STP areas, we have the potential to provide a facilitative and supportive role in making change locally; building on our track record as a high quality community services provider and one with the reach and infrastructure to support others.

1.4 Trust strategy

Our strategic direction covers what we do, where we work and how we work with partners.

The five strategic priorities for 2018/19 were:

- **Strategy Implementation** - implement strategic priorities of integration and place
- **Quality** - maintain and improve the quality of services delivered by CLCH moving from good to outstanding
- **Finance** - deliver the 18/19 financial plan
- **Operations** - deliver all NHS constitutional and contractual standards
- **Workforce** - make CLCH a great place to work for everyone.

1.4.1 Quality strategy 2017-2020

'Simply the Best, Every Time' was developed and launched in February 2017 and its aim is to move us from *Good* to *Outstanding*. It introduced three new quality campaigns alongside the three which continued from the 2013-2016 strategy. These campaigns provide a focus for everything we do and cover all aspects of delivering high quality, safe, effective and efficient care.

- **Positive patient experience:** changing behaviours and care to enhance the experience of our patients and service users

- **Preventing harm:** reducing unwarranted variations in care and increasing diligence in practice

- **Smart, effective care:** ensuring patients and service users receive the best evidence based care, every time.
- **Modelling the way:** providing world class models of care, education and professional practice.
- **Here, happy, heard and healthy:** recruiting and retaining an outstanding workforce.
- **Value added care:** using enhanced tools, technology and lean methodologies to manage resources well.

To deliver the quality strategy objectives we have continued to progress our *shared governance* approach to driving improvement across the Trust.

You can read the 2017-2020 quality strategy on our website at: www.clch.nhs.uk/quality

1.4.2 What we do

Our strategy is to put greater emphasis on planned and integrated services that meet specific local needs through multi-disciplinary services delivered in collaboration with our partners. In practice this means that our services need to:

- Be co-designed with patients and partners.
- Be focussed on specific local need or networks of providers.
- Have integrated assessment, care planning and delivery processes with other providers.
- Have shared information on patients and communities.
- Be bound by common outcomes at the individual and community level.

In all cases services need to be founded on evidence, best practice and shared learning and we need to engage with the full range of resources in the statutory and non-statutory sector. The essence of our services will remain very personal and based on the skilful face-to-face engagement of our staff with patients and their families. We will however, increasingly adopt new technologies that make access to our services easier and help people to do more for themselves.

1.4.3 Where we work

We wish to remain focused, committed and active partners and so we do not seek to take on new services outside of our four current sustainability and transformation partnership (STP) areas. In considering new services within the STP areas we will focus on whether we believe we can improve the quality of care for patients rather than the potential income growth.

CLCH is committed to working with partners in the four sustainability and transformation partnerships of our geography: North West London, South West London, North Central London and Hertfordshire and West Essex.

1.4.4 How we work with partners

The NHS Long Term Plan can be found online and includes a range of integration solutions, but there is no blueprint and integration will take many different forms. We consider the needs of each local area and offer appropriate solutions.

This strategic direction has implications for how we engage with local systems, reshape services, develop our workforce and use supporting technologies.

1.4.5 Engaging with local systems

We have sought to deepen our understanding of what is happening in the different geographies whilst building solid strategies for each around distinct added value. We have also sought to nurture current relationships as well as fostering new ones, particularly with mental health services in order to enable an integration of physical and mental health.

1.4.6 Re-shaping our services

We work collaboratively with staff, patients and our partner providers to design new ways of integrating services. We see local voluntary services as a key part of broadening the resource pool and securing sustainability of support locally.

1.4.7 Developing our workforce

We seek to enable our staff to work successfully and flexibly with other providers to ensure practical integration of assessments, care planning, delivery of service and evaluation of impact and benefit.

1.4.8 Deploying new technologies

We continue to invest in new technologies to engage patients differently and to support their self-management. Technology is also key to enabling integration with other providers; it is vital in helping staff to be productive.

1.5 Performance summary and analysis

We are a high performing Trust that puts quality of care at the heart of everything we do. Our last CQC inspection took place in September 2017 when the Trust hosted 28 CQC inspectors and specialist advisors, who assessed four of our care services: children's; adults; inpatient and end of life care. Following the 2017 inspection, we were pleased to receive an overall 'Good' rating in February 2018. The Trust was not issued with any

regulatory actions by CQC, they did suggest a number of actions that the Trust could do in order to improve services, and all these suggestions have been implemented.

The board monitored 19 key performance indicators (KPIs) across Finance, Workforce and Quality throughout 2018/19. Of these KPIs the Trust improved 3, 11 were maintained and recovery plans were put in place to address the 5 that were not met.

As a result of our strong financial performance the Trust has achieved a Segment 1 rating from NHS Improvement under their Standard Operating Framework. This means the Trust is permitted to operate with the highest levels of autonomy allowed by the regulator.

Key issues and risks which could affect the Trust in delivering its objectives are described in section 2.5 of the report.

1.5.1 2018/19 performance analysis

Each year the board of directors sets a suite of KPIs for the Trust to track our performance in priority areas. For 2018/19, the board monitored 19 KPIs. We monitor performance against these KPIs monthly both within our clinical divisions and at board. Progress throughout the year is published in our integrated finance and performance report which is part of the papers for monthly public board meetings, available at www.clch.nhs.uk/boardpapers.

We set ourselves ambitious targets which are a mix of our own objectives and national targets. In a number of areas we set stretching targets beyond the minimum requirements of national targets. The section below summarises our quality performance against the targets agreed by the board.

We have achieved the intended targets for our quality board KPIs and we're especially proud of the results of both friends and family tests: 'percentage of people that would recommend the services' and 'percentage of staff recommending CLCH to their friends and family as a place for treatment' respectively. Full details of our quality performance are published in our Quality Account, available on our website at www.clch.nhs.uk/publications.

For 2018/19 we reviewed and updated some of our board level key performance indicators, grouping them under five strategic priorities: Strategy Implementation, Quality, Finance, Operations, and Workforce. The objectives for each priority are:

- Strategy Implementation: implement strategic priorities of integration and place.
- Quality: maintain and improve the quality of services delivered by CLCH moving from 'Good' to 'Outstanding'.
- Finance: deliver the 2018/19 financial plan.
- Operations: deliver all NHS constitutional and contractual standards.
- Workforce: make CLCH a great place to work for everyone.

1.5.2 Quality

Proportion of clinical incidents that do not cause harm (moderate to catastrophic categories)

This KPI compares like for like incidents across the Trust that were reported as moderate or above, against a target of 96% the Trust achieved 97.5%.

Friends and family test - percentage of people that would recommend our services

The calculation of this KPI reflects the percentage of those respondents that gave either an "extremely likely" or "likely" response to the survey question 'How likely is it that you would recommend this service to a friend or family if they needed it', minus those who would not recommend. Against a target of 95% the Trust achieved 95.4%.

Percentage of deaths requiring Preventable incidents, survival and mortality (PRISM) for which a review was conducted

On 31 March 2019 the Trust KPI compliance for learning from deaths was 100%. Data for this KPI, provided by the three adult divisions, sets out the number of deaths reviewed using the screening tool compared to the number of total deaths. All divisions achieved 100% compliance

Percentage of statutory and mandatory training audits undertaken by the Trust

The target for statutory and mandatory training audits is 100% and the Trust achieved 100% in 2017/18.

1.5.3 Operations

Contract performance notice

This KPI measures the number of contract performance notices received from the Trust's commissioners. Four performance notices and two information breach notices, for a total of six, were received throughout 2018/19.

Waiting time of 18 weeks from point of referral to treatment (RTT)

Against a target of 92% the Trust achieved 98.2%.

Accident and emergency (walk-in/urgent care centre) maximum waiting time of 4 hours from arrival to treatment/transfer/ discharge

Against a target of 95% the Trust achieved 99%.

Digital maturity

In 2018/19 the Trust met the target increase in digital maturity with the overall score of 980 compared to a target improvement to 954, the significant gains in maturity were in clinical digital leadership, the CLCH Way Transformation programme and the roll out of patient Wi-Fi.

Cyber security

The Trust set a target of undertaking all cyber advisory recommendations from NHS Digital within the month issued, this was achieved in all but two months; technical reasons and a need to fully test the patches meant that they were delayed in these two months and delivered in the following months.

Percentage of bed days lost to delayed transfers of care (DTOC)

Of the 3.5% target, the Trust achieved 2.66% which accounts to 1,004 (NHS days only) delayed transfers of care days.

1.5.4 Workforce

Percentage of staff recommending CLCH to their friends and family as a place for treatment

This KPI is collected quarterly via the Trust's pulse survey for Q1, Q2 and Q4 with the national staff survey covering Q3. The measure reflects those staff who agree or strongly agree with the question asking them whether they would recommend the Trust as a place to work. The 2018/19 results were 72.50%, 72.00%, 68.00% and 64.42% against a target of 75%.

Vacancy level – all staff

This KPI reflects all vacant full time equivalent (less frozen posts) divided by the budgeted establishment. At the close of 2018/19 year the Trust's clinical vacancy rate was 11.76% against a target of 10% or less.

Staff appraisal rate

This KPI shows the number of staff appraised as a percentage of the number due for appraisal in the same period. 85.28% of staff have had their appraisal across 2018/19 against a target of 90%.

Appointment Proportion of BAME for band 7+ Posts

Across the Trust 35.42% of BAME staff are at Band 7 level and above against a target of 36.44%.

1.5.5 Finance

Recurrent value of QIPP delivered against target

This KPI reflects the financial position of the recurrent QIPPs achieved as a percentage of the target. Against a target of 100% across the 2018/19 year the Trust achieved 73%.

Income and expenditure performance

The Trust achieved its 18/19 year-end target of a £9.2m surplus.

Cash balance performance

Against a year-end target of £11,346k, the Trust ended the year with a £39,451k cash balance compared to plan.

1.6 Strategy implementation

Sustainability and transformation plan (STP) engagement

The Trust actively supports and engages with partners to deliver the plans within our local Sustainability and Transformation Partnerships. The Board monitors attendance at STP and locality delivery groups through:

1. A measure of attendance at sustainability and transformation partnership meetings. Against an annual target of 80% the Trust has achieved 93% engagement.
2. The Trust board is updated quarterly on operational actions to support integration in the STPs in which we provide services.

The Trust is committed to creating and embedding sustainable models of care, and ensuring our operations and estates are as efficient, sustainable and as resilient as possible. Increasingly these plans focus on joint working and integrating services to provide better care for our patients. The Trust is committed to this agenda and has actively worked to integrate core community services in localities to improve care delivery. For example, the Trust has been delivering discharge to assess pathways and improved rapid care community service to minimise admission and length of stay in acute hospitals.

1.7 Our staff

We employ 2,270 full-time staff, 1,200 part-time staff and we have 1,414 people registered on our staff bank for temporary work. Our workforce is made up of:

- 78.72% clinical roles
- 86.5% women
- 43.2% staff of Black, Asian and Minority Ethnic (BAME) backgrounds
- 61.32% staff aged 40+

The nature of community healthcare means much of the care we give is one-to-one treatment either in patients' homes or at local health centres. This means great community care is all about great staff; both our frontline clinicians and all those who support them.

Expenditure relating to consultancy is disclosed in our financial statements. Exit package payments are disclosed in the remuneration and staff report.

Details of the board are provided in section 2.11. The board gender breakdown, including non-voting members (2) is seven male to six female.

1.7.1 Supporting a healthy workforce

Physiotherapy service

The physiotherapy service is led by a dedicated musculoskeletal (MSK) senior clinician, who provides a service at 4 sites within CLCH. The aim of the service is to promote health and wellbeing at work, reduce sickness absence and improve self-management by offering a broad range of MSK care. Staff can self-refer or be assessed at the request of line managers, including at the pre-employment screening stage.

In terms of statistics, during the last year, the physiotherapy service has seen 228 new clients and approximately 452 follow up appointments. These figures do not include management referrals/pre referrals, pre-employment screening, pilates courses or staff workshops.

Promoting good mental health

In support of the Time to Change pledge, a dedicated mental health nurse based in the employee health department has developed a network of staff members who are interested in mental health and willing to provide a listening ear and a friendly face in the workplace. They are known as mental health minders and there are 25 of them at the Trust. The mental health minders work to support their colleagues, signpost them to employee health or other services and provide activities to help break down stigma and discrimination, such as coffee and chat mornings, walking groups and workshops.

The dedicated mental health nurse also works with employees to reduce stress and supports them in staying well at work or helping them return to work following absence due to their mental health. A regular blog is published on the Trust intranet that offers advice on mental wellbeing, sleep and common mental health issues. The employee health department also has a therapy team who offer psychological support to employees. The mental health nurse also visits teams to offer stress reduction techniques and emotional resilience workshops. Last year, 65 members of staff attended the workshops.

The employee health department organised two mental wellbeing days for staff in October 2018 as part of World Mental Health Day. The aim was to equip staff with tools to help them keep their emotional health well, and raise awareness on how they can support themselves and others. 100 CLCH staff attended these two days.

In addition to the above we offer a programme providing support to managers and teams by running bespoke half-day support sessions. These help staff to handle the challenges they face, identify the problem and how it affects them mentally and physically, and learn how to develop and use their own unique coping strategies. 11 teams were supported during 2018/19.

1.7.2 Freedom to speak up

Freedom to Speak Up (FTSU) Guardians continued to raise staff awareness of routes available to them if they want to speak up about something that is worrying them or does not feel right. Examples include team talks, site visits, attending events, communications and posters. Information has also been added to the welcome booklet for new staff and statutory and mandatory training handbook.

The guardians themselves received 82 contacts from staff with concerns in 2018/19 compared with 64 in 2017/18, a 27% increase. Of these contacts, 41 contained an element of concern about patient safety or quality of care. Lessons learned are used as part of a culture of continuous improvement.

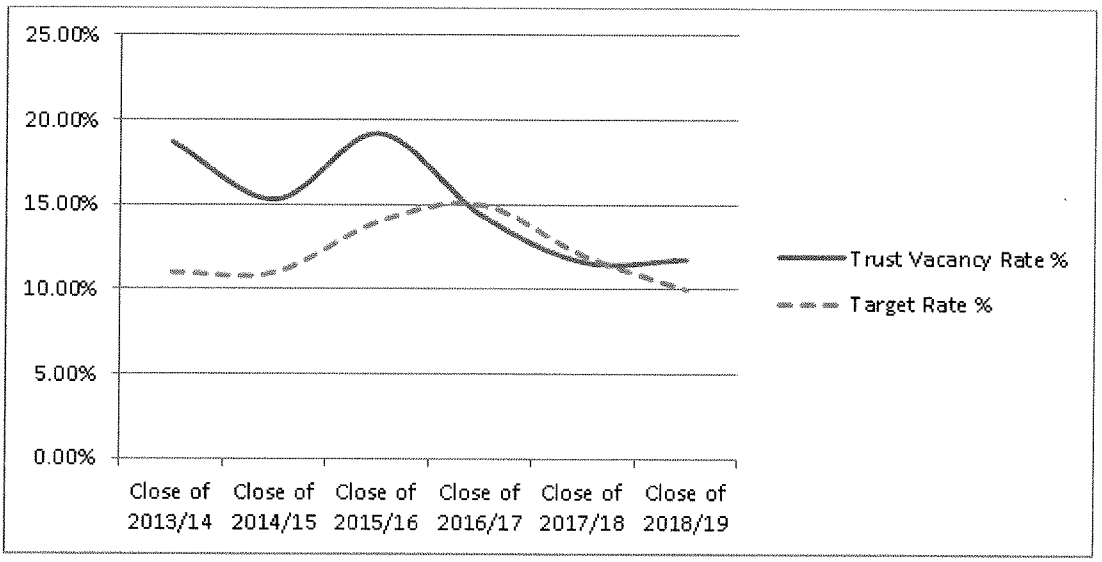
The Freedom to Speak Up (FTSU) vision, strategy and implementation plan, developed by the Trust board with input from the Guardians, were approved in November 2018.

1.7.3 Recruitment and retention

In 2009, CLCH began its life as an autonomous provider organisation, amalgamating three inner London borough's; Hammersmith and Fulham, Kensington and Chelsea and Westminster. The Trust has grown to providing healthcare services in eleven London boroughs and Hertfordshire.

Our recruitment and retention plans and our clinical workforce strategy are key to enabling us to having the current and future workforce we need. We have experienced the challenges that go with recruiting for hard to fill and national shortage occupations. Some of the actions taken to address these challenges are set out below.

The overall vacancy rate at the close of 2018/19 was 11.76% against a target of 10%. Campaign five of CLCH's quality strategy (Here, happy, heard and healthy) aims to achieve a vacancy rate below 8% by March 2020.



CLCH continue to review and undertake specific projects to support our recruitment and retention work. These include:

Nurse apprenticeships

Following the Trust's successful application to become a 3rd wave Nursing Associate test site, 26 Apprentice Nursing Associates (ANAs) have commenced in the November and December 2018 cohorts. 33 ANAs have been recruited for the February 2019 cohort including 4 ANAs who will be based within the Trust's Learning Disability (LD) services.

Fast track nursing

We developed an advanced programme of learning and development to support new nurses to gain higher competencies and move quickly into more senior roles. The project was focused on addressing vacancies in band 6 community nursing roles. Nurses start in band 5 roles and within 12 months develop the skills needed to take on the band 6 role.

International recruitment

During 2018/19 we recruited 18 nurses from the Philippines.

Capital nurse programme

The Trust has continued to receive support from the Capital Nurse Foundation Programme. There are currently nine newly qualified band 5 nurses undertaking the programme, they have been based within the community nursing teams and have had the opportunity to gain experience within other specialist nursing services, for example tissue viability, within the 18 month programme. The programme consists of a structured teaching programme, reflective practice, action learning group support and workplace based assessment in a range of skills and competences. In addition, the programme also aligns to the new preceptorship standards in order to provide the newly qualified nurses with support as they transition from the role of student to qualified nurse.

1.7.4 Recognising quality

We are extremely proud of the work our staff do, and it is always great to see that work acknowledged through national award schemes. In 2018/19 the work of our staff/teams was recognised twice by the Health Service Journal (HSJ).

The Trust won **Organisation of the year** at the **HSJ patient safety congress** for our quality strategy 'Simply the best - every time'. There were over 500 entries in total for the award, reduced to a shortlist of 180 with CLCH being among 20 winners decided by an expert panel.

Our West Herts respiratory team, in collaboration with Herts Valley Clinical Commissioning Group, was shortlisted in the optimisation of medicines management category at the **2018 HSJ awards**. The joint initiative re-defined an approach to optimise the use of oxygen for patients with respiratory illnesses in the home.

In 2018/ 19 the Trust embarked on the **Quality Development Unit (QDU)** programme, awarded to teams or services who have shown excellence in quality through specific assessments.

QDUs are expected to trial new ways of working, offer advice to other teams who are struggling and play a prominent role in the quality councils. Eight teams have applied for QDU status with a number of others expected to apply in the coming year.

1.7.5 CLCH staff awards

Our own annual staff awards were held in November 2018 at Porchester Hall and recognised the excellent work of our staff with winners and commendations across 17 different categories. Over 400 nominations were made and more than 300 staff attended this event which was very positively received.

1.7.6 Staff survey results

Our response rate to the 2018 NHS staff survey was 44% (1,399 staff).

Compared with other community Trusts, across the new ten theme areas, we had two areas with results above average (quality of care and quality of appraisals), four areas at the average and 4 with results below average. The results have been shared within the organisation and action plans are being developed with the involvement of staff at a Trust wide, divisional and corporate services directorate level.

The full and summary reports of our 2018 results are available at http://www.nhsstaffsurveys.com

Information in relation to the staff profile can be found in section 2.22.

1.7.7 Equality and diversity

Since April 2018, CLCH has embarked on an ambitious programme to improve the experiences of staff and patients from diverse groups. In May 2018, the Trust established a Workforce Race Equality Standard (WRES) Taskforce, led by the chief executive to develop an action plan on: Recruitment and selection, bullying and harassment, managing disciplinary cases and career progression. The WRES action report and action plan can be found here: https://www.clch.nhs.uk/application/files/9315/3812/8497/Workforce_Race_Equality_Standard_Report_2018.pdf.

To promote diversity, inclusion and engagement, the Trust now facilitates three staff networks – the Race Equality Network (REN), the Disability and Wellbeing Network (DAWN) and the Rainbow network for lesbian, gay, bisexual and transgender (LGBT) staff.

The Trust published a detailed analysis of its workforce and service users in its Annual Equality Report 2018, which can viewed at:

https://www.clch.nhs.uk/application/files/2115/4158/6411/CLCH_-_Public_Sector_Equality_Duty_Report_2018.pdf.

Its Gender Pay Gap Report for 2018 can be found at: https://www.clch.nhs.uk/application/files/6415/5387/5381/Gender_pay_report_final_version.pdf:

1.7.8 Staff involvement, consultation and recognition

Building strong relationships and engaging with our staff is vitally important. We inform and involve our staff and trade union representatives via the Joint Staff Consultative Committee (JSCC) and Partnership Forum, where there are opportunities to work collaboratively with managers and staff representatives.

1.7.9 Trade union facility time publication report

On 1 April 2017, the Trade Union (Facility Time Publication Requirements) Regulations 2017 came into force. The Regulations require the Trust, as a NHS body to collate and publish on an annual basis, a range of data on the amount and cost of "facility time" within the organisation.

The CLCH report for the 12 months from 1 April 2018 to 31 March 2019 is set out below.

Table 1: The number of employees who were relevant union officials during the relevant period, and the number of full time equivalent employees

Number of employees who were relevant union officials during the relevant period	Full-time equivalent (FTE) Trade union representatives
32	28.56 FTE

Table 2: Percentage of time spent on facility time for each relevant union official

The table below shows how many relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time.

Percentage of time	Number of employees
0%	13*
1-50%	19*
51-99%	0

100%	0

*This data is based on self-reporting by trade union representatives.

Table 3: Percentage of pay bill spent on facility time

The table below sets out the percentage of the CLCH total pay bill spent on facility time.

The total cost of facility time	**£53,430.37**
The total pay bill	£154,578,000
The percentage of the total pay bill spent on facility time	0.035%

Table 4: the number of hours spent by relevant union officials on paid trade union activities as a percentage of total paid facility time hours

Time spent on paid trade union activities as a percentage of total paid facility time hours	15.08%

1.7.10 Staff engagement

The chief executive undertakes a number of roadshows during the year, meeting staff across a number of venues. The introduction of 'Feedback Fridays' provides a regular forum for staff to connect and converse with their managers. The national staff survey and quarterly pulse surveys find out from staff whether they would recommend CLCH as a place to work and a place to receive treatment. We also hold regular workshop sessions for our senior managers and provide regular email communications via 'managers' cascade', 'spotlight on quality' and 'ThisWeek@'.

As a Trust, we like to involve staff and celebrate success through recognising the excellent work they do on a daily basis. This is achieved through employee reward and recognition incentives such as employee of the month and the long service award. Each year, CLCH holds an awards ceremony to celebrate the talented staff, recognised by staff and patients as going the extra mile in delivering great care closer to home.

1.7.11 Shared governance

The Trust has developed a model of shared governance to support continued quality improvement and to support the implementation of the Trust quality strategy. To date we have successfully implemented 17 shared governance quality councils across the Trust:

All quality councils are chaired by a band 6 or lower banded member of staff and nine of the councils have one or two patient representatives as active council members. Each quality council has been asked to focus on one project aligned with one of the quality campaigns outlined in the quality strategy with the aim of making an improvement.

1.7.12 Anti-slavery

CLCH is committed to improving our practices to combat slavery and human trafficking. CLCH will ensure there is no modern slavery or human trafficking in any part of the Trust and in so far as is possible, require our suppliers to have a similar ethos. CLCH will:

- Comply with legislation and regulatory requirements in this area
- Make suppliers and service providers aware that we promote the requirements of this legislation
- Consider modern slavery factors when making procurement decisions
- Develop awareness of modern slavery issues throughout CLCH
- Use NHS Terms and Conditions for goods and services for specification and tender documents which require suppliers to comply with all relevant legislation and guidance, including modern slavery conditions
- Encourage suppliers and contractors to take their own actions and understand their obligations under this legislation
- Ensure that modern slavery is included in safeguarding work plans
- Ensure that all staff undertake mandatory safeguarding training, and training in equality, diversity and human rights
- Ensure that procurement staff members also receive regular legal briefings so that they are aware of legislative requirements in this area.

1.7.13 Counter fraud, anti-bribery and corruption

CLCH takes a zero-tolerance approach towards fraud and bribery and will prosecute in this area wherever possible.

Our counter fraud team works to investigate and prevent fraud and bribery, and ensure that adequate procedures are in place to protect the Trust.

We have an anti-fraud and bribery policy and our counter fraud team gives advice to staff on how to be on the alert for, and report fraud, bribery and corruption as quickly as possible.

1.8 Service changes

Following successful competitive tenders, during 2018/19 CLCH mobilised the following new services:

- On 1st October we launched the new Ealing 0-19 children's service, delivering an integrated offer across Ealing for the local authority.
- In August we added the school nurses service in Richmond and in September we added the school nurses service in Wandsworth to our existing jointly commissioned health visiting contract.

Other service developments included the addition of services for children's haemoglobinopathy and homeless health visiting, including support for refugees and asylum seekers for Wandsworth Clinical Commissioning Group (CCG).

We also ceased providing some services where the contract reached the end of its term and CLCH decided not to re-tender or agreed with commissioners to cease provision. These services were:

- Continuing healthcare assessment and therapies for Hammersmith and Fulham, West London and Central London CCGs
- Merton CCG Continuing healthcare
- Barnet CCG Paediatric occupational therapy and physiotherapy
- Hounslow CCG Community diabetes service
- Hounslow CCG Wheelchair service

1.9 Value for money

During 2018/19 the Trust achieved a surplus on operating expenditure of £10.8m (in line with plan) thus securing a further £6.8m of Provider Sustainability Funding from central Government; this was based on a total Trust turnover of £242m (£217m 2017/18). The Trust financial performance was driven by continual improvements in the control of spend on temporary staffing, delivery of significant operational clinical efficiencies and the continued delivery of our corporate transformation programme.

As a result of our financial performance the Trust has achieved a Segment 1 rating from NHS Improvement meaning the Trust is permitted to operate with the highest levels of autonomy allowed by the regulator.

1.9.1 Quality, innovation, productivity and prevention (QIPP) plans

Recognising the need to deliver value for money we have consistently delivered on our QIPP targets in each of the past seven years. In 2018/9 we successfully delivered QIPP schemes to the value of £8.4m, meeting our QIPP requirements net of contingency. The estates savings highlighted below are an example of where we are looking to maximise value in ways which have minimal impact on the frontline services caring for our patients. Our efficiency programmes have totalled approximately £85m since 2011.

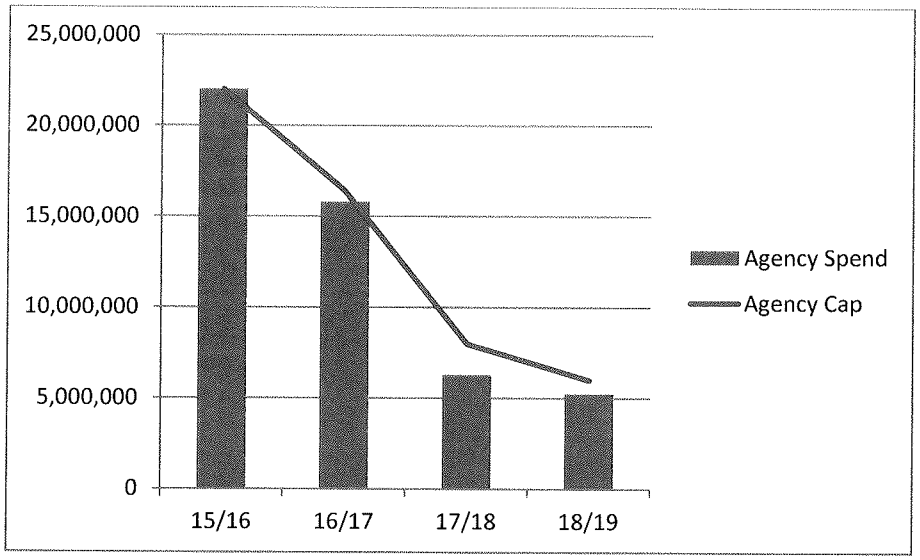
1.9.2 Estates rationalisation

The cost of managing or / renting our various health centres and office bases is the Trust's second biggest expense, after pay costs, and as such remains a focus of annual transformation. Key projects and the savings they released in 2018/19 included:

- Opening three new sexual health hubs, transforming clinical service provision in Hertfordshire and in south London at Clapham Junction.
- Initiating an estates rationalisation programme to review and reduce under-used/unoccupied spaces.
- Introducing a 24/7 email and telephone helpdesk for over 100 sites in our main estate, with 9 different landlords and service providers.
- Supporting CLCH's QIPP plans by delivering £25.2m million recurrent savings since 2016/17 Financial year.
- Delivering an agile working programme implemented within all developments since April 2016.
- Implementing a new single booking system for all meeting rooms.
- Developing a commercial estate proposal to provide key worker accommodation and recurring revenue from under-occupied properties

1.9.3 Reduction in agency staff spending

Building on the significant success in previous years, the Trust continued to target lower agency usage and an internal stretch target of £8 million was applied. We have managed to reduce agency spend of circa £22 million in 2015/16 to £15.8 million at the close of 2016/17 £6.3 million at the close of 2017/18, and £4.6m at the close of 2018/19.



Replacing agency staff with permanent staff is good for patients and for taxpayers. It improves value for money but also improves quality of care through greater continuity of care (patients seeing the same clinicians) and a stronger commitment to and understanding of the Trust by permanently employed staff.

Annual governance statement 2018/19

2.1 Scope of responsibility

As accountable officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Trust Accountable Officer Memorandum*.

2.2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Central London Community Healthcare NHS Trust, 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 has been in place in Central London Community Healthcare NHS Trust (CLCH) for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

2.3 Capacity to handle risk

Risk management sits within the quality governance structure of the Trust, led by the chief nurse.

The Trust has a risk management strategy in place which sets out the key responsibilities and accountabilities to ensure that risk is identified, evaluated and controlled. Risk is considered from the perspectives of: clinical risk, organisational risk and financial risk. The risk management strategy was revised and reviewed by the audit committee in October 2018.

The Trust's risk management strategy sets out a plan for a standardised approach to training and risk assessment of both clinical and non-clinical risks across the Trust to ensure there is a clear flow of risk assessment, identification, treatment and monitoring from front line services to the Board and back.

2.4 The risk and control framework

Risk assessment and grading of risks is based on the Trust's risk matrix adapted for use from the AS/NZS 4360:1999 risk matrix and approved by the National Patient Safety Association (NPSA).

This evaluates the likelihood of exposure and the consequences if exposed. Likelihood is

the probability of an event occurring; consequences are the outcomes that result if the risk occurs. Likelihood and consequence are combined to calculate the risk grading. Risks scoring 15 and above are included in the 'corporate' risk register.

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

The use of risk registers is fundamental to the control process. Divisional risk registers are monitored monthly and significant risks identified are considered for inclusion in the board assurance framework (BAF).

The executive leadership team (ELT) receives a monthly report on risks of 15 and above and BAF risks. The ELT also receive a weekly update on new risks at 15 or above. The patient safety and risk group (which includes representatives from all divisions) reviews all risks of 12 and above including ratification, updates and closure.

Following review by the ELT, the BAF is considered quarterly by both the audit committee and the Trust Board. Strategic risks, for example risks in relation to staff vacancies which could affect the standard of patient care, are allocated to specific executive directors who have responsibility for ensuring that controls to mitigate these risks are effective.

The Board reviews the risks scored 15 and above quarterly and the whole register annually. Scrutiny and detailed review of risks rated 15 and above takes place at committee level, with the exception of fire, health and safety risks for which the Board retains direct responsibility.

As stated above, the system of internal control is designed to manage risk to a reasonable level and not to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

This is achieved by ensuring that risk management and corporate governance is an integrated process with systems and processes in place through which the organisation will identify, assess, treat, analyse and monitor risks and incidents at every level of the organisation. Responsibilities are assigned to manage individual risks within the Trust, and results are aggregated at a corporate level to identify and assess emergent themes for further assessment.

2.4.1 Single oversight framework (SOF)

The Trust has worked closely with NHS Improvement (NHSI) which is responsible for overseeing the performance management and governance of NHS trusts. The single oversight framework, introduced in 2016 and updated in 2018, is designed to help NHS providers attain and maintain Care Quality Commission ratings of 'good' or 'outstanding'. Trusts have been segmented according to the level of support each trust needs across 5 themes of: quality of care, finance and use of resources, operational performance, strategic change and leadership and improvement capability.

For a third year, CLCH has remained in segment 1 (providers with maximum autonomy). Feedback from NHSI throughout the year 2018/19 NHSI has been both supportive and

positive. The Trust was delighted to maintain a rating of 'good' following assessment by the CQC in October 2017.

The Board receives a quarterly update on compliance with the single oversight framework; with the exception of 'use of data' (amber), all areas are classified as 'green'. The Trust now has an operating data warehouse and further work is underway to further improve clinical outcome reporting.

2.4.1.1 Provider licence
The Trust's position, including any risks to the provider licence (as far as is applicable for an NHS trust) is considered quarterly, including condition 4 'fit and proper persons' (green); all Board members have provided self-certification and employment contracts include a clause that gives the Trust the ability to dismiss 'unfit persons'.

2.4.1.2 Well-led framework
The CQC well-led review in 2017, reported in January 2018, included some elements of the well-led framework. An external developmental review of leadership and governance using the well-led framework by PWC commenced in March 2019. The results will be reported to the Board in June 2019.

The specification for the review is compliant with guidance issued by NHSI in June 2017 and informed by supplementary guidance in relation to commissioning external suppliers, October 2017 and lessons learned – published in November 2018.

2.4.2.3 Data Security
The Board considered the annual Board cyber update in March 2019 which reviewed compliance against three external criteria the:

- 'Cyber Essentials PLUS Assessment' from the government national cyber security centre
- October 2018 annual penetration test undertaken by an independent assessor
- Ten data and cyber security standards (2017/18 data security protection requirements [DSPR]).

Current cyber compliance is monitored monthly to identify any potential cyber threats including care computer emergency response team (CareCERT) notifications to determine the required steps to mitigate risks; more urgent updates would be risk assessed and applied immediately as required. This response is monitored at the monthly operational meetings chaired by the Trust's chief information officer. The Board has monitored cyber security as a monthly key performance indicator (KPI) during 2018/19.

The Trust is working with NHS Digital to achieve the mandatory Cyber Essentials Plus accreditation by 2021, This will surpass the cyber compliance the Trust achieved through the 2017/18 DSPR standards. The October 2018 penetration test resulted in a work programme to address identified vulnerabilities working with our information management and technology delivery partner Capita. This work is in direct support of the Cyber Essentials PLUS standards and gives the Trust an increased information security position to protect data and services against known threats. The Trust has also agreed more frequent testing of IT security, in order to improve the integrity and defense of the network. This will be monitored monthly through Board and contractual KPIs with our partner, Capita.

The Trust has successfully completed the 2018/19 data security protection (DSP) toolkit and received a substantial assurance internal audit of compliance. This

position is reported annually to the Board in the information governance and Caldicott guardian's reports. Data security and cyber risks are overseen by the Trust information governance group as a standing item; this group includes the Trust's senior information risk owner (SIRO) and the Caldicott guardian.

Information security is a component of The Data Security and Protection (DSP) Toolkit for which an annual report is made to the Board, most recently in April 2018.

2.5 Risk assessment

The Trust identifies, assesses, prioritises and records its risk profile through a variety of systems both internal and external. The review of risks and current control measures enables risks to be prioritised and supports the Trust in determining the degree of risk that the Trust will accept, ie its risk appetite. A Trust wide analysis of risk is carried out annually both by the ELT and the Board; this is communicated within the annual plan. Strategic risks are identified within the BAF and assurance that the risks are appropriately managed is sought from both external and internal sources as appropriate.

In addition to reactive risk assessment, topic-based and planned risk assessments are undertaken to prevent risk, for example through counter fraud proactive reviews. Other initiatives to prevent risks include a review of whistleblowing processes and safeguarding issues arising from national reports.

For the period – 01.04.18 to 31.03.19, 117 new risks were identified and approved (excluding BAF risks) and 168 approved risks were closed - risk categories are shown in tables 1 and 2 below.

At the end of the year, there were 12 BAF risks on the risk register; 2 of these risks were opened in the period 2018/19 and 1 was closed* – see tables 3-5 below.

New risks opened and approved (excluding BAF risks) in 2018/19	
Category	*Total*
Clinical	47
Environment	5
Event	0
Finance, performance, contracts and strategy	27
Fire, health and safety	4
Information governance	2
Information management and technology	15
Medical directorate	3
Reputational	5
Workforce	13
Total	**121**

Table 1

Risks closed (excluding BAF risks) in 2018/19	
Category	*Total*
Clinical	66
Environment	3
Event	1
Finance, performance, contracts and strategy	49
Fire, health and safety	8
Information governance	1
Information management and technology	23
Medical directorate	1
Reputational	5
Workforce	14
Total	**171**

Table 2

BAF risks opened and approved	
Category	*Total*
Finance, performance, contracts and strategy (risk 2093)	1
Event (risk 2086)	1
Total	**2**

Table 3

BAF risks closed or removed from the BAF register[1]			
Category	*Removed from BAF*	*Closed*	*Total*
Finance, performance, contracts and strategy (risk 930)		1	1
Total	**0**	**1**	**1**

Table 4

Major strategic risks to Trust priorities in 2018/19 included:

ID	Risk	Trust Objectives
1598	BAF Risk: Sustainability and transformation plan (STP) resource. Risk that the Trust has not allocated adequate resources to the engagement with the STP process in the four geographies where CLCH provides services – north west London, north central London and south west London, Herts. This could mean that the Trust's strategic interests and the interests of community healthcare are not sufficiently represented in the development of the STPs. Principal assurance committee: FRIC	*Finance* - Deliver the 18/19 financial plan
831	BAF Risk: Failure to deliver the 2018/19 QIPP (£9.5m) results in a reduced surplus or a deficit which could affect our NHSI segment 1 status. Principal assurance committee: FRIC	*Finance* - Deliver the 18/19 financial plan
833	BAF Risk: Risk of our failure to maintain commissioner satisfaction with Trust delivery - through shortfalls in stakeholder engagement, contract delivery or perceived misalignment of Trust services with commissioners' intentions - leads to commissioner discontent and risk of lost income. Principal assurance committee: FRIC	*Finance* - Deliver the 18/19 financial plan

[1] *Risks that were removed from the BAF register in the 2018/19 period (but continued to be managed as part of the Trust's risk register) are included in this figure*

866	BAF Risk: Failure to compete results in a failure to increase or maintain Trust market share in our core services and STPs. Principal assurance committee: FRIC	*Finance* - Deliver the 18/19 financial plan
2086	BAF Risk: The delivery of corporate services by our partner Capita and/or third party providers, either separately or in conjunction, if not maintained or delivered effectively could result in interruption of service delivery and negatively impact upon the delivery of clinical services. Principal assurance committee: audit	*Finance* - Deliver the 18/19 financial plan, *Operations* - Deliver all NHS constitutional and contractual standards, *Quality* - Maintain and improve the quality of services delivered by CLCH moving from good to outstanding, *Strategy Implementation* - Implement strategic priorities of integration and place, *Workforce* - Make CLCH a great place to work
2093	BAF risk: That the services of the Trust do not provide value for money, and that this would impact upon commissioning views and market share. Principal assurance committee: FRIC	*Finance* - Deliver the 18/19 financial plan, *Operations* - Deliver all NHS constitutional and contractual standards, *Quality* - Maintain and improve the quality of services delivered by CLCH moving from good to outstanding, *Strategy Implementation* - Implement strategic priorities of integration and place, *Workforce* - Make CLCH a great place to work
1218	BAF Risk: Currently the Trust's business information and analytics function is under-performing, providing inconsistent contractual information requirements. There are also variable sign-off arrangements for data submission externally. This represents a reputational risk with commissioners and regulators. There is also a financial risk through loss/failure to win contracts and inability to recover income that is due through poor/no information. Principal assurance committee: FRIC	*Operations* - Deliver all NHS constitutional and contractual standards
1961	BAF Risk: Weaknesses in NHS and Trust cyber security make the Trust IMT services and in turn clinical services and essential data (staff, patient and business related) at risk. This could result in clinical risk, information governance breaches, loss of reputation and risk for staff and patient. Principal assurance committee: FRIC	*Operations* - Deliver all NHS constitutional and contractual standards

1154	BAF Risk: Failures in adherence to Information Governance national standards can lead to reputational damage, conflict with regulatory compliance and undermine the quality of Trust service delivery. Principal assurance committee: FRIC	*Quality* - Maintain and improve the quality of services delivered by CLCH moving from good to outstanding
1960	BAF Risk: Medium to long term changes in workforce (nursing & therapies) presents a risk that CLCH will not be able to recruit and retain suitably qualified clinical staff to deliver a safe and effective service. Principal assurance committee: workforce	*Quality* - Maintain and improve the quality of services delivered by CLCH moving from good to outstanding, *Workforce* - Make CLCH a great place to work
1797	BAF Risk: Risk that the Trust will have less flexibility to enter into new care models/joint ventures as it is not a foundation trust (FT) and there is a national pause in FT programme. Principal assurance committee: FRIC	*Strategy Implementation* - Implement strategic priorities of integration and place
2217	BAF Risk: The Trust is acquiring significant new clinical services (Herts Adult Community) and following transfer of these services, the Trust may identify risks to quality and compliance within the services which will require remedial actions. These could trigger regulatory breaches. Principal assurance committee: quality	*Quality* - Maintain and improve the quality of services delivered by CLCH moving from good to outstanding

Table 5

2.6 Quality governance

The Trust's clinical strategy, approved in November 2018, is influenced by national strategy and the strategic plans published by the STPs in the areas that we work. The clinical strategy supports the Trust's ambition to develop a place based integrated strategy enabled by strong leadership, workforce and technology strategies.

The quality account, published in June annually, defines the Trust's annual quality objectives, linked to the objectives in the quality strategy, and provides a public report on the success year on year of the Trust's plans. The quality strategy supports the Trust's objectives and clinical strategy by clearly defining the vision and success criteria (campaigns) for maintaining and improving quality through all Trust services. Governance arrangements for the 6 campaigns: a positive patient experience; preventing harm; smart, effective care; modelling the way; here, happy, healthy and heard; value added care, are defined in the quality strategy together with clearly defined measures of success each year.

A revised, national, 'never events' policy and framework was published in March 2015; the Trust has had no incidents of national reportable 'never events' since the first list was published, in 2011.

The Trust has committed to creating and maintaining a culture of being open and honest and takes seriously its duty of candour. The Trust was rated as 'outstanding' in the Department of Health learning from mistakes league table published in 2016. There is a clear procedure for managing serious incidents in a timely manner and the Board receives a monthly report on serious incidents which have occurred, together with lessons learned from those incidents, following root cause analysis and compliance with the Trust's being open policy. Key messages are shared with staff through the Trust's regular '*spotlight on quality*' publication.

CLCH continues to develop a positive relationship with local stakeholders, including clinical commissioning groups and partner organisations, in order to provide high quality patient care within the resources available.

2.7 Corporate governance framework

The Board governance structure is shown in figure 1 below.

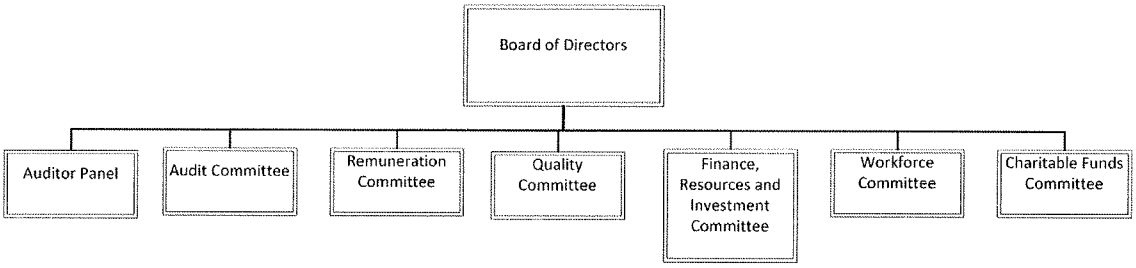


Figure 1

2.8 The role of the Board's committees

Auditor panel – meetings arranged as required
The role of the auditor panel is to advise the Board on the selection and appointment of the external auditor.

Audit committee – minimum of 4 meetings per year
The audit committee is a standing committee of the Board. The role of the committee is to support the Board and the accountable officer by reviewing the comprehensiveness, reliability and integrity of controls and assurances to meet the requirements of the Board and the Accountable Officer. To support this, the audit committee has particular engagement with the work of internal and external audit and with financial reporting issues.

The audit committee has responsibility for overseeing the organisation's risk management structures, processes and responsibilities. Individual Board committees each have primary responsibility for monitoring specific risk categories.

In addition to its core responsibilities, the audit committee has focused on the following areas as part of its programme of work during 2018/19:

- To monitor progress against the implementation of the data quality strategy to gain assurance on the accuracy, timeliness and relevance of key performance data sets
- To receive notifications of identified control issues and gain assurance that relevant recommendations and management actions have been complete to mitigate future recurrences
- To gain assurance that relevant Trust policies have been reviewed for consistency with Trust standing orders and standing financial instructions.

Remuneration committee - minimum of 3 meetings per year
The remuneration committee is a standing committee of the Board and is responsible for ensuring that the Trust recruits, retains and develops a strong executive director team capable of achieving the Trust's objectives for performance. The committee has oversight of succession planning and very senior staff pay and contractual arrangements.

Quality committee – minimum of 4 meetings per year
The quality committee focuses on quality issues including the clinical agenda to ensure that appropriate clinical governance structures, systems and processes are in place across all services and are developed in line with national, regional and commissioning expectations. This is based on the three (Darzi) pillars of quality: safe, effective with a positive patient experience which support the Trust's 6 quality strategy campaigns: a positive patient experience; preventing harm; smart, effective care; modelling the way; here, happy, healthy and heard; value added care.

Finance, resources and investment committee – minimum of 10 meetings per year
The finance, resources and investment committee is responsible for seeking assurance regarding the control and management of the Trust's performance, finances, resources and investments. Duties of the committee include: consideration of the finance strategy (revenue and capital), post investment reviews and overseeing performance indicators and the implementation of the Trust's procurement strategy, together with monitoring the key financial outcomes.

Workforce committee – minimum of 3 meetings per year
The workforce committee is responsible for seeking assurance on the appropriateness of the people strategy and its implementation across the Trust and strategic partnership. Similar to the remuneration committee, the committee is mindful of the need to improve the diversity of the workforce so that it better reflects the populations which the Trust serves.

Charitable funds committee - minimum of 3 meetings per year
A charitable funds committee has been established by the Board (as corporate trustee) to make and monitor arrangements for the control and management of Trust's charitable funds. Key duties of the committee are to apply the charitable funds in accordance with their respective governing documents; to make decisions involving the sound investment of charitable funds in a way which both preserves their capital value and produces a proper return consistent with prudent investment; and compliance with the Trustee Act 2000 and the Charities Act 2011.

2.9 Board and committee attendance

Summary attendance by members of Board and committee meetings during 2018/19 is shown in the table below[2].

	Board of directors, including non-voting members[3]	Auditor panel	Audit committee	Remuneration committee	Quality committee	Finance, resources and investment committee (FRIC)	Workforce committee	Charitable funds committee
April 2018	13/13	-	-	-	6/7	5/6[NV]	-	4/5
May 2018	11/13	-	3/3	-	-	4/6	-	-
June 2018	11/13	-	-	3/3 3/3	-	4/6	5/6	-
July 2018	12/13	-	3/3	-	5/7	6/6	-	-
August 2018	-	-	-	-	-	-	-	-
September 2018 (AGM)	13/13	-	-	-	-	-	-	-
September 2018	12/13	-	-	-	-	6/6	-	-
October 2018	14/14*	-	3/3	-	6/8	7/7*	-	-
November 2018	13/14	-	-	3/3	-	6/7	6/6	4/5
December 2018	-	-	3/3	-	-	-	-	4/5
January 2019	11/14 [ANV]	-	-	-	7/8	6/7	-	-
February 2019	-	-	-	3/3	-	7/7	6/6	-
March 2019	13/14 [ANV]	-	-	-	-	7/7	-	4/5

Table 6

Key	
ANV	Associate non-executive director vacancy
NV	Non-executive director vacancy
*	In October the director of improvement joined the Board, FRIC and the Quality Committee

The executive team oversees the day-to-day operational management of governance, risk and internal control across the whole organisation's activities in support of the organisation's objectives. The weekly meeting of the ELT includes the divisional directors of operations and chief information officer.

Each committee is required to consider how well it has performed during the year against the terms of reference and annual work plan. The audit committee, finance, resources and investment committee and workforce committee also agree specific annual objectives.

There are a range of mechanisms available to provide assurance that systems are robust and effective. These include utilising internal and external audit and assessment, management reporting and clinical audit. Committee chairs provide both oral and written reports to the Board; minutes from committee meetings are included with Board papers and, where appropriate, published on the Trust's website.

[2] Board attendance is based on the meeting in public, part-attendance at meetings is included
[3] Associate NED, director of people and communications and director of improvement

2.10 Committee programmes and issues reported to the Board

All committees have an agreed programme of work for the year, cross referenced to the BAF in support of the Board.

In line with the Local Audit and Accountability Act 2014 requirements, an Auditor Panel was established in 2016.

CLCH is the corporate trustee of the CLCH NHS Trust Charity having been appointed on 22 December 2011. The Board has devolved responsibility for the on-going management of funds to the charitable funds committee, which administers the funds on behalf of the corporate trustee.

Issues highlighted by committees of the Board during the year include matters in relation to the following:

2.10.1 Auditor panel

KPMG were recommended in 2016 as the Trust's external auditor from 01.04.17. There have been no meetings of the panel in 2018/19.

2.10.2 Audit committee

The committee has highlighted matters in relation to: risk management; progress against the internal audit and counter fraud plan; policy management, aged debt, salary overpayments, and procurement.

Following the committee's recommendations to the Board, responsible directors are now, routinely, asked to attend meetings when limited assurance reports are considered. During the year, members have expressed some concern that limited assurance reports had identified issues in relation to basic controls, processes and compliance. The ELT have confirmed how processes will be strengthened for routine business functions in order to give the committee greater assurance.

2.10.3 Remuneration committee

During the year a number of important issues have been managed on behalf of the Board, including the composition of the Board, executive and non-executive vacancies and succession planning.

The committee has also considered severance arrangements and has, again, noted the effectiveness of proactive redeployment initiatives to prevent the loss of talented members of staff and to minimise costs.

2.10.4 Quality committee

The committee has routinely considered assurance reports in support of the quality strategy and has scrutinised, on behalf of the Board, the annual reports in relation to: research and development; complaints; safeguarding; infection prevention and control; flu vaccination and medicines management.

An external review in relation to the speech and language therapy service and the Harrow cardiology service was commissioned during the year and reported to the Board.

A review of the quarterly divisional red flag process has been commissioned from London Southbank University and will be reported in 2019/20.

The committee has also considered, in detail, limited assurance report recommendations in relation to records management and medicines management (pharmacy stock).

2.10.5 Finance, resources and investment committee

The committee has highlighted issues in relation to: financial planning; performance (operational, contractual and financial); lessons learned from post investment reviews; the CLCH way change programme; the data warehouse rectification plan, the Capita oversight group, financial plans and risks and delivery of savings targets.

Progress against the estates, procurement and IM&T strategies has been monitored, together with regular review of contracts and new business.

An external review of issues identified in relation to the South division was reported during the year – the findings have been used to inform the Trust's mobilisation processes. Turnaround and recovery plans for the division has been closely monitored during the year. A deep dive into the deteriorating financial position of the North division was also undertaken.

2.10.6 Workforce committee

Issues brought to the attention of the Board have included: vacancy, turnover and sickness rates and establishment control processes.

The committee has routinely considered workforce performance, clinical workforce transformation and education updates, together with annual reports in relation to revalidation of doctors and nurses.

The committee has also considered, in detail, limited assurance report recommendations in relation to induction, compliance and disclosure and barring service checks.

2.10.7 Charitable funds committee

Risks in relation to fundraising and expenditure have been closely monitored throughout the year. The corporate trustee has been advised that the 3-year fundraising forecast remains a concern and that there is an anticipated net deficit of between £170k-180k for the year 2019/20.

2.11 Directors' report

Our board of directors has overall responsibility for setting the strategy of CLCH, as well as monitoring performance, finance and maximising the efficiency of services provided by the organisation.

The board meets in public at least ten times a year to discuss performance, challenges and strategy. When discussing issues of a confidential nature it excludes members of the public in accordance with the Public Bodies (Admission to Meeting) Act 1960. Our standing orders and standing financial instructions include the scheme of delegation and decisions reserved for the board. The board has a majority of non-executive directors.

2.11.2 Board members

During 2018/19 there were a number of changes to the membership of our board.

2.11.3 Executive directors

Louella Johnson joined the Trust as director of people and communications on 03.04.18.

Louise Ashley, chief nurse and chief operating officer left the Trust on 07.10.18 to take up a role as a NHS Trust chief executive in Kent. We would like to formally thank Louise for her excellent leadership and determination.

Charlie Sheldon was appointed to the post of chief nurse from 01.10.18.

James Benson, formerly our director of improvement, was appointed to the post of chief operating officer from 01.10.18.

Elizabeth Hale was appointed as interim director of improvement on 01.10.18.

2.11.4 Non-executive director (NED) changes

Anne Barnard, NED, left the Trust on 31.03.18, having served as a non-executive director since the Trust was established. We would like to formally thank Anne for her commitment and outstanding contribution to the Trust.

Paula Constant, associate non-executive left the Trust on 31.12.18. We would like to thank Paula for her contribution to the organisation.

Jane Slatter, NED, joined the board on 09.04.18.

2.11.5 Board members

The table below details our board members' positions at 31 March 2019 on the formal sub-committees of the board. Profiles of our board members are available on our website: https://www.clch.nhs.uk/about-us/our-board

Non-executive team	Committee membership (* chair)
Jitesh Chotai	Audit Finance, resources and investment*
Dr Carol Cole Vice chair	Quality* Remuneration Workforce
Angela Greatley, OBE Chair of the board	Finance, resources and investments Quality Remuneration Workforce
Professor David Sines, CBE	Quality

Senior independent director	Remuneration* Workforce*
Jane Slatter	Audit Quality
Clive Sparrow	Audit* Audit panel* Charitable funds committee* Finance, resources and investment
Executive team (voting)	Committee membership
James Benson, chief operating officer	Finance, resources and investment Quality
Mike Fox, director of finance, contracting and performance	Charitable funds Finance, resources and investment
Dr Joanne Medhurst, medical director	Charitable funds Quality
Andrew Ridley, chief executive	Finance, resources and investment Workforce
Charlie Sheldon, chief nurse	Quality Workforce
Executive team (non-voting)	Committee membership
Elizabeth Hale, interim director of improvement	Finance, resources and investment Quality
Louella Johnson, director of people and communications	Workforce

The following non-executive board member has ownership or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS:

- Jane Slatter
- David Sines

The board's register of interests is published on our website: www.clch.nhs.uk/publications

2.11.6 Board of directors

The Board generally meets in public. When this is not possible, due to reasons of confidentiality, it excludes members of the public pursuant to the Public Bodies (Admission to Meetings) Act 1960. In their meetings, the Board regularly considers strategic, operational and governance issues, including the assurance framework and risk management. The Trust's standing orders and standing financial instructions include the scheme of delegation and decisions reserved for the Board. There have been a number of changes to the membership and composition of the Board during the year as shown in table

7 below.

Board membership and composition	Post holder	Notes
Chief nurse and chief operating officer	To 07.10.18 Louise Ashley	The role of chief nurse and chief operating officer was split when L Ashley left the Trust.
Chief nurse	From 01.10.18 Charlie Sheldon, substantive	
Chief operating officer	From 01.10.18 James Benson, substantive	
Director of improvement	From 01.10.18 – 31.03.19 Elizabeth Hale, interim (substantive from 01.04.19)	Non-voting position
Director of people and communications	From 03.04.18 Louella Johnson	Non-voting position
Non-executive director	From 09.04.18 Jane Slatter	
Senior independent director	From 01.04.18 David Sines	
Deputy chair	From 01.04.18 Carol Cole	
Associate non-executive director	To 31.12.18 Paula Constant	Non-voting position (vacancy)

Table 7

With the exception of the Director of Improvement position, the Board has had a full complement of substantive executive and non-executive directors since April 2018.

2.11.7 Committee chair arrangements

Committee	Chair – 2018/19
Auditor panel	From 01.04.18 Clive Sparrow
Audit committee	From 01.04.18 Clive Sparrow
Remuneration committee	David Sines
Quality committee	Carole Cole
Finance, resources and investment committee	From 01.04.18 Jitesh Chotai
Workforce committee	David Sines
Charitable funds committee	Clive Sparrow

Table 8

2.12 Board performance and development

Board development over the past few years has demonstrated a strong commitment to maintaining an engaged and effective Board.

In February 2019, Board members participated in a self-assessment showing continued strong performance – in line with previous years. Together with the findings of the well-led development review, results will be used to inform the Board's development plan to support Board effectiveness during 2019/20.

Facilitated development during 2018/19 has supported the Trust's leadership approach, the NHS long-term plan, integrated care system governance and primary care operating models.

The Board is compliant with the Code of Conduct and Code of Accountability for NHS Boards and has previously undertaken comparisons with the NHS foundation trust (Monitor) Code of Governance in support of: best practice principles and processes to maintain good quality corporate governance, performance and the provision of safe, effective services for patients.

A register of relevant and material Board member interests is maintained and published on the Trust's website. Board and committee meeting agendas routinely include an opportunity for members to declare any interests in agenda items. Any such interests are recorded in the minutes of the meeting and in a separate register held by the trust secretary. There have been no occasions during the year where a member has had to withdraw from the discussion or decision taken at any Board or committee meeting.

2.13 Statutory duties

Arrangements are in place to ensure legal compliance and effective discharge of statutory duties, for example safeguarding, medicines management, infection prevention and control, health and safety and data protection.

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

2.14 Staff – National Quality Board

In order to ensure rosters are robust and account for all staff hours and balance service needs and deployment of annual and study leave, the rosters are signed off to scheduled deadlines. Compliance with this requirement is reported, discussed and monitored by the zero agency group chaired by the chief operating officer.

The Trust completes the care hours per patient day (CHPPD) metric in the community (in-patient bedded areas) monthly as required. This now includes nursing and allied health professional staff.

As part of the internal audit annual plan, a safe staffing audit was undertaken in November 2018. The overall objective was to provide assurance over the effectiveness of the staffing arrangements in place within the Trust to ensure that safer staffing levels are achieved. The audit included compliance with nursing rosters and the extent to which a sample of departments and wards were making the most effective use of their nursing staffing establishments in managing variables such as annual leave, short-term sickness and training to minimise temporary staffing expenditure. The review found that rosters were being reviewed and managed closely with respect to safe staffing. However, in some cases there was poor quality of roster data being produced and an action plan was put in in place overseen by the director of people and communications.

In February 2019, we undertook a self-assessment against the NHSI workforce safeguards guidance with recommendations to be considered at the clinical staffing establishment panel in March (outlined below) and in order to identify any further actions needed. An update will be provided in the report for the Workforce Committee in June 2019, which receives a regular report on safe / nurse staffing levels.

The quality impact assessment (QIA) process is well-established and meets regularly on pre-scheduled dates. The requirement to take any quality innovation productivity or preventative proposal through the QIA process for approval prior to implementation is well understood. This includes any redesign or introduction of new roles, changes in staffing establishment, or changes to skill mix.

A new clinical staffing establishment review panel was implemented in November 2018. The panel, which meets monthly, is made up of senior clinical staff from across the Trust and is chaired by the director nursing. The purpose of the panel is: to check, challenge and review areas where staffing levels are being changed or proposed. The aim is to enable greater scrutiny of any proposals for clinical establishments prior to the QIA sign-off process. The panel will also undertake an annual review of staffing numbers within services to ensure that staffing numbers are within national / CLCH agreed guidance.

The rehabilitation transformation programme was established with the aim of developing a clear model for the care of in-patient rehabilitation patients, benchmarking against evidence based best practice both nationally and internationally continues. Five design groups have been established to focus on specific components of the patient pathway. These groups have worked with patient representatives, staff and other representatives to take work forward in a number of areas.

Workforce action teams are established when required to support the services where risks or concerns that specifically relate to the workforce are identified. These concerns could include factors that impact on staffing levels, for example high vacancy, turnover and sickness absence rates. Complementing this the workforce business partner team work with their senior service managers to identify 'hotspots' where vacancy rates are highest and support managers in regularly monitoring the root causes, and developing service specific recruitment and retention plans. The Trust is part of cohort 4 of the NHSI retention direct support programme and developing action plans using the guidance and supporting tools and techniques.

Further to the guidance issued by NHSI in December 2018, The Trust has self-assessed our current levels of attainment for e-job planning and e-rostering against the NHSI standards. The Trust is also developing an approach to ensure that clinical staff have job plans, and exploring the options for investment in e-job planning software which will support demand and capacity planning. This complements the existing project optimising our e-rostering systems and embedding good rostering practices.

The Trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are compliant.

As part of the review of equality delivery system (EDS2) Goal 4, the Trust has identified areas for improvement in the way equality, diversity and inclusion are integrated within Board papers. We will be developing a checklist for the governance team and guidance for managers to ensure equality-related risk analysis is integrated in a systematic manner from April 2019.

2.15 Climate Change Act

The Trust is committed to create and embed sustainable models of care ensuring our estate and operations are as efficient, sustainable and resilient as possible. Drivers for change include requirements to adhere to legislation such as the Climate Change Act 2008, International and UK guidance and health specific requirements including sustainable transformation partnerships (STP) plans.

The Trust has reduced energy consumption by 21% in its estate since 2015 and we continue to improve initiatives including agile working to reduce staff travel journeys and time, annual reductions in footprint of its estate.

The Trust's sustainable development plan sees further development of the Trust's corporate approach, including aassessment and management of utilities, travel and logistics, adaptation and capital projects. The Trust is developing further its approach to green space and biodiversity.

Sustainable use of resources and reduction of carbon and greenhouse gases are a theme across the plan.

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

We are proud to have maintained high quality services and to have achieved our target surplus for an 8th consecutive year.

We have implemented a number of major transformation schemes and the majority of schemes in the 2018/19 quality, innovation, productivity and prevention (QIPP) plan relate to the efficient use of resources rather than a reduction in staff numbers. This programme has been delivered whilst maintaining the safety and quality of services which is assured by a process of quality impact assessments – co-chaired by the Trust's medical director and chief nurse. However not all cost improvement plans were achieved on a recurrent basis in-year.

The Trust has worked closely with NHSI as a member of the group supporting development of the Carter report for community services. Implementation of the Carter recommendations has been monitored by the ELT together with metrics from the Model Hospital and a number of relevant NHS/NHSI benchmarking reviews. This has led to agreed savings for key

corporate services for 2019/20 where benchmarking indicated the costs were high compared to similar trusts. The procurement function has delivered a strong programme of savings across the year, and has supported STP level savings through shared procurement which increased the savings level due to increased volume.

2.17 Information governance

The Information Commissioner's Office (ICO) has issued new guidance, including a matrix of reportable events. Incidents with a severity level of 6 or above or where the likelihood for harm is at a level 3 or above are classed as serious incidents and must be reported to the ICO via the data security and protection toolkit incident reporting.

During 2018/2019 a total of 5 serious incidents were reported to the ICO. One incident was immediately withdrawn as the new reporting tool identified this as a non-reportable incident (the investigation revealed that there was no breach since the data was not been accessed). This number of incidents (4 reportable) is a decrease from the previous year (2017/18) when a total of 8 incidents were reported. All 4 incidents have been investigated by the ICO, and have been closed with no further action required by the Trust.

The information governance team is supported by the Caldicott Guardian. The quality committee receives an annual report from the Caldicott Guardian, including issues raised / reported to the ICO.

2.18 Annual quality account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare quality accounts for each financial year.

The draft quality account is scrutinised by the quality committee on behalf of the Board. Recommendations from our external auditor in relation to previous voluntary audits of the quality account have been implemented in full. A further, voluntary audit has been planned in 2019/20.

2.19 Quality and accuracy of elective waiting time data

Consultant led services are subject to the 18 week (maximum) wait target, for example referral to treatment time (RTT). Services subject to this target are identified by managers and as part of the Trust's mobilisation process for services. All such services are communicated to the business intelligence team for inclusion in national reporting.

The Trust follows national guidance on submission of RTT reports. Reports are issued through the NHS UNIFY2 system. Since July 2018, reports have been generated via the informatics team from the data warehouse. Information is extracted directly from the Trust's

clinical systems. RTT performance is reviewed on a weekly basis through the enhanced performance management processes instigated by the chief operating officer.

There are scheduled data quality checks to find distinct data issues within the waiting times data (for example, referrals that have not been linked to appointments and where contact methods have not been completed). The Trust has developed a revised waiting time and RTT dashboard which categorises patients by the number of weeks' waiting. This information is available to divisions to support effective operational management. The clinical business units are asked to validate the automatically generated numbers extracted from clinical systems before they are issued to national monitoring and reporting systems in order to ensure the quality and accuracy of data.

Some control issues, in relation to the Harrow cardiology service were identified during the year, for which an external review was undertaken. See summary of issues identified and action taken in table 9 below.

Summary control issue	Action taken
Weaknesses in the management of patient referrals led to delays in patients being seen.	Cardiac rehabilitation stopped and alternative provision arranged.
	Serious incident investigation undertaken together with external management review – 4 patients may have suffered moderate harm due to the length of time they had waited to be seen.

Table 9

2.20 Review of effectiveness

As accountable officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board and the audit committee. In addition to the role of the Board's committees in assessing the effectiveness of the Trust's risk management and internal control processes, reliance is placed on the assurance gained from internal audit review of the Trust's internal control systems.

During the year 2018/19, internal audit undertook a review of the Trust's BAF which confirmed 'substantial assurance'.

The Head of Internal Audit Opinion is provided annually to contribute to the assurances available to the accounting officer and the Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control. During 2018/19, an overall opinion of "reasonable assurance" was provided.

Of the 13 internal audits reported during the year, 4 reports confirmed substantial assurance, 4 reasonable assurances, with 5 limited assurance opinions.

A summary of the key findings from each of the 5 limited assurance reports is provided below:

Management of HR and recruitment

- Testing found gaps in compliance with the induction process for new staff, follow up of work permits and disclosure and barring service (DBS) renewals.

Pharmacy stock management

- Testing noted a need to review and produce local guidelines for monitoring and recording of stock and cases of non-compliance with processes for purchase ordering, controlled drug reconciliations, stock returns and refrigerator management.

Nursing staffing and rostering

- The quality of roster data in a number of locations needed to be improved in respect of prompt addition of new starters and corrections to annual leave, maternity leave to ensure owed and owing hours were correct.
- Roster creation and approval needed to be undertaken by at least two separate individual processes to ensure separation of duties.

Contract management

- Certain weaknesses in controls were observed from review of arrangements in place for contract management, specifically around completeness of the contracts register, lack of evidence of quotes / waivers, and undertaking of contract management meetings.

Key finance systems

- The review noted gaps in respect of invoice approval processes and management reporting and review. A number of the issues highlighted had already been identified by Trust staff and had been recorded on the Capita action log, however had remained outstanding for some time. Local workarounds had been developed to mitigate some of the risks but this was not representative of how the finance function should operate in the long-term.

During the year TIAA Ltd undertook a detailed follow-up exercise of the recommendations in relation to the key finance system review noting that key actions had been implemented and therefore that reasonable assurance could be confirmed.

While there have been 5 limited assurance reports, the Trust has a risk based approach to preparing the internal audit plan – focusing on areas where further assurance is required in order to identify necessary change or improvement.

There were no overdue internal audit recommendations at year-end.

In its annual report to the Board, the audit committee will indicate that it has received a satisfactory level of assurance that the systems of internal control and risk management in place within the Trust are fit for purpose and are operating effectively, with a noted continued improvement in the active monitoring of the BAF and risk register.

2.21 Conclusion

As accountable officer, my conclusion is that the Trust's risk management process is effective and has been improved through the implementation of recommendations identified within internal audit reports.

There have been no significant internal control issues raised by internal audit during the year. Control issues identified in relation to the Harrow cardiac rehabilitation service and data security are being addressed by the management team.

Signed.....A Ridley.....Andrew Ridley, chief executive

Date: 22/5/19

Statement of the chief executive's responsibilities as the accountable officer of the Trust

The chief executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the chief executive should be the accountable officer of the Trust. The relevant responsibilities of accountable officers are set out in the *NHS Trust Accountable Officer Memorandum.* These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the Trust;
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an accountable officer.

Signed.....A Ridley.....Andrew Ridley, chief executive

Date: ...22/5/19.....

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities. The directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the accounts.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Trust's performance, business model and strategy.

By order of the Board

Signed.....

Andrew Ridley, chief executive

Date: 22/5/2019

Signed.....

Mike Fox, director of finance, contracting and performance

Date: 22/5/2019

2.21 Remuneration and staff report

This report is made by the board on the recommendation of the remuneration committee in accordance with chapter 6 of part 15 of the Companies Act 2006 and schedule 8 of SI 2008 no 410. The first part of the report provides details of remuneration policy; the second part provides details of the remuneration and pensions of our senior managers for the year ended 31 March 2019.

The report is in respect of the senior managers of the trust, who are defined as *'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body'*. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments.

2.21.1 Remuneration committee

The remuneration committee is made up of the chairman and two non-executive directors of the trust board as voting members: the director of HR & OD and chief executive are attendees. The committee meets as necessary to advise the board on the appropriate remuneration and terms of service for the chief executive and directors.

2.21.2 Remuneration policy

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.

The main components of the chief executive's and senior officers' remuneration for current and future years are set out below.

2.21.3 Basic Salary

Directors and senior managers with remuneration set by the very senior managers' (VSM) pay framework

The remuneration of all executive directors and co-opted directors with continuing service with the Trust is set by the VSM pay framework.

The reward package set by the VSM pay framework is as follows:

1. Basic pay is a spot rate for the post, determined by the role and an organisation specific weighting factor;

2. Additional payments are made where such payments are appropriate and within the limits described in the framework; and

3. An annual performance bonus scheme under incentive arrangements (further details of which are provided below).

4. As a community trust the trust's arrangements for VSM pay are governed by the 2013 pay framework for community trusts which sets benchmark levels for VSM pay linked to population and trust size. Central London Community Healthcare (CLCH) VSM salaries are in line with this framework and all changes to salaries are subject to NHS Improvement approval.

The 2013 VSM framework for community trusts is available to the general public on the Department of Health website.

2.21.4 Directors and senior managers with remuneration paid via an agency

The trust did not pay the remuneration of any board members via an agency during 2018/19 (2017/18 nil).

2.21.5 Incentive arrangements

During 2008/09 the Department of Health implemented a performance related pay scheme for VSM contracts.

As part of these arrangements those CLCH employees on a VSM contract are eligible to be considered for a performance related bonus scheme. The ability to make performance payments is still subject to NHSI approval.

Two performance related bonuses were paid by CLCH in 2018/19 that related to 2017/18.

2.21.6 NHS pension entitlement

All staff including senior managers is eligible to join the NHS pension scheme. The scheme has fixed the employer's contribution at 14.3% (2017/18: 14.3%) of the individual's salary as per the NHS Pension Agency Regulations. Employee contribution rates for trust employees and practice staff, and the prior year comparators, are as follows:

Tier	Annual pensionable pay (full time equivalent)	Contribution rate 2018/19	Contribution rate 2017/18
1	Up to £15,431.99	5.0%	5.0%
2	£15,432.00 to £21,477.99	5.6%	5.6%
3	£21,478.00 to £26,823.99	7.1%	7.1%
4	£26,824.00 to £47,845.99	9.3%	9.3%
5	£47,846.00 to £70,630.99	12.5%	12.5%
6	£70,631.00 to £111,376.99	13.5%	13.5%
7	£111,377.00 and over	14.5%	14.5%

Scheme benefits are set by the NHS Pensions Agency and are applicable to all members.

2.21.7 Service contracts

Each of the directors and very senior managers listed below has or has had a substantive or fixed term contract which can be terminated by either party giving between 3 and 6 months'

written notice. The trust can request that the senior manager either works his or her notice or be paid an amount in lieu of notice.

Each director's service or fixed term contract became effective on the following dates:

Executive director	Role	Contract start date	Contract end date
Andrew Ridley	chief executive	01/10/2016	-
Dr Joanne Medhurst	medical director	14/01/2013	-
Mike Fox	director of finance, contracting and performance	12/12/2016	-
Louise Ashley	chief nurse and director of quality governance	21/11/2012	01/01/2017
Louise Ashley	acting chief nurse and chief operating officer	01/01/2017	07/07/2017
Louise Ashley	chief nurse and chief operating officer	07/07/2017	07/10/2018
James Benson	director of improvement	01/05/2017	30/09/2018
James Benson	chief operating officer (COO)	01/10/2018	-
Louella Johnson	director of people and communications	03/04/2018	-
Charlie Sheldon	chief nurse	01/10/2018	-
Elizabeth Hale	director of improvement (Interim)	01/10/2018	-

None of the service contracts for directors or senior managers make any provision for compensation outside of the national pay and remuneration guidelines or NHS pension scheme regulations.

2.21.8 Termination arrangements

Termination arrangements are applied in accordance with statutory regulations as modified by national NHS conditions of service agreements (specified in Whitley Council/Agenda for Change), and the NHS pension scheme. Specific termination arrangements will vary according to age, length of service and salary levels. The remuneration committee will agree any severance arrangements. Her Majesty's Treasury approval will be sought where appropriate.

2.21.9 Salaries direct to limited companies

The trust has a policy that all substantive staff are paid through the payroll. The trust paid the remuneration of no director to an associated limited company during the financial year 2018/19 (2017/18: 0).

2.21.10 Pay Multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the Trust in the financial year 2018/19 was £170,000 to £175,000 (2017/18: £165,000 to £170,000). This reflects the chief executive's

remuneration. This was 6 times (2017/18: 5 times) the median remuneration of the workforce, which was £29,608 (2017/18: £31,333).

In 2018/19 one employee, a temporary medical staff, received remuneration higher than the highest paid Director (2017/18: 2 employees). Remuneration paid to employees during 2018/19 ranged from £6k to £183k (2017/18 £13k to £208k).

The VSMs in post received a yearly cost of living payment of £2,075. This was back dated to 1st April 2018 or after, depending on start date in the year.

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

2.21.11 Non-executive directors

Non-executive directors do not have service contracts. They are appointed by NHS Improvement for a set period, which may be extended.

Non-executive directors are paid a fee set nationally. Travel and subsistence fees incurred in respect of official business are payable in accordance with nationally set rates. Non-executive directors are also able to reclaim expenses related to all necessary carer's expenses incurred as a result of their work. Non-executive members do not receive pensionable remuneration and therefore are not eligible to join the NHS pension scheme.

The non-executive appointments became effective on the following dates:

Non-executive director	Role	Contract start date	Contract end date
Jitesh Chotai	non-executive director	01/06/2016	-
Angela Greatley	board chair	01/04/2016	-
David Sines	non-executive director	27/06/2012	-
Carol Cole	non-executive director	01/08/2014	-
Clive Sparrow	non-executive director	01/04/2017	-
Jane Slatter	non-executive director	09/04/2018	-
Paula Constant	associate non-executive director	01/07/2017	31/12/2018

a) Paula Constant post as associated non-executive director was unremunerated.

2018/19 Remuneration report

2.21.12 Directors' and very senior managers' salaries and allowances

	2018/19						2017/18					
Name and title	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (band of £2,500)	Total (bands of £5,000)	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (band of £2,500)	Total (bands of £5,000)
Executive directors												
Andrew Ridley (chief executive) (b)	165-170	0	0-5	0	0	170-175	165-170	0	0	0	0-2.5	165-170
Dr Joanne Medhurst (medical director) (a)	130-135	0	0	0	70-72.5	205-210	115-120	0	0	0	102.5-105	220-225
Louise Ashley (chief nurse and chief operating officer) (b) (d)	65-70	0	0-5	0	162.5-165	230-235	120-125	0	0	0	52.5-55	170-175

Mike Fox (director of finance, contracting and performance) – from 12 December 2016)	120-125	0	0	0	22.5-25	145-150	115-120	0	0	0	150-152.5	265-270
James Benson chief operating officer (COO)from 1 October 2018 (c)	115-120	0	0	0	42.5-45	155-160	105-110	0	0	0	95-97.5	200-205
Louella Johnson (director of people and communications)	120-125	0	0	0	20-22.5	140-145	0	0	0	0	0	0
Charlie Sheldon (chief nurse) (e)	55-60	0	0	0	52.5-55	110-115	0	0	0	0	0	0
Elizabeth Hale (e)	50-55	0	0	0	37.5-40	90-95	0	0	0	0	0	0
Non-Executive Directors												
Angela Greatley (non-	30-35	0	0	0	0	30-35	30-35	0	0	0	0	30-35

executive director and chair)												
Carol Cole (non-executive director)	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Jitesh Chotai (non-executive director and chairman of the audit committee)	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Professor David Sines (non-executive director)	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Clive Sparrow (non-executive director)	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Jane Slatter (non-executive director)	5-10	0	0	0	0	5-10	0	0	0	0	0	0

a) Dr Joanne Medhurst now works full-time for the Trust, after previously working part-time (0.9 WTE). This is reflected in her salary banding.

b) Louise Ashley and Andrew Ridley both received a performance related bonus that was agreed and paid in 2018/19 due to their performance in 2017/18.
c) James Benson's role changed from director of improvement to chief operation officer from the 1st October 2018. The disclosure is based on his revised salary.
d) Louise Ashley's salary is prorated as she left the Trust on the 7th October 2018.
e) Charlie Sheldon and Elizabeth Hale's salaries are prorated as they were appointed to the board from the 1st October 2018.

2.21.13 Directors' and very senior managers' pension benefits – audited

Name and title	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 2019 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2019 - £'000 (Note d)	Real increase in Cash Equivalent Transfer Value £000 (Note e)	Cash Equivalent Transfer Value at 31 March 2018 - £'000 (Note d)	Employer's contribution to stakeholder pension (£000)
	£000	£000	£000	£000	£000	£000	£000	£000
Dr Joanne Medhurst (medical director)	2.5-5	2.5-5	25-30	60-65	539	88	421	0
Louise Ashley (chief nurse and chief operating officer)	2.5-5	7.5-10	35-40	110-115	807	96	579	0
Mike Fox (director of finance, contracting and performance)	0-2.5	0	30-35	65-70	442	53	360	0
James Benson (chief operating officer)	0-2.5	0-2.5	20-25	40-45	326	52	251	0

Louella Johnson (director of people and communications)	0-2.5	0	15-20	0	377	36	314	0
Charlie Sheldon (chief nurse)	0-2.5	0-2.5	35-40	85-90	633	35	516	0
Elizabeth Hale (director of improvement)	0-2.5	0	10-15	0	160	9	109	0

2018/19 Remuneration report

Notes

a) Non-executive members do not receive pensionable remuneration. There are no payments in respect of pensions for non-executive members (2017/18: £nil).

b) During 2018/19 the Trust paid no employer's contribution into director's personal pension plans (2017/18: £nil).

c) Cash Equivalent Transfer Values (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

d) Real Increase in CETV. This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period. The factor used to calculate a CETV increased on 29 October 2018.

e) The 2018/19 and 2017/18 Pension, Lump Sum and CETV for Dr Joanne Medhurst exclude practitioner (i.e. GP) pension benefits.

f) The real discount rate applicable on 31 March 2019 is 0.29% (the previous year's rate was 0.10%)

2.22 Staff report

All figures are subject to audit.

The profile of CLCH has altered throughout the year with movement of services into and out of the organisation in line with the commissioning intentions and outcomes of competitive tender processes. Key services to leave CLCH's portfolio in 18/19 have included continuing care and continuing care therapies in Inner London, child therapies in Barnet and diabetes services in Hounslow. Meanwhile 0-19 services in Ealing and school nursing services in Wandsworth have been key additions to CLCH's portfolio in 18/19. CLCH's contract portfolio will grow significantly in financial value in 19/20 with the expected mid-year addition of a new contract to be the primary provider of community services for Herts Valley CCG.

Staff sickness absences rates are within targeted tolerances closing at a 12 month rolling position of 3.92% (31 March 2018: 3.65%).

Expenditure relating to consultancy is disclosed in note 7 of the financial statements. Exit package payments are disclosed below.

The head count split of individuals paid through CLCH payroll at 31 March 2019 was (13%) male to (87%) female (31 March 2018: 13% male to 87% female). Our Board Management gender breakdown as at 31 March 2019 was as follows: 7 Male, 6 Female (31 March 2018 was as follows: 6 Male, 5 Female). Please see also section 1.7 'our staff' and workforce performance measures in section 1.5.4.

2.22.1 Average number of employees (WTE basis)

	2018/19			2017/18		
	Permanent Number	Other Number	Total Number	Permanent Number	Other Number	Total Number
Medical and dental	30	8	38	30	6	36
Ambulance staff	0	0	0	0	0	0
Administration and estates	588	86	674	583	92	675
Healthcare assistants and other support staff	466	112	578	406	54	460
Nursing, midwifery and health visiting staff	1,285	210	1,495	1,188	209	1,397
Nursing, midwifery and health visiting learners	3	26	29	0	0	0
Scientific, therapeutic and technical staff	468	57	525	476	63	539
Healthcare science staff	0	0	0	0	0	0
Social care staff	0	0	0	0	0	0
Other	0	0	0	9	3	12
Total average numbers	2,840	499	3,339	2,692	427	3,119
Of which:						
Number of employees (WTE) engaged on capital	4	0	4	5	0	5

projects

The calculations have been produced based on the year-end position and not as an average throughout the year.

2.22.2 Staff costs

	Permanent £000	Other £000	2018/19 Total £000	2017/18 Total £000
Salaries and wages	121,974	0	121,974	111,389
Social security costs	11,573	0	11,573	11,333
Apprenticeship levy	584	0	584	536
Employer's contributions to NHS pensions	14,634	0	14,634	13,400
Pension cost - other	0	0	0	0
Other post-employment benefits	0	0	0	0
Other employment benefits	0	0	0	0
Termination benefits	0	0	0	0
Temporary staff	0	5,896	5,896	8,132
Total gross staff costs	**148,765**	**5,896**	**154,661**	**144,790**
Recoveries in respect of seconded staff	0	0	0	0
Total staff costs	**148,765**	**5,896**	**154,661**	**144,790**
Of which				
Costs capitalised as part of assets	52	0	52	92

2.22.3 Exit packages agreed for staff

Reporting of compensation schemes - exit packages 2018/19

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
Exit package cost band			
<£10,000	0	0	0
£10,001 - £25,000	2	0	2
£25,001 - 50,000	0	0	0
£50,001 - £100,000	0	0	0
£100,001 - £150,000	0	0	0
£150,001 - £200,000	0	0	0
>£200,000	0	0	0
Total number of exit packages by type	2	0	2

Reporting of compensation schemes - exit packages 2017/18

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
Exit package cost band			
<£10,000	1	0	1
£10,001 - £25,000	2	0	2
£25,001 - 50,000	5	0	5
£50,001 - £100,000	1	0	1
£100,001 - £150,000	1	0	1
£150,001 - £200,000	0	0	0
>£200,000	0	0	0
Total number of exit packages by type	10	0	10

The total cost of exit packages was £31k (2017/18: £407k).

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS scheme as the employee's role is made redundant through service redesign or reconfiguration.

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

This disclosure reports the number and value of exit packages taken by staff leaving in the year. The expense associated with these departures may have been recognised in part or in full in a previous period.

2.22.4 Sickness absences

During the 2018/19 financial year the Trust's staff took a total of 26,738 days (2017/18: 21,876 days) of sickness absence. This is an average of 9 days (2017/18: 8) per FTE.

2.22.5 Retirements due to ill-health

During 2018/19 three persons retired early on ill-health grounds during the financial period (2017/18: four). The associated additional accrued pension liabilities total £186K (2017/18: £212K).

2.22.6 Off-payroll engagement

There are no off-payroll engagements to report under this heading.

2.22.7 Staff policies applied during the financial year

For giving full and fair consideration to applications for employment by the company made by disabled persons, having regard to their particular aptitudes and abilities

For continuing the employment of, and for arranging appropriate training for, employees of the company who have become disabled persons during the period when they were employed by the company

Otherwise for the training, career development and promotion of disabled persons employed by the company.

2.22.8 Other employee matters

Full details of 'other employee matters' can be found in the Annual Report section 1.7 'Our Staff'.

Signed A Ridley ..... **Date** 22/5/19 .....
Andrew Ridley, chief executive
(on behalf of the Board)

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF CENTRAL LONDON COMMUNITY HEALTHCARE NHS TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Central London Community Healthcare NHS Trust ("the Trust") for the year ended 31 March 2019 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2019 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as being relevant to NHS Trusts in England and included in the Department of Health Group Accounting Manual 2018/19.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Directors have prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements. In our evaluation of the Director's conclusions we considered the inherent risks to the Trust's operations, including the impact of Brexit, and analysed how these risks might affect the Trust's financial resources, or ability to continue its operations over the going concern period. We have nothing to report in these respects.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information. In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health Group Accounting Manual 2018/19. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health Group Accounting Manual 2018/19.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 46, the directors are responsible for: the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust'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 Trust without the transfer of its services to another public sector entity. As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on page 45 the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

Auditor's responsibilities

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

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust'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 the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained in the statement set out on page 45, the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust 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 Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017 as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- 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 Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Board of Directors of Central London Community Healthcare NHS Trust, 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 Board of the Trust, as a body, 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 Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Central London Community Healthcare NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Neil Hewitson
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
15 Canada Square
London
E14 5GL

May 2019

3 Financial overview

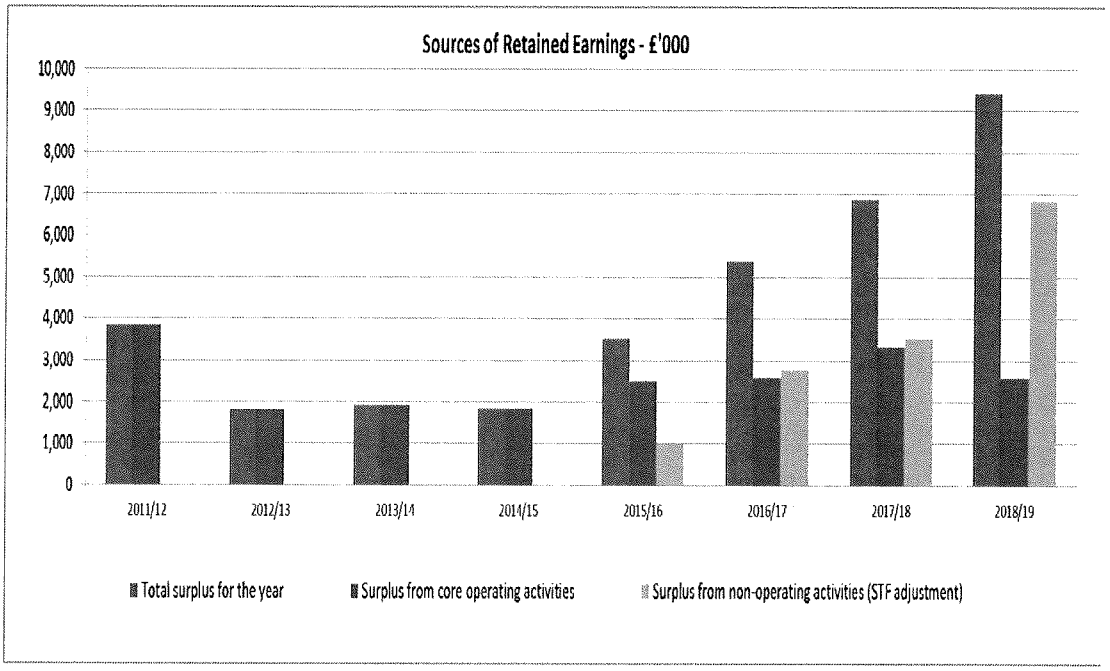
In 2018/19 the Trust achieved all key financial targets agreed with the Department of Health and NHS Improvement at the start of the financial year. These achievements include

- Achieving a surplus of £9,434k against plan of £7,186k;
- Investing £5,771k of Capital in IT, Estates and Medical Equipment (£157k lower than our Capital Resource Limit);
- Cash on hand was £39,451k at the end of March 2019 (£28.2m higher than plan);
- Reducing reliance on high cost temporary staffing resulting in agency spend to £4,619k in 18/19 being £1,815k lower than the £6,434k reported in 2017/18. This means that the Trust has achieved the cap on agency spend set by NHSI ; and
- Achieving 'Segment 1' status on the Single Oversight Framework performance indicator instituted by NHS Improvement.

Our Earnings before Interest Tax Depreciation and Amortisation (EBITDA) for the year ended 31 March 2019 were £16,872k which equates to a 7.0% gross margin (2017/18: £14,233k, 6.6% gross margin).

The Trust had capital and reserves totaling £73,444k at 31 March 2019 (2017/18: £63,449k). Our capital and reserves have risen by £9,995k during the year; which includes the increase to net surplus retained for the year of £9,434k, PDC granted of £582k for Parsons Green development and a decrease in the revaluation reserve of £19k.

The Trust delivered a full year surplus of £9,434k (2017/18: £6,883k), £2,248k (32.7%) more than plan due to £2,242k of STF received above plan from NHS Improvement for meeting key performance indicators (£6,835k in total) and the Trust having a £3k surplus higher than plan. The Trust surplus consisted of £2,599k generated from operating activities and £6,835k of STF. The surplus generated by our operating activities was mainly driven by increased efficiency in services and reductions in spend on high cost agency staffing.

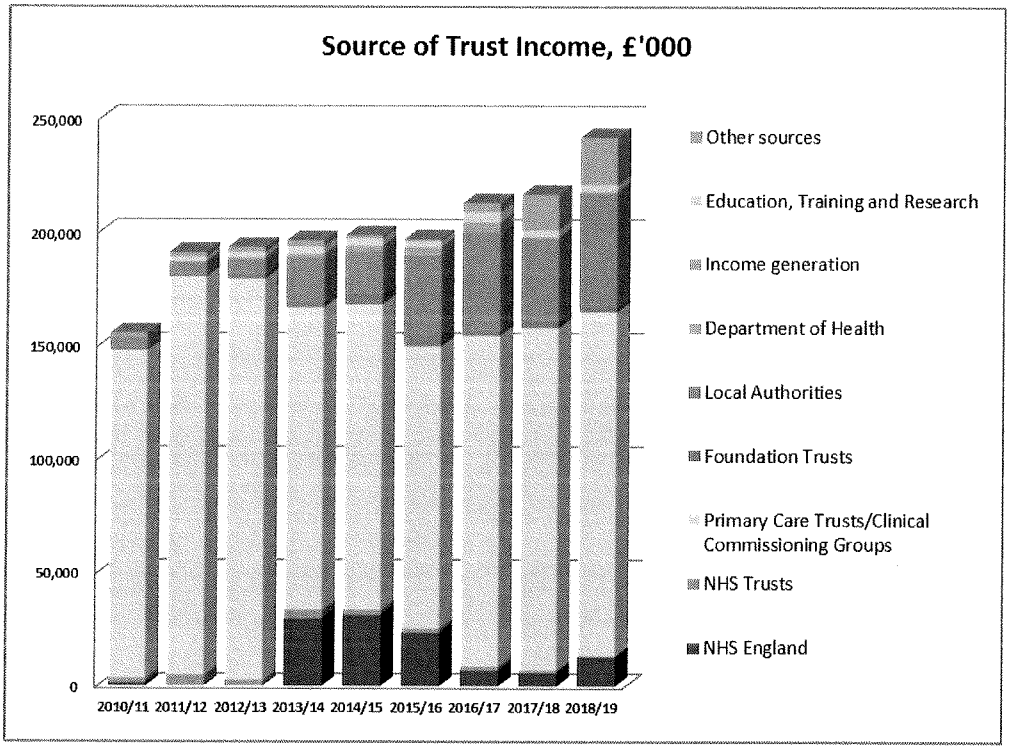


The Trust's working capital remains a source of strength and ensures that the Trust is both a good organisation for stakeholders to do business (as we pay our bills on time and in full) and provides a stable platform on which we can make the investment decisions needed to secure the future of the essential services we deliver. At 31 March 2019 the Trust had cash balances of £39,451k (2017/18: £22,709k), sufficient to pay for over 63 days of the Trust's operating expenditure. During the year the Trust continued to carefully manage its working capital, outstanding receivables and payables. A significant driver of our improved cash position is as a result of difficulties in agreeing payments to several significant suppliers.

The Trust will continue to monitor all known cost pressures, notably around agency costs, improving staff productivity through the transformation programme and better purchasing through procurement services provided by the Trust's Strategic Partners to renegotiate more favourable prices from suppliers.

Income

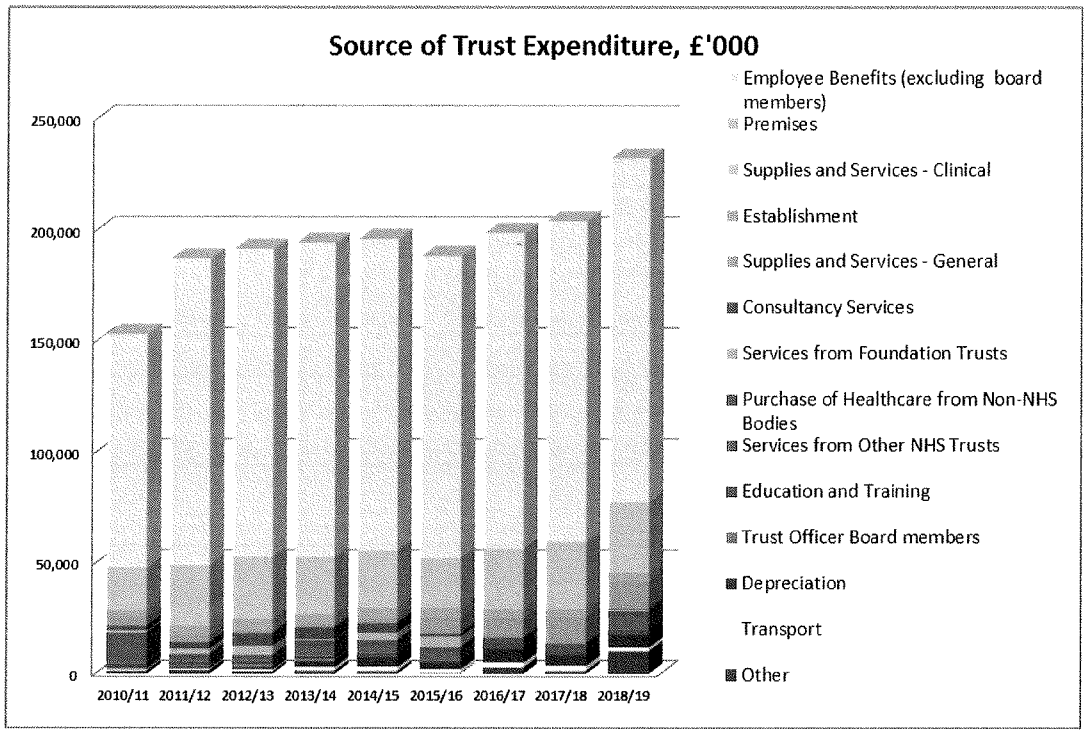
Our operating income (which excludes interest earned) for the year to 31 March 2019 was £241,667k (2017/18: £216,614k) which came from the following sources:



Income increased by 12% or £25m due to net gain in business as the profile of CLCH has altered throughout the year with movement of services into and out of the organisation in line with the commissioning intentions and outcomes of competitive tender processes. Key services to leave CLCH's portfolio in 18/19 have included Harrow School Nursing, Hounslow Diabetes, London Borough of Westminster Health Improvement and Barnet Therapies. Meanwhile Ealing 0 -19 and Wandsworth School Nursing have been key additions to CLCH's portfolio in 18/19. The key variation in service expected in 19/20 is the addition of the provision of Adult Community Services for Hertfordshire Valleys CCG from October 2019.

Expenditure

Expenditure increased by 10% or £22.5m primarily due to increased activities. Our operating expenditure (which does not include financing costs) for the year to 31 March 2019 was £230,792k (2017/18: £208,273k) and was spent in the following areas:



Treasury policies and objectives and liquidity of the Trust

CLCH has an established treasury and liquidity policy that ensures the Trust manages its working capital balances in an effective and efficient manner: this means that our liabilities can be paid when they fall due and losses from unrecoverable debtors are minimised.

The Trust's treasury philosophy is that the security and safety of public funds is paramount. Within this secure environment, the Trust ensures that it manages public funds to provide liquidity to discharge its obligations on a timely basis. Only when these two objectives are achieved can the Trust invest surplus funds.

Our BPPC performance against target:

While the Trust did not meet the target against the Better Payment Practice Code (BPPC) performance was significantly improved. In February 2016 the Trust implemented new temporary staff management software to help better manage rosters and a new finance ledger in April 2016. The transformation as a result of these two system implementations impacted our ability to pay suppliers promptly:

	Q1	Q2	Q3	Q4	Target
2018/19	95%	85%	80%	76%	95%

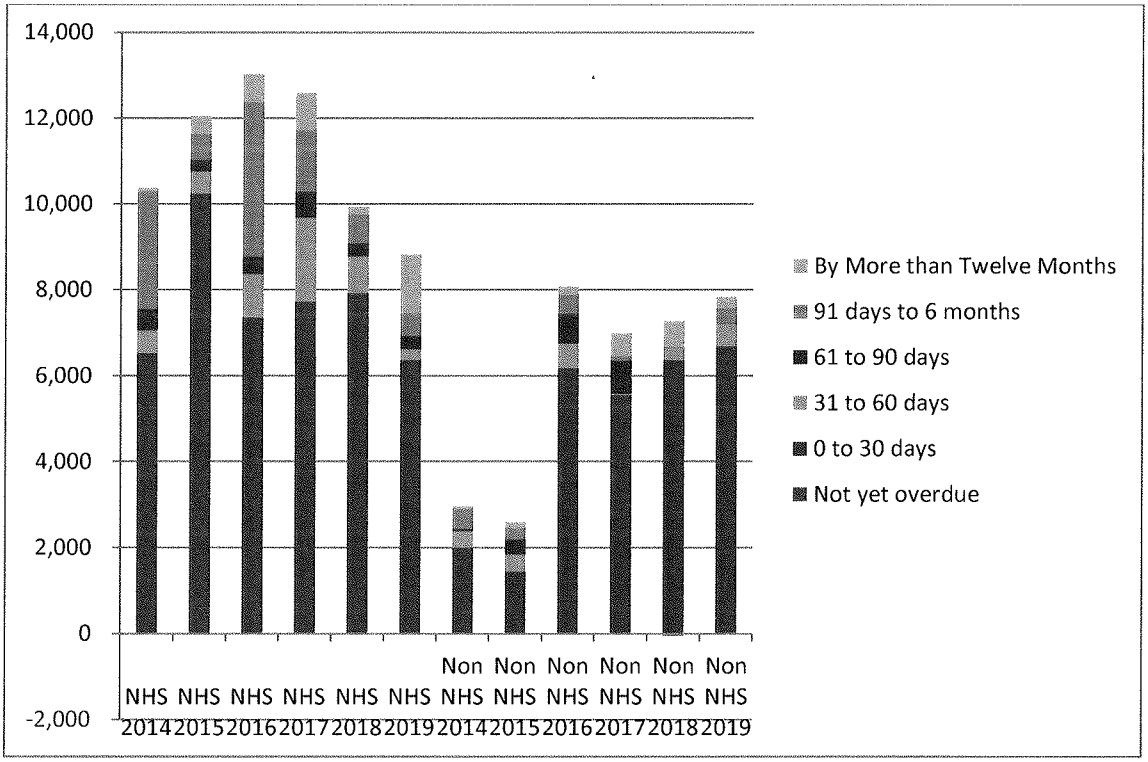
Our working capital management performance against target:

	31-Mar-19	31-Mar-18	Target
Receivables uncollected over 90 days past due	18%	17%	5%
Payables unpaid over 90 days past due	62%	91%	5%

We did not achieve the targets for the percentage of Receivables uncollected over 90 days past due and Payables unpaid over 90 days past due. The Receivables uncollected over 90 days past due is due to delays in payment by CCGs for Walk-in-Centre/Urgent Care Centre charges due to delays in commissioners validating information, long overdue payments from one NHS Trust and Local Authorities taking longer to pay their SLA invoices due to restructuring of their financial services. We have a plan in place to further improve our performance during 2019/20. The underperformance on Payables unpaid over 90 days past due is as a result of unpaid invoices due to a small number of organisations where ongoing queries are being resolved

CLCH has a track record of recovering amounts owed. During 2018/19 the Trust wrote off £79k debt that related to salary overpayments, during 2017/18 the Trust did not write-off any debt of amounts due. The Trust has a provision against unrecoverable debts of £630k (2017/18: £259k). The Trust had a healthy cash position throughout the year relative to plan which enabled it to mobilise new services without recourse to external sources of finance. Much of the cash balance carried forward to 2019/20 is allocated to meet existing financial commitments and fund future service developments.

The Trust has £22,169k aged receivable from NHS and non-NHS bodies at 31 March 2019 (31 March 2018: £19,023k). The age of this debt is as follows:



This chart reflects an overall reduction in our receivables outstanding for more than 90 days when compared to previous years. Non-overdue NHS receivables have decreased and old NHS debts have also slightly decreased. Overall, debt recovery in 2018/19 has improved when compared to prior year as this activity was prioritised during the financial year. The Trust has plans in place to collect these debts in 2019/20.

Key Metric – Single Oversight Framework

In September 2016, NHS Improvement introduced the Single Oversight Framework which replaced the Financial Sustainability Risk Rating. In this, NHSI has unified its approach for overseeing providers irrespective of their legal form. This framework also helps identify potential support needs, by theme, as they emerge and allows the regulator to tailor support packages to the specific needs of providers in the context of their local health systems, drawing on expertise from across the sector as well as within NHS Improvement. The Single Oversight Framework ("SOF") comprises five equally weighted financial metrics:

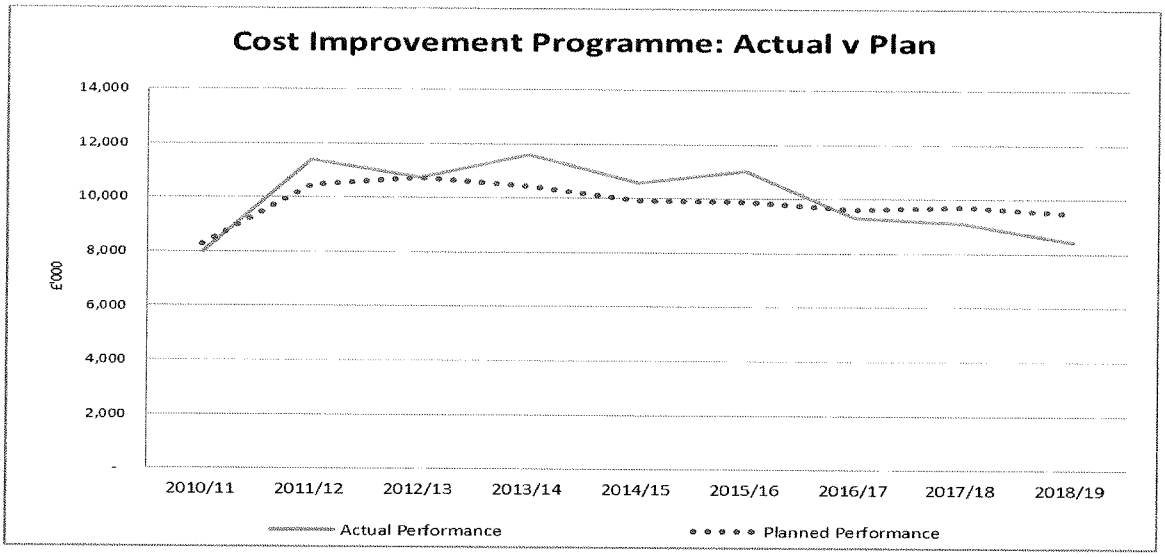
- **Capital Servicing Capacity ("CSC"):** The degree to which the organisation's generated income covers its financing obligations. This ratio indicates whether the provider can meet its financing obligations, i.e. its ability to service debts or other financing obligations (including PDC dividends, interest and debt repayment and Private Finance Initiative capital and interest payments. It is calculated as EBITDA / (PDC dividend + finance interest)). The Trust achieved a score of 1 out of 4 in this category with an EBITDA of 15.8 times its CSC compared with 2.5 times required to achieve score of 1 out of 4;
- **Liquidity:** days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown, i.e. its liquidity (expressed in days of liquid assets i.e. net assets/cash*365). The Trust achieved a score of 1 out of 4 in this category with liquidity days of 34.6 days at year-end compared with 0 days minimum requirement to achieve score of 1 out of 4;
- **Income and Expenditure (I&E) Margin:** the degree to which the organisation is operating at a surplus/deficit - the Trust achieved a score of 1 out of 4 in this category, ending the year with 3.9% gross margin (EBITDA) which is 2.5% greater than the threshold of 1% required to be assessed a 1 for this criteria;
- **Distance from Financial Plan in Relation to I&E Margin:** variance between the trust's planned I&E margin in its annual forward plan and its actual I&E margin within the year. The Trust achieved a score of 1 out of 4 in this category, as the Trust achieved its planned surplus in addition to receiving bonus STF funds for achieving all key financial indicators;
- **Agency Cap:** distance from provider's cap - the Trust achieved a score of 1 out of 4 in this category, ending the year with £3.6m less in agency spend than plan of £8.2m agreed with NHS Improvement.

The Trust achieved the highest rating of '1' out of '4' for all individual metrics and for overall weighted rating throughout 2016/17.

QIPP (Quality, Innovation, Productivity and Prevention)

The QIPP requirement for 2018/19 was £9.5m (excluding identified contingency).

The Trust achieved £8.4m QIPP for 2018/19 which represented a £1.1m adverse variance against plan.



QIPP is essential to deliver services within the financial revenues agreed with commissioners and to deliver a surplus that CLCH reinvests in developments in line with our service strategy. It will support CLCH in succeeding as a provider of choice in a more competitive market environment and create a financial contingency against future risks.

The QIPP requirement for 2019/20 is £9.7m (inclusive of contingency), as of Month 1 c.£6m of schemes have been identified. The programme is comprised of Trust wide transformational initiatives focusing on reducing agency use, estates rationalization and the use of technology to enable workforce efficiencies. This will be supplemented by localised schemes focused on remodeling existing operations to enhance the efficiency and effectiveness of the services the Trust delivers.

The majority of the schemes in the 2019/20 QIPP plan focus on the efficient use of resources and productivity rather than absolute reductions in staff numbers. This programme will be delivered whilst maintaining the safety and quality of services which is assured by a process of Quality Impact Assessments undertaken by the Trust Medical Director and Chief Nurse.

Financing and investment

During 2018/19 we made significant investments in various capital projects.
These investments are core to how we will achieve our QIPP programme over the coming years and maintain our financial sustainability. Our 2018/19 capital investments totaled £5,771k (2017/18: £7,166k). The most significant investments were:

- Estates £3,550k invested in various CLCH owned (Colville HC, Lisson Grove, Woodfield Rd, Parsons Green and Worlds End) and leased buildings (Ealing, Hatfield and SWLSH).

  Redecoration, of areas that have not been redecorated for some years.
  Replacement of lighting with new energy efficient LED lighting.
  Various other infection prevention improvements.
  Improvement to support the footprint project.
  Adults Integration Project and Inner QIPP Savings.

- IM&T £1,628k Clinical System Development continuation to utilise available technologies in both clinical services and administrative activities sites to reduce the Trust's estate footprint while ensuring that all CLCH sites remain compliant with CQC and HSE requirements. The balance on e-rostering, Govroam and IT coms upgrade.

- Medical Equipment £460k spend on modern medical devices including Intraoral Imaging Plate System, Bladder Scanners, Ankle & Toe Pressure Kit, Defibrillator and other.

- Furniture and Fittings £133k spend on furniture and fit-out work to the Sexual Health Hertfordshire hubs.

We have identified a number of areas where future investment will help us to achieve service quality and technological growth and therefore will allow us to maintain our financial sustainability and provide excellent service to our patients. For our estates investments we have identified schemes primarily to focus on achieving financial efficiency and investment in backlog of existing estate. Our backlog investment will continue to ensure that all CLCH sites remain compliant with CQC and HSE requirements.

Political and charitable donations

We have not made any political or charitable donations this year.

Pension Liabilities
The Trust's substantive employees are eligible to become members of the defined benefits NHS Pension scheme. Details of this scheme are disclosed in Note 10, Pension costs, of the financial statements.

The Trust does not reflect in its financial statements any NHS Pension scheme assets or liabilities attributable to scheme members who are employed by the Trust. There is £2,026k in respect of outstanding NHS Pension contributions at 31 March 2019 (31 March 2018: £2,009k).

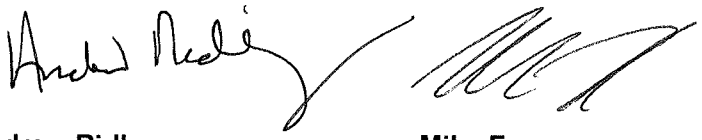
Disclosure of information to Auditors
As far as each of the directors is aware, there is no relevant audit information that the auditors are unaware of. Each director has taken all the steps they ought to have taken to make themselves aware of any relevant audit information and to establish that the auditors are aware of such information.

Our annual accounts
The Chief Executive is our designated Accounting Officer with the duty to prepare the accounts in accordance with the National Health Service Act 2006. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgments and estimates which are reasonable and prudent; and
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.



Andrew Ridley
Chief Executive

Mike Fox
Director of Finance, Contracting and Performance

STATEMENT OF COMPREHENSIVE INCOME
FOR THE YEAR ENDED 31 MARCH 2019

	Note	2018/19 £000	2017/18 £000
Revenue from patient care activities	5	229,399	206,263
Other operating revenue	6	12,268	10,351
Employee benefits	7, 9	(154,609)	(144,698)
Other Operating expenses	7	(76,183)	(63,575)
net operating surplus		**10,875**	**8,341**
Finance Income	12	19	0
Finance Costs		(1)	0
Other gains / (losses)		(388)	(5)
Surplus / (deficit) for the financial year		**10,505**	**8,336**
Public Dividend Capital dividends payable	30	(1,071)	(1,453)
Retained surplus / (deficit) for the year		**9,434**	**6,883**
Other comprehensive income			
Net gain/(loss) on revaluation of property, plant, equipment	13	(19)	2,145
Other reserve movements		(2)	0
Total comprehensive income for the year		**9,413**	**9,028**

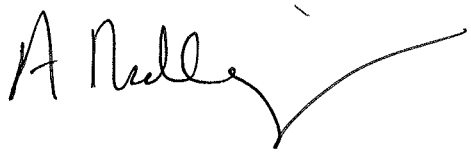
The notes on pages 77 - 117 form part of these financial statements.

There is no difference between the retained surplus noted above and the reported NHS financial performance position.

STATEMENT OF FINANCIAL POSITION
AS AT 31 MARCH 2019

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	**14**	7,164	8,338
Property, plant and equipment	**13**	45,242	44,701
Receivables	**15**	2,029	2,665
Total non-current assets		**54,435**	**55,704**
Current assets			
Receivables	**15**	24,698	24,283
Cash and cash equivalents	**17**	39,451	22,709
Total current assets		**64,149**	**46,992**
Current liabilities			
Trade and other payables	**18**	(38,923)	(34,548)
Other liabilities	**18**	(1,871)	(2,068)
Provisions	**20**	(4,162)	(2,426)
Total current liabilities		**(44,956)**	**(39,042)**
Total assets less current liabilities		**73,628**	**63,654**
Non-current liabilities			
Provisions	**20**	(184)	(205)
Total non-current liabilities		**(184)**	**(205)**
Total assets employed		**73,444**	**63,449**
Financed by			
Public dividend capital		1,578	996
Revaluation reserve		13,128	13,148
Income and expenditure reserve		58,738	49,305
Total taxpayers' equity		**73,444**	**63,449**

The notes on pages 77-117 form part of these accounts.
The financial statements on pages 72 - 76 and accompanying notes were approved by the Audit committee on behalf of the Board on the 22nd May 2019 and signed on its behalf by:

Chief Executive:  **Date:** 22/5/2019

Director of Finance, Contracting and Performance: **Date:** 22/5/2019

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2019

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2018 - brought forward	**996**	**13,148**	**49,305**	**63,449**
Impact of implementing IFRS 15 on 1 April 2018	0	0	0	0
Impact of implementing IFRS 9 on 1 April 2018	0	0	0	0
Surplus/(deficit) for the year	0	0	9,434	**9,434**
Revaluations	0	(19)	0	**(19)**
Other movements	0	(3)	1	**(2)**
Transfer between reserves	0	2	(2)	0
Public dividend capital received	582	0	0	**582**
Taxpayers' equity at 31 March 2019	**1,578**	**13,128**	**58,738**	**73,444**

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2017 - brought forward	**202**	**11,003**	**42,422**	**53,627**
Surplus/(deficit) for the year	0	0	6,883	**6,883**
Revaluations	0	2,145	0	**2,145**
Public dividend capital received	794	0	0	**794**
Taxpayers' equity at 31 March 2018	**996**	**13,148**	**49,305**	**63,449**

The notes on pages 77 - 117 form part of these financial statements.

These financial statements have been prepared using the Department of Health Group Accounting Manual.
Retained surpluses reflect the accumulated surpluses of CLCH since its inception plus those inherited from predecessor organisations.

Information on Reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED 31 MARCH 2019

	2018/19 £000	2017/18 £000
Cash flows from operating activities		
Operating surplus / (deficit)	10,875	8,341
Non-cash income and expense:		
Depreciation and amortisation	5,997	5,892
(Increase) / decrease in receivables and other assets	650	(1,640)
Increase / (decrease) in payables and other liabilities	4,300	4,689
Increase / (decrease) in provisions	1,715	(41)
Net cash generated from / (used in) operating activities	**23,537**	**17,241**
Cash flows from investing activities		
Interest received	20	0
Purchase of intangible assets	(982)	(1,635)
Purchase of property, plant, equipment and investment property	(4,661)	(3,838)
Cash movement from disposals	0	1
Net cash generated from / (used in) investing activities	**(5,623)**	**(5,472)**
Cash flows from financing activities		
Public dividend capital received	582	794
Other interest	(1)	0
PDC dividend (paid) / refunded	(1,753)	(1,200)
Net cash generated from / (used in) financing activities	**(1,172)**	**(406)**
Increase / (decrease) in cash and cash equivalents	**16,742**	**11,363**
Cash and cash equivalents at 1 April - brought forward	**22,709**	**11,346**
Cash and cash equivalents at 31 March	**39,451**	**22,709**

The notes on pages 77 - 117 form part of these financial statements.

NOTES TO THE ACCOUNTS
Note 1 Principal Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Accounting Manual 2018-19, issued by the Department of Health.

The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DH Group Accounting Manual permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going concern

The Trust's annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Movement of assets within the DH Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury Financial Reporting Manual 2018-19 (FReM). The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. 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 SOCI, and is disclosed separately from operating costs. Other transfers of assets and liabilities within the Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries

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.

Accruals

The effects of transactions and other events are recognised when they occur (and not as cash or its equivalent is received or paid) and they are recorded in the accounting records and reported in the financial statements of the periods to which they relate.

1.3 Subsidiaries (IAS 27 *Consolidated and Separate Financial Statements*)

Material entities over which the Trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust or where the subsidiary's accounting date is not co-terminous. Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

During the year, the Trust decided on the substance and form of consolidation of the Trust's charitable funds and concluded the accounts are not material to the Trust's separate financial statements for the purpose of consolidation.

1.4 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management are required to make judgments, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.4.1 Critical judgements in applying accounting policies

The following are the critical judgments, apart from those involving estimations (see below) that management has made in the process of applying the entity's accounting policies and that have the most significant effect on the amounts recognised in the financial statements. The Trust has made the following judgements that have an immaterial effect on the financial statements:

Recoverability of NHS debtors

The Trust does not provide against amounts due from other NHS bodies and believes that these amounts are recoverable in full.

Leases

Ascertaining if an arrangement contains a lease; and if it does so assess whether it is an Operating or Finance Lease. The Trust recognises leases when in the judgment of the Board the transaction either meets the definition of a lease as set down by IAS 17 or where the transaction has the substance of a lease as required by IFRIC 4. The Trust will decide on whether to recognise leases as finance or operating leases using the criteria laid down by IAS 17. Within IAS 17 there is a rebuttable presumption that, where the net present value of future lease payments exceeds 90% of the asset's fair value at the inception of the lease, the lease will be capitalised as a finance lease. However, where other factors suggest a finance lease

category better reflects the substance of the transaction and the transfer of risks and rewards of the leased asset the Trust will capitalise the lease even if the 90% target is not met.

Consolidation of the Charity

The Trust did not consolidate the NHS charitable funds for which it is a corporate Trustee as the Central London Community Healthcare Charity and Related Charities' income, resources, assets and liabilities are not material for the year ended 31 March 2019. The Trust have assessed the impact of not consolidating the accounts of its related Charity and deemed it to be immaterial and not adversely affect the interpretation of the accounts by its stakeholders.

Valuation of Buildings (Leased)

The Trust has not revalued its Leased Buildings during 2018/19 due to materiality.

1.4.2 Key sources of estimation uncertainty

The following are the key assumptions concerning the future key sources of estimation uncertainty at the Statement of Financial Position date that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Valuation of Land and Buildings (Owned)

The Trust holds land and buildings at fair value (as defined by our accounting policies). To ensure they remain at fair value, land and buildings are subject a full valuation every five years and indexed between these dates using revaluation indices as supplied by a professional third party valuer. This is based on the professional judgement of the Trust's Independent Valuer with extensive knowledge of the physical estate and market factors. It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period. On the basis of existing knowledge, outcomes within the next financial year that are different from the assumption around the valuation of our land, property, plant and equipment could require a material adjustment to the carrying amount of the assets recorded.

Expenditure Recognition

Accrued expenditure is estimated based on the supplies and services purchased by the Trust in the year and upon best estimates of the expenditure still to be incurred for this financial year. These amounts form part of the balances disclosed within Note 7 Operating Expenses and Note 18 Trade and Other Payables.

The Trust also makes the following assumptions about the sources of estimation uncertainty that could result in an immaterial adjustment to the carrying amounts of assets and liabilities within the next financial year:

- The useful economic life of Trust tangible and intangible fixed assets as set by Professional third party valuers (buildings) and Trust professionals responsible for the custody and maintenance of the assets. No asset class is estimated to have a residual value, with current fair value depreciated or amortised over its estimated useful life to £nil
- Provisions are based on the best estimates of future payments that will need to be made to meet current obligations. The basis of these estimates and the timing of the cash flows are described in the relevant note. Provisions are discounted and unwound using rates as set by HM Treasury.

Valuation of Buildings (Leased)
The Trust has not revalued its Leased Buildings during 2018/19 due to materiality.

1.5 Revenue

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pensions Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.6 Employee Benefits

1.6.1 Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the

end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.6.2 Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period. The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

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 Trust commits itself to the retirement, regardless of the method of payment.

1.7 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.7.1 Value Added Tax

Most of the activities of the NHS 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.

1.8 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has a cost of at least £5,000; or
    - Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
    - Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation
All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value. Land and buildings are measured at their current value in existing use.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.
Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use;
- Specialised buildings – depreciated replacement cost.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Operational land and buildings owned by CLCH are held at Current Values. The effective date of revaluation of land and buildings owned by the Trust is 31 March 2019. The revaluation was carried out by Gareth Palmer MRICS, a Senior Surveyor (RICS registered valuer) with the DVS property services arm of the Valuation Office Agency, using the market and cost approach valuation techniques to determine the Current Value of land and buildings owned by the Trust. The Trust has a full revaluation every five years with Desktop revaluations in the intervening years.

Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-off and charged to operating expenses.

Depreciation
Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

Property, plant and equipment are depreciated over the following useful lives:

- Buildings are depreciated on a straight line basis, after accounting for residual value, over the remaining useful economic life of 20 to 65 years;
- Dwellings and leasehold improvements are depreciated over the shorter of the useful economic life or lease term;
- Information technology and plant and machinery are depreciated on a straight line basis over the useful economic life of the asset, deemed as 3 to 5 years for short life assets, 6 to 10 years for medium life assets and 10 to 15 years for long life assets;
- Furniture and fittings are depreciated on a straight line basis over the useful economic life of the asset, deemed as between 2 and 4 years for short life assets, between 5 and 9 years for medium life assets and between 10 and 15 years for long life assets.

Impairments and reversal of impairments
At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.9 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably; and where the cost is at least £5,000.
Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement
The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), and indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

Amortisation
Amortisation is charged to write off the costs of intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.
Intangible assets including application software are amortised over 3-10 years.

1.10 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.10.1 The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's Statement of Comprehensive Income.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.
Where a lease is for land and buildings, the land and building components are separated. Leased land is treated as an operating lease. Leased buildings are assessed as to whether they are operating or finance leases.

1.10.2 The Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.11 Inventories

The Trust does not hold any inventories.

1.12 Cash and 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 three months or less from the date of acquisition and that are readily convertible to known amounts of cash with an 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 Trust's cash management. Cash and bank balances are measured at current value.

1.13 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust 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 amount using the discount rates published and mandated by HM Treasury

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.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust 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 ongoing activities of the entity.

1.14 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to the NHS Resolution Policy 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 the Trust.

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 or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, 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 Trust. A contingent asset is disclosed where an inflow of

economic benefits is probable. Where the time value of money is material, contingencies are disclosed at their present value.

1.16 Financial assets

Financial assets are recognised when the Trust 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 and the Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset. Financial assets are initially recognised at fair value. Financial assets are classified into the following categories: financial assets 'at fair value through profit and loss'; 'held to maturity investments'; 'available for sale' financial assets and 'loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition. Financial assets are initially recognized at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices, where possible, or by valuation techniques.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

1.16.1 Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or those that do not fall within any of the other three financial asset classifications. They are measured at fair value, determined by the future cash flows associated with the asset and with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to the statement of comprehensive income on de-recognition. Financial assets are classified as subsequently measured at amortised cost

1.17 Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques best suited to the asset being valued. If possible the Trust values its assets using a discounted cash flow method.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly or through a provision for impairment of receivables.
If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the Statement of Comprehensive Income to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.18 Financial liabilities

Financial liabilities are recognised on the Statement of Financial Position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are derecognised when the liability has been discharged, that is, the liability has been paid or has expired. Financial liabilities are initially recognised at fair value. Financial liabilities are classified as either financial liabilities 'at fair value through profit and loss' or other financial liabilities. The Trust does not have any financial liabilities at fair value through profit or loss and does not expect to hold any such liabilities in the future.

1.18.1 Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. 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.

1.19 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.20 Foreign currencies

The functional and presentational currencies of the Trust are Sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction. Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the statement of financial position date) are recognised in income or expense in the period in which they arise. Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.21 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them.

1.22 Research and Development

The Trust does not carry out Research and Development expenditure.

1.23 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority 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.

1.24 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is 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 NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.25 Accounting Standards that have been issued but have not yet been adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019-20, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- IFRS 16 *Leases* – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 17 *Insurance Contracts* – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 23 *Uncertainty over Income Tax Treatments* – Application required for accounting periods beginning on or after 1 January 2019.

Note 2 Authorisation of the Financial Statements

These financial statements were authorised for issue on 22nd May 2019 by order of the Board of Central London Community Healthcare NHS Trust.

Note 3 Operating Segments

CLCH has one operating segment reportable under IFRS 8, the provision of community healthcare to the population of the London Boroughs of Hammersmith and Fulham, Kensington and Chelsea, Westminster, Hounslow, Richmond, Harrow, Brent, Merton, Barnet and Wandsworth as well as the county of Hertfordshire. This covers a wide range of services, including:

- Adult community nursing services, including 24 hour district nursing, community matrons and case management;
- Child and family services, including health visiting, school nursing, children's community nursing teams, speech and language therapy, haemaglobinopathy nursing and children's occupational therapy;
- Rehabilitation and therapies, including physiotherapy, occupational therapy, podiatry, speech and language therapy and osteopathy;
- Palliative care services;
- Long-term condition management supporting people with complex and substantial ongoing health needs caused by disability or chronic illness;

- Specialist services including delivering parts of long term condition management for people living with diabetes, heart failure, Parkinson's and lung disease, homeless health services, community dental services, sexual health and contraceptive services and psychological therapies;
- Walk-in and minor injury services; and
- PMS and GPWSI (dermatology and musculo-skeletal).

The segment has been determined by the information presented to Trust's chief decision making body, the Board, so that it can assess the financial performance of the Trust's business activities. The Trust's board is its chief decision making body as the board is the body responsible for the strategic decisions concerning the allocation of the Trust's resources and how these are used to address the Trust's objectives.

Reconciliation to the final month 12 position reported to Trust's chief decision making body

The Trust management reported to the Board an aggregate surplus of £9,434k which was the final position disclosed below.

	Revenue from customers	Retained surplus for the year	Interest revenue	Interest expense	Depreciation and amortisation	Net gain/(loss) on revaluation of property, plant, equipment
	£'000	£'000	£'000	£'000	£'000	£'000
12 months to 31/3/2019	241,667	9,434	19	0	5,997	(19)
12 months to 31/3/2018	216,614	6,883	0	0	5,892	2,145

Income is earned in the provision of community healthcare to the population of the London Boroughs of Hammersmith and Fulham, Kensington and Chelsea, Westminster, Hounslow, Richmond, Harrow, Brent, Merton, Barnet and Wandsworth as well as the county of Hertfordshire. Income is also earnt for Rental Income and Walk in Centre's.

The Trust has two customers (2017:18 three) who individually accounted for over 10% of the Trust's turnover. These customers account for 29% (2017/18: 41%) of the Trust's turnover on aggregate. The significant sources of external income, including those sources that account for at least 10% of the Trust's total external income, are as follows:

Organisation name	**2018/19 £'000**	**2017/18 £'000**
NHS Barnet CCG	41,556	38,405
NHS West London (K&C) CCG	27,452	26,842
NHS Merton CCG	22,090	22,805
NHS Central London (Westminster) CCG	18,079	17,843
NHS Hammersmith and Fulham CCG	15,366	15,819
NHS Harrow CCG	11,035	11,886
NHSE	13,122	9,662
Battersea Healthcare Community Interest Company (Wandsworth)	15,686	7,811
Sub Total	**164,386**	**151,073**
Income from other organisations	77,281	65,541
Total Revenue	**241,667**	**216,614**

Note 4 Income generating activities

The Trust undertakes limited non-patient activity mainly relating to rental of surplus clinical and administrative space to other NHS bodies and General Practitioners (GP's), the provision of interpreting and occupational health services to public sector bodies, including Clinical Commissioning Groups. Income attributable to these activities is disclosed in Note 6 below. These income generating activities break even. CLCH does not have any private patient activity but does generate income from overseas patients without reciprocal agreements.

Note 5 Revenue from patient care activities

Income from patient care activities received from:	**2018/19 £000**	**2017/18 £000**
NHS England	6,196	6,071
Clinical commissioning groups	151,715	150,736
NHS Foundation Trusts	2,138	3,086
NHS Trusts	332	850
Local authorities	49,931	36,432
Department of Health and Social Care	2,343	0
Injury costs recovery	289	327
Other non-NHS patient care income	16,455	8,761
Total income from activities	**229,399**	**206,263**

Revenue is almost exclusively from the supply of services. Revenue from the sale of goods is immaterial. Overseas patient income relates to income received for treating overseas patients at

the Trust's Walk in Centres which has been charged to Clinical commissioning groups in 2018/19. No overseas income has been charged directly to overseas patients during 2018/19. Non NHS Other includes Community Adult Health Services (Wandsworth) charged to Battersea Healthcare Community Interest Company £15.7m, Speech and Language £0.3m and other £0.5m.

Income from patient care activities (by nature)

	2018/19 £000	2017/18 £000
Community services		
Community services income from CCGs and NHS England	157,911	156,807
Income from other sources (e.g. local authorities)	69,277	49,456
All services		
Agenda for Change pay award central funding	2,211	0
Total income from activities	**229,399**	**206,263**

Note 6 Other operating revenue

	2018/19 £000	2017/18 £000
Education and training	2,824	2,897
Charitable and other contributions to expenditure	239	193
Provider Sustainability fund income	6,835	3,550
Rental revenue from operating leases	1,281	1,330
Income generation	1,034	762
Other income	55	1,619
Total other operating income	**12,268**	**10,351**

Provider Sustainability fund income relates to non-recurrent income from NHS England / NHS Improvement to support investments in various transformation programmes in the Trust. Other income relates to income earned through the recharging of costs associated with prescription charge income, and other miscellaneous income.

Note 7 Operating Expenses

7.1 Analysis of other operating expenses

	2018/19 £000	2017/18 £000
Purchase of healthcare from NHS and DH bodies	4,530	4,192
Purchase of healthcare from non-NHS/DH bodies	4,917	3,838
Staff and executive directors costs	154,578	144,291
Chair and non-Executive Directors' Costs	69	69
Supplies and services - clinical (excluding drugs costs)	9,958	8,374
Supplies and services - general	12,544	12,010
Drug costs (consumed and purchase of non-inventory drugs)	1,560	1,579
Consultancy services	457	584
Establishment	4,749	3,582
Premises	4,228	4,221
Transport (including patient travel)	1,627	2,276
Depreciation on property, plant and equipment	3,841	3,507
Amortisation on intangible assets	2,156	2,385
Net impairments	0	0
Increase/(decrease) in provision for impairment of receivables	450	0
Increase/(decrease) in other provisions	0	(1,073)
audit services- statutory audit	64	58
other auditor remuneration (external auditor only)	0	12
Internal Audit Expenditure	87	105
Clinical negligence	486	416
Legal fees	420	364
Insurance	57	71
Education, Training and Conferences	1,452	830
Operating Lease Expenditure	18,203	16,142
Redundancy	31	407
Hospitality	21	5
Other	4,307	28
Total	**230,792**	**208,273**

7.2 Auditor remuneration

The statutory audit fee is payable to the External Auditor Net of VAT. 2018/19 £54K (2017/18 £49K).

	2018/19 £000	2017/18 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	0	0
2. Audit-related assurance services	0	12
3. Taxation compliance services	0	0
4. All taxation advisory services not within item 3	0	0
5. Internal audit services	0	0
6. All assurance services not within items 1 to 5	0	0
7. Corporate finance transaction services not within items 1 to 6	0	0
8. Other non-audit services not within items 2 to 7	0	0
Total	0	**12**

7.3 Limitation on auditor's liability

The contract signed on 21st March 2017, states that the liability of KPMG, its members, partners and staff (whether in contract, negligence or otherwise) shall in no circumstances exceed £2m, aside from where the liability cannot be limited by law. This is in aggregate in respect of all services.

Note 8 Operating leases

8.1 Trust as lessee

	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	18,203	16,142
Total	**18,203**	**16,142**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due:		
- not later than one year;	18,203	15,596
- later than one year and not later than five years;	0	507
- later than five years.	0	0
Total	**18,203**	**16,103**

CLCH leases some of the properties it occupies for both the provision of healthcare and the administration of the Trust's activities. These properties are leased to CLCH by the Community Health Partnership (CHP), NHS Property Services, Local Authorities and other Individual landlords. The Trust has no contingent rentals. There are no unusual or onerous renewal restrictions within CLCH leases. The minimum lease payments disclosed have been discounted using the NHS Cost of Capital at 3.5%.

CLCH also has a 5 year lease contract with Canon (UK) Ltd for Printing and photocopy ending on 30th March 2021, with an option to extend up to a further 2 years. A small number of cars have been leased for its employees during the period. These car leases were on an ad hoc basis for staff to use to deliver clinical services which are a requirement of the job and represent good value to the public and there is no material liability outstanding at the reporting date.

The future relations with the Trust partner Capita is for Capita Managed Workspace (leasing of IT equipment) which will commence during 2019/20.

8.2 Trust as lessor

	2018/19 £000	2017/18 £000
Operating lease revenue		
Minimum lease receipts	1,281	1,330
Total	**1,281**	**1,330**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease receipts due:		
- not later than one year;	0	0
- later than one year and not later than five years;	0	0
- later than five years.	0	0
Total	**0**	**0**

CLCH owns ten freehold properties. CLCH is the landlord for other tenants in these properties. Additionally CLCH is the Landlord for other tenants in some properties it Leases. Rental income from these properties is based on the rates reasonably incurred by the Trust on a pro rata basis for occupancy. CLCH inherited the properties on 1 April 2013 from the former PCTs. The minimum lease payments disclosed have been discounted using the NHS Cost of Capital at 3.5%. CLCH charges market rents on some of these properties and there are no unusual or onerous restrictions within the agreements with these tenants.

Note 9 Employee benefits

9.1 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	121,943	110,982
Social security costs	11,573	11,333
Apprenticeship levy	584	536
NHS Pension Costs	14,634	13,400
Redundancy	31	407
Temporary staff (external bank)	1,277	1,698
Temporary staff (including agency)	4,619	6,434
Total gross staff costs	**154,661**	**144,790**
Less Costs Capitalised	52	92
Total net staff costs	**154,609**	**144,698**

During 2018/19 3 persons retired early on ill-health grounds during the financial period (2017/18: four). The associated additional accrued pension liabilities total £186K (2017/18: £212K). Permanently employed includes £2,131k (2017-18: £1,292k) in respect of cost of staff seconded into the Trust from other NHS organisations. The Trust processes the cost of some temporary staff through a third party payroll bureau. In 2018-19, the Trust processed £1,277k (2017-18: £1,698k) through this bureau.

Note 10 Pension 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 in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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 report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 11 Better payment practice code

11.1 Measure of compliance

	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	20,384	86,206	18,369	85,631
Total non-NHS trade invoices paid within target	16,140	75,150	14,229	74,631
Percentage of non-NHS trade invoices paid within target	79.2%	87.2%	77.5%	87.2%
NHS Payables				
Total NHS trade invoices paid in the year	331	6,092	352	4,348
Total NHS trade invoices paid within target	133	2,948	135	2,239
Percentage of NHS trade invoices paid within target	40.2%	48.4%	38.4%	51.5%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The dip in performance from prior year is due to impact of changes in the accounts payables and general ledger system at the beginning of the financial year.

Note 12 Investment revenue

	2018/19 £'000	2017/18 £'000
Interest earned from monies held on deposit at the National Loans Fund.	19	0

Note 13a Property plant and equipment

	Land £000	Buildings excluding dwellings £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2018 - brought forward	**13,920**	**28,109**	**3,084**	**13,023**	**569**	**58,705**
Additions						
Purchased	0	3,550	460	646	133	4,789
Revaluations	(218)	(527)	0	0	0	(745)
Reclassifications	0	0	0	0	0	0
Disposals other than for sale	0	(797)	0	0	0	(797)
Valuation/gross cost at 31 March 2019	**13,702**	**30,335**	**3,544**	**13,669**	**702**	**61,952**
Accumulated depreciation at 1 April 2018 - brought forward	**0**	**1,732**	**2,216**	**9,991**	**65**	**14,004**
Charged during the year	0	2,062	323	1,362	94	3,841
Revaluations	0	(726)	0	0	0	(726)
Disposals other than for sale	0	(409)	0	0	0	(409)
Accumulated depreciation at 31 March 2019	**0**	**2,659**	**2,539**	**11,353**	**159**	**16,710**

Net book value at 31 March 2019	Land £000	Buildings excluding dwellings £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Owned - purchased	**13,702**	**27,676**	**1,005**	**2,316**	**543**	**45,242**

	Land	Buildings excluding Dwellings	Plant & Machinery	Information Technology	Furniture & Fittings	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Attributable revaluation reserve:						
Revaluation Reserve Balance for Property, Plant & Equipment:						
As at 1 April 2018	**5,552**	**7,596**	**0**	**0**	**0**	**13,148**
Impairments in the year	0	0	0	0	0	0
Revaluations in the year	(218)	199	0	0	0	(19)
Other movements	0	(1)	0	0	0	(1)
As at 31 March 2019	**5,334**	**7,794**	**0**	**0**	**0**	**13,128**

	Land	Buildings excluding Dwellings	Plant & Machinery	Information Technology	Furniture & Fittings
Useful economic life:					
Minimum life (years)	**-**	**20**	**3**	**3**	**2**
Maximum life (years)	**-**	**65**	**15**	**15**	**15**

All assets are initially recognised at purchase cost plus any incremental costs to bring the asset into its operational location and condition and depreciated over its estimated useful economic life to £nil residual value. Thereafter assets are held at cost less depreciation recognised since purchase plus any previously recognised upwards indexation (revaluation) as this is estimated to be not materially different to fair value. At the balance sheet date the Trust continues to use assets with a gross book value of £1,584K (2017/18: £1,020K) that have no net book value. There are no temporarily idle assets. Operational land and buildings owned by CLCH are held at Current Values. The effective date of revaluation of land and buildings owned by the Trust is 31 March 2019. The revaluation was carried out by Gareth Palmer MRICS, a Senior Surveyor (RICS registered valuer) with the DVS property services arm of the Valuation Office Agency, using the market and cost approach valuation techniques to determine the Current Value of land and buildings owned by the Trust.

The Trust's valuers have included the following caveat in their valuation report at 31 March 2019: Following the referendum held on 23 June 2016 concerning the UK's membership of the EU, the impact to date on the many factors that historically have acted as drivers on property values, together with BCIS and Location Factor indices, has generally been muted in most sectors and localities. The outlook nevertheless remains cautious for market activity over the coming months as work proceeds on negotiating detailed arrangements for EU exit and sudden fluctuations in value remain possible. It follows that any potential impact on the levels of value of Trusts' assets valued for financial accounting purposes at next review date is also uncertain at the present time. Our building surveying specialists are in discussions with BCIS representatives.

Note 13b Property plant and equipment prior year

	Land	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**13,920**	**23,757**	**2,563**	**11,934**	**115**	**52,289**
Additions						
Purchased	0	3,467	521	1,089	454	**5,531**
Revaluations	0	891	0	0	0	**891**
Reclassifications	0	0	0	0	0	**0**
Disposals other than for sale	0	(6)	0	0	0	**(6)**
Valuation/gross cost at 31 March 2018	**13,920**	**28,109**	**3,084**	**13,023**	**569**	**58,705**
Accumulated depreciation at 1 April 2017 - brought forward	**0**	**1,732**	**1,924**	**8,045**	**50**	**11,751**
Charged during the year	0	1,254	292	1,946	15	**3,507**
Revaluations	0	(1,254)	0	0	0	**(1,254)**
Disposals other than for sale	0	0	0	0	0	**0**
Accumulated depreciation at 31 March 2018	**0**	**1,732**	**2,216**	**9,991**	**65**	**14,004**

	Land	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
Net book value at 31 March 2018	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Owned - purchased	**13,920**	**26,377**	**868**	**3,032**	**504**	**44,701**

	Land	Buildings excluding Dwellings	Plant & Machinery	Information Technology	Furniture & Fittings	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Attributable revaluation reserve:						
Revaluation Reserve Balance for Property, Plant & Equipment:						
As at 1 April 2017	**5,552**	**5,451**	**0**	**0**	**0**	**11,003**
Impairments in the year	0	0	0	0	0	0
Revaluations in the year	0	2,145	0	0	0	2,145
Other movements	0	0	0	0	0	0
As at 31 March 2018	**5,552**	**7,596**	**0**	**0**	**0**	**13,148**

Note 14a Intangible Non-current Assets

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2018 - brought forward	**17,546**	**17,546**
Additions	982	982
Gross cost at 31 March 2019	**18,528**	**18,528**
Amortisation at 1 April 2018 - brought forward	**9,208**	**9,208**
Charged during the year	2,156	2,156
Disposals other than for sale	0	0
Amortisation at 31 March 2019	**11,364**	**11,364**
Net book value at 31 March 2019	**7,164**	**7,164**

Useful economic life:
Minimum life (years) 3
Maximum life (years) 10

All assets are initially recognised at purchase cost plus any incremental costs to bring the asset into its operational location and condition and amortised over its estimated useful economic life to £nil residual value. All assets thereafter are held at cost less amortisation recognised since purchase as this is estimated to be not materially different to fair value. At the balance sheet date the Trust continues to use assets with a gross book value of £635K (2017/18: £857K) that have no net book value. There are no temporarily idle assets.

Note 14b Intangible Non-current Assets prior year

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2017 - brought forward	**15,911**	**15,911**
Additions	1,635	1,635
Gross cost at 31 March 2018	**17,546**	**17,546**
Amortisation at 1 April 2017 - brought forward	**6,823**	**6,823**
Charged during the year	2,385	2,385
Disposals other than for sale	0	0
Amortisation at 31 March 2018	**9,208**	**9,208**
Net book value at 31 March 2018	**8,338**	**8,338**

Useful economic life:

Minimum life (years) 3

Maximum life (years) 10

Note 15 Trade and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables NHS*	16,085	0
Contract receivables Non-NHS*	6,084	0
Prepayments NHS	0	0
Prepayments Non NHS	1,265	0
NHS receivables - revenue	0	11,452
NHS prepayments and accrued income	0	5,113
Non-NHS receivables - revenue	0	7,571
Non NHS prepayments and accrued income	0	(1,430)
Allowance for impaired contract receivables*	(630)	0
Provision for impaired receivables	0	(259)
VAT receivable	229	1,044
PDC dividend receivable	429	0
Other receivables	1,236	792
Total current trade and other receivables	**24,698**	**24,283**
Non-Current		
Prepayments Non NHS	2,029	2,665
Total non-current trade and other receivables	**2,029**	**2,665**

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Other receivables relate to amounts due from CLCH employees relating to the purchase of season travel tickets and salary sacrifice schemes including lease cars and cycle scheme.

During the period under review the majority of CLCH trade was with NHS England, Clinical Commissioning Groups, London Borough and City Councils as commissioners of patient healthcare services. As these organisations were funded by the Government to buy NHS patient care services, no credit scoring of them was considered necessary. The Board of CLCH maintains close working relationships with these bodies and considers them credit worthy and that no formal credit scoring is appropriate.

15.1 Allowances for credit losses - 2018/19

	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 Apr 2018 - brought forward	0	259
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	259	(259)
New allowances arising	0	0
Changes in existing allowances	709	0
Reversals of allowances	(259)	0
Utilisation of allowances (write offs)	(79)	0
Allowances as at 31 Mar 2019	**630**	0

15.2 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables £000
Allowances as at 1 Apr 2017 - as previously stated	**1,332**
Prior period adjustments	0
Allowances as at 1 Apr 2017 - restated	**1,332**
Increase in provision	0
Amounts utilised	0
Unused amounts reversed	(1,073)
Allowances as at 31 Mar 2018	**259**

Note 16 Financial Instruments

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 of the continuing service provider relationship that the Trust has with commissioners and the way the commissioners are financed, the Trust 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 Trust 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 Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk
The Trust is a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust has no current exposure to interest rate risk as it has no interest bearing liabilities.
The Trust does invest temporary excess liquidity with the National Loans Fund as this is the only counterparty with whom a Trust can invest.

Credit Risk
The majority of the Trust's income comes from government backed Clinical Commissioning Groups with a high degree of certainty and continuity over the short / medium term and with no credit risk. The Trust also has amounts outstanding from other NHS bodies and Local Authorities which have themselves limited credit risk.

Liquidity Risk
The Trust's operating costs are incurred in order to perform contracts with clinical commissioning groups and other healthcare commissioners and local authorities, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from surplus funds and grants obtained from government departments. The Trust is not, therefore, exposed to significant liquidity risks.

16.1 Financial Assets

Carrying values of financial assets as at 31 March 2019 under IFRS 9	Held at amortised cost £000	Total book value £000
Trade and other receivables excluding non financial assets	22,169	**22,169**
Cash and cash equivalents at bank and in hand	39,451	**39,451**
Total at 31 March 2019	**61,620**	**61,620**

Carrying values of financial assets as at 31 March 2018 under IAS 39	Total book value £000
Trade and other receivables excluding non financial assets	**20,917**
Cash and cash equivalents at bank and in hand	**22,709**
Total at 31 March 2018	**43,626**

Financial assets are defined by IAS 32 as contractual rights to receive cash in the future. Balances that arise through statute, for example assets related to the operation of Value Added Tax £141k (2017/18: £1,044k) are not contractual and so are excluded from the disclosure. Other assets recognised by the Trust whose discharge requires the delivery of goods and services – such as prepayments £3,294K (2017/18: £5,468K) and the allowance for credit losses £630k (2017/18: £259k) are also excluded from this note.

16.2 Financial Liabilities

	Held at amortised cost £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9		
Trade and other payables excluding non financial liabilities	36,554	**36,554**
Total at 31 March 2019	**36,554**	**36,554**

	Other financial liabilities £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39		
Trade and other payables excluding non financial liabilities	33,637	**33,637**
Total at 31 March 2018	**33,637**	**33,637**

Financial liabilities are defined by IAS 32 as contractual obligations to pay out cash in the future. Balances that arise through statute, for example tax, social security costs and pension contributions £2,275K (2017/18: £2,009K), are not contractual and so are excluded from the disclosure.

16.3 Maturity of financial liabilities

	31 March 2019 £000	31 March 2018 £000
In one year or less	36,554	33,637
Total	**36,554**	**33,637**

The Trust has no financial liabilities due in more than one year as its Injury and Sickness Benefits do not constitute a financial liability and are therefore excluded from this note.

Note 17 Cash and cash equivalents

	2018/19 £000	2017/18 £000
At 1 April	**22,709**	**11,346**
Net change in year	16,742	11,363
At 31 March	**39,451**	**22,709**
Broken down into:		
Cash at commercial banks and in hand	32	21
Cash with the Government Banking Service	39,419	22,688
Total cash and cash equivalents as in SoFP	**39,451**	**22,709**

Note 18 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
NHS payables - revenue	(513)	163
NHS - accruals and deferred income	13,607	10,908
Non - NHS trade payables - revenue	(7)	(270)
Non - NHS accruals and deferred income	22,587	20,904
Non NHS - Capital creditors	2,751	2,620
Tax	141	1
Social security costs	108	7
PDC dividend payable	0	253
Other payables	2,120	2,030
Total current trade and other payables	**40,794**	**36,616**

Other payables include £2,026K in respect of outstanding pension contributions at 31 March 2019 (31 March 2018: £2,009K).

Note 19 Borrowings

Central London Community Healthcare NHS Trust has no borrowings at the Statement of Financial Position reporting date.

Note 20 Provisions for liabilities and charges

	Early Departure Costs £000	Re-structuring £000	Redundancy £000	Other £000	Total £000
At 1 April 2018	**221**	**108**	**1,000**	**1,302**	**2,631**
Arising during the year	0	0	1,787	368	**2,155**
Utilised during the year	(21)	0	(31)	(312)	**(364)**
Reversed unused	0	(76)	0	0	(76)
At 31 March 2019	**200**	**32**	**2,756**	**1,358**	**4,346**
Expected timing of cash flows:					
- not later than one year;	16	32	2,756	1,358	**4,162**
- later than one year and not later than five years;	184	0	0	0	**184**
- later than five years.	0	0	0	0	**0**
Total	**200**	**32**	**2,756**	**1,358**	**4,346**

	Early Departure Costs £000	Re-structuring £000	Redundancy £000	Other £000	Total £000
At 1 April 2017	**237**	**402**	**495**	**1,538**	**2,672**
Arising during the year	0	0	884	741	**1,625**
Utilised during the year	(16)	0	(379)	(199)	**(594)**
Reversed unused	0	(294)	0	(778)	**(1,072)**
At 31 March 2018	**221**	**108**	**1,000**	**1,302**	**2,631**
Expected timing of cash flows:					
- not later than one year;	16	108	1,000	1,302	**2,426**
- later than one year and not later than five years;	64	0	0	0	**64**
- later than five years.	141	0	0	0	**141**
Total	**221**	**108**	**1,000**	**1,302**	**2,631**

The Trust's provision relating to injury and sickness benefits is for payments made to two staff members who ceased work due to an injury or disease wholly or mainly attributable to their NHS duties. When it is assessed by the NHS Business Agency that the employee's sickness or injury was due to performing NHS duties and they are no longer capable of work the employee is entitled as part of their NHS terms and conditions to future payments for loss of earnings. When an employee qualifies for these payments the Trust recognises in the year the full cost of future payments. The provision is then paid to the NHS Business Agency over the life of the staff member and is adjusted for medical advice. The provision for legal claims has been recognised to reflect the payments that will be made to exit a loss making contract, the legal claims provision is under the Heading of Re-Structuring. Payments to exit loss making contracts are

only made when in the opinion of the board it is financially beneficial to do so and there is no impact on patient care.

NHS Resolution is holding clinical negligence provisions with a value of £949k (2017/18: £1,000k) and non-clinical provisions with a value of £187k (2017/18: £202k) on behalf of the Trust at the reporting date. Should these claims prove successful the Trust will incur a liability excess payable to NHS Litigation Authority of £63K (2017/18: £63K). This excess is fully provided for within the provisions for 'Legal' above. The NHS Resolution has estimated a probability that the Trust will have to pay this excess. Other provisions of £1,358k (2017/18: £1,302k) is in respect of dilapidations provisions £402k and overseas recruitment £956k.

Note 21 Contingent liabilities and assets

NHS Resolution manages and if necessary settles clinical and other negligence compensation cases on behalf of the Trust. The Trust pays an amount for this service dependent upon a risk rating set by the NHS Resolution. CLCH has seven non-clinical claims outstanding (2017/18: seven) for which the Trust will have to pay a set excess. This excess is estimated by the NHS Resolution as £63K (2017/18: £63K). The NHS Resolution believes that it is unlikely the Trust will have to pay £23K (2017/18: £27K) excess and recommends that this amount is therefore disclosed as a contingent liability.

Note 22 Related party transactions

In financial years 2018/19 and 2017/18 there were no transactions between CLCH board members or their families and key members of staff, and CLCH.

Central London Community Healthcare NHS Trust was appointed as corporate trustee of The Central London Community Healthcare Charity and related Charities on 22 December 2011. The Trust Board serves as the Charity's agent in the administration of the charitable funds. The Charity is a related party of the Trust. During 2018/19 the Charity paid the Trust £291K for goods and services provided by CLCH (2017/18: £146K). As at 31 March 2019 the Trust had a total of nil (2017/18: £18k) receivable from the Charity.

The Department of Health is regarded as the parent department of CLCH NHS Trust. During the year CLCH had a number of material transactions with entities controlled by the Department, and other entities for which the Department is regarded as the parent. The main entities within the public sector with which the body has had dealings are listed below:

Organisation name
NHS England - London Specialised Commissioning Hub
London Regional Office
NHS Barnet CCG
NHS Brent CCG
NHS Camden CCG
NHS Central London (Westminster) CCG
NHS Ealing CCG

NHS Enfield CCG
NHS Hammersmith and Fulham CCG
NHS Haringey CCG
NHS Harrow CCG
NHS Herts Valleys CCG
NHS Hounslow CCG
NHS Merton CCG
NHS West London (K&C & Qpp) CCG
NHS England
Health Education England
Department of Health and Social Care
NHS Property Services
Community Health Partnerships
Chelsea and Westminster NHS Foundation Trust
Royal Free London NHS Foundation Trust
Hounslow and Richmond Community Healthcare NHS Trust
Imperial College Healthcare NHS Trust
Barnet London Borough Council
Brent London Borough Council
Ealing London Borough Council
Hammersmith and Fulham London Borough Council
Hertfordshire County Council
Kensington and Chelsea Council (Royal Borough of)
Merton Borough Council
Richmond upon Thames Borough Council
Wandsworth London Borough Council
Westminster City Council
HM Revenue & Customs
NHS Pension Scheme

Note 23 Third party assets: patients' monies

The Trust held £124K cash at bank and in hand at 31 March 2019 on behalf of patients (31 March 2018: £126K).

Note 24 Losses and Special Payments

During the year, the Trust has had the following losses and special payments:

	2018/19		2017/18	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Bad debts and claims abandoned	59	79	0	0
Total losses	**59**	**79**	**0**	**0**
Special payments				
Compensation under court order or legally binding arbitration award	1	0	2	8
Ex-gratia payments	3	2	5	1
Total special payments	**4**	**2**	**7**	**9**
Total losses and special payments	**63**	**81**	**7**	**9**

Note 25 Events after the reporting date

There have been no events after the reporting period since the Statement of Financial Position date.

Note 26 External Financing Limit

The trust is given an external financing limit against which it is permitted to underspend:

	2018/19 £000	2017/18 £000
Cash flow financing	(16,160)	(10,569)
External financing requirement	(16,160)	(10,569)
External financing limit (EFL)	13,798	8,149
Under / (over) spend against EFL	29,958	18,718

Note 27 Breakeven performance

	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000
Breakeven duty in-year financial performance	2,196	3,835	1,766	1,735	1,836	3,506	5,380	6,883	9,434
Breakeven duty cumulative position	2,196	6,031	7,797	9,532	11,368	14,874	20,254	27,137	36,571
Operating income	155,379	190,946	193,270	196,191	198,409	196,671	212,749	216,614	241,667
Cumulative breakeven position as a percentage of operating income	**1.4%**	**3.2%**	**4.0%**	**4.9%**	**5.7%**	**7.6%**	**9.5%**	**12.5%**	**15.1%**

Note 28 Capital Resource Limit

	2018/19 £000	2017/18 £000
Gross capital expenditure	5,771	7,166
Less: Disposals	(388)	(6)
Less: Donated and granted capital additions	0	0
Plus: Loss on disposal of donated/granted assets	0	0
Charge against Capital Resource Limit	5,383	**7,160**
Capital Resource Limit	7,782	7,187
Under / (over) spend against CRL	**2,399**	**27**

All capital investments in 2018/19 and 2017/18 were funded from the Trust's internally generated cash reserves and Public Dividend Capital received.

Note 29 Capital commitments

The Trust had no capital commitments (amounts ordered at 31st March 2019 but not yet delivered) at the statement of financial reporting date (2017/18: £0).

Note 30 Annual capital cost absorption rate

	2018/19 £'000	2017/18 £'000
Dividends on Public Dividend Capital	1,071	1,453
Opening Capital and Reserves (Total Assets Employed)	63,449	53,627
Adjustment to closing balances re Q4 Provider Sustainability fund	(1,708)	(558)
Opening Relevant Net Assets	**61,741**	**53,069**
Closing Capital and Reserves (Total Assets Employed)	73,444	63,449
Closing adjustment- Incentive & Bonus PSF	(3,545)	(1,708)
Closing Relevant Net Assets	**69,899**	**61,741**
Sum of Opening/Closing Relevant Net Assets	131,640	114,810
Initial Average Relevant Net Assets	65,820	57,405
Average Daily Cleared Balances in GBS/NLF	(35,232)	(15,899)
Final Average Relevant Net Assets	**30,588**	**41,506**
Full Year Effect for Part Year Trusts	**1,071**	**1,453**
Capital Cost Absorption Rate (%)	**3.5**	**3.5**

Note 31.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £0k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £449k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £0k.

Note 31.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

The application of the standard has had no impact for the Trust.