NHS
Central London
Community Healthcare
NHS Trust

Annual Report 2019/20

Section 1 – Performance report

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Section 1 – Performance report

1.1 Overview

The purpose of the annual report is to provide details on the performance of CLCH for the year 2019/20.

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 2020/21 financial year.

1.2 Foreword

In 2019/20, following publication of the NHS Long Term Plan, community healthcare became even more integral to the NHS agenda. CLCH supported the drive for greater investment in community health services by continuing its vital role in supporting millions of patients across London and Hertfordshire.

We were pleased to have welcomed new services to the Trust including: haemoglobinopathy and the children's homeless, refugees and asylum seeker service in Wandsworth and the children's weight management service in Ealing.

In October 2019, more than 650 staff joined the Trust as we began delivering adult community services in West Hertfordshire – the largest mobilisation of services we have ever undertaken at CLCH. Since then, the focus has been on transforming these services to meet the needs of the local population.

Our Academy programme has 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.

Two of our quality councils achieved national and international awards for their projects in 2019/20. These councils chaired by frontline staff, work together with patient representatives to identify projects that will make improvements to our services. We now have 30 quality councils running across 5 divisions and the number of staff involved has more than doubled this year.

We updated our equality, diversity and inclusion strategy in 2019/20, setting out clear objectives and areas of focus for the next 3 years. The progress of the strategy is monitored

closely by an equality group, made up of staff representatives.

Our continued focus on integrated care in the Long Term Plan provides us with increased opportunities to cultivate strong partnerships with GPs, other NHS Trusts, social care and voluntary sector partners.

We will be launching a refreshed Trust strategy in the year ahead to address how we navigate and support an ever changing landscape. Whilst we can expect some challenges, the dedication and resilience of our workforce will enable us to face these head on, as we strive to provide the best quality care to so many patients in our local communities.

This annual report records the great work that has been undertaken by all our staff over the last year and begins to look ahead to a new year for CLCH.

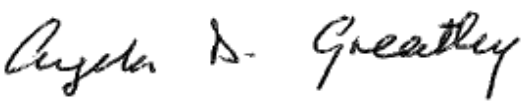
However, in early 2020, we began to hear of a novel Coronavirus that was to have major implications for the whole world. We supported the response to the COVID 19 outbreak by working in collaboration with our local and regional NHS system partners to operate and deliver a number of services. This included providing drive through testing hubs at a number of our sites for patients and NHS staff, and caring for staff with and recovering from COVID 19 both in their homes, and on our wards and with our wide range of community services. We are incredibly proud of the way in which our staff have responded to this unprecedented situation in order to support national efforts to manage this global outbreak.

As a Trust I know that we all prepared as well as we could; our executives and the whole staff team behaved in an exemplary fashion going above and beyond anything that might have been expected even a few months earlier. I want to offer real and heartfelt thanks to every single member of the staff team who have worked in completely new ways, in new roles and have done this in the face of challenges to their own health. The patients and carers cannot offer thanks themselves so I am very pleased to have this chance to do so on their behalf.

My non-executive director colleagues and I have worked with the executive to ensure that governance remained effective and to offer leadership in extraordinary circumstances. My thanks go to them to as to the executives and the whole board.

Hindsight will offer perspective. I am sure that I shall be leading a much changed Trust in an altered landscape over the coming months. I intend to make sure that CLCH and its brilliant staff learn from what has not been as good as we would have wished and that we retain and build on the good work that has characterised this period of great challenge.

Angela Greatley, Trust Chair



Angela Greatley, OBE
Chair

Date 24 June 2020

Andrew Ridley
Chief executive

Date 24 June 2020

1.3 About us

This section outlines the purpose and activities of the Trust. Central London Community Healthcare NHS Trust (CLCH) was established in 2008 as a community services provider for Hammersmith and Fulham, Kensington and Chelsea and Westminster. We now operate in 11 London boroughs including: Richmond, Merton, Wandsworth, Brent, Barnet, Harrow, Hounslow and Ealing as well as Hertfordshire.

Over 4,000 of our staff care for more than 2 million patients, helping them 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 line with the NHS Long Term Plan, our priority is to focus on developing integrated community services, working closely with primary care, 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 in order to improve the needs of local populations. We provide:

- 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, neuro-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 7-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 4 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 4 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.

1.4 Trust strategy

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

Our seven strategic priorities for 2019/20 were:

- **Population health** – improving the health of our patients and staff
- **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 2019/20 financial plan
- **Operations** - deliver all NHS constitutional and contractual standards
- **Workforce** - make CLCH a great place to work for everyone
- **Digital transformation** – implement the vision of the NHS Long Term Plan.

During 2019/20 we refreshed our organisational strategy for the next 5 years (2020/25), building on our previous strategy, and expect to publish this in 2020 having considered the impact of national recovery plans in response to COVID 19.

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

1.4.1 Quality strategy 2017-2020

'Simply the Best, Every time' was developed and launched in February 2017 with the aim to move us from a '*Good*' to '*Outstanding*' rated Trust. It introduced 3 new quality campaigns alongside the 3 which continued from the 2013-2016 strategy. These campaigns provided 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 our 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 here. Looking forward, our 2020-2025 quality strategy, 'Improving Quality in Everything We Do' launched in 2020; its overall purpose is to ensure that CLCH remains as the best provider of high quality community healthcare it can be. It will provides us with a framework through which improvements in the services we offer to patients can be focused and measured for the planning, implementation, evaluation and reporting of quality services.

1.4.2 What we do

Our organisational strategy is to put greater emphasis on delivering services in a more integrated or joined up way with other providers, particularly with colleagues in primary care, through the new primary care networks. These deliver care to a population of around 30-50,000 residents. In practice this means that our services need to:

- be co-designed with patients and partners
- be focussed on specific local need and based on population health data
- have integrated assessment, care planning and delivery processes with other providers
- have shared records
- 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 throughout the communities we serve. The essence of our services will remain 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 themselves.

1.4.3 Where we work

Our focus has been on working hard to build effective partnerships within our existing remit, so we have not sought to take on new services outside of our 4 current sustainability and transformation partnership (STP) areas.

When considering new services within our STP areas, we will continue to focus on whether we believe we can improve the quality of care rather than the potential income growth.

CLCH is committed to working with partners in our 4 STPs:

- North West London
- South West London
- North Central London
- Hertfordshire and West Essex

We have continued to support the development of the emerging integrated care systems and partnerships in each area.

On 1 October 2019, we commenced delivery of adult community services in West Hertfordshire following a successful competitive tender. As a result of the contract award, CLCH are delivering 18 new services across 14 sites in Hertfordshire with more than 650 staff that transferred from the previous provider. These services are in addition to existing CLCH Hertfordshire services for respiratory and sexual health, which have been delivered by the Trust for a number of years.

1.4.4 How we work with partners

We are working with our partners in each of our geographies to develop our response to the NHS Long Term Plan (www.longtermplan.nhs.uk). This means developing more collaborative ways of working that join up health and care for our patients and taking a population health approach, which focuses on prevention, self-care and wellbeing and supporting people within their communities. We are working with our colleagues in primary care to develop new primary care networks which are providing care for populations of 30 - 50,000 people across our geography.

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 and general practice (through primary care networks) in order to enable integration of community-based services. We are playing an active role in the emerging integrated care systems and partnerships with our health, local authority and voluntary sector partners to reshape services for the future.

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 and wider community assets 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 (for example video conferencing since the outbreak of COVID 19), to support their self-management and improve models for delivery of care. Digital technology is also key to enabling integration with other providers.

1.5 Performance summary and analysis

We continue to be a high performing Trust that puts quality of care at the heart of everything we do. In September 2017 the Trust hosted 28 Care Quality Commission (CQC) inspectors and specialist advisors, who assessed 4 of our care services: children's; adults; inpatient and end of life care. We were pleased to receive an overall ‘Good’ rating in February 2018.

The Trust’s services for children, young people and families were inspected by the CQC in February 2020, however, due to COVID 19, the well-led inspection was postponed and we will not receive a rating before year-end.

The Board monitored 24 key performance indicators (KPIs) across population health, strategy implementation, quality, operations, finance, workforce and digital transformation throughout 2019/20. Of these KPIs, 10 achieved the target set by the Trust, 4 were within the amber threshold of performance and a further 5 KPIs were not being assessed against a target as 2019/20 was a baseline year. The remaining 5 KPIs did not achieve their targets; recovery plans were put in place to address this position.

As a result of COVID 19, the recording of a few KPIs was suspended in March 2020. In these cases the annual performance is taken from the February 2020 data. The impact of COVID 19 also affected the year end performance of certain KPIs.

As a result of our strong financial performance the Trust has achieved a segment 1 rating from NHSE/NHSI under the ‘oversight framework’ for the year up to Q3. This means the Trust is permitted to operate with the highest levels of autonomy allowed by the regulator. The assessment process was suspended in Q4 due to COVID 19 but the Trust anticipates

that it will be continue to be within segment 1.

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 2019/20 performance analysis

Each year the Board of Directors sets a suite of KPIs for the Trust to track performance in priority areas. For 2019/20, the Board monitored 24 KPIs (compared to 19 in 2018/19). Performance against these KPIs is monitored monthly both within our clinical divisions and at Board level. Progress throughout the year is published in our integrated finance and performance report which is part of the papers for regular public Board meetings, available here.

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.

For 2019/20 we reviewed and updated some of our Board level key performance indicators, grouping them under 7 strategic priorities: population health, strategy implementation, quality, finance, operations, workforce and digital transformation.

The objectives for each priority are:

- **Population health:** improving the health of our patients and staff
- **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 2019/20 financial plan.
- **Operations:** deliver key service standards to patients
- **Workforce:** make CLCH a great place to work for everyone.
- **Digital transformation:** implement the vision of the NHS Long Term Plan.

1.5.2 Population health

Making every contact count - uptake of level 1 training

The Trust trained 91% of its clinical staff in 'making every contact count at level 1 against a target of 95%. This performance is based on month 11 performance and was on track to achieve the annual target, however further progress was halted due to the operational response to COVID 19.

1.5.3 Strategy implementation

Assessment of Trust actions related to STP Integration

Throughout the year the Trust has been assessing the Trust's actions in relation to system integration on a quarterly basis. Our leadership has been actively involved in the development of integrated care systems and partnerships and at operational level we are making steady progress in our integration strategy, such as in aligning our district nursing teams with the new primary care network areas.

1.5.4 Quality

Percentage of reported incidents that did not cause harm (moderate to catastrophic categories)

This KPI compares like-for-like incidents across the Trust that were reported as moderate or above. Of reported clinical incidents, 98.5% did not cause harm (moderate or above) against a target of 97%.

Friends and family test - percentage of people that would recommend the 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%.

Percentage of deaths requiring preventable incidents, survival and mortality (PRISM) reviews

Data for this KPI, sets out the number of deaths reviewed using the screening tool (PRISM) compared to the total number of deaths. Due to COVID 19, collation of KPI data was suspended nationally from the beginning of March to free up clinicians to lead the response. Therefore the performance below is for April 2019 – February 2020 only.

On 29 February 2020 the KPI compliance for learning from deaths in North Central, North West and South West divisions was 100%.

On 29 February 2020, the KPI compliance for learning from deaths for the Hertfordshire division was 79%. CLCH acquired services in Hertfordshire in October 2019 and these services had a transition period of 4 months (until the beginning of February 2020), to embed CLCH learning from death processes across the division. Compliance was 55% in November, 60% in December and 100% from January onwards.

Percentage of statutory and mandatory audits undertaken by the Trust

In order to prioritise clinical time to respond to COVID 19, the Trust stopped monitoring performance against this KPI at the end of month 11. Up to the end of month 11 the Trust achieved 100% compliance with statutory and mandatory audits – in line with the target.

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

The calculation of this KPI reflects the percentage of those staff respondents that gave either an "extremely likely" or "likely" to the question ‘How likely are you to recommend this organisation to friends and family if they needed care or treatment?’ minus those who would not recommend. Against a target of 75%, the Trust achieved 70%.

1.5.5 Operations

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

Of the Trust patients within the definition of the national RTT target, 96.7% were treated within 18 weeks of referral against at a target of 92%.

Percentage of all Trust patients seen within 18 weeks and 10 weeks

During the year the Trust monitored waiting times for all patients; during the year an average of 79% of patients were seen within 18 weeks and 65% of patients seen within 10 weeks against a target of 90%. During 2019/20 performance against this KPI was showing steady improvement but this was impacted in February and March 2020 by the Trust’s response to COVID 19.

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

The Trust monitors waiting times for patients seen in its walk-in-centres and urgent care centres against the national 4 hour waiting target. During the year, 98.5% of all patients were seen within 4 hours compared to a target of 95%.

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

Against a target of 3.5%, the Trust reported 5.5% of transfers of care were delayed for NHS reasons - 2810 beds lost.

Percentage of patients seen within 2 hours within commissioned 2 hour services

During the year an average year 91% of patients were seen within 2 hours (commissioned 2 hours services only) exceeding our target of 85%.

1.5.6 Workforce

Percentage of staff that recommend CLCH as a place to work

This KPI is a measure of staff satisfaction with the Trust as an employer. During the year, 58% of staff agreed with the statement that they would recommend CLCH as a place to work against a target of 62%.

Vacancy level – all staff

This KPI reflects all vacant full time equivalent (less frozen posts) divided by the budgeted establishment. At the close of 2019/20 year the Trust's clinical vacancy rate was 14.17% for all staffing against the target of 8%. Further work is planned on this metric during 2020/21, including a significant overseas recruitment campaign.

Staff appraisal rate

This KPI shows the number of staff appraised as a percentage of the number due for appraisal in the same period. In 2019/20, 81.56% of staff had their appraisal against a target of 90%. This performance was impacted by the Trust's decision to deprioritise staff appraisals in order to prioritise the clinical response to COVID 19.

Appointment proportion of BAME for band 7+ Posts

During 2019/20, across the Trust 42.8% of staff appointed at band 7 and above declared a BAME background against a target of 36.44%.

1.5.7 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 2019/20 year the Trust achieved 94% recurrently.

Income and expenditure performance

The Trust achieved its 2019/20 year-end target of a £5.2 million surplus as a result of a £2m surplus delivered by operational services and £3.2m of provider sustainability funding from central government.

Cash balance performance

Against a year-end target of £12m, the Trust ended the year with a £52m cash balance; this represents a £40m favourable variance compared to plan.

Recurrent surplus/deficit delivered against target

At the end of 2019/20 the Trust reported a recurrent deficit of £1.34m, which represents a recurrent adverse variance to plan of £1.5m. The KPI has not, therefore, been met.

1.5.8 Digital transformation

The Trust set a number of digital KPIs associated with our digital transformation strategic priority.

Cyber security

The Trust measures this KPI to ensure that all CareCERT advisories are implemented within one month of receipt. The Trust target for this is 100%; during 2019/20 – 2 of the 28 advisories were not implemented in the target timeframe as it was not practical to do so.

New digital KPIs to reflect the Trust ambition to use digital technologies to support and transform effective care were established during 2019/20; these are in baseline development to determine the appropriate target levels and are described below:

Integrated/shared records

Ability for shared records between community services and primary care to support integrated, safe and effective care.

Real time recording

Contemporaneous clinical record keeping to ensure an up-to-date record for care and an indicator of staff working in an agile manner.

Contact method

In order to monitor delivery of care via digital and non-face-to-face means - the percentage of contacts that are digital, by telephone and video.

1.6 Strategy implementation

The Trust continues to be actively involved in the delivery of sustainability and transformation partnerships (STPs) and the development of integrated care systems (ICS), integrated care partnerships (ICPs) or 'place', and primary care networks (PCNs) 'neighbourhoods', which is progressing at differential pace, across the geographical footprint of the Trust.

CLCH remains committed to the delivery of integrated services in the interests of joining up care for its population.

The Board monitors the leadership team's engagement in system development through quarterly update reports. The Board also receives reports on progress with divisional integration programmes at place and PCN level.

1.7 Our staff

We employ 2,618 full-time staff, 1,338 part-time staff and we have 1,627 people registered on our staff bank for temporary work. Our workforce comprises:

- 79.15% clinical roles
- 86.58% women

- 42.62% staff of Black, Asian and Minority Ethnic (BAME) backgrounds
- 61.83% 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 (annual governance statement). The Board gender breakdown, including non-voting members (2) is 7 male and 6 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.

Promoting good mental health

We have 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 across 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. Their collaboration with the Trust's employee health service continues and we provide support as and when is necessary.

Employee health continues to support and bolster the mental health of employees through resilience workshops and team interventions. These workshops were launched by the mental health nurse and they have continued through further training by the employee health psychologist.

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. During 2019/20, 39 team sessions were provided.

Mental health training

There is a Trust-wide mental health awareness training programme for managers and during 2019/20, a further 9 sessions were delivered. The course, designed by our employee health

service, to better equip managers with the skills to handle mental health issues in the work environment and, in so doing, reduce or pre-empt sickness absence due to stress and other mental health issues. The training allowed managers across the Trust to explore basic mental health models, identify some of the biggest and most prominent mental health issues in the workplace and address mental health issues, difficult conversations and more.

Mental health week (13 May - 17 May 2019)

As part of national mental health week, employee health ran drop-in sessions across our sites. The sessions aimed to reach out to as many staff as possible, offer support and verbal guidance, and signpost staff to relevant services and resources where needed.

During the week, blogs on happiness, post-traumatic stress disorder (PTSD), bereavement, chronic pain and self-compassion were also shared with staff.

Kaido

Kaido is an important part of CLCH's approach to achieving the third aim of the health and wellbeing aspect of the people strategy. It was introduced in August 2019 and is a cost-effective way of providing staff with easily accessible information about health and wellbeing and to encourage staff to take positive steps to improve their health by participating in 3 fun challenges during the year.

The first challenge launched in August 2019 with almost 500 employees across 120 teams registered to take part. Feedback from participants has been positive:

- 33% said to have lost weight
- 35% said to have noticed decreased feelings of stress
- 67% reported increased physical activity
- 93% said they would participate in the challenge again.

The second challenge began in January 2020 and the third will run in May 2020.

1.7.2 Freedom to speak up

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

During the year 2019/20, 178 staff contacted the FTSU guardian with concerns compared with 84 in 2018/19, an increase of 112%. The concerns are categorised under original National Guardian's office headings. Of the 411 categorised concerns, 49% (203) are behaviour-related. FTSU concerns are triangulated with other staff feedback and lessons learned are used as part of a culture of continuous improvement.

The Freedom to Speak Up vision, strategy and implementation plan, developed by the Trust

Board with input from the guardians, and approved in November 2018, continues to be implemented, with progress reported twice yearly to the Board.

1.7.3 Recruitment and retention

Our recruitment and retention plans and our clinical workforce strategy are key to enabling us to have 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.

On 1 October 2019, we commenced delivery of adult community services in West Hertfordshire. As a result of the contract award, CLCH is delivering 18 new services across 14 sites in Hertfordshire with more than 650 staff that transferred from the previous provider.

Campaign 5 of CLCH's quality strategy (Here, happy, heard and healthy) aimed to achieve a vacancy rate of 8% by March 2020. The overall vacancy rate at the close of 2019/20 was 14% against the target of 8%.

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

Workforce Action Teams (WATs)

In 2019/20, the approach to improving recruitment and retention included the setting up of WATs for Clinical Business Units (CBUs) across the Trust along the following criteria:

- vacancy rate greater than 8.8%
- ranking by number of actual vacancies (in the top 20, ranked highest first 0)
- clinical vacancy rate greater than 8.8%
- clinical sickness rate greater than 3.65%
- all staff 12 month turnover rate greater than 8.8%.

The following seven WATs were set up in September 2019.

- Children's division: Barnet and Brent; Merton's children's services
- North Central division: Barnet walk-in centres and inpatients
- North West: Inner walk-in centres and inpatients; Hammersmith and Fulham planned care
- South West: Merton Planned Care; Wandsworth planned care.

Three new WATs were set up in February 2020: our South West division (unplanned care and Heathlands) and Hertfordshire (bedded unit; and planned care).

The WATs were given a target to halve their vacancy rates over 6 months. The WATs, which meet every two weeks, have analysed the root causes of poor recruitment and retention in each CBU and have taken actions to improve performance in line with the retention and recruitment drivers approved by the Board in October 2019.

The WATs have taken pro-active steps to improve supply through wider advertising using a diverse range of channels and to increase the attraction of applicants by re-branding adverts to better promote jobs, services and the Trust and these efforts need to be complemented by wider international recruitment for shortage roles in order to meet demand.

Nurse apprenticeships

The Apprentice Nursing Associate (ANA) role continues to be embedded across the Trust. Currently we have 62 ANAs in training and our attrition rate is 7% which compares favourably with a national rate of 50%. The CLCH Academy has also successfully completed a project to support the implementation of apprentice nursing associates in primary care in North West London.

International recruitment

The Trust continues with its international recruitment campaign. Despite being unable to travel to the Philippines due to unforeseen natural disasters, the Trust successfully recruited 58 candidates in 2019/20.

The Trust is also engaged in work through Capital Nurse to explore and develop how London trusts could collectively collaborate and join up with regards to the recruitment of overseas nurses. This is aligned to the NHS People Plan (2019) that suggests a regional approach to overseas recruitment. There has been good engagement across London to develop a best practice guide related to developing a parity of offer across London and also to provide support and foster collaborative working. The other key element of work that has been taking place alongside the development of the best practice toolkit is developing and designing a process whereby London trusts could come together to share resources and have a single point of reference for overseas nursing recruitment.

Capital Nurse programme

The Capital Nurse rotation programme for community nursing is now established across the Trust. The Academy has seen a rise in the number of staff undertaking the 18 month programme consisting of a structured teaching programme, reflective practice, action learning group support and workplace based assessment in a range of skills and competences. 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. The Trust has been successful in obtaining the Capital Nurse quality mark for preceptorship for a second year.

Increasing our engagement with young people

The Academy has implemented a work stream to develop the Trust's engagement plan with schools as part of our future workforce. This covers 3 areas; careers fairs and leadership talks, work experience placements in clinical areas and Health Education England (HEE) engagement with NHS awareness initiatives in schools. As a result, a high number of school careers fairs and talks have been scheduled either directly with a school

or via the local authority or STP. Alongside this, the Academy has been working with HEE to develop standard guidance for work experience placements.

1.7.4 CLCH Academy

The CLCH Academy has 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, for example, through the introduction of the apprentice nursing associates as well as facilitating rotations for staff across community and primary care to build their experience.

The Academy has overseen the implementation of the Trust education strategy for 2018-2020 and has developed an Academy education and training plan for March 2020 – March 2023. This plan supports the educational and workforce aspirations of the Trust as well as its strategic objectives. The Academy provides an excellent opportunity to support the development of a workforce that is fit for the future with staff that are competent and capable to provide care within new models of working.

During 2019/20, working with NHS Elect, the Trust has run a leadership programme for our clinical business managers as well as a range of programmes for clinical leaders.

1.7.5 Recognising quality

We are extremely proud of the work our staff do and it is always great to see this acknowledged through awards and schemes.

Our inner boroughs were awarded the UNICEF baby friendly initiative gold sustainability award and were highly commended for “the progress made with embedding and developing care related to the baby friendly standards.”

Our care home in-reach team in Wandsworth was short-listed in the ‘Care of Older People’ category at the Nursing Times Awards 2020. By working closely with Wandsworth Council and the London Ambulance Service, our team is able to target homes with high call-out rates and maintains a strong visual presence by attending regular GP rounds at care homes.

CLCH Academy, our learning and development service, was shortlisted for the Nursing Times Awards 2020, in the ‘Managing Long Term Conditions’ category. This is for the work it has undertaken with Macmillan Cancer Support and the South West London Health and Care Partnership in the development of a community nursing module in cancer as a long term condition.

Patient stories and feedback are used in service improvement when a Trust project was undertaken as part of the 90 day NHS England collaborative focusing on frailty. The Trust project group gathered patient stories to inform a new training package for staff ensuring that as a Trust, we identify and use a single frailty index score, and explain to our patients what frailty means to them and how they can improve their condition.

Quality development unit accreditations (QDU)

The QDUs process was introduced as a way of recognising those teams or services which have shown excellence in quality through the assessments process. As described in our quality strategy, teams and services that have been awarded QDU accreditation status will be held up as centres of excellence and receive a team award of £1000 and lapel badges for team members. Additionally QDU accredited teams will be expected to trial new ways of working, offer advice to other teams who are struggling and to play a prominent role in our quality councils.

Since the introduction of QDU status 2 years ago, 8 teams have been accredited with QDU status. We currently have 9 teams in the process of applying for QDU accreditation by completing the QDU excellence standards, which were introduced in 2019/20 to strengthen the QDU accreditation process. Harrow podiatry team has now been successfully reaccredited following completion of the maintaining excellence standards and review of their evidence.

1.7.6 CLCH staff awards

Our annual staff awards were held in November 2019 at Porchester Hall and recognised the excellent work and exceptional dedication of our staff. Over 600 nominations were made across the 21 different categories. The event was very positively received and attended by more than 350 staff.

1.7.7 Staff survey results

Our response rate to the 2019 NHS staff survey was 45% (1,451 staff).

Compared with other community Trusts, across the new 10 theme areas, we had 3 areas with results above average (quality of care, quality of appraisals and safe environment - violence), and seven 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 2019 results are available at here.

Information in relation to the staff profile can be found in section 3 of this report.

1.7.8 Equality and diversity

The Trust published its refreshed equality, diversity and inclusion strategy in 2019/20; this sets out its equality objectives and key work streams for the next 3 years. This is monitored corporately by the equality group, which is co-chaired by the chief executive and medical director and includes staff network representatives.

Other reports published by the Trust in 2019/20 include: Equality Delivery System (EDS2) report, Workforce Disability Equality Standard, Workforce Race Equality Standard (WRES)

and Gender Pay Gap report. These reports can be found here.

The Trust's latest WRES report showed improvements in 3 areas:

- recruitment and selection
- access to non-mandatory training
- the number of staff going through formal disciplinary proceedings.

The Trust improved its representation of Black, Asian and Minority Ethnic (BAME) staff at Band 8A and above in clinical roles, in the numbers appointed from shortlisting, accessing non-mandatory training and going through formal disciplinary proceedings.

Thanks to the changes resulting from the work of our WRES taskforce members, we are seeing positive improvements in some areas and have developed a plan of work focussing on others.

Other highlights of our equality and diversity work in 2019/20 include:

- Meeting our target to train 150 recruiting staff (managers and support staff)
- Training a group of managers on a 'leading inclusively with cultural intelligence' programme. The programme will be rolled out to all line managers, middle and senior managers in 2020/21
- Organising 2 multi-channel campaigns to address unacceptable behaviour from patients, carers and staff. These included corporate messaging, workshops on conflict resolution and a range of resources made available to staff on our intranet. This was followed up with a Schwartz Round focussing on bullying and harassment faced by district nurses. We will continue this work through a respect programme in 2020/21
- Piloting a reverse mentoring programme with pairs of BAME staff and executive leadership team members, while actively promoting our existing mentoring and coaching programmes
- Strengthening our race equality and rainbow networks and establishing the disability and wellness network (DAWN). All 3 staff networks now meet bi-monthly, organise annual events, co-design training and participate in decision-making
- Developing a new appraisal system, which will launch in 2020/21, to ensure career development and one-to-one meetings take place systematically, along with needs related to reasonable adjustments and flexible working. The Trust is working with its Academy to offer staff career clinics, mentoring and shadowing opportunities
- Delivering a focus group for staff returning from maternity or adoption leave to identify challenges related to pay and progression, which will help us make targeted improvements to our employment practices.

These interventions have helped to raise greater awareness of equality and inclusion within the Trust with more staff coming forward to contribute to making the Trust a happier and healthier workplace.

1.7.9 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.

1.7.10 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 collaborative partnerships with trade unions and representative bodies are vital to us. The Trust's management and staff representatives meet regularly to review policies and staff experience. The Trade Unions are pivotal to the development of a number of initiatives including: organisational changes and consultations, job evaluation, health and safety (H&S), employee relations (ER) case work as well as training.

The Joint Staff Consultative Committee (JSCC) is held bi-monthly and is well attended by the Trust management, trade unions and staff representatives. There is also the Managers' and Staff Representatives' Partnership Forum (PF) which is held bi-monthly in the opposite months to the JSCC. This means that the Trust management and the Trade Unions and staff representatives meet every month.

The Trust is required to publish the following information relating to Trade Union Facility Time:

Table a: 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
31	30.46

Table b: The percentage of time spent on facility time for each relevant union official

The table below illustrates 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%	16
1% - 50%	15
51% - 99%	0
100%	0

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

Table c: The 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	£46,194*
The total pay bill	£123,743,130
The percentage of the total pay bill spent on facility time	0.04%

* This is an estimated cost of the facilities time

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

Note – In previous years all activity, including unpaid activities outside of the Trust were reported. This year, only paid activities carried out during work time are included.

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

1.7.11 Staff engagement

The chief executive undertakes a number of roadshows, which are very positively received, meeting staff across a number of our sites. 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 loyalty award. See also 1.7.6 above.

1.7.12 Shared governance

The Trust has developed a model of shared governance to support continued quality improvement and the implementation of the Trust's quality strategy.

Quality councils are a dynamic staff-leader partnership that promote collaboration, shared decision-making and accountability for improving quality of care, safety and enhancing work life. They each focus on one project aligned with one of the quality campaigns in the quality strategy, with the aim of making an improvement. These councils also act as a two-way resource for frontline staff and managers and will give informed advice on issues.

There are now 33 quality councils in place across the Trust, double the number we had at the beginning of 2019, and involving over 190 frontline staff.

The quality councils are chaired by a member of staff between Band 3 to Band 6 with membership consisting of 6 to 10 members of frontline staff, from clinical and non-clinical backgrounds.

Uniquely at CLCH, patients and members of the public are included in our shared governance model. Patient representatives are integral to the projects and have had training in continuous improvement methodology and chairing meetings.

Projects delivered over the last year in each division include:

- North Central - reducing waste and time district nurses spend dealing with inappropriate/incomplete referrals and establishing and ensuring compliance with controlled drugs
- North West - investigating do-not-attend (DNA) rates of initial assessment appointments in the specialist dental service, and improving morale and time wasting in Harrow by improving contact details
- South West - improving meal attendance of patients in bedded areas and information folders for patients and/or carers
- Children's - improving the communication of safeguarding information between social care services, health visitors and school nurses and improving support given to the parents and carers during waiting times for behavioural therapy appointments.

Trust-wide examples include quality councils tackling unacceptable behaviour in the workplace, improving digital clinical recording and retaining staff.

1.7.13 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. During 2019/20 CLCH has and will continue to:

- 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.

The Trust's full modern slavery and human trafficking statement is available here.

1.7.14 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

New business started during 2019/20:

- Haemoglobinopathy service (1 April 2019, Wandsworth CCG)
- Children's homeless, refugees and asylum seekers service (1 April 2019, Wandsworth CCG)
- Family weight management service (1 May 2019 , Wandsworth Local Authority)
- Child weight management service (1 October 2019, Ealing Local Authority)
- West Herts adult community service (1 October 2019, Herts Valley CCG).

In addition, the alternative and augmentative communication/communication aids (complex disability equipment) service was retained on a 12 month contract (1 April 2019 - 31 March 2020) following a successful bid to NHS England in the previous financial year.

Services that were decommissioned during the year:

- Family Nurse Partnership (30 September 2019, Kensington & Chelsea Local Authority)
- Family Nurse Partnership (30 September 2019, Westminster Local Authority)

1.8.1 COVID 19

The COVID19 disruption brought with it unprecedented change and had a significant impact on services across the organisation. The Trust enacted its business continuity plans and followed national guidance from NHS England in temporarily suspending some services to enable staff to be redeployed to support immediate and urgent services, including the discharge of patients from acute care and opening up additional community beds. Services

suspended included a number of walk in centres and non-urgent appointments across a range of areas. For those services still in operation, remote appointments using telephone and video calls have been used wherever possible, with face to face visits only where necessary. At the time of writing (April 2020), our plans remain dynamic as we respond to the crisis.

Over the coming year, there will be a strong emphasis on integrated care systems (ICS) to support system recovery and our own plans will be complementary.

The challenges ahead will be significant and across London, there will be 8 key priorities to:

- retain resilience to deal with the demands of COVID19
- minimise excess mortality and morbidity from other causes
- support access to services
- respond to the indirect effects of the pandemic, for example on public health
- support and prioritise staff and patients
- adopt and learn from innovations introduced during the pandemic
- ensure that the new health and care system is fundamentally better at addressing inequalities
- ensure the system is higher quality, more productive and better governed.

A similar recovery framework is being developed for Hertfordshire.

1.9 Value for money

During 2019/20 the Trust achieved a surplus on operating expenditure of £6.0 million (in line with plan) thus securing a further £3.2 million of provider sustainability funding (PSF) from central government; this was based on a total Trust turnover of £273 million (£242 million 2018/19). 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 eight years. In 2019/20 we successfully delivered savings of £9.8m million (100%) against a plan of £9.7 million. 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 £90 million since 2011.

All QIPP schemes are reviewed by the medical director and chief nurse and are monitored throughout the year to ensure that there are no adverse effects on the quality of patient care

or staff experience.

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 2019/2020 included:

- Opening the final of 3 new sexual health hubs in Hertfordshire, continuing the transformation of clinical service provision in Hertfordshire and building on that in south London at the new Falcon Road centre
- Continuing with further estates rationalisation to reduce under-used/unoccupied spaces
- Supporting CLCH's QIPP plans by delivering £25.2 million recurrent savings since 2016/17 financial year
- Delivering an agile working programme implemented within all new developments since April 2016
- Developing proposals to provide CLCH staff accommodation.

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 £6.75 million was applied. From a total spend on agency staff of £22 million in 2015/16 we have management reduce agency spend year on year, to the point where spend in 2019/20 was £5.7 million. This has also come during a period where the Trust has expanded its service provision substantially across South West London, North West London and Hertfordshire.

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.

A copy of any web link information can be provided by emailing the communications team clch.communications@nhs.net

Section 2 – Corporate governance report

2.1 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 generally meets in public[1]. 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 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.

Information Governance and Information Commissioner's Office (ICO) reportable events are included in section 2.2.24 below.

2.1.2 Changes to the Board

There has only been one change to the membership and composition of the Board during the year as shown in table 1 below.

Board membership and composition	Post holder	Note
Director of improvement	Elizabeth Hale joined the Board in a substantive position on 01.04.19	This is a non-voting position

Table 1

The Board has had a full complement of substantive executive and non-executive directors since April 2019. We were pleased to welcome Jacqueline Hinds in May 2020 as an Associate Non-Executive Director (this is a non-voting position).

2.1.3 Committee chair arrangements

Committee	Chair – 2019/20
Auditor panel	Clive Sparrow
Audit committee	Clive Sparrow
Remuneration committee	David Sines
Quality committee	Carol Cole
Finance, resources and investment committee	Jitesh Chotai
Workforce committee	David Sines
Charitable funds committee	Clive Sparrow

Table 2

[1] In March 2020 it was not possible to meet in public due to the COVID 19 pandemic

2.1.4 Board members

The table below details the composition of our Board during 2019/20, and the position of members as at 31 March 2020 on the formal committees of the Board. Profiles of our Board members are available here.

Non-executive team	Committee membership (*chair)
Jitesh Chotai	Audit Finance*
Dr Carol Cole Vice chair	Quality* Remuneration Workforce
Angela Greatley, OBE Chair of the Board	Finance Remuneration
Professor David Sines, CBE Senior independent director	Quality Remuneration* Workforce*
Jane Slatter	Audit Quality Charitable funds committee
Clive Sparrow	Audit* Auditor panel* Charitable funds committee* Finance
Executive team (voting)	Committee membership
James Benson, chief operating officer	Finance
Mike Fox, director of finance, contracting and performance	Charitable funds Finance
Dr Joanne Medhurst, medical director	Charitable funds Quality
Andrew Ridley, chief executive	Quality attendee at least once each year
Charlie Sheldon, chief nurse	Quality Workforce
Executive team (non-voting)	Committee membership
Elizabeth Hale, director of improvement	Finance
Louella Johnson, director of people[2]	Workforce

Table 3

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.

The Board's register of interests is published on our website.

[2] From January 2020 (formerly Director of People and Communications)

2.1.5 Statement of directors

The directors confirm that they know of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and that they have taken all the steps necessary to make themselves aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

2.2 Annual governance statement 2019/20

2.2.1 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*.

2.2.2 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 2020 and up to the date of approval of the annual report and accounts.

2.2.3 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 2019.

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.

2.2.4 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 the 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.

2.2.5 NHS oversight framework

The NHS oversight framework published in 2019 is used to address both performance issues in organisations directly affecting system delivery and development issues which could, if not addressed, threaten future performance. Trusts are 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.

The Trust has worked closely with NHS Improvement (NHSI) which is responsible for overseeing the performance management and governance of NHS trusts. For a fourth year, CLCH has remained in segment 1 (providers with maximum autonomy). Feedback from NHSI throughout the year 2019/20 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. A targeted inspection of children's services took place in February 2020 and we look forward to receiving the results, including the updated provider report. Due to COVID 19, the report was delayed beyond year-end.

The Board receives a quarterly update on compliance with the NHS oversight framework; with the exception of 'use of data' (amber) and culture and organisational health (amber), all other (8) areas are classified as 'green'. The Trust approved a revised data quality framework in 2019 and the annual data quality plan is monitored by the data quality forum. Work to improve inclusion and to address bullying and harassment experienced by staff is being led by the workforce race equality standard (WRES) taskforce, chaired by the chief executive.

2.2.5.1 Well-led framework

An external developmental review of leadership and governance using the well-led framework was commissioned in 2019 (PwC) covering all key lines of enquiry and specifically to assess the effectiveness of the Board's committees. The final report was received by the Board in July 2019. The action plan in response to recommendations was reviewed in November 2019 demonstrating strong progress.

2.2.5.2 Data Security

The Board received cyber security training in November 2019, this supported the achievement of GCHQ accreditation and management of cyber risks to the organisation. The annual Board cyber update was considered in March 2020.

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. The Board has monitored cyber security as a key performance indicator (KPI) during 2019/20; CareCERT compliance at March 2020 was 100%.

The Trust conducts regular penetration testing across all IT systems, in conjunction with its IT provider. Any required remedial action is planned and carried out in a controlled and timely manner, with evidence of the remedial work provided to relevant groups.

The Trust has successfully completed the 2019/20 data security protection (DSP) toolkit and received a substantial assurance internal audit of compliance. 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 March 2020.

The Trust is working with NHS Digital to achieve the mandatory Cyber Essentials Plus accreditation by 2021.

2.2.6 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 – 01/04/2019 to 31/03/2020, 141 new risks were identified and approved (excluding BAF risks) and 137 approved risks were closed - risk categories are shown in tables 4 and 5 below.

At the end of the year, there were 13 BAF risks on the risk register; 5 of these risks were opened in the period 2019/20 and 3 were closed – see tables 6-8 below.

New risks opened and approved (excluding BAF risks) in 2019/20

Category	*Total*
Clinical	49
Information management and technology	34
Finance, performance, contracts and strategy	29
Medical directorate	9
Workforce	9
Fire, health and safety	5
Environment	3
Reputational	2
Information governance	1
Total	**141**

Table 4

Risks closed (excluding BAF risks) in 2019/20

Category	*Total*
Clinical	45
Finance, performance, contracts and strategy	44
Information management and technology	19
Workforce	9
Fire, health and safety	8
Reputational	5
Information governance	4
Medical directorate	2
Security	1
Total	**137**

Table 5

BAF risks opened and / or approved	
Category	*Total*
Finance, performance, contracts and strategy	2
Clinical	2
Event*	1
Total	**5**

Table 6

BAF risks closed or removed from the BAF register[3]			
Category	*Removed from BAF*	*Closed*	*Total*
Finance, performance, contracts and strategy	0	3	3
Total	**0**	**3**	**3**

Table 7

Major strategic risks to Trust priorities in 2019/20 included:**

ID	Risk	Trust objectives
2393*	BAF Risk: There is a significant risk to service delivery, business continuity and high levels of staff sickness due to the coronavirus outbreak. Principal Assurance Committee: Audit	Digital transformation - implement the vision of the NHS Long Term Plan, finance - deliver the 2019/20 financial plan, operations - deliver key service standards to patients, population Health - Improving the health of our patients and staff, workforce - make CLCH a great place to work for everyone
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 (NWL), North Central London (NCL), South West London (SWL), Hertfordshire. 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 2019/20 financial plan
2238	BAF Risk: Failure to deliver the 2019/20 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 2019/20 financial plan
2329	BAF Risk: CLCH services that are commissioned by Local Authorities may become unviable if	Finance - Deliver the 2019/20 financial plan

** This table includes all Board Assurance Framework risks that are currently open, as well as those that were closed in 19/20. The risks that were closed are shown at the bottom of the table.

ID	Risk	Trust objectives
	additional funding is not made available, either by the Local Authorities or the Department of Health, to reflect increased pay inflation for NHS staff.	
866	BAF Risk: Failure to support and lead on the delivery of integrated care in line with the NHS Long Term Plan could result in a loss of services Principal assurance committee: FRIC	Finance - Deliver the 2019/20 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 2019/20 financial plan; operations - deliver key service standards to patients; quality - maintain and improve the quality of services delivered by CLCH; strategy Implementation - Implement strategic priorities of integration and place; workforce - make CLCH a great place to work for everyone
2093	BAF risk: That the services of the Trust do not provide value for money, and that this would impact upon partner and commissioning views and market share Principal assurance committee: FRIC	Finance - Deliver the 2019/20 financial plan, Operations - Deliver key service standards to patients, Quality - Maintain and improve the quality of services delivered by CLCH, Strategy Implementation - Implement strategic priorities of integration and place, Workforce - Make CLCH a great place to work for everyone
1218	BAF Risk: There is a risk of an impact upon operational performance, quality and regulatory compliance which may lead to failure to secure contracts or recover income from contract commissioners as a result of inaccurate data recording and reporting, providing inconsistent information against contractual requirements and or an inability to provide accurate performance data in support of service delivery. Principal assurance committee: FRIC	Operations - Deliver key service standards to patients
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 breaches, loss of reputation and risk for staff & patient. Principal assurance committee: FRIC	Operations - Deliver key service standards to patients
1154	BAF Risk: Failures in adherence to Information Governance national standards can lead to reputational damage, conflict with regulatory	Quality - Maintain and improve the quality of services delivered by CLCH

ID	Risk	Trust objectives
	compliance and undermine the quality of Trust service delivery. Principal assurance committee: FRIC	
2217	BAF Risk: The Trust has acquired significant new clinical services (Herts Adult Community) and following this transfer the Trust may identify risks to quality and compliance within the services which will require remedial actions. Principal assurance committee: Quality	Quality - Maintain and improve the quality of services delivered by CLCH
1960	BAF Risk: Medium to long term changes in workforce (nursing and 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, Workforce - Make CLCH a great place to work for everyone
2290	BAF Risk: There is a risk that if the Trust does not effectively engage in place-based integration and operational changes indicated within the NHS Long Term plan, then the Trust will not be able to promote and maximise the value of community services. Principal assurance committee: Quality	Strategy Implementation - Implement strategic priorities of integration and place
Risks closed in 2019/20		
831	BAF Risk: Failure to deliver the 2018/19 QIPP (£9.5m) results in a reduced surplus or a deficit which could affect our NHS Improvement segment 1 status. Principal assurance committee: FRIC	Finance - Deliver the 2019/20 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 2019/20 financial plan
1797	BAF Risk: Risk that the Trust will have less flexibility to enter into new care models/joint ventures as it is not an FT and there is a national pause in FT programme. Principal assurance committee: FRIC	Strategy Implementation - Implement strategic priorities of integration and place

Table 8

2.2.7 Quality governance

The Trust's clinical strategy[4], reviewed in January 2019, is influenced by national strategy and the strategic plans published by the sustainability and transformation partnerships (STP) 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[5], defines the Trust's annual quality objectives, linked to the objectives in the quality strategy, and provides a public report on the success 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 new quality strategy was agreed at the end of the year for implementation in 2020.

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.

2.2.8 Corporate governance framework

The Board governance structure is shown in figure 1 below.

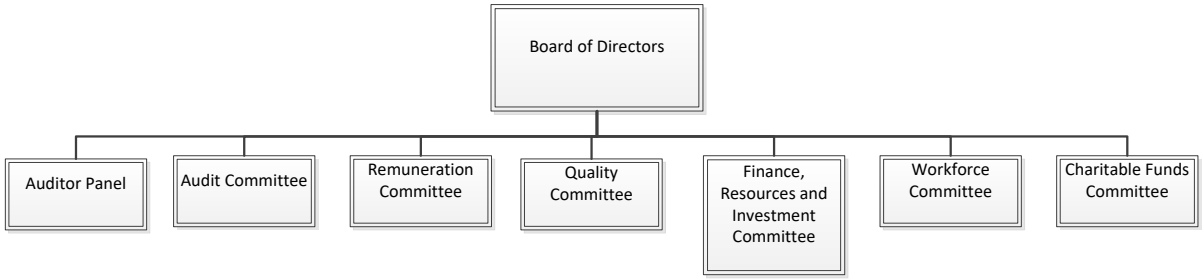


Figure 1

[4] 2018-2021
[5] Though 2020 is an exception due to COVID 19

2.2.9 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 2019/20:

- 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 gain assurance that new accounting standards in relation to leases is implemented in advance of the year-end accounts
- To gain assurance in relation to the integration of new geographies and services into the CLCH governance and control framework.

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 (VSM) 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.

2.2.10 Board and committee attendance

Summary attendance by members of Board and committee meetings during 2019/20 is shown in the table below[6].

	Board of directors, including non-voting members[7]	Auditor panel	Audit committee	Remuneration committee	Quality committee*	Finance, resources and investment committee*	Workforce committee*	Charitable funds committee
April 2019	12/13	-	2/3	3/3	8/8	7/7	-	-
May 2019	11/13	-	3/3	-	-	4/7	-	-
June 2019	-	-	-	3/3	-	6/7	6/7	3/5
July 2019	11/13	-	3/3	-	8/8	5/7	-	-
August 2019	-	-	-	-	-	7/7	-	-
September 2019 (AGM)	11/13	-	-	-	-	-	-	-
September 2019	11/13	-	-	3/3	-	6/7	-	-
October 2019	-	-	3/3	-	7/8	5/7	-	-
November 2019	13/13	-	-	2/3	-	6/6[8]	3/4[9]	5/5
December 2019	-	2/3	2/3	-	-	-	-	-
January 2020	12/13	-	-	-	5/5[10]	5/6	-	-
February 2020	-	-	-	-	-	5/6	-	3/5
March 2020	13/13	-	-	3/3	-	4/6	4/4	-

Table 9

Key	
AN	Associate non-executive director
*	Following the well-led development review in 2019, the membership of these three committees was reduced. There were no changes made to the statutory committees (audit and remuneration), the auditor panel or the charitable funds 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.

[6] Board attendance is based on the meeting in public, part-attendance at meetings is included
[7] director of people and director of improvement
[8] In November the membership was reduced from 7 to 6
[9] In November the membership was reduced from 7 to 4
[10] In November 2019 the membership was reduced from 8 to 5

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 and finance, resources and investment 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.

2.2.11 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 as appropriate.

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

The Board is the corporate trustee of the CLCH NHS Trust Charity (registered charity 1120231) having been appointed on 22 December 2011. Responsibility for the on-going management of funds has been devolved 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:

2.2.12 Auditor panel

Following the appointment of KPMG as the Trust's external auditor from 01.04.17, the panel met in December 2019 and agreed to extend the contract for a further year to 31.03.20.

2.2.13 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, the lease register, data quality 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, the committee has sought further assurance in relation to rostering and payroll enablement and disclosure and barring service (DBS) checks. The committee has asked for a zero tolerance to overdue internal and external audit recommendations to be taken by ELT.

2.2.14 Remuneration committee

During the year a number of important issues have been managed on behalf of the Board, including: performance related payments, the composition of the Board and succession planning.

The committee has also considered severance arrangements and has commended the effectiveness of redeployment initiatives to prevent the loss of talented members of staff and

to minimise costs as far as possible.

2.2.15 Quality committee

The committee has routinely considered assurance reports in support of the quality strategy and has scrutinised, on behalf of the Board, reports in relation to: the Hertfordshire mobilisation, continuous improvement, research and development; complaints; safeguarding; infection prevention and control; flu, death regulations, medicines management and medicines incidents.

During the year, the committee has sought further assurance in relation to some specific issues: medicines management in Hertfordshire, clinical vacancies and sickness absence, clinical risks and the recording of allergies and sensitivities. The committee has also highlighted the importance of waiting time management for patients who choose not to attend appointments – this was a finding of a harm review in relation to podiatric surgery.

2.2.16 Finance, resources and investment committee

The committee has highlighted issues in relation to: operational and financial planning; performance (operational, contractual and financial); lessons learned from post investment reviews; the CLCH way change programme; the cyber security rectification plan, the strategic partnership, the long term plan, in-year and 3-year financial plans, delivery of savings targets and risks.

Progress against the estates, procurement and IM&T strategies has been monitored, together with regular review of contracts and new business. The findings of the independent review of the Hertfordshire mobilisation and subsequent post go-live report were also considered.

Further assurance in relation to the recurrent value of savings plan delivery, corporate benchmarking, disclosure and barring service (DBS) checks staff recommending the Trust as a place to work preparations to implement the new accounting standard (IFRS 16) have been sought.

The committee has been pleased to note that controls in relation to minimising salary overpayments have been strengthened. It has been agreed that the committee will maintain oversight of all workforce indicators in support of the Board and workforce committee (which meets less frequently).

2.2.17 Workforce committee

The committee has routinely considered updates in relation to the implementation of the following strategies: equality; people; education, together with annual reports in relation to revalidation of doctors and nurses.

The committee has also considered, follow-up reports in relation to 2018/19 limited assurance report recommendations (induction, compliance and disclosure and barring service checks). Further assurance in relation to workforce indicators, for example appraisal rates, has been requested during the year; the Board has considered a specific report in relation to staff recommending CLCH as a place to work.

The findings in relation to the external review of HR services will be considered in March – for action during 2020.

2.2.18 Charitable funds committee

Risks in relation to fundraising and expenditure have, again, been closely monitored throughout the year. The corporate trustee has been advised that the 3-year fundraising forecast will not be met and the committee have agreed a number of measures to reduce expenditure, specifically in relation to fundraising and financial management costs.

2.2.19 Board performance and development

Board development has continued to demonstrate a strong commitment to maintaining an engaged and effective Board. This is evidenced by the completion of NHS Improvement's '*leadership for improvement'* development programme in January 2020.

In February 2020, Board members participated in a self-assessment showing continued strong performance – in line with previous years. Together with the findings of the CQC well-led inspection (March 2020), results will be used to inform the Board's development plan to support Board effectiveness during 2020/21.

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. In October 2019, the Board considered the national guidance in relation to the alignment of remuneration for chairs and non-executive directors of NHS trusts and NHS foundation trusts. Having declared their interests NEDs remained in the room but did not take part in the decision making process. There have been no other occasions during the year where a member has had to withdraw from the discussion or decision taken at any Board or committee meeting.

2.2.20 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.

2.2.21 Staff – National Quality Board

In order to ensure rosters are robust, account for all staff hours and balance service needs with leave, the rosters are signed off to scheduled deadlines. Compliance with this requirement is reported, discussed and monitored by a weekly operational 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 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.

In February 2019, the Trust undertook a self-assessment against the NHSI workforce safeguards guidance. Agreed actions have been fully implemented and the workforce committee regularly reviews 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 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 of nursing and therapies. 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.

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 based on our data and in line with the objectives of our clinical workforce strategy, our areas of focus include retire and return and a focus on clinical staff that leave within 12 months of joining.

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 has also been working with services and NHSI to ensure a rigorous approach to community demand and capacity modelling has been developed. In addition, our approach has been cross checked with internal teams and external peers including Kent, Norfolk and Sussex NHS Trust, to ensure it is fit for purpose. The Trust is developing an approach to ensure that clinical staff have job plans, and is exploring 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 on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) 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.

In January 2020, the Board considered an update on the equality delivery system review (EDS2) goals, in support of the public sector equality duty requirements to improve the outcome for people with protected characteristics. Findings from the review have helped shape the Trust's equality objectives which will be implemented through the equality strategy.

2.2.22 Climate Change Act

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are compliant.

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 sustainability and 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.

During 2019/20, the Trust moved to new models of desktops and laptops which have a reduced carbon footprint (approximately 75%). It is anticipated that by the end of 2020/21 at least 50% of all Trust devices will have been replaced.

The Trust's sustainable development plan supports the Trust's corporate approach, including assessment and management of utilities, travel and logistics, adaptation and capital projects. The Trust is developing plans to support green space and biodiversity.

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

2.2.23 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 a 9th consecutive year.

We have implemented a number of major transformation schemes and, once again, the majority of schemes in the 2019/20 quality, innovation, productivity and prevention (QIPP) plan related to the efficient use of resources and transformation 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.

2.2.24 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. These serious incidents must be reported via the Data Security and Protection Toolkit (DSPT) within 72 hours. Dependent on the information provided via the DSPT, a notification is sent to the Information Commissioner's Office, the Department of Health and Social Care (DHSC), NHS England and the National Cyber Security Centre.

During 2019/20 a total of 3 serious incidents were reported to the ICO. This showed a decrease in the number of reportable serious incidents from the previous year (2018/19), when a total of 5 incidents were reported. All 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 and the Senior Information Risk Owner. The quality committee receives an annual report from the Caldicott Guardian, including issues raised and/or reported to the ICO.

2.2.25 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.

KPMG have welcomed the positive progress made in completing and progressing actions in

relation to the external audit of the quality account in 2019.

Due to the COVID 19 pandemic the quality account will be finalised in accordance with the amended regulations. Data quality is regularly discussed at the Audit Committee, accuracy of waiting time data is described below.

2.2.26 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.

In 2019 the Trust expanded elective waiting time performance to (applying RTT rules) to all services. This was to ensure that there was a clear performance management approach to all waiting times within the organisation. Some control issues, in relation to the Harrow cardiology service were identified during the 2019, for which an external review was undertaken. Issues identified have now been addressed in full.

2.2.27 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 and a plan to address weaknesses and ensure continuous improvement of the system is in place. 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 2019/20, 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 2019/20, an overall opinion of “reasonable assurance” was provided.

Of the 12 internal audits reported during the year, 3 reports confirmed substantial assurance, 9 reasonable assurances[11], with no limited assurance opinions. An operational review of cyber security was also undertaken.

There were 2 overdue internal audit recommendations at year-end; progress had, however, been made towards their implementation.

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.

2.2.28 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.

The Trust’s governance structures and business continuity plans enabled the organisation to respond effectively to the COVID 19 pandemic, whilst maintaining control over decision making processes to ensure governance arrangements remained effective in the extraordinary circumstances.

Andrew Ridley, chief executive

Date 24 June 2020

[11] One report has not yet been agreed with the management team

2.3 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, other items of comprehensive income and cash flows for the year.

As far as I am aware, there is no relevant audit information of which the Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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.

Andrew Ridley, chief executive

Date 24 June 2020

2.4 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, other items of comprehensive income 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 and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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 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, and 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.

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

Andrew Ridley, chief executive

Date 24 June 2020

Mike Fox, director of finance, contracting and performance

Date 24 June 2020

2.5 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 2020.

See also section 1.7 – our staff and section 2.2.21 – national quality board.

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.

2.5.1 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 people and the 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.

2.5.2 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.

2.5.3 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.

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 2019/20 (2018/19 nil).

2.5.4 Off-payroll engagements of Board members/senior officials

For any off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020

Number of off-payroll engagements of Board members, and/or senior officers with significant responsibility, during the financial year.	0
Total number of individuals on payroll and off-payroll that have been deemed "Board members, and/or, senior officials with significant responsibility", during the financial year. This figure must include both on payroll and off-payroll engagement.	7

2.5.5 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.

Four performance related bonuses were paid by CLCH in 2019/20 that related to 2018/19.

2.5.6 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% (2018/19: 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 2019/20	Contribution rate 2018/19
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.

2.5.7 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	-
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	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.

2.5.8 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.

2.5.9 Off-payroll engagements

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 2019/20 (2018/19: 0).

2.5.10 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 2019/20 was £170,000 to £175,000 (2018/19: £170,000 to £175,000). This reflects the chief executive's remuneration. This was 6 times (2018/19: 6 times) the median remuneration of the workforce, which was £27,877 (2018/19: £30,070).

In 2019/20 no employee received remuneration higher than the highest paid Director (2018/19: 1 employees). Remuneration paid to employees during 2019/20 ranged from £1k to £174k (2018/19 £6k to £183k).

The VSMs in post received a yearly cost of living payment which is included in their salary.

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.

2.5.11 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	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	-

2.5.12 Directors' and very senior managers' salaries and allowances

	2019/20						2018/19					
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) (a)	170-175	0	0-5	0	0	170-175	165-170	0	0-5	0	0	170-175
Dr Joanne Medhurst (Medical director) (a)	130-135	0	0-5	0	45-47.5	180-185	130-135	0	0	0	70-72.5	205-210
Mike Fox (Director of finance, contracting and performance) (a)	120-125	0	0-5	0	70-72.5	195-200	120-125	0	0	0	22.5-25	145-150
James Benson (Director of improvement) (a)	115-120	0	0-5	0	45-47.5	160-165	115-120	0	0	0	42.5-45	155-160
Louella Johnson (Director of people and communications)	120-125	0	0	0	32.5-35	155-160	120-125	0	0	0	20-22.5	140-145

Charlie Sheldon (Chief nurse)	115-120	0	0	0	45-47.5	160-165	55-60	0	0	0	52.5-55	110-115
Elizabeth Hale	115-120	0	0	0	30-32.5	145-150	50-55	0	0	0	37.5-40	90-95
Non-Executive Directors												
Angela Greatley (Non-executive director and chair)	30-35	0	0	0	0	30-35	30-35	0	0	0	0	30-35
Carol Cole (Non-executive director and chair of the quality committee)	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 finance committee)	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Professor David Sines (Non-executive director and chairman of he people and remuneration committee)	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Clive Sparrow (Non-executive director and chairman of the charitable funds	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10

committee and audit committee)												
Jane Slatter (Non-executive director)	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10

a) Andrew Ridley, Joanne Medhurst, Mike Fox, and James Benson received a performance related bonus that was agreed and paid in 2019/20 due to their performance in 2018/19.

2.5.13 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 2020 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2020 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2020 - £'000 (Note d)	Real increase in Cash Equivalent Transfer Value £000 (Note e)	Cash Equivalent Transfer Value at 31 March 2019 - £'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	0	30-35	60-65	599	27	539	0
Mike Fox (Director of Finance, Contracting and Performance)	2.5-5	2.5-5	30-35	70-75	504	34	442	0
James Benson (Director of Improvement)	0-2.5	0-2.5	25-30	45-50	368	19	326	0
Louella Johnson (Director of People and Communications)	0-2.5	0	20-25	0	0	0	377	0
Charlie Sheldon (Chief Nurse)	0-2.5	0	40-45	85-90	686	21	633	0
Elizabeth Hale (Director of Improvement)	0-2.5	0	10-15	0	199	19	160	0

Notes

a) Non-executive members do not receive pensionable remuneration. There are no payments in respect of pensions for non-executive members (2018/19: £nil).

b) There are no payments in respect of pensions for Andrew Ridley who is not a member of the NHS pension scheme.

c) During 2019/20 the Trust paid no employer's contribution into director's personal pension plans (2018/19: £nil).

d) 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.

e) 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 method used to calculate CETVs changed, to remove the adjustment for Guaranteed Minimum Pension (GMP) on 8 August 2019. If the individual concerned was entitled to a GMP, this will affect the calculation of the real increase in CETV. This is more likely to affect the 1995 Section and the 2008 Section.

f) The 2019/20 and 2018/19 Pension, Lump Sum and CETV for Dr Joanne Medhurst exclude practitioner (i.e. GP) pension benefits.

g) The real discount rate applicable on 31 March 2020 is 0.50% (the previous year's rate was 0.29%)

2.6 Staff report

All figures are subject to audit.

CLCH's service portfolio has increased materially in 2019/20 as the organisation was successful in its bid to be the new primary provider of community services commissioned by Herts Valley CCG. The full year effect of the new contract will increase CLCH's annual revenue by over £40m. CLCH did not have any significant long term losses of services in 2019/20.

Staff sickness absences rates are within targeted tolerances closing at a 12 month rolling position of 4.64% (31 March 2019: 3.92%).

Expenditure relating to consultancy is £1,169k (2018/19: £457k) as disclosed in note 8 of the financial statements. Exit package payments are disclosed below.

The head count split of individuals paid through CLCH payroll at 31 March 2020 was (14%) male to (86%) female (31 March 2019: 13% male to 87% female). Our Board Management gender breakdown as at 31 March 2020 was as follows: 7 Male, 6 Female (31 March 2019 was as follows: 7 Male, 6 Female). Please see also section 1.7 'our staff' and workforce performance measures in section 1.5.4.

2.6.1 Average number of employees (WTE basis)

	2019/20			2018/19		
	Permanent Number	Other Number	Total Number	Permanent Number	Other Number	Total Number
Medical and dental	33	5	38	30	8	38
Ambulance staff	0	0	0	0	0	0
Administration and estates	621	85	706	588	86	674
Healthcare assistants and other support staff	525	66	591	466	112	578
Nursing, midwifery and health visiting staff	1,353	215	1568	1,285	210	1,495
Nursing, midwifery and health visiting learners	4	28	32	3	26	29
Scientific, therapeutic and technical staff	521	67	588	468	57	525
Healthcare science staff	0	0	0	0	0	0
Social care staff	0	0	0	0	0	0
Other	0	0	0	0	0	0
Total average numbers	3,057	466	3,523	2,840	499	3,339
Of which:						
Number of employees (WTE) engaged on capital projects	4	0	4	4	0	4

2.6.2 Staff costs

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	135,967	121,943
Social security costs	13,017	11,573
Apprenticeship levy	715	584
Employer's contributions to NHS pensions	23,021	14,634
Termination benefits	142	31
Temporary staff (including agency)	7,152	5,896
Total gross staff costs	**180,014**	**154,661**
Of which		
Costs capitalised as part of assets	203	52

2.6.3 Exit packages agreed for staff

Reporting of compensation schemes - exit packages
2019/20

	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	1	0	1
£25,001 - 50,000	1	0	1
£50,001 - £100,000	0	0	0
£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	3	0	3

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

The total cost of exit packages was £143k (2018/19: £31k).

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.

2.6.4 Sickness absences

During the 2019/20 financial year the Trust's staff took a total of 55,379 days (2018/19: 26,738 days) of sickness absence. This is an average of 16 days (2018/19: 9) per FTE.

2.6.5 Retirements due to ill-health

During 2019/20 three persons retired early on ill-health grounds during the financial period (2018/19: three). The associated additional accrued pension liabilities total £152K (2018/19: £186K).

2.6.6 Off-payroll engagements

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 2019/20 (2018/19: 0).

2.6.7 Staff policies applied during the financial year

The Trust has a Disability Policy & Code of Practice which seeks to ensure that any staff who consider themselves to have a disability and long term conditions are supported in a positive way.

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.

By order of the Board

Andrew Ridley, chief executive

Date 24 June 2020

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 2020 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 one.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2020 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 and Social Care Group Accounting Manual 2019/20.

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 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 a year 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 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 and Social Care Group Accounting Manual 2019/20. 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 and Social Care Group Accounting Manual 2019/20.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 49, the Directors are responsible for the preparation of financial statements that give a true and fair view. They are 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 48 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 48, 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 December 2019 and updated in April 2020 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 for the year ended 31 March 2020 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
Chartered Accountants
15 Canada Square
London
E14 5GL

24 June 2020

Section 4 - Financial overview

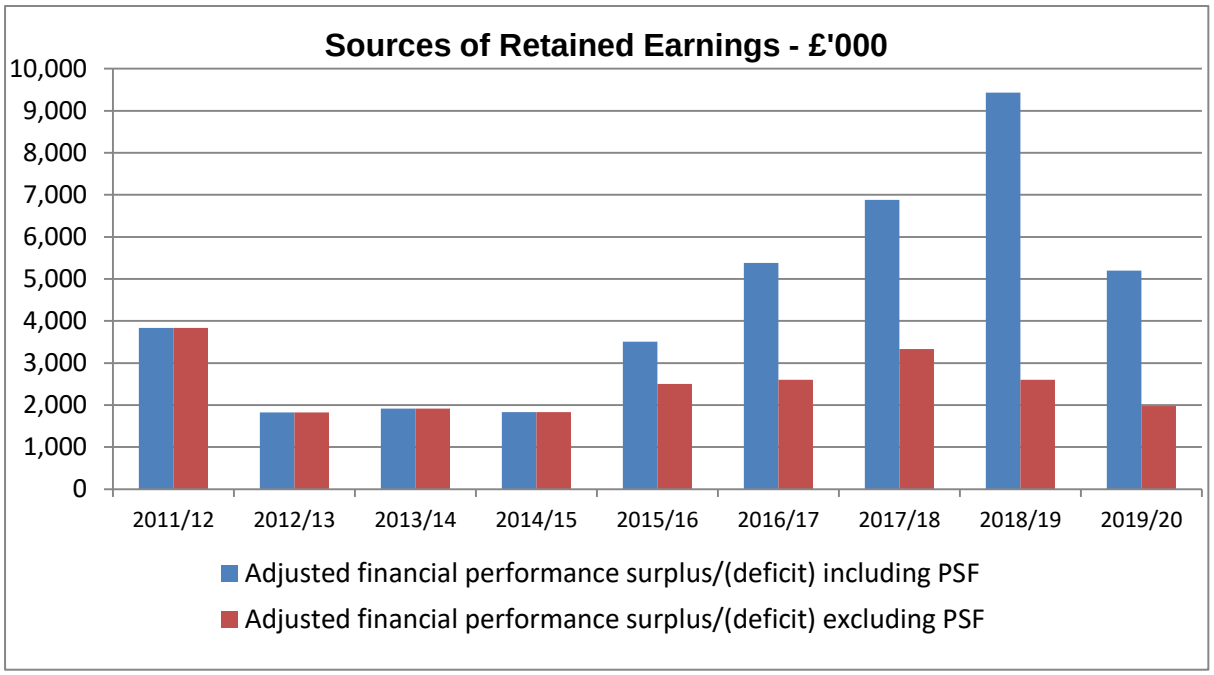
In 2019/20 the Trust achieved all key financial targets agreed with the Department of Health and NHS Improvement at the start of the financial year. These achievements include

- Achieving a surplus of £5,197k against plan of £3,384k;
- Investing £9,801k of Capital in IT, Estates and Medical Equipment (matching our Capital Resource Limit);
- Cash on hand was £52,418k at the end of March 2020 (£40.5m higher than plan);
- Reducing reliance on high cost temporary staffing resulting in agency spends of £5,717k in 19/20 being £3,911k lower than the £9,628 in the plan. 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 2020 were £12,853k which equates to a 4.7% gross margin (2018/19: £16,872k, 7.0% gross margin).

The Trust had capital and reserves totaling £101,815k at 31 March 2020 (2018/19: £73,444k). Our capital and reserves have risen by £28,371k during the year; which includes the increase to net surplus retained for the year of £5,197k, PDC granted of £2,101k of £400k for Soho Centre for Health for Creation of extra space to create a Hub for swab testing and £1,701k for HSLI, an increase in the revaluation reserve of £3,479k and absorbed assets of £17,593k from Hertfordshire Community Healthcare NHS Trust.

The Trust delivered a full year surplus of £5,197k (2018/19: £9,434k), £1,813k more than plan. There have been a number of non-recurrent measures, such as favourable settlements in supplier disputes that have enabled the trust to achieve this position.

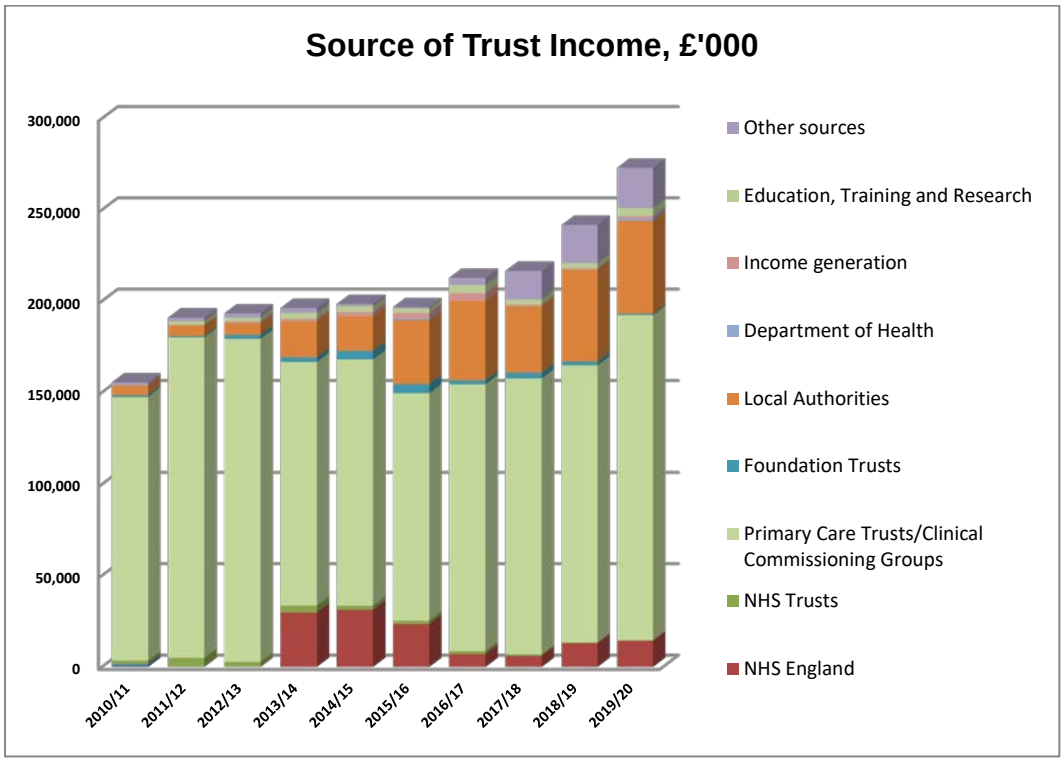


The Trust's working capital remains a source of strength and ensures that the Trust is both a good organisation for stakeholders to do business (as we pay our bills on time and in full) and provides a stable platform on which we can make the investment decisions needed to secure the future of the essential services we deliver. At 31 March 2020 the Trust had cash balances of £52,418k (2018/19: £39,451k), sufficient to pay for over 71 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.

4.1 Income

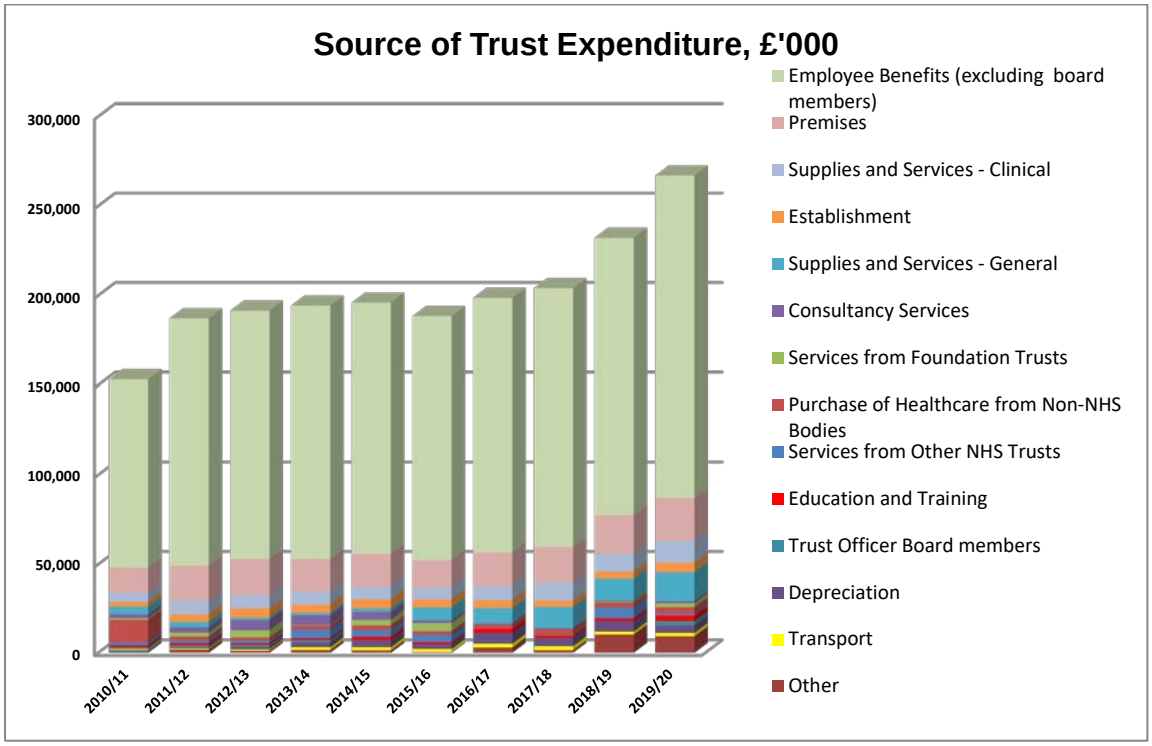
Our operating income (which excludes interest earned) for the year to 31 March 2020 was £273,058k (2018/19: £241,667k) which came from the following sources:



Income increased by 13% or £31m 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. The main services to leave CLCH's portfolio in 19/20 are Family Nurse Partnership from both the Royal Borough of Kensington & Chelsea and also from Westminster City Council. The key service that has been added is the provision of Adult Community Services for Hertfordshire Valleys CCG from October 2019.

4.2 Expenditure

Expenditure increased by 16% or £36.2m primarily due to increased activities. Our operating expenditure (which does not include financing costs) for the year to 31 March 2020 was £267,025k (2018/19: £230,792k) and was spent in the following areas:



4.3 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.

4.4 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:

End of Quarter	Q1	Q2	Q3	Q4	YTD	Target
2019/20	68%	84%	77%	86%	79%	95%

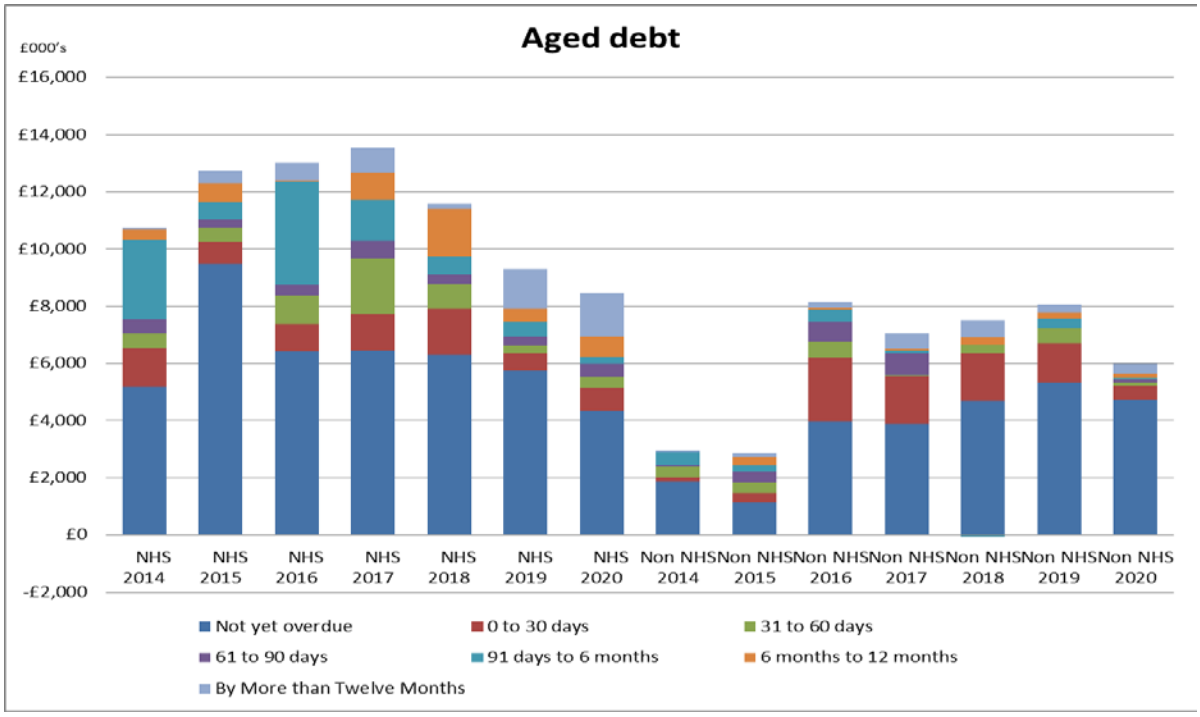
Our working capital management performance against target:

	31-Mar-20	31-Mar-19	Target
Receivables uncollected over 90 days past due	21%	18%	5%
Payables unpaid over 90 days past due	60%	62%	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 2019/20 the Trust wrote off £25k debt that related to salary overpayments, during 2018/19 the Trust wrote off £79k debt that related to salary overpayments. 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 £14,477k aged receivable from NHS and non-NHS bodies at 31 March 2020 (31 March 2019: £22,169k). 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 2019/20 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 2020/21.

4.5 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 14.4 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 34.0 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 1.9% gross margin (EBITDA) which is 2.5% greater than the threshold of 1% required to be assessed a 1 for this criteria;

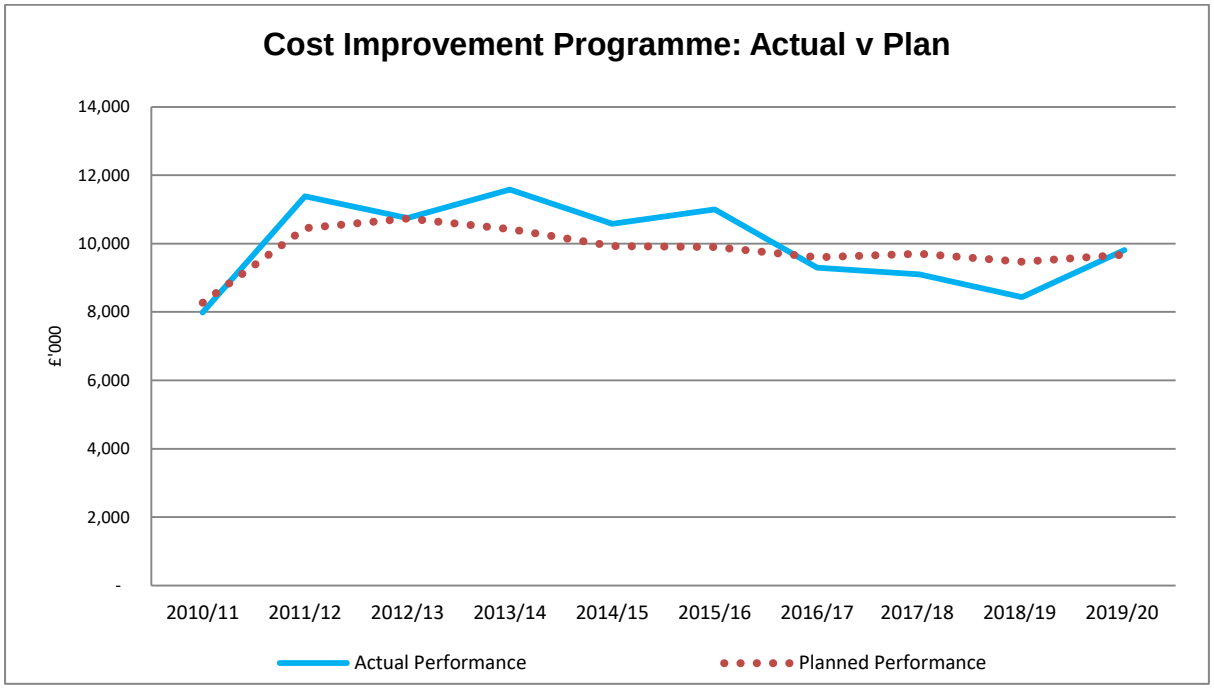
- **Distance from Financial Plan in Relation to I&E Margin:** variance between the Trust's planned I&E margin in its annual forward plan and its actual I&E margin within the year. The Trust achieved a score of 1 out of 4 in this category, as the Trust achieved its planned surplus in addition to receiving 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 £3.9m less in agency spend than plan of £9.6m 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 2019/20.

4.6 QIPP (Quality, Innovation, Productivity and Prevention)

The QIPP requirement for 2019/20 was £9,680k (excluding identified contingency).

The Trust achieved £9,814k QIPP for 2019/20 which represented a £134k favourable 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 2020/21 was £9.7m (inclusive of contingency) based on initial planning assumptions. However due to the COVID-19 pandemic, emergency funding measures have been put in place to cover as a minimum the first four months of 2020/21. These measures allow (and also require) all NHS organisations to pause QIPP delivery during this period.

A significant number of schemes had been identified prior to emergency measures coming into place, however these will need to reassessed as and when the emergency measures are eased and the road map back to business as usual has been established. The foundation of the Trust's QIPP delivery would be expected to be 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.

4.7 Financing and investment

During 2019/20 we made significant investments in various capital projects.
These investments are core to how we will achieve our QIPP program over the coming years and maintain our financial sustainability. In 2019/20 this was £9,801k (2018/19: £5,771K).
The most significant investments within this total were:

- Estates £6,214k invested in various CLCH properties Hemel One, BRE Building, Harpenden Memorial Hospital, Parsons Green, Ealing, Hatfield, Graham Park and the New Soho Academy.

- Improvement to support the footprint project.
  Various fit-out works and alterations to enable the mobilisation of the new West Hertfordshire Community contract.
  Strip out of the existing library and conversion to a new Sexual Health Centre.
  Various backlog repairs, CQC compliance work and improvements to the Trust Health Centre's, offices and clinics.
  Capital works to support the Trusts Covid 19 Response.

- IM&T £1,196k Technologies to support the mobilisation of the new West Hertfordshire Community contract.

- Medical Equipment £533k spend on modern medical devices including Vital Graph – 3L/1L Lung, Bladder Scanners, Patient Hoists, Innov8 Bed with mattress.

- Furniture and Fittings £201k spend on furniture and fit-out work to the Hertfordshire and The Soho Academy.

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.

4.8 Political and charitable donations

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

4.9 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 £3,032k in respect of outstanding NHS Pension contributions at 31 March 2020 (31 March 2019: £2,026k).

4.10 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.

4.11 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

Date 24 June 2020

Mike Fox, director of finance, contracting and performance

Date 24 June 2020

STATEMENT OF COMPREHENSIVE INCOME
FOR THE YEAR ENDED 31 MARCH 2020

	Note	2019/20 £000	2018/19 £000
Operating income from patient care activities	5	262,939	229,399
Other operating income	6	10,119	12,268
Operating expenses	8,10	(267,025)	(230,792)
Operating surplus/(deficit) from continuing operations		**6,033**	**10,875**
Finance income	13	56	19
Finance expenses		0	(1)
PDC dividends payable		(892)	(1,071)
Net finance costs		**(836)**	**(1,053)**
Other gains / (losses)		0	(388)
Gains / (losses) arising from transfers by absorption	33	17,593	0
Surplus / (deficit) for the year from continuing operations		**22,790**	**9,434**
Surplus / (deficit) for the year		**22,790**	**9,434**
Other comprehensive income			
Revaluations	14	3,479	(19)
Other recognised gains and losses		1	0
Other reserve movements		0	(2)
Total comprehensive income / (expense) for the period		**26,270**	**9,413**

The notes on pages 80 to 123 form part of these financial statements.

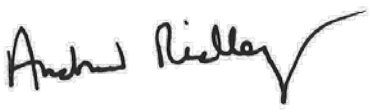
There is no difference between the retained surplus noted above and the reported NHS financial performance position.

STATEMENT OF FINANCIAL POSITION
AS AT 31 MARCH 2020

	Note	31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	15	6,513	7,164
Property, plant and equipment	14	70,055	45,242
Receivables	16	1,207	2,029
Total non-current assets		**77,775**	**54,435**
Current assets			
Receivables	16	22,014	24,698
Cash and cash equivalents	18	52,418	39,451
Total current assets		**74,432**	**64,149**
Current liabilities			
Trade and other payables	19	(46,823)	(38,923)
Provisions	22	(1,241)	(4,162)
Other liabilities	20	(2,162)	(1,871)
Total current liabilities		**(50,226)**	**(44,956)**
Total assets less current liabilities		**101,981**	**73,628**
Non-current liabilities			
Provisions	22	(166)	(184)
Total non-current liabilities		**(166)**	**(184)**
Total assets employed		**101,815**	**73,444**
Financed by			
Public dividend capital		3,679	1,578
Revaluation reserve		22,672	13,128
Income and expenditure reserve		75,464	58,738
Total taxpayers' equity		**101,815**	**73,444**

The notes on pages 80 to 123 form part of these accounts.

The financial statements on pages 75 to 79 and accompanying notes were approved by the Audit committee on behalf of the Board on the 24 June 2020 and signed on its behalf by:



Andrew Ridley, chief executive

Date 24 June 2020

Mike Fox, director of finance, contracting and performance

Date 24 June 2020

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY
FOR THE YEAR ENDED 31 MARCH 2020

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**1,578**	**13,128**	**58,738**	**73,444**
Surplus/(deficit) for the year	0	0	22,790	22,790
Transfers by absorption: transfers between reserves	0	6,066	(6,066)	0
Revaluations	0	3,479	0	3,479
Other recognised gains and losses	0	0	1	1
Public dividend capital received	2,101	0	0	2,101
Other reserve movements	0	(1)	1	0
Taxpayers' and others' equity at 31 March 2020	**3,679**	**22,672**	**75,464**	**101,815**

Statement of Changes in Equity for the year ended 31 March 2019

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

The notes on pages 80 to 123 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 2020

	Note	2019/20 £000	2018/19 £000
Cash flows from operating activities			
Operating surplus / (deficit)		6,033	10,875
Depreciation and amortisation	8.1	6,711	5,997
(Increase) / decrease in receivables and other assets		3,785	650
Increase / (decrease) in payables and other liabilities		5,321	4,300
Increase / (decrease) in provisions		(2,939)	1,715
Net cash flows from / (used in) operating activities		**18,911**	**23,537**
Cash flows from investing activities			
Interest received		56	20
Purchase of intangible assets		(1,856)	(982)
Purchase of PPE and investment property		(5,074)	(4,661)
Net cash flows from / (used in) investing activities		**(6,874)**	**(5,623)**
Cash flows from financing activities			
Public dividend capital received		2,101	582
Other interest		0	(1)
PDC dividend (paid) / refunded		(1,171)	(1,753)
Net cash flows from / (used in) financing activities		**930**	**(1,172)**
Increase / (decrease) in cash and cash equivalents		**12,967**	**16,742**
Cash and cash equivalents at 1 April - brought forward		**39,451**	**22,709**
Cash and cash equivalents at 31 March	18	**52,418**	**39,451**

The notes on pages 80 to 123 form part of these financial statements.

NOTES TO THE ACCOUNTS
Note 1 Principal Accounting Policies

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2019/20 issued by the Department of Health and Social Care. 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 GAM 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 2019-20 (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 2020. 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 2019/20 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. The Trust valuers have concluded within their report a disclosure on uncertainty linked to COVID-19, further information is in note 14a.

Expenditure Recognition

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.

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).

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 eg 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 two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employer, general practices and other bodies, allowed under the direction of Secretary of State for Health and

Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.7 Other expenses

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

1.7.1 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 2020. 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. The Trust is in year three of its five yearly site visit revaluation cycle. This financial year the valuer has carried out a full valuation of the newly absorbed assets from Hertfordshire Community NHS Trust, all other freehold assets have been valued via a desktop exercise. Refer to note 14a for valuation uncertainty.

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. 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.

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 Transfers of functions from other NHS bodies

For functions that have been transferred to the Trust from another NHS body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

1.26 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

1.27 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2021, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for

any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2021 for existing finance leases.

For leases commencing in 2021/22, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The Trust has made a judgement with the Lease for the premises at Finchley Memorial Hospital. The current Lease expires midnight on 16th June 2043. The Lease has a break clause which allows the lease to be terminated at any time with 6 months' notice. The Trust has considered that the most prudent approach to account for this specific lease is to align the lease term to the Trust Long term planning model. This long term model plans up to 31st March 2024 and that date is accounted for under IFRS16 as the most likely date for terminating this Lease as the Trust currently has no developed finalised plans for after this date.

In order to implement IFRS16 on 1 April 2021, the Trust has been working during the past 12 months on an IFRS16 project. This project has involved obtaining and reviewing all Leases held by the Trust. The estates project has involved having regular meetings between the Trust Estates Department and NHSPS in order to obtain either signed Heads of Terms or signed Leases. The Non estates project has involved Trust procurement and the Trust Finance department reviewing all Leases for right of use. All non-estates leases have now been reviewed to ascertain if any possible right of use is within this Lease followed by detailed scrutiny where possible right of use was identified.

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable. However, the Trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

Note 2 Authorisation of the Financial Statements

These financial statements were authorised for issue on 24 June 2020 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 £5,197k 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 31/3/2020	273,058	5,197	56	0	6,711	3,479
12 months to 31/3/2019	241,667	9,434	19	(1)	5,997	(19)

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 (2018/19 two) who individually accounted for over 10% of the Trust's turnover. These customers account for 27% (2018/19: 29%) 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	**2019/20**	**2018/19**
	£'000	**£'000**
NHS Barnet CCG	44,731	41,556
NHS West London (K&C) CCG	28,559	27,452
NHS Herts Valleys CCG	26,091	3,707
NHS Merton CCG	20,846	22,090
NHS Central London (Westminster) CCG	19,861	18,079
NHS Hammersmith and Fulham CCG	16,262	15,366
NHS Harrow CCG	10,384	11,035
NHSE	11,641	13,122
Battersea Healthcare Community Interest Company (Wandsworth)	16,135	15,686
Sub Total	**194,510**	**168,093**
Income from other organisations	78,548	73,574
Total Revenue	**273,058**	**241,667**

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) for 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

	2019/20	2018/19
Income from patient care activities received from:	**£000**	**£000**
NHS England	15,160	6,196
Clinical commissioning groups	177,730	151,715
Department of Health and Social Care	0	2,343
Other NHS providers	968	2,470
Local authorities	51,133	49,931
Injury cost recovery scheme	309	289
Non NHS: other	17,639	16,455
Total income from activities	**262,939**	**229,399**

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 2019/20. No overseas income has been charged directly to overseas patients during 2019/20. Non NHS Other includes Community Adult Health Services (Wandsworth) charged to Battersea Healthcare Community Interest Company £16.2m, Speech and Language £0.2m, Dietetics £0.1m and Strategic Partnership income of £0.2m, School Nursing/Podiatry/Health Visiting Westminster £0.1m and other of £0.3m.

Income from patient care activities (by nature)	2019/20 £000	2018/19 £000
Community services		
Community services income from CCGs and NHS England	186,056	157,911
Income from other sources (eg local authorities)	70,049	69,277
Agenda for Change pay award central funding*		2,211
Additional pension contribution central funding**	6,834	
Total income from activities	**262,939**	**229,399**

*Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 for NHS this funding is incorporated into tariff for individual services. For Local Authorities this is shown under Department of Health and Social Care.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 6 Other operating revenue

	2019/20			2018/19		
	Contract income £000	Non-contract income £000	Total £000	Contract income £000	Non-contract income £000	Total £000
Research and development	40	0	**40**	0	0	**0**
Education and training	4,440	0	**4,440**	2,824	0	**2,824**
Provider sustainability fund (PSF)	3,221		**3,221**	6,835		**6,835**
Charitable and other contributions to expenditure		212	**212**		239	**239**
Rental revenue from operating leases		1,107	**1,107**		1,281	**1,281**
Other income	1,099	0	**1,099**	1,089	0	**1,089**
Total other operating income	**8,800**	**1,319**	**10,119**	**10,748**	**1,520**	**12,268**

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, income generation and other miscellaneous income.

Note 7 Additional information on contract revenue (IFRS 15) recognised in the period

	2019/20 £000	2018/19 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,871	2,068

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 8 Operating Expenses

8.1 Analysis of other operating expenses

	2019/20 £000	2018/19 £000
Purchase of healthcare from NHS and DHSC bodies	3,017	4,530
Purchase of healthcare from non-NHS and non-DHSC bodies	4,562	4,917
Staff and executive directors costs	179,669	154,578
Remuneration of non-executive directors	82	69
Supplies and services - clinical (excluding drugs costs)	12,250	9,958
Supplies and services - general	16,410	12,544
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	1,690	1,560
Consultancy costs	1,169	457
Establishment	5,301	4,749
Premises	4,614	4,228
Transport (including patient travel)	1,884	1,627
Depreciation on property, plant and equipment	4,204	3,841
Amortisation on intangible assets	2,507	2,156
Movement in credit loss allowance: contract receivables / contract assets	417	450
Increase/(decrease) in other provisions	(2,639)	0
audit services- statutory audit	55	64
other auditor remuneration (external auditor only)	12	0
Internal audit costs	105	87
Clinical negligence	423	486
Legal fees	368	420
Insurance	73	57
Education and training	3,073	1,452
Rentals under operating leases	20,535	18,203
Redundancy	142	31
Hospitality	6	21
Losses, ex gratia & special payments	3	0
Other	7,093	4,307
Total	**267,025**	**230,792**

8.2 Auditor remuneration

The statutory audit fee is payable to the External Auditor Net of VAT. 2019/20 £46K (2018/19 £54K).

	2019/20 £000	2018/19 £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	12	0
3. Taxation compliance services	0	0
4. All taxation advisory services not falling within item 3 above	0	0
5. Internal audit services	0	0
6. All assurance services not falling within items 1 to 5	0	0
7. Corporate finance transaction services not falling within items 1 to 6 above	0	0
8. Other non-audit services not falling within items 2 to 7 above	0	0
Total	**12**	**0**

8.3 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 9 Operating leases

9.1 Trust as lessee

	2019/20 £000	2018/19 £000
Operating lease expense		
Minimum lease payments	20,535	18,203
Contingent rents	0	0
Less sublease payments received	0	0
Total	**20,535**	**18,203**

	31 March 2020 £000	31 March 2019 £000
Future minimum lease payments due:		
- not later than one year;	20,535	18,203
- later than one year and not later than five years;	0	0
- later than five years.	0	0
Total	**20,535**	**18,203**

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.

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 cars are used in order for the employees to be able to carry out their duties. 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. Lease expenditure has increased partly due to new leases in Hertfordshire.

9.2 Trust as lessor

	2019/20 £000	2018/19 £000
Operating lease revenue		
Minimum lease receipts	1,107	1,281
Contingent rent	0	0
Other	0	0
Total	**1,107**	**1,281**

	31 March 2020 £000	31 March 2019 £000
Future minimum lease receipts due:		
- not later than one year;	1,107	1,281
- later than one year and not later than five years;	0	0
- later than five years.	0	0
Total	**1,107**	**1,281**

CLCH owns fourteen freehold properties. CLCH is the landlord for other tenants who are 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 10 of these properties on 1 April 2013 from the former PCTs. A further 4 of these properties were absorbed in 1st October 2019 from Hertfordshire Community Healthcare NHS Trust. CLCH charges market rents on some of these properties and there are no unusual or onerous restrictions within the agreements with these tenants.

Note 10 Employee benefits

10.1 Employee benefits

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	135,967	121,943
Social security costs	13,017	11,573
Apprenticeship levy	715	584
Employer's contributions to NHS pensions	23,021	14,634
Termination benefits	142	31
Temporary staff (including agency)	7,152	5,896
Total gross staff costs	**180,014**	**154,661**
Of which		
Costs capitalised as part of assets	203	52

During 2019/20 3 persons retired early on ill-health grounds during the financial period (2018/19: three). The associated additional accrued pension liabilities total £152K (2018/19: £186K). Permanently employed includes £558K (2018/19: £2,131k) 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 2019/20, the Trust processed £1,435k (2018/19: £1,277k) through this bureau.

Note 11 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 and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as at 31 March 2019, updated to 31 March 2020 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 to 20.6%, and the Scheme Regulations were amended accordingly.

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 12 Better payment practice code

12.1 Measure of compliance

	2019/20 Number	2019/20 £0	2018/19 Number	2018/19 £0
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	26,146	108,115	20,384	93,413
Total non-NHS trade invoices paid within target	20,816	87,417	16,140	81,045
Percentage of non-NHS trade invoices paid within target	79.6%	80.9%	79.2%	86.8%
NHS Payables				
Total NHS trade invoices paid in the year	463	4,877	331	4,463
Total NHS trade invoices paid within target	122	1,414	133	2,300
Percentage of NHS trade invoices paid within target	26.3%	29.0%	40.2%	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 13 Investment revenue

	2019/20 £'000	2018/19 £'000
Interest earned from monies held on deposit at the National Loans Fund.	56	19

Note 14a Property plant and equipment

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2019 - brought forward	**13,702**	**30,335**	**0**	**3,544**	**13,669**	**702**	61,952
Transfers by absorption	6,037	11,290	378	95	0	10	17,810
Additions	0	4,120	2,032	405	1,196	192	7,945
Revaluations	132	2,376	0	0	0	0	2,508
Valuation/gross cost at 31 March 2020	**19,871**	**48,121**	**2,410**	**4,044**	**14,865**	**904**	**90,215**
Accumulated depreciation at 1 April 2019 - brought forward	**0**	**2,659**	**0**	**2,539**	**11,353**	**159**	**16,710**
Transfers by absorption	0	214	0	3	0	0	**217**
Provided during the year	0	2,626	0	271	1,175	132	**4,204**
Revaluations	0	(971)	0	0	0	0	**(971)**
Accumulated depreciation at 31 March 2020	**0**	**4,528**	**0**	**2,813**	**12,528**	**291**	**20,160**
Net book value at 31 March 2020	**19,871**	**43,593**	**2,410**	**1,231**	**2,337**	**613**	**70,055**
Net book value at 1 April 2019	**13,702**	**27,676**	**0**	**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 2019	**5,334**	**7,794**	**0**	**0**	**0**	**13,128**
Impairments in the year	0	0	0	0	0	0
Revaluations in the year	132	3,346	0	0	0	3,478
Absorbed Assets revaluation reserve transferred in	0	6,066	0	0	0	6,066
As at 31 March 2020	**5,466**	**17,206**	**0**	**0**	**0**	**22,672**

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	20	65
Dwellings	-	-
Plant & machinery	3	15
Transport equipment	-	-
Information technology	3	15
Furniture & fittings	2	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 £2,251K (2018/19: £1,584K) 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 2020. 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 valuation exercise was carried out in March 2020 with a valuation date of 31 March 2020. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020, the valuer has declared a ‘material valuation uncertainty’ in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust. The Trust is in year three of its five yearly site visit revaluation cycle. This financial year the valuer has carried out a physical inspection of the newly absorbed assets from Hertfordshire Community NHS Trust, all other assets have been valued via a desk top exercise.

Note 14b Property plant and equipment prior year

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - as previously stated	**13,920**	**28,109**	**0**	**3,084**	**13,023**	**569**	**58,705**
Additions	0	3,550	0	460	646	133	**4,789**
Revaluations	(218)	(527)	0	0	0	0	**(745)**
Disposals / derecognition	0	(797)	0	0	0	0	**(797)**
Valuation/gross cost at 31 March 2019	**13,702**	**30,335**	0	**3,544**	**13,669**	**702**	**61,952**
Accumulated depreciation at 1 April 2018 - as previously stated	**0**	**1,732**	**0**	**2,216**	**9,991**	**65**	**14,004**
Provided during the year	0	2,062	0	323	1,362	94	**3,841**
Revaluations	0	(726)	0	0	0	0	**(726)**
Disposals / derecognition	0	(409)	0	0	0	0	**(409)**
Accumulated depreciation at 31 March 2019	0	**2,659**	0	**2,539**	**11,353**	**159**	**16,710**
Net book value at 31 March 2019	**13,702**	**27,676**	0	**1,005**	**2,316**	**543**	**45,242**
Net book value at 1 April 2018	**13,920**	**26,377**	0	**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 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**

Note 15a Intangible Non-current Assets

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2019 - brought forward	**18,528**	**18,528**
Additions	1,856	**1,856**
Valuation / gross cost at 31 March 2020	**20,384**	**20,384**
Amortisation at 1 April 2019 - brought forward	**11,364**	**11,364**
Provided during the year	2,507	**2,507**
Amortisation at 31 March 2020	**13,871**	**13,871**
Net book value at 31 March 2020	**6,513**	**6,513**
Net book value at 1 April 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 £936K (2018/19: £635K) that have no net book value. There are no temporarily idle assets.

Note 15b Intangible Non-current Assets prior year

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2018 - as previously stated	**17,546**	**17,546**
Additions	982	**982**
Valuation / gross cost at 31 March 2019	**18,528**	**18,528**
Amortisation at 1 April 2018 - as previously stated	**9,208**	**9,208**
Provided during the year	2,156	**2,156**
Amortisation at 31 March 2019	**11,364**	**11,364**
Net book value at 31 March 2019	**7,164**	**7,164**
Net book value at 1 April 2018	**8,338**	**8,338**

Useful economic life:

Minimum life (years) 3

Maximum life (years) 10

Note 16 Trade and other receivables

	31 March 2020 £000	31 March 2019 £000
Current		
Contract receivables	15,176	22,169
Allowance for impaired contract receivables / assets	(1,022)	(630)
Prepayments (non-PFI)	1,965	1,265
PDC dividend receivable	708	429
VAT receivable	3,230	229
Other receivables	1,957	1,236
Total current receivables	**22,014**	**24,698**
Non-current		
Prepayments (non-PFI)	1,207	2,029
Total non-current receivables	**1,207**	**2,029**
Of which receivable from NHS and DHSC group bodies:		
Current	11,421	16,514

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.

16.1 Allowances for credit losses

	2019/20		2018/19	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**630**	**0**	**0**	**259**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018			259	(259)
New allowances arising	417	0	709	0
Changes in existing allowances	0	0	(259)	0
Utilisation of allowances (write offs)	(25)	0	(79)	0
Allowances as at 31 Mar 2020	**1,022**	**0**	**630**	**0**

Note 17 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.

17.1 Financial Assets

Carrying values of financial assets as at 31 March 2020	**Held at amortised cost**	**Total book value**
	£000	**£000**
Trade and other receivables excluding non financial assets	15,176	**15,176**
Cash and cash equivalents	52,418	**52,418**
Total at 31 March 2020	**67,594**	**67,594**

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

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 £3,230k (2018/19: £141k) 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 £3,172K (2018/19: £3,294K) and the allowance for credit losses £1,022k (2018/19: £630k) are also excluded from this note.

17.2 Financial Liabilities

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost	Total book value
	£000	£000
Trade and other payables excluding non financial liabilities	44,580	**44,580**
Total at 31 March 2020	**44,580**	**44,580**

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

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 £2,900K (2018/19: £2,275K), are not contractual and so are excluded from the disclosure.

17.3 Maturity of financial liabilities

	31 March 2020	31 March 2019
	£000	£000
In one year or less	44,580	36,554
Total	**44,580**	**36,554**

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 18 Cash and cash equivalents

	2019/20 £000	2018/19 £000
At 1 April	**39,451**	**22,709**
Net change in year	12,967	16,742
At 31 March	**52,418**	**39,451**
Broken down into:		
Cash at commercial banks and in hand	25	32
Cash with the Government Banking Service	52,393	39,419
Total cash and cash equivalents as in SoFP	**52,418**	**39,451**
Total cash and cash equivalents as in SoCF	**52,418**	**39,451**

Note 19 Trade and other payables

	31 March 2020 £000	31 March 2019 £000
Current		
Trade payables	(501)	(520)
Capital payables	5,621	2,751
Accruals	39,460	34,323
Social security costs	0	108
Other taxes payable	0	141
Other payables	2,243	2,120
Total current trade and other payables	**46,823**	**38,923**
Of which payables from NHS and DHSC group bodies:		
Current	7,132	13,005

Other payables include £3,032K in respect of outstanding pension contributions at 31 March 2020 (31 March 2019: £2,026K).

Note 20 Other Liabilities

	31 March 2020 £000	31 March 2019 £000
Current		
Deferred income: contract liabilities	2,162	1,871
Total other current liabilities	**2,162**	**1,871**

Note 21 Borrowings

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

Note 22 Provisions for liabilities and charges

	Pensions: early departure costs	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2019	**200**	**32**	**2,756**	**1,358**	**4,346**
Arising during the year	0	0	479	0	**479**
Utilised during the year	(17)	0	(142)	(141)	**(300)**
Reversed unused	0	(4)	(2,614)	(500)	**(3,118)**
At 31 March 2020	**183**	**28**	**479**	**717**	**1,407**
Expected timing of cash flows:					
- not later than one year;	17	28	479	**717**	**1,241**
- later than one year and not later than five years;	68	0	0	0	**68**
- later than five years.	98	0	0	0	**98**
Total	**183**	**28**	**479**	**717**	**1,407**

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 £1,227k (2018/19: £949k) and non-clinical provisions with a value of £107k (2018/19: £187k) 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 £28K (2018/19: £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 £717k (2018/19: £1,358k) is in respect of dilapidations provisions £402k and overseas recruitment £315k.

Note 23 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 four non-clinical claims outstanding (2018/19: seven) for which the Trust will have to pay a set excess. This excess is estimated by the NHS Resolution as £28K (2018/19: £63K). The NHS Resolution believes that it is unlikely the Trust

will have to pay £7K (2018/19: £23K) excess and recommends that this amount is therefore disclosed as a contingent liability.

Note 24 Related party transactions

In financial years 2019/20 and 2018/19 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 2019/20 the Charity paid the Trust £289K for goods and services provided by CLCH (2018/19: £291K). As at 31 March 2020 the Trust had a total of nil (2018/19: nil) 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 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 Harrow CCG
NHS Herts Valleys CCG
NHS Lambeth CCG
NHS Merton CCG
NHS Wandsworth 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
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
Royal Free London NHS Foundation Trust
Imperial College Healthcare NHS Trust
Hertfordshire Community NHS Trust
West Hertfordshire Hospitals NHS Trust
HM Revenue & Customs
NHS Pension Scheme
Department of Health

Note 25 Third party assets: patients' monies

The Trust held £124K cash at bank and in hand at 31 March 2020 on behalf of patients (31 March 2019: £124K).

Note 26 Losses and Special Payments

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

	2019/20		2018/19	
	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	45	25	59	79
Stores losses and damage to property	1	1	0	0
Total losses	**46**	**26**	**59**	**79**
Special payments				
Compensation under court order or legally binding arbitration award	0	0	1	0
Ex-gratia payments	4	2	3	2
Total special payments	**4**	**2**	**4**	**2**
Total losses and special payments	**50**	**28**	**63**	**81**

Note 27 Events after the reporting date

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

Note 28 External Financing Limit

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

	2019/20 £0	2018/19 £0
Cash flow financing	(10,497)	(16,160)
External financing requirement	(10,497)	(16,160)
External financing limit (EFL)	28,782	13,798
Under / (over) spend against EFL	39,279	29,958

Note 29 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	2019/20 £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	5,197
Breakeven duty cumulative position	2,196	6,031	7,797	9,532	11,368	14,874	20,254	27,137	36,571	41,768
Operating income	155,379	190,946	193,270	196,191	198,409	196,671	212,749	216,614	241,667	273,058
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%	15.3%

Note 30 Capital Resource Limit

	2019/20 £000	2018/19 £000
Gross capital expenditure	9,801	5,771
Less: Disposals	0	(388)
Charge against Capital Resource Limit	**9,801**	**5,383**
Capital Resource Limit	9,801	7,782
Under / (over) spend against CRL	**0**	**2,399**

All capital investments in 2019/20 and 2018/19 were funded from the Trust's internally generated cash reserves and Public Dividend Capital received.

Note 31 Capital commitments

The Trust had no capital commitments (amounts ordered at 31st March 2020 but not yet delivered) at the statement of financial reporting date (2018/19: £0).

Note 32 Annual capital cost absorption rate

	2019/20 £'000	2018/19 £'000
Dividends on Public Dividend Capital	892	1,071
Opening Capital and Reserves (Total Assets Employed)	73,444	63,449
Adjustment to closing balances re Q4 Provider Sustainability fund	(3,545)	(1,708)
Opening Relevant Net Assets	**69,899**	**61,741**
Closing Capital and Reserves (Total Assets Employed)	101,815	73,444
Closing adjustment- Incentive & Bonus PSF	0	(3,545)
Closing Relevant Net Assets	**101,815**	**69,899**
Sum of Opening/Closing Relevant Net Assets	**171,714**	**131,640**
Initial Average Relevant Net Assets	**85,857**	**65,820**
Average Daily Cleared Balances in GBS/NLF	(60,362)	(35,232)
Final Average Relevant Net Assets	**25,495**	**30,588**
Full Year Effect for Part Year Trusts	**892**	**1,071**
Capital Cost Absorption Rate (%)	3.5	3.5

Note 33 Transfers by absorption

On 1st October 2019 the Trust received in via absorption accounting from Hertfordshire Community NHS Trust the service and associated assets for adult community health services covering West Hertfordshire. The value of the asset base transferred in was £17,593,734.

On the date of transfer the Trust conducted an impairment review of the assets with 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. This valuation did not report a material difference in the value of these transferred in assets. Therefore the Trust has not recognised this transfer in, any gains or losses in the SOCI.