NHS
Central London
Community Healthcare
NHS Trust

Annual Report 2020/21

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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 Central London Community Healthcare NHS Trust (CLCH) for the year 2020/21.

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 2021/22 financial year.

1.2 Foreword

Change and challenge are familiar territory in the NHS, but never in all our combined years of leadership, could we have predicted a crisis of the magnitude of COVID-19. Its impact has been felt by every single member of staff at CLCH, our patients and the communities we serve. It is with deep sadness that we remember colleagues both past and present who lost their lives or loved ones to COVID-19 and our thoughts remain with those who continue to battle its effects.

Over the last 12 months the Trust has transformed its working practices, adopted new guidance, staff have been deployed into new roles and we have remodelled, stood down and resumed services - all at an unprecedented pace and scale.

We are humbled by the extraordinary resilience, determination, innovation and creativity that has been demonstrated by colleagues during such a challenging period; their efforts have been recognised at a local, regional and national level; both within and outside the health and care system.

Amidst a rapidly changing and unpredictable environment throughout 2020/21, we maintained focus and published our new Trust strategy, setting out our priorities for the next 5 years. These commit to our leadership within local systems, achieving further integration of services, developing our expertise and achieving a more sustainable, greener future.

As part of this, development of the Trust's Green Plan will support us to embed sustainable models of care, and ensure our operations and estates are as efficient, sustainable and resilient as they can be, through a focus on reducing travel, waste and energy usage, and identifying and delivering other environmental improvements that are important to our staff.

The Trust recently refreshed its strategy for embedding equality, diversity and inclusion into our culture and working practices, which was accelerated by the disproportionate impact of COVID-19 on our Black, Asian and Minority Ethnic communities and the momentous Black Lives Matter movement in 2020. The strategy focuses on creating values based cultural change in which equality, diversity and inclusion become part of everything we do at CLCH and embedded at every level of our organisation.

Staff engagement and support for our staff has never been as important as it has been this year. The rapid deployment of technology, enhanced support from our employee health services and the launch of a new staff intranet has facilitated increased levels of engagement with and support for staff across our wide geography despite the restrictions imposed by the pandemic. Hundreds of our staff have come together remotely to join live health and wellbeing webinars, take part in our Race Equality Network virtual conference

and to watch our staff awards online broadcast.

In June 2020, we were pleased to be notified that the Trust had maintained its ‘Good’ rating from the Care Quality Commission (CQC). As always, our staff welcomed inspectors and took great pride in showcasing our services.

Looking ahead to 2021, we anticipate beginning to deliver new adult services in Brent and Harrow. We have established relationships with our health and social care partners in both boroughs, where we already provide a number of services, and we look forward to welcoming around 450 colleagues to the Trust in summer 2021.

Whilst we expect challenges presented by the pandemic to remain, the rollout of the COVID-19 vaccination programme gives us hope and optimism for the future. With many new learnings now embedded into our working practices, we are confident in our ability to navigate the year ahead and deliver on our commitment to support our staff whilst providing the best quality care to our patients.

Angela Greatley, chair

Andrew Ridley, chief executive

1.3 About us

This section outlines the purpose and activities of the Trust.

Central London Community Healthcare NHS Trust (CLCH) was established in 2008 as a community services provider. 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.

We are committed to improving the care we provide. We received an overall Good rating by the CQC in its most recent inspection report published in June 2020.

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 address the needs of local populations.

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.

1.3.1 What we do

We provide a wide breadth of community health services, encompassing:

- 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, sickle cell and occupational therapy
- End of life care supporting people to make decisions and receive the care they need
- 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 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 organisational strategy reinforces our commitment to place based integrated care, working with colleagues at integrated care system (ICS) level and more locally, as part of integrated care partnerships (ICP) and primary care networks (PCN). 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 shared goals for individuals and the community.

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.

Some of this work is at policy level, developing approaches to integrated community based care; other initiatives have been at the operational level delivering services to support early years work for children and for older patients with longer term conditions.

COVID-19 has highlighted inequalities across our communities and as we come out of the pandemic, we are focused on ensuring that our services are designed to tackle those inequalities.

1.3.2 Where we work

CLCH delivers a range of community healthcare services across 11 London boroughs and Hertfordshire.

Across these areas, we operate in 4 ICSs: North Central London, North West London, South West London and Hertfordshire & West Essex. We continue to support the development of these emerging systems and partnerships in each area. We are an active partner in all our geographies, supporting the development of the emerging ICSs and working to integrate services locally.

Our focus is on working hard to build effective partnerships within our existing remit, so we do not seek to take on new services outside of our 4 ICS areas. When considering new services within our ICS areas, we continue to focus on whether we believe we can improve the quality of care.

Following an evaluation process, the North West London Collaboration of CCGs (NWL CCGs) confirmed in January 2021 that CLCH had been selected as the preferred provider for community services currently provided by London North West University Healthcare (LNWUH) NHS Trust in Brent and Harrow. As part of established transition processes, CLCH is working closely with LNWUH and NWL CCGs to ensure a safe and effective transfer of staff and services from 1 August 2021.

1.4 Trust strategy

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

Our 2017-2020 strategy set out a direction for services that focussed on integration at a very local level. Over this period we developed closer working relationships with health and care partners and extended our range of services.

We began to review our strategy in 2019, with input from our Board and staff groups. The COVID-19 pandemic that followed profoundly affected our staff and our relationship with patients, revealing real issues around health inequalities. This made the process of refreshing our strategy even more important.

Our new 2020-2025 organisational strategy was published in November 2020 and is particularly influenced by COVID-19 learning and by the emerging priorities of ICSs and ICPs.

The strategy integrates thinking and actions set out in our supporting clinical, quality, people, estates and digital strategies along with our Green Plan. It is supported by a framework of 4 key priorities for the next 5 years:

1. Leading in local systems
2. Achieving integration of services as local partners
3. Putting our collective CLCH expertise to use
4. Ensuring a sustainable future

These priorities will drive investment and change for our people, our information and systems, where and how we work. The pandemic has profoundly affected our patients and their access to services, highlighting the importance of our role in tackling health inequalities. We wish to be an exemplary employer in the way in which we appreciate diversity and promote equality, both internally and, with our partners externally. Within our local communities, we want to be regarded as an anchor for building skills and opportunities which support local development. We intend to play our part in becoming a greener and more sustainable organisation by reducing our adverse impact on the environment.

Our 2020-25 Strategic Direction can be viewed on the CLCH website: https://clch.nhs.uk/about-us/publications/corporate-publications

Strategic priorities

Our 6 strategic priorities for 2020/21 were:

- Strategy implementation - implement strategic priorities of integration and place
- Quality - maintain and improve the quality of services delivered by CLCH
- Finance - deliver the 20-21 financial plan including COVID-19 related financial changes
- 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.

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 Leading in local systems

Our experience of working with colleagues in our ICSs and ICPs has demonstrated that we can play a significant role as a large specialist community health services Trust in leading community based care. Our geography is complex and there are different dynamics at play in terms of the role and relationships between hospitals and community services, primary care providers, local authorities and the voluntary sector. We have an organisational home in North West London where we play a key role in the design and provision of care to meet the needs of our populations, building on our existing collaborative arrangements with other Trusts there.

All services and partners need to work as a system to address health inequalities, to restore and protect services, to integrate services and to simplify how we work. We will take a lead role in shaping and organising out of hospital services to achieve this, through our leadership within place based partnerships and membership of provider collaboratives.

1.4.2 Achieving integration of services as local partners

Population health management and the effective delivery of community services will be managed at the borough, local network and neighbourhood levels, working as ICPs. It is anticipated that this will bring about provider led alliances formed of primary care, community, physical and mental health providers, with the social care and the voluntary sector. These local systems will understand local populations, agree priorities and then integrate the delivery of preventive and care services.

As an active partner in these systems, we will work across organisational boundaries, supported by tools, information and training, to integrate services for the benefit of users. This will enable us to further develop our practical joint working on services from early years through to end of life.

1.4.3 Putting our collective CLCH expertise and efficiencies to work

Developing our core capabilities in digital and information, the deployment of technology and above all, investing in the skills of our staff has been a key focus for 2020/21.

As part of this and accelerated by the pandemic, the Trust carried out a mass deployment of mobile equipment at pace, which has seen hundreds of staff in both clinical and corporate roles equipped to work safely and remotely to keep our patients and staff protected.

The implementation of video conferencing technology has enabled our clinicians to deliver care virtually where the clinical model permits. It has transformed the way we communicate with colleagues and enhanced the ability of staff to work effectively, from multiple locations, from home and in an agile way.

The patient access programme reviews how CLCH delivers administrative services to patients, focusing on referral management, outpatient appointment booking and patient led booking where possible.

The Trust tested a self-booking system for the staff rollout of the COVID-19 vaccination programme in December 2020. This enabled a streamlined booking process, securing high volumes of appointments within a short timeframe. We continue to identify best practise approaches to further develop and align our systems and processes.

1.4.4 Ensuring a sustainable future

Environmental sustainability forms one of the 4 core priorities of the new CLCH Integrated Strategy 2020-25. Green plans are required under NHS planning guidance and NHS standard contract the Public Services (Social Value) Act 2012 and local authority contracts. The new CLCH Green Plan 2020-23 sets out our commitments to reduce the Trust's negative impact on the environment.

In line with the UK government and NHS commitments to reach net-zero greenhouse gas emissions, the Trust is undertaking a carbon baseline assessment. which will lead to the development of a CLCH net zero trajectory for the 2040 deadline.

During 2020/21 the Trust has made significant progress in a number of areas of the Green Plan.

- Staff engagement: a network of Green Champions has been established that provides ideas and feedback on Trust Green initiatives
- Estates and Energy: surveys have been completed of 15 key sites to identify energy efficiency schemes that will reduce carbon emissions and save money. These include schemes for insulation, heating controls, solar panels and LED lighting. Total expected carbon emission savings are circa 180 tCO2 pa.
- Transport: A Green Fleet review has been conducted and all new Trust vehicle leasing arrangements will switch to electric vehicles from 1 April 2021. The intention is to install electric vehicle charging points at key Trust sites early in 2021/22.
- Waste and Recycling: new recycle bins have been purchased and guidance and signage improved
- Procurement: Trust procurement criteria have been reviewed for environmental sustainability. In addition, all Trust electricity is purchased from 100% renewable contracts.

Looking forward to 2021-22 a big focus of the Trust's Green planning will be in the area of sustainable models of care. This will obviously need to take into account COVID-19 and the impact this has had on the way we work. Aspects of the changes to working practices for COVID-19 are beneficial for environmental sustainability (eg increased remote working) but some other changes are not (eg the increased utilisation of PPE).

1.4.5 Supporting strategies

The 4 priorities of our Trust strategy are underpinned by the following supporting strategies, helping us achieve our objectives.

Clinical Strategy 2018–2021

Our clinical strategy sets out a core clinical model that provides a way of thinking about the purpose of our services, be that prevention or care through the various life stages (birth to death) with a focus on:

- self-management
- primary prevention
- secondary prevention
- end of life care

- effective use of medicines
- managing ambulatory conditions
- care coordination.

You can read the 2018-2021 clinical strategy on our website here: https://clch.nhs.uk/about-us/publications/corporate-publications.

Quality Strategy 2020-2025

'Improving Quality in Everything We Do' was developed and launched with the aim of ensuring that CLCH remains the best provider of high-quality community healthcare it can be through 4 key quality campaigns. These campaigns provide a focus for everything we do and cover all aspects of delivering high-quality, safe, effective and efficient care.

- **Positive patient experience**: enhancing the experience of our patients and their families
- **Preventing harm**: keeping our patients, their families and our staff safe
- **Smart, effective care**: ensuring patients and service-users receive the best evidence-based care, every time
- **Modelling the way**: providing innovative models of care, education and professional practice.

To deliver our quality strategy objectives, we continue to adopt a shared governance approach to improvement across the Trust. For a description of shared governance please see section 1.7.7.

You can read our 2020-2025 quality strategy on our website here: https://clch.nhs.uk/about-us/publications/corporate-publications.

People Strategy 2019–2022

Our people strategy is designed to value our staff and create an organisation where every person in our employment can deliver excellent care and feel supported, well led and managed, engaged, healthy and happy at work. The leadership of the Trust pledges to work to make sure that the environment within which they work is the best it can be for staff, who feel valued and respected as envisaged by the NHS constitution.
The strategy aims to:

- promote the culture of equality, inclusion and learning
- support the objectives of our clinical workforce, clinical and quality strategies
- retain and grow our workforce
- develop leadership
- promote staff wellbeing
- raise levels of staff engagement
- develop new roles that work across traditional organisational boundaries.

You can read our people strategy on our website here: https://clch.nhs.uk/application/files/5816/1400/3631/People_Strategy_2019-2022.pdf.

Estates strategy 2019-2024

Our estates strategy aims to:

- provide a high-quality, efficient, affordable and fit-for-purpose estate that supports the Trust's operational requirements
- underpin the provision of high-quality, effective community health services
- provide a safe and appropriate space for all stakeholders
- enhance the experiences of our patients by providing accessible and pleasant environments to receive care
- develop divisional area plans with external partners to minimise underutilised estate across the system.

You can read our estates strategy on our website here: https://clch.nhs.uk/application/files/6616/1372/6049/Estate_Strategy_2019_-_2024.pdf.

Digital strategy 2021-2024

Our digital strategy sets out how the Trust will use digital systems, data and information to deliver the Trust's integrated strategy.

This refreshed strategy forms the bedrock of digital thinking within CLCH and focuses on the following strategic themes:

- delivering integrated care
- working effectively and from anywhere
- delivering care digitally
- bringing information to bear for the populations we serve
- service, response, governance and security
- leadership, culture and capability.

You can read our digital strategy on our website here: https://clch.nhs.uk/application/files/1916/1494/3782/CLCH_Digital_Strategy_Document_2021_-_2024.pdf

1.5 Performance overview and performance analysis

In June 2020, CQC published their report which rated the Trust as 'Good' overall, with no changes to the individual domain ratings in the core services inspected.

The Board monitored 24 key performance indicators (KPIs) across population health, strategy implementation, quality, operations, workforce, finance and digital transformation throughout 2020/21. Of these KPIs, 15 achieved the target set by the Trust, with 6 not achieving their targets; a further 3 KPIs were suspended as a result of COVID-19.

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 financial year. This means the Trust is permitted to operate with the highest levels of autonomy allowed by the regulator. Key issues and risks which could affect the Trust in delivering its objectives are described in section 2.5 of the report.

1.5.1 2020/21 performance analysis

Each year the Board of Directors sets a suite of KPIs for the Trust to track performance in priority areas. For 2020/21 the Board monitored 24 KPIs (compared to 24 in 2019/20). 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. Due to the COVID-19 pandemic the reporting of some KPIs was suspended for part of the year.

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 2020/21 we reviewed and updated some of our Board level key performance indicators, grouping them under 6 annual strategic priorities: strategy implementation, quality, finance, operations, workforce and digital transformation.

The objectives for each priority are:

- Strategy implementation: implement strategic priorities of integration and place.
- Quality: maintain and improve the quality of services delivered by CLCH
- Operations: Deliver all NHS constitutional and contractual standards
- Workforce: make CLCH a great place to work for everyone.
- Finance: Deliver the 2020/21 financial plan including COVID related financial changes
- Digital transformation: implement the vision of the NHS Long Term Plan.

1.5.2 Population health

Making every contact count (MECC) - uptake of level 1 training

At year-end level 1 clinical MECC training was just below the target of 95% at 92.9% and non-clinical exceeded target at 95.7%, reflecting clinical staff's ability to achieve compliance during the pandemic, as is also seen in statutory and mandatory training as a whole.

1.5.3 Strategy implementation

Assessment of Trust actions related to Partnerships and Integration

The focus of the Trust's actions in relation to system integration during 2020/21 became largely focussed on mobilising the response to the pandemic. Our leadership played an active role in all 4 of our systems, both in bringing partners together in its leadership role and contributing as key partners, strategically and operationally, including, for example, establishing integrated discharge arrangements and multi-disciplinary care home teams, involving closer working with acute and primary care teams.

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, 99.1% 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 patients reporting their overall experience as very good or good at 95%. This KPI has been achieved throughout 2020/21 with a year-end position of 96.9%.

Percentage of deaths in community hospitals

This KPI measures the percentage of deaths in community hospitals (expected and unexpected) compared to all discharges (excluding palliative and end of life care). The death rate has remained within the expected limits for 2020/21.

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 2019/20. Up to the end of month 11 2019/20 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. Nationally it was agreed that, due to the pressures of COVID-19, the Q4 staff FFT would not be collected, therefore the Q3 result (66.2%) against a target of 75%, is the last result for 2020/21.

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, 82.8% were treated within 18 weeks of referral against a target of 92%. Active management of waiting lists has been in place across all divisions throughout the pandemic ensuring that RTT management has been maintained.

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

The Trust entered the financial year with 78% of patients being seen within 18 weeks. During the pandemic the Trust continued to focus on ensuring patients accessed services, maximising the use of digital technologies where this was suitable to patients. At the end of March 2021, the Trust achieved over 88% performance at 18 week, an increase of 10% in performance. Similarly the access for patients at ten weeks improved from 49% to 75.1%.

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, only the Finchley walk-in centre remained fully operational. The Trust achieved 99.96% against the target.

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

Against a target of 3.5%, the Trust reported 6.92% of transfers of care that were delayed for NHS reasons; this was a 1.42% increase from the previous year, with performance impacted by the need to isolate and delay discharge for patients due to COVID-19.

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

During the year an average of 92.3% of patients were seen within 2 hours (commissioned 2 hours services only) exceeding our target of 85%. The Trust improved performance from 91% in April 2020 to 95.1% in March 2021.

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, 66.20% 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 posts (less frozen posts) divided by the budgeted establishment. At the close of 2020/21 year the Trust's vacancy rate was 9.84% for all staffing against the target of 11%. Further work is planned to continue on this metric during 2021/22, 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 2020/21, 82.09% 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 Black, Asian and Minority Ethnic staff for band 7+ posts

At the close of 2020/21, 51.85% of staff appointed at band 7 and above declared a Black, Asian and Minority Ethnic background against a target of 36.44%.

1.5.7 Finance

Recurrent value of QIPP delivered against target

This KPI reports the financial position of the recurrent QIPPs achieved as a percentage of the target. This was not reported in 2020/21 because the financial framework removed the need for the Trust to achieve QIPP.

Income and expenditure performance

The Trust has achieved a £1m allowable overspend for 2020/21, which equates to a £1m adverse variance against the breakeven plan. The adverse variance is an allowable overspend as it is all linked to the unfunded element of the enhanced annual leave accrual.

Cash balance performance

As at the end of month 12 the Trust had a cash balance of £72.4m (2019/20 £52.0m). This was a £20.4m increase over 2019/2020. Cash has increased partly due to delayed payment to NHS and non NHS suppliers with whom there are disputes.

Recurrent surplus/deficit delivered against target

As a result of COVID-19, the recording of this KPI was suspended in 2020/21.

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 2020/21 this target level of 100% was achieved with all advisories applied within one month.

The following digital KPIs reflect the Trust ambition to use digital technologies to support and transform effective care:

Integrated/shared records

The ability for shared records between community services and primary care to support integrated, safe and effective care. By year end, the Trust shared records in place for 67% of patients who received services from the Trust against a target of 70%. The inclusion of Merton services as shared records was delayed in 2020/21 as a consequence of the impact of COVID-19 postponing the move to the EMIS clinical system to 2021-22 which impacted target delivery.

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. By year end the Trust recorded 79% of clinical contacts completed within 24 hours of the visit, against a target of 65%.

Contact method

Monitoring delivery of care via digital and non-face to face methods. The percentage of contacts that are digital, by telephone and video were at 35% of all patient contacts against a target of 18%. This KPI was impacted by the increase of digital delivery as a consequence of the COVID-19 pandemic particularly in our children's services.

1.5.9 Flu campaign

65% (**2452 staff**) received their annual flu jab. This is our highest level of uptake yet and marked a big improvement on our 2019/20 score (55%).

1.5.10 COVID-19

The Trust implemented its staff COVID-19 vaccination programme in January 2021 with 5 hubs located across the Trust. By the end of April 2021, 81% had received a first dose and just over 55% had received a second dose.

All divisions at the Trust introduced new services and adapted existing ones in order to respond to the many challenges created by COVID-19. CLCH staff were redeployed both within the Trust and externally to support our ICS/IPC partners, amidst a surge in pressure on the acute sector, which meant we were able to work together to manage patient care

through an unprecedented time for the NHS.

New/adapted services in response to COVID-19

North West

- Drive through swabbing centre at PG
- COVID-19 positive surge beds at Pembridge
- Integrated discharge hubs at Charing Cross, St Marys & Hammersmith, ChelWest and Northwick Park
- IPC Support, training, advice and swabbing support to care homes in tri-borough and Harrow
- Post COVID-19 recovery pathways in tri-borough and Harrow
- Support to PCN vaccine hubs
- Wembley and Byron Hall mass vaccination hubs
- Dental team had 3,238 contacts (743 face-to-face; 2495 phone/virtual) via the newly created urgent dental care hub

South West

- Discharge to assess hub & enhanced discharge to assess
- Integrated community response (Merton)
- Therapy provision to support rehab on Temporary Alternative Discharge Destination (TADD) step down beds for COVID-19 patients
- Wandsworth care home team trained 1300 staff across 35 care, nursing mental health and learning disability homes in Wandsworth in PPE, swabbing and some IPC
- Creation of a dedicated patient immunisation team
- Wandsworth phlebotomy, tissue viability and complex care service 7 days a week
- Holistic assessment & rapid investigation (HARI)
- Sexual Health South West London telephone triage service

North Central

- Barnet integrated discharge team/system partner
- 7 days therapy (8am - 8pm) 7 days a week
- One care home team (8am - 8pm) 7 days a week
- Dedicated GP Federation support for rapid response 7 days a week (8am-8pm)
- Dedicated short term GP Federation support for therapy wrap around beds
- Surge beds - Ruby ward 17 beds & 15 therapy wrap around beds within a residential home
- Service extensions/flexing of access criteria
- Mobilisation of post COVID-19 pathway
- Clinical screening team to support increased district nursing demand

Hertfordshire

- Drive through swabbing centre at Harpenden
- COVID-19 positive patients accepted through rehab beds and increased use of step-up beds
- Enhanced integrated discharge hubs at Watford General Hospital
- Delivery of an integrated COVID-19 hospital model with West Herts Hospital Trust
- Expansion of procedures delivered through the community treatment unit
- Post COVID-19 recovery pathways in West Herts

- Planned care (community) nursing teams divided into red and blue teams to support COVID-19 and non-COVID-19 patients safely at home
- Enhanced care home support for complex patients and enhanced rapid response offer
- Support to PCNs in the delivery of housebound and care home vaccination programmes
- Health and social care swabbing site delivered from Harpenden

Children's

- The children's division undertook 105,836 video consultations between April 2020 and March 2021
- Community children's nursing team flexed the service criteria

Number of staff redeployed to support COVID-19 response

North West - 125

South West - 97

North Central - 23

Hertfordshire - 24

Children's - 80

Patients in COVID-19 positive beds

North West - 109 admissions

North Central - 310 admissions

Hertfordshire - 239 admissions

South West - South West Division delivered therapy in reach to COVID-19 positive patients in commissioned TADD beds in two care homes, supporting over 40 positive patients.

COVID-19 vaccinations

North West

- 2,434 first doses and 1,884 second doses to housebound patients
- 42,164 vaccinations in Wembley mass vaccination hub

South West

- 1,206 COVID-19 patients vaccinated by the adult immunisation team

North Central

- 1,504 housebound patients

Hertfordshire

- 931 first doses and 700 second doses to housebound patients
- 1,018 care home residents fully vaccinated

The Trust provided 34,577 vaccinations at the Wembley mass vaccination hub to March 2021

1.6 Our Staff

We employ **2,819** full-time staff, **1,284** part-time staff. In addition we have **1,314** people registered on our staff bank for temporary work. Our workforce comprises:

78.67% clinical roles

85.44% women

48.94% staff of Black, Asian and Minority Ethnic backgrounds

62.46% staff aged 40+

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 8 female.

1.6.1 Supporting a healthy workforce

Supporting staff health and wellbeing is always a priority for CLCH, but the COVID-19 pandemic resulted in unprecedented pressure on our workforce. Many more resources were needed to address the stress and anxiety created by COVID-19.

Central to our approach has been to offer support that staff can access easily through different channels, be that email, phone, face-to-face or both recorded and live virtual sessions.

Our charitable funds committee supported the use of NHS Charities Together grants to support the health and wellbeing of our staff. During the year, in response to COVID-19, a number of additional (grant funded) services were provided. We will continue to implement these initiatives and adapt them to meet the changing situation and needs of our staff.

Mental health support

The Trust has a longstanding commitment to supporting staff wellbeing through its employee health service which offers a range of one-to-one and team interventions across the organisation. Training programmes include support for managers to deal with mental health issues and workshops for identifying stress in the workplace.

Since the start of the pandemic, we have increased the capacity for access to mental health services by increasing counselling time by 50% and providing the additional capacity of a clinical psychologist.

In addition, a psychological helpline for staff concerned about COVID-19 was established, providing immediate support from a clinician over the phone. Blogs and on line resources were published weekly by clinical occupational health psychologists to support staff.

Team support

Teams were provided with support through team supervision, debriefs and resilience building sessions to help with emotional wellbeing and to provide a reflective space.

Risk assessments

The Trust provided personalised COVID-19 risk assessments for all staff and actively supported staff who had been identified as required to shield or as clinically extremely vulnerable.

These assessments took into account personal characteristics (age, ethnicity and gender), medical history (LTC and BMI) and socio-demographic factors (deprivation score). Recommendations/adjustments were made regarding the working environment depending on the outcome of the assessment. Risk assessments and cohorting continues and is adapted to the changing national situation and guidance.

Other staff support

As well as an in-house physiotherapist, the employee health team supported the newly established Healthy Workforce Group and facilitated live Health and Wellbeing webinars to inform colleagues about the support available to them. All staff including bank and agency workers were offered flu and COVID-19 vaccines.

1.6.2 Freedom to Speak Up

The Freedom to Speak Up (FTSU) Guardian continues to raise staff awareness of routes available to them if they want to speak up about something that is worrying them or does not feel right.

The Freedom to Speak Up vision has been reviewed and the strategy and implementation plan continue to be implemented, with progress reported twice yearly to the Board

During the year 2020/-21, 169 staff contacted the FTSU Guardian or a FTSU Champion with concerns compared with 178 in 2019/20, a decrease of 5%. The contacts from the staff were categorised as 403 concerns. 193 of these, equivalent to 48%, were behaviour-related.

The concerns were categorised under original National Guardian's office headings. Sub-headings were added to improve data quality, such as whether behaviour-related concerns were linked to managers or colleagues.

FTSU concerns are triangulated with other staff feedback. Lessons learned are then used as part of a culture of continuous improvement.

1.6.3 Developing our workforce

Recruitment and retention

The vacancy rate reduced in the last 12 months from 14.18% and at the close of 2020/21 was 9.84% against the target of 11%.

Our recruitment and retention plans and our clinical workforce strategy are designed to address the national and local staff shortages by introducing new roles to enhance skill mix; offer new development opportunities and pathways and improve our attraction by increasing our visibility. The candidate attraction strategy has been continuously reviewed to position the Trust as an employer of choice within a competitive market.

The Trust Clinical Workforce Strategy Group, Workforce Action Teams as well as Recruitment and Retention Group focus on improving attraction, development and retention. We continue our focus on recruiting hard to fill roles whilst increasing our professional development offer to existing and new colleagues

CLCH Academy

The CLCH Academy continues to provide new opportunities for education and training, enabling community and primary care professionals to learn together. Through the Academy staff can gain skills, knowledge, academic accreditation and professional support, enabling them to grow and develop their careers.

Throughout the pandemic, the Academy has supported staff to gain new skills to support them during redeployment and when working in a different way. In addition, the Academy has supported training in care homes and is the lead provider for vaccination training in North West London.

Over 1,200 unregistered vaccinators and 1000 administrators have been trained via the Academy since late December 2020 as part of this provision. The Academy is also working closely with the Health & Care Partnerships and Health Education England (HEE) to support CLCH's role as an Anchor organisation, supporting sustainable and equitable employment opportunities for our local communities.

You can read more about the CLCH Academy on our website: https://clch.nhs.uk/academy

1.6.4 Staff recognition

External awards for clinical teams

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

Clare Johnstone, Head of Infection Prevention and Medical Devices at CLCH was awarded a British Empire Medal (BEM) in the Queen's Birthday Honours list.

The Honours List recognises the outstanding achievements of people across the United Kingdom. This year, they include national honours for contributions to the response COVID-19

Our homeless health team in Westminster were selected as winners of the Student Nursing Times Award for Student Placement of the Year: Community 2020.

In October 2020, Rosa Ungpakorn from our homeless health service won the Advanced Nurse Practitioner category at the Royal College of Nursing Institute (RCNi) Nurse Awards 2020 for our Westminster Street Nurse project.

A team leader in our Children's division, Judith Davis, was announced as a recipient of the Royal College of Nursing (RCN) London's Rising Star Awards.

One of our district nurses, Freddy King, received the Philip Goodeve-Docker Memorial Prize from the Queen's Nursing Institute (QNI), a registered charity dedicated to improving the nursing care of people in the home and community.

Our Trust, in collaboration with London South Bank University and the Mary Seacole Centre in Surrey, was successful in obtaining a Burdett Trust grant to undertake a research project entitled 'Rehabilitation and Recovery following Critical Illness related to COVID-19'.
Our respiratory team in Hertfordshire received a high commendation award for the Respiratory Care Initiative of the Year category at the Health Service Journal (HSJ) Value Awards 2020.

Early this year, our health visiting service in the inner boroughs received gold reaccreditation for the UNICEF Baby Friendly Initiative (BFI). Our health visiting service in the inner boroughs were the first in London to achieve the UNICEF Baby Friendly Gold Sustainability Award in September 2019, and their reaccreditation is a tremendous achievement and recognises the highest quality service provided by health visiting teams and commitment from senior management to support the implementation of BFI standards into practice.

In February 2021, 2 community staff nurses, Niko Poyugao and Zoe Bryson, were awarded with Cavell Star Awards for their exceptional care, and for going above and beyond for patients and colleagues.

In order to recognise the enormous contribution of staff this past year, the Trust is awarding all employees an additional annual leave day. We are also committed to a team based approach to reflection and recuperation in the year ahead.

Quality development unit accreditations (QDU)

The QDU accreditation process has continued throughout 2020 with another 3 teams successfully gaining accreditation and Harrow Podiatry reapplying and being re-accredited. 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 and play a prominent role in our quality councils. We now have 11 teams who have been accredited with QDU status and another 9 teams on their journey to accreditation.

Internal awards for staff

A number of internal award schemes and programmes run throughout the year at the Trust to recognise the work and dedication of our staff.

Our **employee of the month** scheme enables colleagues to nominate individuals and groups of staff who have excelled in their roles. Each month, nominees are announced in our Trust-wide internal communications, and winners are invited to a small celebratory event and awarded with vouchers for their efforts.

This year, we introduced new initiatives to thank staff for their extraordinary contributions during COVID-19.

During the first wave of the pandemic, our '**CLChampions**' campaign was launched to recognise new ways of working and supporting patients in response to COVID-19 and we used generous donations from the public to issue staff with care packages.

In light of the national COVID-19 restrictions, our annual **Staff Awards** was held virtually for the first time, as a pre-recorded video broadcast. In the video broadcast, colleagues from across the Trust reflected on their experiences of working during the pandemic, and our winners and highly commended nominees were announced.

The commitment of our staff was recognised during a **CLCH Thank You Week**, in which our executive team shared special video messages across the week thanking staff for their remarkable efforts and resilience. Each member of staff also received a thank you letter from the Chair and Chief Executive, which was accompanied by a £10 e-voucher gift from funds awarded by the CLCH Charity and the national NHS Charities Together campaign.

As we approached the end of 2020, we made a commemorative thank you badge available to each member of staff, to mark their contributions to communities across London and Hertfordshire.

1.6.5 Staff survey results

Our response rate to the 2020 NHS staff survey was 45% (1,661). Although the response rate remains unchanged from the 2019 NHS staff survey the Trust's scores improved significantly in 9 out of 10 themes when compared to the 2019 results.

Compared to other community Trusts, across the 10 theme areas, we have 7 areas with results on or above average (an increase of 2 from 2019), and 3 with results below average.

The full summary reports of our 2020 results are available here.

The executive leadership team approved 3 overarching Trust-wide actions following the staff survey results in 2019/20. These focused on inequalities, communications and leadership. Highlights from subsequent activity addressing these actions included; a staff thank you campaign led by senior management marking the end of 2020; multiple activities to support our disabled staff and the organisational development team undertaking a number of interventions with divisional Clinical Business Unit (CBU) teams providing support in leadership and team working.

Information in relation to the staff profile can be found in section 2 of this report.

1.6.6 Equality and diversity

This year we developed our new strategy Tackling Inequality and Promoting Equality which draws together our work in this area for patients, staff and the communities we serve.

The strategy focuses on 4 campaigns:

Campaign 1 - access to services
Campaign 2 - workforce equality
Campaign 3 - understanding our communities
Campaign 4 - becoming an anchor organisation

Each campaign has clear objectives, actions and success measures and is led by an executive director. The overall lead at Board level for equalities is our chief nurse .

The Trust's Equality Group was reviewed to ensure the delivery of the strategy and involves executives, senior managers, clinical leaders and representatives from professional groups, staff side and staff networks.

Key highlights from our equality, diversity and inclusion activity in 2020/21 include:

- Improvement in Workforce Race Equality Standard (WRES) Metrics 3 and 4 which relate to relative likelihood of Black Asian and Minority Ethnic (Black, Asian and Minority Ethnic) staff entering formal disciplinary proceedings when compared with white staff; and relative likelihood of white staff accessing non-mandatory training compared with Black, Asian and Minority Ethnic staff.
- Reporting of bullying and harassment by Black, Asian and Minority Ethnic staff and disabled staff improved by 3% and 7% respectively compared with last year – a positive trend showing increased staff confidence and much of the improvement has been driven by our clinical divisions who have focussed on staff experience. Access to staff networks, Freedom to Speak Up Guardian and champions, Staff Side and employee health have also contributed to this improvement. Whilst the Trust acknowledges this improved result, there is more work required to ensure improvements in overall experience reported by our staff from minority groups.
- The Workforce Disability Equality Standard (WDES) results showed improvements on 6 metrics since last year– including those relating to feeling valued at work, reasonable adjustments and engagement.
- As part of a series of activities to celebrate Black History Month, our Race Equality Staff Network (REN) hosted a virtual annual conference which was attended by more than 300 members of staff.
- The REN Network launched its 'You Are Not Alone' campaign in April 2020 to support Black, Asian and Minority Ethnic staff affected by COVID-19 anxiety, bereavement and loss.
- Disability and Wellness Network engagement events including a webinar on the impact of COVID-19 on Disabled staff took place in December 2020.
- Using a shared governance approach (see section 1.7.7) we initiated a quality council to raise awareness and reduce the prevalence of incidents of bullying and harassment at the Trust. The quality council collected staff stories and carried out a survey on staff experiences and used the results to create an animation demonstrating how unacceptable behaviour affects staff.
- The CLCH Academy continued to look at ways of making access to education and training easier through more blended learning and virtual training. In addition, practice development roles have now been introduced into new areas such as podiatry and allied health to support supervision and competency assessment in

practice. The Academy is also continuing to build training and development programmes accessible for all staff groups supporting competence in practice and career development.
- Our Rainbow Network hosted webinars to mark Pride Month and World Aids Day in June and December 2020.

1.6.7 Staff involvement and consultation

Staff consultation

CLCH is committed to colleagues' engagement and a culture of openness and transparency. The Trust continues to work collaboratively and in partnership with the newly elected staff side executive team and staff side colleagues from the many unions represented in CLCH as a central mechanism for a strong employee voice in policy and strategy development.

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. We inform and involve our staff and trade union representatives via the Joint Staff Consultative Committee (JSCC) and Partnership Forum.

The Trade Unions are pivotal to the development of a number of initiatives including: organisational changes and consultations, job evaluation, health and safety, employee relations case work, health and wellbeing, tackling bullying and harassment, improving recruitment and retention as well as providing training.

Shared governance

The Trust continues to use a model of shared governance to support our continuous quality improvement processes as we work to implement the Trust's quality strategy.

Our shared governance approach uses quality councils which are a dynamic staff-leader partnership that promotes 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.

Over the 3 year life of the Trust's shared governance programme, we have seen our quality councils grow from strength to strength by achieving the outcome set out in our 2017-2020 quality strategy of having 6 quality councils per division based on the 6 quality campaigns. By December 2020, we had 32 quality councils in place with over 200 employees involved, which marks an increase on last year.

In the last year, we have focused on ensuring closer working between shared governance and quality improvement (QI), in particular in the Re-imagining Health Visiting programme which is showing early indicators of positive results of closer joined up working between the 2 approaches. Staff have been fully engaged across the division for a common purpose and have been very positive about the use of shared governance and QI methods as a vehicle for their changes.

1.6.8 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 an 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 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
27	24

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%	7
1% - 50%	20
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	£49,832*
The total pay bill	£124,652,132
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%

1.6.9 Staff engagement

At the start of the year we launched a new staff intranet, which represented a significant upgrade to our previous system. The enhanced functionality supports staff interaction and mobile access when working remotely, which has been essential during the COVID-19 pandemic.

Due to the outbreak of COVID-19, we launched a new series of virtual listening events in place of our face-to-face staff roadshows. The events are team-led and provide staff across the organisation with an opportunity to meet with the Chief Executive and executive leadership team virtually and share their experiences of working during the COVID-19 pandemic.

We introduced regular Trust-wide, divisional and health and wellbeing webinars, to share key updates across the organisation, and respond to staff questions. The rollout of this technology has significantly improved engagement with staff across our wide geography.

We continued to share regular email communications via 'Managers' Cascade', 'Spotlight on Quality' and 'ThisWeek@'. In addition, we launched a regular 'COVID-19 bulletin' to ensure colleagues received news and updates related to COVID-19 in an accessible and comprehensive format.

1.6.10 Anti-slavery

CLCH is committed to improving our policies and practices to combat slavery and human trafficking.

CLCH ensures 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 2020/21, 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 on our website: https://clch.nhs.uk/about-us/publications/publications-required-regulators.

1.6.11 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.

1.7 Service changes

New services commissioned during 2020/21:

- NHS South London DAFNE (Dose Adjustment for Normal Eating) lay education training programme (1 April 2020, Merton CCG)
- The provision of a prevention and outbreak testing centre (1 July 2020, Hertfordshire County Council)
- Other short term emergency temporary services were established in order to manage COVID-19 pandemic services across CLCH divisions such as discharge hubs.

No services were decommissioned at CLCH during the year.

1.7.1 COVID-19

COVID-19 transformed service delivery across the organisation throughout 2020/21. Services were stood down and restored and staff were redeployed in response to continually evolving demands for both CLCH services and our wider system partners.

All of the teams at the Trust refreshed and strengthened their business continuity plans which involved undertaking a detailed review of operational activity, and clinical teams using a risk matrix to prioritise care for the most vulnerable patients.

The Trust piloted the very first drive through COVID-19 vaccination centre at its site in Parson's Green and a large number of CLCH staff continue to support the national testing and vaccination programmes.

Central to adapting to the new COVID-19 environment was increased access to technology

to support staff working from home and continued access to our services for patients. Within a matter of weeks in early 2020, the IT team undertook a mass roll out of mobile devices to thousands of staff.

CLCH led patient discharge for 8 acute Trust partners across London and Hertfordshire, which helped improve system flow during a very challenging period.

1.8 Value for money

During 2020/21 the Trust has achieved a £1m allowable overspend which equates to a £1m adverse variance against the breakeven plan. The adverse variance is an allowable overspend as it is all linked to the unfunded element of the enhanced Annual Leave accrual.

This was based on a total Trust turnover of £318 million (£273 million 2019/20).

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.

1.8.1 Estates rationalisation

Work on rationalising and reducing our estate was impacted by COVID-19 measures and whilst we have continued planning and development through the year, all delivery of change activities were focussed almost entirely on the numerous COVID-19 related demands of the estate

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

Section 2 - Annual governance statement 2020/21

2.1 Scope of responsibility

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

2.2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Central London Community Healthcare NHS Trust (CLCH), 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 CLCH for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

2.3 Capacity to handle risk

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

The Trust has a risk management strategy in place which sets out the key responsibilities and accountabilities to ensure that risk is identified, evaluated and controlled. Risk is considered from the perspectives of: clinical risk, organisational risk and financial risk. The risk management strategy was revised during the year and approved by the Board in November 2020.

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

2.4 The risk and control framework

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

This evaluates the likelihood of exposure and the consequences if exposed. Likelihood is the probability of an event occurring; consequences are the outcomes that result if the risk

occurs. Likelihood and consequence are combined to calculate the risk grading. Risks scoring 15 and above are included in the 'corporate' risk register.

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

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

The executive leadership team (ELT) receives a monthly report on risks of 15 and above and 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 the financial uncertainty linked to lack of clarity around 2021/22 financial framework, are allocated to specific executive directors who have responsibility for ensuring that controls to mitigate these risks are effective.

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

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

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

2.4.1 NHS oversight framework / provider licence

The NHS single oversight framework is based on the provider licence and is used to address both performance issues in organisations directly affecting system delivery and development issues which could, if not addressed, threaten future performance. Prior to the pandemic, quarterly exception reports were considered by the Board; this process will be resumed when possible during 2021/22. Financial metrics continue to be reported through the integrated performance report monthly and for a fifth year, CLCH remained in segment 1 (providers with maximum autonomy).

The Trust has worked closely with NHS Improvement (NHSI) which is responsible for overseeing the performance management and governance of NHS trusts. Feedback from NHSI throughout the year 2020/21 has been both supportive and positive. The Trust was

delighted to maintain an overall Care Quality Commission (CQC) rating of 'good' in all domains following a targeted inspection of children's services in February and March 2020. Due to COVID-19 the published report was delayed beyond year-end (2019/20) – to June 2020.

Governance arrangements (licence condition 4) are robust as evidenced by the external developmental review of leadership and governance using the well-led framework commissioned in 2019 (PwC). The review covered all key lines of enquiry and specifically to assess the effectiveness of the Board's committees. Due to COVID-19, the CQC well-led inspection was unable to proceed in 2020 as planned.

2.4.2 Data quality

The Trust approved a revised data quality framework in October 2019. Progress is routinely reported to the finance committee and the audit committee has an agreed objective to monitor progress against the implementation to gain assurance on the accuracy and relevance of key performance data sets. In October 2020 the audit committee received assurance on the wide range and value of work being undertaken to monitor and improve data quality, noting in particular the urgent work used to support the COVID-19 response, and that there are adequate plans and structures in place to continue to deliver the data quality framework and plan. An audit opinion of substantial assurance was confirmed in March 2021.

In January 2021, the Board approved a digital strategy including information assurance mechanisms to ensure the '*right data is used for the right decisions*' and that there is accountability for decisions made based on the data.

In February 2021 a new change programme was agreed to *'ensure that the Trust is an intelligence-led organisation, producing accurate and relevant information to facilitate better decision making and operational improvement so that we deliver the best care and outcomes for the local population.'*

Data security is included in section 2.18 below.

Accuracy of waiting time data is described in section 2.20 below.

2.5 Risk assessment

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

In addition to reactive risk assessment, topic-based and planned risk assessments are undertaken to prevent risk, for example through counter fraud proactive reviews.

For the period – 1 April 2020 to 31 March 2021, 142 new risks were identified and approved (excluding BAF risks) and 136 approved risks were closed - risk categories are shown in tables 1 and 2 below.

At the end of the year, there were 15 BAF risks on the risk register; 5 were opened/approved in the period 2020/21 and 5 were closed – see tables 3-5 below.

New risks opened and approved (excluding BAF risks) in 2020/21	
Category	*Total*
Clinical	50
Information Management and Technology	35
Finance, performance, contracts and strategy	33
Workforce	10
Environment	4
Fire, health and safety	3
Security	3
Reputational	2
Event	1
Information governance	1
Total	**142**

Table 1

Risks closed (excluding BAF risks) in 2020/21	
Category	*Total*
Clinical	47
Finance, performance, contracts and strategy	26
Information management and technology	24
Workforce	11
Medical directorate	9
Environment	6
Reputational	6
Fire, health and safety	5
Information governance	1
Security	1
Total	**136**

Table 2

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

Table 3

BAF risks closed or removed from the BAF register[1]			
Category	*Removed from BAF*	*Closed*	*Total*
Finance	0	2	2
Workforce	0	1	1
Clinical	0	1	1
Event	0	1	1
Total	**0**	**5**	**5**

Table 4

2.5.1 Major strategic risks to Trust priorities in 2020/21 included[2]:

ID	Board assurance framework (BAF) risk	Trust objectives (2020/21)
866	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: finance committee.	Finance - Deliver the 2020/21 financial plan including COVID-19 related financial changes
1154	Failures in adherence to Information Governance national standards can lead to reputational damage, conflict with regulatory compliance and undermine the quality of Trust service delivery. Principal assurance committee: finance committee.	Quality - Maintain and improve the quality of services delivered by CLCH
1218	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: finance committee.	Operations - Deliver all NHS constitutional and contractual standards
1598	Sustainability and Transformation Plan (STP) / Integrated Care System (ICS) Resource. Risk that the Trust has not allocated adequate resources to the engagement with the STP/ICS process in the four geographies where CLCH provides services – North West London (NWL), North Central London (NCL), South West London (SWL) and 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/ICSs. Principal assurance committee: finance committee.	Finance - Deliver the 2020/21 financial plan including COVID-19 related financial changes
1961	Weaknesses in NHS and Trust cyber security make the Trust IM&T services and in turn clinical services and essential data (staff, patient and business related) at risk. This could result in clinical risk, information governance breaches,	Operations - Deliver all NHS constitutional and contractual standards

[2] This table includes all BAF 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. Note – 2 new risks were agreed in May 2021 these are not included in the table above.

	loss of reputation and risk for staff and patients. Principal assurance committee: finance committee.	
2086	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 committee.	Finance - Deliver the 2020/21 financial plan including COVID-19 related financial changes Operations - Deliver all NHS constitutional and contractual standards 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	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: finance committee.	Finance - Deliver the 2020/21 financial plan including COVID-19 related financial changes Operations - Deliver all NHS constitutional and contractual standards 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
2290	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 committee.	Strategy Implementation - Implement strategic priorities of integration and place
2329	CLCH services that are commissioned by Local Authorities may become unviable if additional funding is not made available, either by the Local Authorities or the Department of Health, to reflect increased pay inflation for NHS staff.	Finance - Deliver the 2020/21 financial plan including COVID-19 related financial changes

	Principal assurance committee: finance committee.	
2393	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 committee.	Digital Transformation - Implement the vision of the NHS `Long Term Plan Finance - Deliver the 2020/21 financial plan including COVID-19 related financial changes, Operations - Deliver all NHS constitutional and contractual standards Workforce - Make CLCH a great place to work for everyone
2467	As a novel disease there is some uncertainty regarding the transmissibility, infectivity and immunity of COVID-19 leading to a risk that staff may contract COVID-19 as a direct result of the nature and location of their employment with CLCH. This may be as a direct result of the increase in exposure to the virus in the general population and /or a lack of adequate compliance with agreed Infection Prevention guidance leading to illness and that may cause morbidity or mortality as a primary or secondary cause of death. Principal assurance committee: people committee.	Quality - Maintain and improve the quality of services delivered by CLCH Workforce - Make CLCH a great place to work for everyone
2485	The statutory responsibilities and governance of the Trust could be undermined by the work of ICSs, which are currently not statutory bodies, given the ambiguity around the future system governance in moving to a new health and care system for London from March 2022. Principal assurance committee: audit committee.	Strategy Implementation - Implement strategic priorities of integration and place
2529	Financial uncertainty linked to lack of clarity around 2021/22 Financial Framework. Principal assurance committee: finance committee.	Finance - Deliver the 2020/21 financial plan including COVID-19 related financial changes

2543	BAF: Trust-wide vacancy rate for all staff (but in particular clinical staff) could affect the standard of patient care and the ability to deliver clinical and operational services. Principle assurance committee: people committee.	Finance - Deliver the 2020/21 financial plan including COVID-19 related financial changes Operations - Deliver all NHS constitutional and contractual standards Population Health - Improving the health of our patients and staff Quality - Maintain and improve the quality of services delivered by CLCH Workforce - Make CLCH a great place to work for everyone
2565	Due to the pandemic, there is a risk that staff will suffer ongoing psychological harm over a prolonged period of time while they go through the period of reconstructive recovery during the restoration of services. * Pending approval.	Operations - Deliver all NHS constitutional and contractual standards Quality - Maintain and improve the quality of services delivered by CLCH Workforce - Make CLCH a great place to work for everyone
Risks closed in 2020/21		
1960	Medium to long term changes in workforce (nursing & therapies) presents a risk that CLCH will not be able to recruit and retain suitably qualified clinical staff to deliver a safe and effective service. Principal assurance committee: people committee.	Quality - Maintain and improve the quality of services delivered by CLCH Workforce - Make CLCH a great place to work for everyone
2217	The Trust has acquired significant new clinical services (Hertfordshire 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 committee.	Quality - Maintain and improve the quality of services delivered by CLCH
2238	Failure to deliver the 2019/20 quality, innovation, productivity and prevention (QIPP) (£9.5m) results in a reduced surplus or a deficit which could affect our NHS Improvement segment 1 status. Principal assurance committee: finance committee.	Finance - Deliver the 2020/21 financial plan including COVID-19 related financial changes

2389	2020/21 QIPP risk – Currently the Trust has yet to identify full QIPP schemes for 2020/21. This risk will be mitigated through further detailed work on those identified schemes as well as further work by the director of improvement and operation directors to identify further schemes. The Trust will also maintain a 15% contingency against failing to achieve the target. Principal assurance committee: finance committee.	Finance - Deliver the 2020/21 financial plan including COVID-19 related financial changes
2549	The impact of Brexit could lead to short term disruption to CLCH's ability to deliver clinical services in a timely manner and a medium to long term risk of increased costs through higher prices of supplies. Principal assurance committee: audit committee.	Finance - Deliver the 2020/21 financial plan including COVID-19 related financial changes Operations - Deliver all NHS constitutional and contractual standards Quality - Maintain and improve the quality of services delivered by CLCH Workforce - Make CLCH a great place to work for everyone.

Table 5

2.6 Quality governance

The Trust's clinical strategy[3], 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 quality account, published in June annually, defines the Trust's annual quality objectives, linked to the objectives in the quality strategy, and provides a public report on the success of the Trust's plans.

The quality strategy[4] '*Improving quality in everything we do*' was agreed in May 2020. This supports both the organisational strategy and clinical strategy with 4 clearly defined campaigns: a positive patient experience; preventing harm; smart, effective care and modelling the way.

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

[3] 2018-2021
[4] 2020-2025

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 partner organisations, in order to provide high quality patient care within the resources available.

2.7 Corporate governance framework

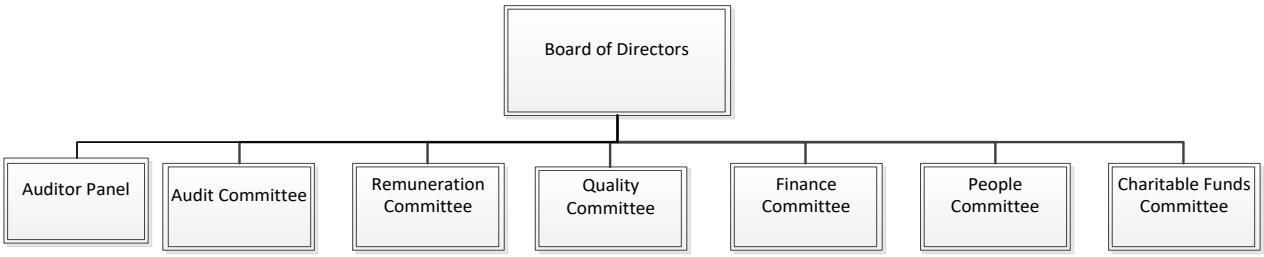


Figure 1

2.8 The role of the Board's committees

Auditor panel – meetings arranged as required

The role of the auditor panel is to advise the Board on the selection and appointment of the external auditor.

Audit committee – minimum of 4 meetings per year

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

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

In addition to its core responsibilities, the audit committee has focused on the following areas as part of its programme of work during 2020/21 to gain assurance in relation to the:

- management and mitigation of control issues
- accuracy and relevance of key performance data sets
- changes to controls in support of COVID-19
- impact of integration and partnership working.

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 manager (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 quality strategy '*Improving quality in everything we do*'.

Finance committee – minimum of 10 meetings per year

The finance 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, gateway reviews, overseeing performance indicators and the implementation of the Trust's procurement strategy, together with monitoring the key financial outcomes.

People committee – minimum of 3 meetings per year

The people committee is responsible for seeking assurance on the appropriateness of the people strategy and its implementation across the Trust. 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 2 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. During the year 2020/21 there was only one formal meeting, however there were several urgent virtual meetings to consider how funds (both local and national) could be used to support staff and patients in response to the pandemic.

2.9 Board and committee attendance

Summary attendance by members of Board and committee meetings during 2020/21 is shown in the table below[5].

	Board of directors, including non-voting members[6]	Auditor panel	Audit committee	Remuneration committee	Quality committee *	Finance committee*	People committee*	Charitable funds committee
April 2020	-	-	3/3	-	5/5	5/6	-	-
May 2020	15/15	-	3/3	-	-	5/6	-	-
June 2020	-	-	-	-	-	6/6	-	Cancelled due to pandemic
July 2020	14/15	-	2/3	3/3	5/5	6/6	4/4	-
August 2020	-	-	-	-	-	-	-	-
September 2020 (Annual General Meeting)	15/15	-	-	-	-	-	-	-
September 2020	14/15	-	-	-	-	5/6	-	-
October 2020		3/3	3/3	-	5/5	6/6	-	-
November 2020	13/15	-	-	3/3	-	6/6	4/4	-
December 2020	-	-	-	-	-	-	-	3/5
January 2021	15/15	-	3/3	-	5/5	5/6	-	-
February 2021	-	-	-	-	-	5/6	-	-
March 2021	13/15	-	-	3/3	-	5/6	4/4	-

Table 6

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 the chief information officer.

Each committee is required to consider how well it has performed during the year against the terms of reference and annual work plan. The audit committee and finance 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.

2.10 Committee programmes and issues reported to the Board

All committees have an agreed programme of work for the year, cross referenced to the BAF in support of the Board as appropriate. Due to the pandemic, lighter governance arrangements were instituted, however, while some reports were delayed, assurance processes have remained robust.

[5] Board attendance is based on the meeting in public, part attendance at meetings is included
[6] Director of people, director of improvement and associate non-executive director

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.

2.10.1 Auditor panel

In line with the Local Audit and Accountability Act 2014 requirements, an Auditor Panel was established in 2016. Following the appointment of KPMG LLP as the Trust's external auditor from 1 April 2017, the panel met in October 2020 and agreed to extend the contract for a further (final) year to 31 March 2022. The tender results and recommendations for the new contract will be considered in January 2022.

2.10.2 Audit committee

The committee has highlighted matters in relation to: risk management; progress against the internal audit and counter fraud plan; partnership working at scale; policy management; aged debt; data quality and procurement.

Responsible directors are, routinely, asked to attend meetings when limited assurance reports are considered.

During the year the audit committee has:

- asked the quality committee to consider the impact on quality improvement due to delays to the implementation of prior year recommendations and delivery of the clinical audit plan (due to COVID-19 response)
- reported a control issue in relation to disclosure and barring service (DBS) checks to the people committee
- escalated concerns relating to HR processes and controls to the chief executive.

2.10.3 Remuneration committee

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

2.10.4 Quality committee

The committee has routinely considered assurance reports in support of the quality strategy and has scrutinised, on behalf of the Board, reports in relation to performance, infection prevention and control, COVID-19, flu, clinical audit, research and development and medicines management.

During the year the committee reviewed in detail: the CQC report following the inspection of children's services (overall 'good'), the quality account and priorities for the year 2020/21, the updated quality strategy and revised scorecard. The findings of the independent health visiting review were also considered including the new model and health visitor skill mix.

During the year, the committee has sought further assurance in relation to some specific issues: infection prevention and control in Hertfordshire, the management of patient aggression towards staff, freedom to speak up (behavioural and management issues), and safer staffing.

2.10.5 Finance committee

The committee has highlighted issues in relation to: emergency planning (national financial framework), estates and asset optimisation – none of which were categorised as significant. At the request of the committee, the people committee will consider the outcome of the HR transformation programme - for which a business case to support efficiency has been considered.

The committee has routinely scrutinised operational and financial performance, data quality and major change programmes, for example new and safer ways of working in response to the pandemic.

Further assurance in relation to digital inclusion, HR performance, tender waivers, salary overpayments, delivery of the capital expenditure plan, recovery planning and Brent and Harrow service due diligence has been sought.

The committee welcomed the findings of the Hertfordshire post investment review; a positive partnership story – well received by local stakeholders and formally recognised by commissioners.

2.10.6 People committee

The committee has routinely considered updates in relation to workforce performance indicators, safer staffing (and redeployment), together with annual reports in relation to revalidation of doctors and nurses.

The committee has also considered reports and plans in relation to national standards for race equality and disability equality, workforce action teams, disclosure and barring service (DBS) compliance and freedom to speak-up. Regular updates in relation to HR transformation, a major change programme to improve the quality of the HR service have also been received.

In the early months of the pandemic, the concerns of black and minority ethnic group (BAME) were considered urgently. A COVID-19 sub-group of the race equality network (REN) was established and issues and concerns were discussed at a special Board meeting in July 2020.

Due to the pandemic it has not, however, been possible to progress work in support of equality relating to sickness absence and employee relations; this will be a priority in 2021/22.

The innovative and impressive work of the Academy in response to the pandemic and in support of integrated care systems has been applauded throughout the year.

2.10.7 Charitable funds committee

The corporate trustee was advised that the contract for the investment manager (Cazenove) has been extended for a further year to April 2022. Following the resignation of the fundraising manager, options for future fundraising were considered in December 2020, it was concluded that given the challenges of covering the costs of the fundraising post it should not be replaced. The committee has reported their concern and disappointment that an internal audit had identified that staff had not received loyalty and retirement gifts to which they were entitled to the Board.

2.11 Directors' report

The 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. During the COVID-19 response period (throughout 2020/21), with the agreement of the Board, the Trust did not rate key performance indicators (KPI) performance against targets, however, data collection continued throughout the year.

The Board generally meets in public. When this is not possible, due to reasons of confidentiality, it excludes members of the public pursuant to the Public Bodies (Admission to Meetings) Act 1960. Throughout 2020/21, in line with national guidance relating to the pandemic, all Board meetings were held virtually. From September 2020, members of the public were able to attend meetings as observers and a recording of the meeting has been published.

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.

2.11.1 Changes to the Board

There have only been 2 changes to the membership and composition of the Board during the year as shown in table 7 below.

Board membership and composition	Post holder	Note
Director of partnerships and integration (new post)	Anne Whateley joined the Board in a substantive position in July 2020	This is a non-voting position
Associate non-executive director	Jaqueline Hinds joined the Board in May 2020	This is an unremunerated, non-voting position

Table 7

The Board has had a full complement of substantive executive and non-executive directors since April 2020.

2.11.2 Committee chair arrangements

Committee	Chair – 2020/21
Auditor panel	Clive Sparrow
Audit committee	Clive Sparrow
Remuneration committee	David Sines
Quality committee	Carol Cole
Finance committee	Jitesh Chotai
People committee	David Sines
Charitable funds committee	Clive Sparrow

Table 8

2.11.3 Board members

The table below details the board members' positions at 31 March 2021 on the formal committees of the board. Profiles of Board members are available here.

Non-executive team	Committee membership (*chair)
Jitesh Chotai	Audit Finance*
Dr Carol Cole Vice chair	Quality* Remuneration People
Angela Greatley, OBE Chair of the Board	Finance Remuneration
Professor David Sines, CBE Senior independent director	Quality Remuneration* People*
Jane Slatter	Audit Quality Charitable funds
Clive Sparrow	Audit* Auditor panel* Charitable funds* 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 and deputy chief executive[7]	Charitable funds Quality
Andrew Ridley, chief executive	Quality attendee at least once each year
Charlie Sheldon, chief nurse	Quality People
Executive team (non-voting)	**Committee membership**
Elizabeth Hale, director of improvement	Finance
Louella Johnson, director of people	People

Table 9

The following members have ownership or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS:

Jacqueline Hinds, associate non-executive director
Jane Slatter, non-executive director

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

[7] Since March 2021

2.12 Board performance and development

Board development plans have been adapted in response to the pandemic. Due to COVID-19, weekly briefings were introduced (a question and answer session, written report or formal Board meeting) and there have been several COVID-19 specific sessions, for example to consider BAME issues, the impact on services, changes to service delivery and recovery of services (locally and regionally).

The Board has also held sessions on: the HR transformation programme, financial framework, equality, developing the digital strategy, integrated care systems (ICS) and integration plans in North West London (NWL - the home ICS).

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 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 November 2020, the remuneration committee considered national guidance in relation to the remuneration of chairs. The Trust chair, who is a member of the committee did not take part in the decision making process. Similarly, in March 2021, NED members (only) considered whether the executive leadership team should receive an additional day's annual leave (in common with all CLCH staff and staff across North West London). 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.

2.13 Statutory duties

Arrangements are in place to ensure legal compliance and effective discharge of statutory duties, for example: safeguarding, medicines management, infection prevention and control, health and safety and data protection. Gold command and the Trust's response to COVID-19 has been, and continues to be led by the Medical Director, Dr Joanne Medhurst.

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

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.

2.14 Developing workforce safeguards[8]

In February 2019, the Trust undertook a self-assessment against the NHS Improvement workforce safeguards guidance. Agreed actions have been fully implemented and the people 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, comprises senior clinical staff from across the Trust and is chaired by the deputy chief nurse. 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.

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.

As a result of the pandemic, services continue to have developed and implemented new ways of working to support essential activity. This has been undertaken in line with agreed business continuity plans enabling staff to be deployed as needed. Recovery plans to restore services where possible are now being reviewed with the aim of restoring services as the second wave of the pandemic reduces in addition to the continuation of new services such as care home support teams and discharge to assess models.

Work to ensure that the right staff and establishments are in place and to ensure alignment with workforce safeguards guidance includes:

- Internal monitoring of the care hours per patient bed day (CHPPD) metric in the community for the inpatient units
- The clinical staffing establishment review panel - to check, challenge and review areas where staffing levels are being changed or proposed and existing establishments
- The operational intelligence programme - job planning and demand and capacity modelling

The Trust has monitored staffing levels for the bedded inpatient areas monthly, including registered nurse shifts and health care assistant fill rates.

[8] Published in October 2018

2.15 Equality

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

In November 2020, the Board approved the promoting equality and tacking inequality strategy structured around 4 campaigns of access to services, workforce equality, understanding our communities and becoming an anchor organisation. To ensure a continued focus on the strategic aims, they will be integrated into the Trust business planning cycle. This will ensure there is a golden thread that runs through the business of the Trust. The Trust already requires an equality impact assessment for all new policies which will continue.

- Each campaign of the strategy has a 5-year implementation plan with associated actions and measures of success, overall monitoring will be by the equality group
- Strategic aims will be reflected in the Trust business planning process and the Board will establish associated KPI's relating to equality, diversity and inclusion
- Each division will incorporate objectives relating to the strategy into their divisional business planning, and subsequently into team and service planning within their respective clinical business units
- Equality action teams will provide a process for supporting teams where indicators or feedback suggests there is a need to improve equality standards for patients or staff – progress will be reported to the quality committee.

In March 2021, 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.

2.16 Climate Change Act

The requirement states that 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 not fully compliant with this statement, the adaptation plan is in the process of being updated to align with the new Trust Green Plan (formerly sustainable development management plan) approved by the Trust Board in July 2020. This will also reflect the inclusion of the expansion of the Trust into Hertfordshire and the transfer of premises and hospitals into the Trust portfolio. The Trust climatic impact assessments for its freehold sites will be updated to include site level climate adaption risk assessments. A program is in place to complete these by end of Q2 2021/22.

The Trust, as an NHS provider, is not currently required to report under the Climate Change Act Adaption reporting as at round 3, December 2018.

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

Due to COVID-19 quality, innovation, productivity and prevention (QIPP) plans were suspended throughout the whole of 2020/21 at the instruction of NHS England / Improvement. QIPP savings will be a requirement in 2021/22; all savings plans are routinely subject to quality impact assessment.

There are robust contract management and procurement processes in place to ensure economy, supported by the standing orders and standing financial instructions. During the year there has been significant scrutiny of expenditure attributed to COVID-19 through internal and external audit, together with reclaims submitted to NHS England / Improvement and routine review of the tender waiver report by the audit committee.

Having been scrutinised by the finance committee, the Board approves the annual budget and capital plan. For regulatory purposes, the Trust achieved the required break-even position in 2020/21 (the £1.1m reported overspend was due to an 'allowable overspend' to cover the 2020/21 annual leave accrual resulting from COVID-19). Prior to the reported year, the Trust achieved the target surplus in 9 consecutive years.

2.18 Information governance and data security

During 2020/21, 2 serious incidents were reported to the Information Commissioners Office (ICO) / Department of Health and Social Care (DHSC) via the data security incident reporting tool. This showed a further decrease in the number of reportable incidents from the previous year (2019/20 - 3 incidents reported). Following investigation, the ICO decided that no further action would be taken and therefore both matters were closed.

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.

The data security and protection toolkit (DSPT) is a structured assurance framework and provides the basis for compliance with the new UK General Data Protection Regulation (GDPR), the Data Protection Act 2018 and the National Data Guardian (NDG) 10 data security standards. The final submission for the DSPT is 31 March of every year, however, in response to COVID-19, the deadline for the 2019/20 DSPT submission was extended to 30 June 2021. The data security and protection toolkit assurance assessments (part 1 and part 2) were undertaken in April and May 2021 respectively.

The Board receives an annual data security and protection annual report.

The Trust continues to respond and adapt to challenges and changes in regulatory requirements, national policy, technology and working practices to keep pace with changing information management and handling environment, while maintaining protection and security of the patient and staff information.

2.19 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.

2.20 Quality and accuracy of elective waiting time data

The Trust has a large range of services, localities, clinical systems and staff; it is vital that data gathered from all activities is accurate, meaningful and fit for purpose. This contributes to the effective management of services and ensures patients receive the right care. The Trust has established a data forum; a body of relevant technical and operational management staff, to oversee the data quality agenda, and create and manage the data quality plan. This is reviewed annually to assign work for specific data quality enhancements and data developments. During the year, areas of progress include: access to information, an information portal (as part of the urgent COVID-19 response), data warehouse infrastructure and data marts[9] (providing readily-accessible data for analytical use).

2.20.1 Equity of care by ethnicity and waiting lists

In July 2020, in response to COVID-19, trusts were instructed to substantially improve the completeness of ethnicity recording by the end of the year, to facilitate the monitoring of equity of care and measurement of outcomes. The Trust has applied ethnic category as a mandatory field within core clinical systems; however, patients are able to decline to provide this information; this can impact on the ability of the Trust to provide 100% completeness. The information and data quality lead is working closely with divisions to increase completeness and good progress has been made at >80% compliance.

Further consideration is being given into how additional protected characteristics amongst the patient cohort can be monitored more closely, and how this can support the wider work of studying the local population health.

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

[9] A subset of a data warehouse oriented to a specific business line.

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 / waiting time 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 response to COVID-19, the Trust enacted a revised and detailed risk matrix for all services to ensure that 'urgent' patients in all services lines were seen; a full patient treatment list was also maintained for all patients waiting to receive care (due to lockdown). Due to the rapid instigation of virtual technology patients were able to access care, or advice to ensure that ongoing needs could be managed. During the easing of lockdown (summer 2020), the Trust made significant improvements in managing the waiting lists and access for patients, ensuring that the chronological order of referral and access was maintained. This has meant that the Trust has a clear understanding of the waiting times for all children and adults and has improvement plans in place as part of the restoration of services to improve access.

2.21 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 2020/21, 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 2020/21, an overall opinion of "reasonable assurance" was provided that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk.

Of the 13 internal audit assurance assessments reported during the year, 4 reports confirmed substantial assurance 6 reasonable assurances with 3 limited assurance opinions.

There were no overdue internal audit recommendations at year-end, with the agreement of the Audit Committee, 2 deadlines were extended.

A summary of the key findings from each of the 3 limited assurance reports is provided below:

HR processes health check

Five of the 19 HR-related policies provided for audit review were out of date at the time of audit fieldwork and due for review. Audit testing of starters, leavers, sickness absences, and appraisals, revealed weaknesses in controls and non-compliance with policies and procedures. Review of performance reporting arrangements also revealed non-compliance with related HR Policies, which specified the reporting required to senior management.

Retirement gifts and long service (loyalty) awards

There was a lack of compliance with policy and the processes needed to be reviewed, documented and implemented properly, with clear roles and responsibilities. The qualifying criteria in long service awards policy was not supported by the electronic staff record (ESR) system hence the policy needed updating to recognise the manual process required or criteria needed reviewing.

ICT programme and project management

The results of the testing showed that relevant project documentation was not available in all cases. Testing of a sample of 5 change control notices (CCNs) showed that relevant officers needed to be reminded to raise and agree CCNs within agreed timeframes set out in the CCN guidance. Other areas for improvement included: compliance with documented project methodology; developing formal terms of references for project boards; and ensuring composition of project teams include representation from all relevant stakeholders.

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.

2.22 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 during the year. Section 2.10 outlines issues managed through the committees of the Board.

Throughout 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 10 June 2021

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 10 June 2021

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 10 June 2021

Mike Fox, director of finance, contracting and performance

Date 10 June 2021

2.23 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 2021.

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.

2.24 Remuneration committee

The remuneration committee is made up of the chair 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.

2.25 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.

2.26 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).

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 and Social Care 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 2020/21 (2019/20 nil).

2.27 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 2020 and 31 March 2021

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.	8

2.28 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.

Seven performance related bonuses were paid by CLCH in 2020/21 that related to 2019/20.

2.29 NHS pension entitlement

All staff including senior managers are eligible to join the NHS pension scheme. The scheme has fixed the employer's contribution at 14.3% (2019/20: 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 2020/21	Contribution rate 2019/20
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.

2.30 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
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	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
Anne Whateley	Director of partnership and integration	01/07/2020

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.

2.31 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.

2.32 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 2020/21 (2019/20: 0).

2.33 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 2020/21 was £185,000 to £190,000 (2019/20: £170,000 to £175,000). This reflects the chief executive's remuneration, including pension-related benefits. This was 5 times (2019/20: 6 times) the median remuneration of the workforce, which was £31,628 (2019/20: £27,877).

In 2020/21 one employee received remuneration higher than the highest paid director (2019/20: nil employees). Remuneration paid to employees during 2020/21 ranged from £1k to £188k (2019/20 £1k to £174k).

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.

2.34 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
Jitesh Chotai	Non-executive director	01/06/16
Angela Greatley	Chair	01/04/16
David Sines	Non-executive director	27/06/12
Carol Cole	Non-executive director	01/08/14
Clive Sparrow	Non-executive director	01/04/17
Jane Slatter	Non-executive director	09/04/18
Jacqueline Hinds	Associate non-executive director	01/07/20

2.35 Directors' and very senior managers' salaries and allowances

	2020/21						2019/20					
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)	165-170	0	10-15	0	0	180-185	170-175	0	0-5	0	0	170-175
Dr Joanne Medhurst (medical director) (a)	135-140	0	5-10	0	42.5-45	185-190	130-135	0	0-5	0	45-47.5	180-185
Mike Fox (director of finance, contracting and performance) (a)	120-125	0	10-15	0	40-42.5	170-175	120-125	0	0-5	0	70-72.5	195-200
James Benson (director of improvement) (a)	115-120	0	10-15	0	35-37.5	160-165	115-120	0	0-5	0	45-47.5	160-165
Louella Johnson (director of people)	120-125	0	0	0	40-42.5	160-165	120-125	0	0	0	32.5-35	155-160
Charlie Sheldon (chief nurse)	115-120	0	10-15	0	40-42.5	165-170	115-120	0	0	0	45-47.5	160-165
Elizabeth Hale (director of	110-115	0	5-10	0	30-32.5	150-155	115-120	0	0	0	30-32.5	145-150

improvement)												
Anne Whateley (director of partnerships and integration)	90-95	0	0-5	0	50-52.5	140-145	0	0	0	0	0	0
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)	10-15	0	0	0	0	10-15	5-10	0	0	0	0	5-10
Jitesh Chotai (non-executive director and chair of the finance committee)	10-15	0	0	0	0	10-15	5-10	0	0	0	0	5-10
Professor David Sines (non-executive director and chair of the people committee and remuneration committee)	10-15	0	0	0	0	10-15	5-10	0	0	0	0	5-10
Clive Sparrow (non-executive director and	10-15	0	0	0	0	10-15	5-10	0	0	0	0	5-10

chair of the charitable funds committee and audit committee)												
Jane Slatter (non-executive director)	10-15	0	0	0	0	10-15	5-10	0	0	0	0	5-10

a) Andrew Ridley, Joanne Medhurst, Mike Fox, James Benson, Charlie Sheldon, Elizabeth Hale and Anne Whateley received a performance related bonus that was agreed and paid in 2020/21 due to their performance in 2019/20.

2.36 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 2021 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2021 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2021 - £'000 (Note d)	Real increase in Cash Equivalent Transfer Value £000 (Note e)	Cash Equivalent Transfer Value at 31 March 2020 - £'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	0-2.5	30-35	60-65	658	29	599	0
Andrew Ridley (chief executive)	0-2.5	0-2.5	35-40	100-105	810	0	806	0
Mike Fox (director of finance, contracting and performance)	2.5-5	0-2.5	35-40	70-75	548	17	504	0
James Benson (director of improvement)	2-2.5	0-2.5	25-30	45-50	406	15	368	0
Louella Johnson (director of people)	2.5-5	0	25-30	0	0	0	0	0
Charlie Sheldon (chief nurse)	0-2.5	0-2.5	40-45	90-95	739	24	686	0
Elizabeth Hale (director of improvement)	0-2.5	0	15-20	0	240	21	199	0
Anne Whateley (director of partnerships and integration)	0-2.5	0-2.5	50-55	110-115	1,018	27	949	0

2020/21 Remuneration report

Notes

a) Non-executive members do not receive pensionable remuneration. There are no payments in respect of pensions for non-executive members (2019/20: £nil).

b) Andrew Ridley became a member of the NHS pension scheme since 01/08/2020. The comparatives for the previous year were provided by NHS Pensions.

c) During 2019/20 the Trust paid no employer's contribution into director's personal pension plans (2019/20: £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 in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

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

f) The 2020/21 and 2019/20 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 2021 is minus 0.95% (the previous year's rate was minus 0.50%).

2.37 Staff report

All figures are subject to audit.

There were no significant changes to CLCH's portfolio of contracts in 2020/21, however the full year effect of the addition of the Adult Community Services for Hertfordshire Valleys CCG in October 2019 we seen in the Trust finances.

Staff sickness absence rates are within targeted tolerances closing at a 12 month rolling position of 5.23% (31 March 2020: 4.64%).

Expenditure relating to consultancy is £nil (2019/20: £1,169k) 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 2021 was (15%) male to (85%) female (31 March 2020: 14% male to 86% female). Our Board Management gender breakdown as at 31 March 2021 was as follows: 7 Male, 8 Female (31 March 2020 was as follows: 7 Male, 6 Female). Please see also section 1.7 'our staff' and workforce performance measures in section 1.5.4.

2.38 Average number of employees (WTE basis)

	2020/21 Permanent Number	Other Number	Total Number	2019/20 Permanent Number	Other Number	Total Number
Medical and dental	36	8	44	33	5	38
Administration and estates	683	121	804	621	85	706
Healthcare assistants and other support staff	594	156	750	525	66	591
Nursing, midwifery and health visiting staff	1,399	313	1,712	1,353	215	1,568
Nursing, midwifery and health visiting learners	9	33	42	4	28	32
Scientific, therapeutic and technical staff	567	96	663	521	67	588
Total average numbers	3,288	727	4,015	3,057	466	3,523
Of which: Number of employees (WTE) engaged on capital projects	6	0	6	4	0	4

2.39 Staff costs

	2020/21 Total £000	2019/20 Total £000
Salaries and wages	158,463	135,967
Social security costs	15,985	13,017
Apprenticeship levy	2,545	715
Employer's contributions to NHS pensions	26,385	23,021
Termination benefits	137	142
Temporary staff (including agency)	14,741	7,152
Total gross staff costs	**218,256**	**180,014**
Of which		
Costs capitalised as part of assets	934	203

2.40 Exit packages agreed for staff

Reporting of compensation schemes - exit packages
2020/21

	Number of compulsory redundancies	Total number of exit packages
Exit package cost band		
<£10,000	8	8
£10,001 - £25,000	2	2
£25,001 - £50,000	2	2
£50,001 - £100,000	0	0
£100,001 - £150,000	0	0
£150,001 - £200,000	0	0
>£200,000	0	0
Total number of exit packages by type	12	12

Reporting of compensation schemes - exit packages
2019/20

	Number of compulsory redundancies	Total number of exit packages
Exit package cost band		
<£10,000	0	0
£10,001 - £25,000	1	1
£25,001 - £50,000	1	1
£50,001 - £100,000	0	0
£100,001 - £150,000	1	1
£150,001 - £200,000	0	0
>£200,000	0	0
Total number of exit packages by type	3	3

The total cost of exit packages was £137k (2019/20: £143k).

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.

2.41 Sickness absences

During the 2020/21 financial year the Trust's staff took a total of 69,176 days (2019/20: 55,379 days) of sickness absence. This is an average of 20 days (2019/20: 16) per FTE.

2.42 Retirements due to ill-health

During 2020/21 two persons retired early on ill-health grounds during the financial period (2019/20: three). The associated additional accrued pension liabilities total £11K (2019/20: £152K).

2.43 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 10 June 2021

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 2021 which comprise the Trust 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 2021 and of the Trust's 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 2020/21.

Basis for opinion

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

Going concern

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

In our evaluation of the Directors' conclusions, we considered the inherent risks to the Trust's business model and analysed how those risks might affect the Trust's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified, and concur with the Directors' assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

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.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an

opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the Trust's high-level policies and procedures to prevent and detect fraud including the internal audit function, and the Trust's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reviewing the Trust's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we performed procedures to address the risk of management override of controls and the risk of fraudulent revenue recognition, in particular NHS and non-NHS revenue is recorded in the wrong period and the risk that Trust management may be in a position to make inappropriate accounting entries.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to year-end accruals.

We did not identify any additional fraud risks in response to the risk that non-pay expenditure may be manipulated in order to report that the control total has been met through manipulating accruals and prepayments at the end of the year to defer expenditure to the following year.

In determining the audit procedures, we took into account the results of our evaluation and testing of the operating effectiveness of some of Trust-wide fraud risk management controls.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included Journal entries made to unusual or seldom used accounts; duplicate journals entries; journal entries made by individuals who typically do not make journals entries or are not authorised to post journals; journal entries posted after accounts close down; and journals with unusual accounts combination to cash.
- Assessing significant estimates for bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Assessing significant estimates for bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Agreeing a sample of year end accruals to relevant supporting documents, including actual invoices after year end, where applicable.
- Performing cut-off testing of income and expenditure in the period before and after 31 March 2021 to determine whether amounts have been recorded in the correct period.

Identifying and responding to risks of material misstatement due to non-compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors and other management (as required by auditing standards), and

discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

As the Trust is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

Firstly, the Trust is subject to laws and regulations that directly affect the financial statements including financial reporting legislation. Under paragraph 2(1) of Schedule 5 to the National Health Service Act 2006 the Trust must ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to revenue account (the breakeven duty). In reporting on compliance with the breakeven duty the Trust is required to comply with the Department of Health and Social Care's 'Guidance on Breakeven Duty and Provisions', We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

We are also required to make a referral to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 if 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.

Whilst the Trust is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

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; and
- 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 2020/21. 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 2020/21.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 52, the directors are responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on Page 52 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 if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure 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 52, 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 and related statutory guidance having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and

performance to improve the way it manages and delivers its services. 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 2021 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Dean Gibbs
for and on behalf of KPMG LLP
Chartered Accountants
15 Canada Square
London
E14 5GL

11 June 2021

Section 4 - Financial overview

In 2020/21 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 an adjusted financial performance surplus of £6k against plan of (£1,365k);
- Investing £9,468k of Capital in IT, Estates and Medical Equipment (matching our Capital Resource Limit);
- Cash on hand was £72,424k at the end of March 2021 (£61.9m higher than plan);
- 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 2021 were £7,088k which equates to a 2.2% gross margin (2019/20: £12,744k, 4.7% gross margin).

The Trust had capital and reserves totaling £100,043k at 31 March 2021 (2019/20: £101,815k). Our capital and reserves have decreased by £1,772k during the year; which includes a decrease to net surplus retained for the year of £1,076k before allowable adjustment for annual leave, PDC granted of £1,991k of £705k for COVID estates work, £1,166k for HSLI and £120k other, a decrease in the revaluation reserve of £2,687k.

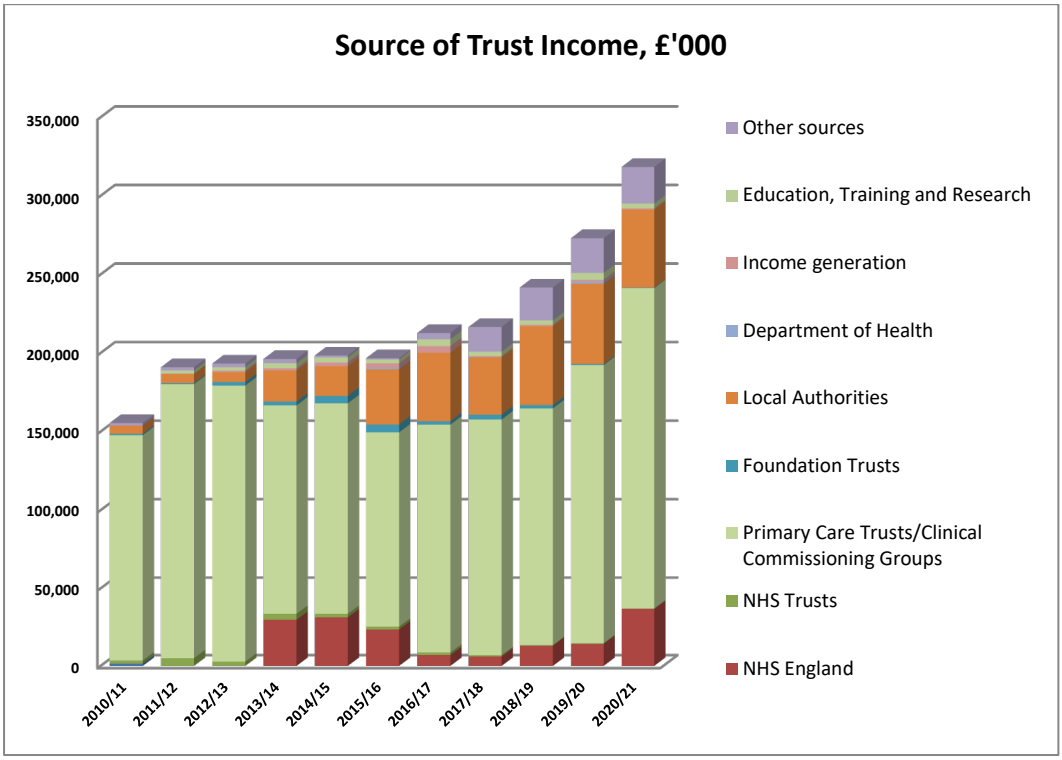
The Trust delivered a full year adjusted financial performance surplus of £6k (2019/20: £5,197k), £1,371k more than plan. There have been a number of non-recurrent measures, such as favourable settlements in supplier disputes that have enabled the trust to achieve this position.

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 2021 the Trust had cash balances of £72,424k (2019/20: £52,418k), sufficient to pay for over 252 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

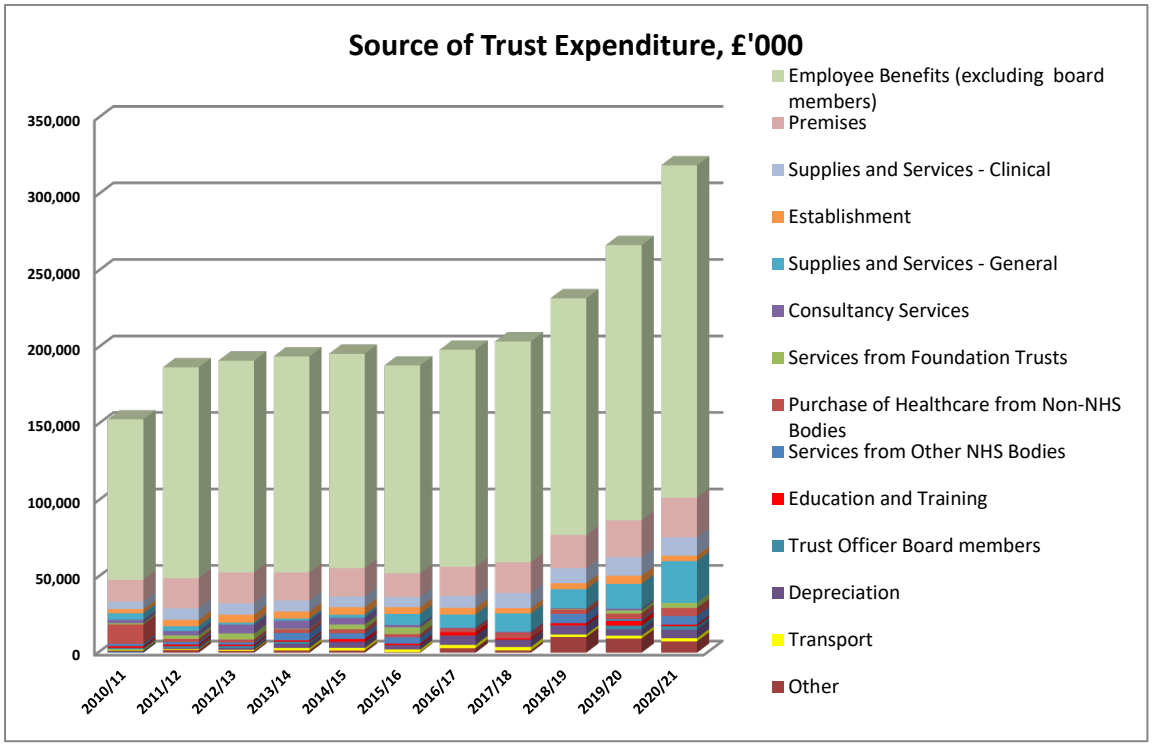
Our operating income (which excludes interest earned) for the year to 31 March 2021 was £318,360k (2019/20: £273,058k) which came from the following sources:



Income increased by 17% or £45m. There were no significant changes to CLCH's portfolio of contracts in 20/21, however the full year effect of the addition of the Adult Community Services for Hertfordshire Valleys CCG in October 2019 we seen in the Trust finances.

4.2 Expenditure

Expenditure increased by 20% or £52.1m primarily due to increased activities. Our operating expenditure (which does not include financing costs) for the year to 31 March 2021 was £319,141k (2019/20: £267,025k) 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:

	Q1	Q2	Q3	Q4	YTD	Target
2020/21	91%	88%	94%	88%	76%	95%

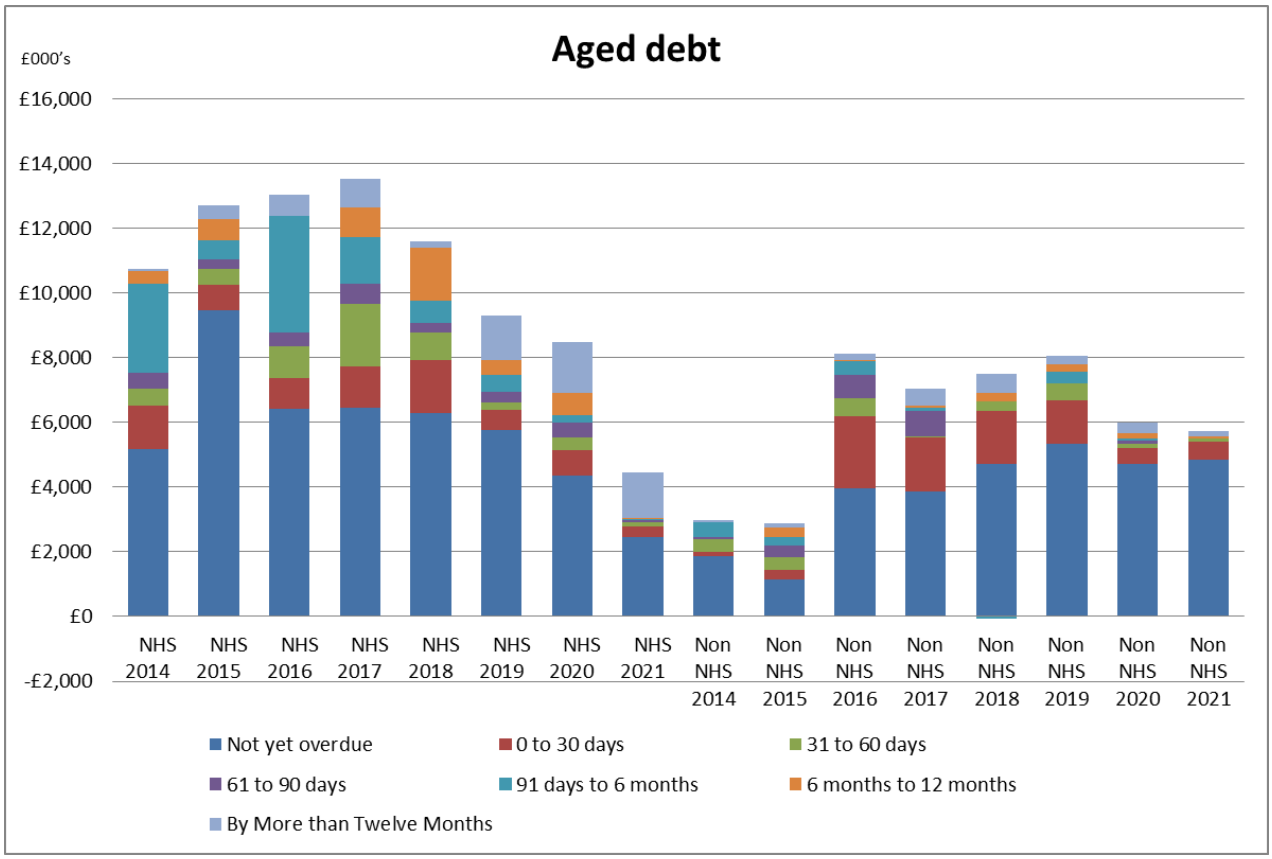
Our working capital management performance against target:

	31-Mar-21	31-Mar-20	Target
Receivables uncollected over 90 days past due	17%	21%	5%
Payables unpaid over 90 days past due	53%	60%	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 a CCG rent dispute which is proving difficult to resolve. We have a plan in place to further improve our performance during 2020/21. 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 2020/21 the Trust wrote off £4k debt that related to salary overpayments, during 2019/20 the Trust wrote off £25k 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 2020/21 is allocated to meet existing financial commitments and fund future service developments.

The Trust has £10,185k aged receivable from NHS and non-NHS bodies at 31 March 2021 (31 March 2020: £14,477k). 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 2020/21 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 2021/22.

4.5 QIPP (Quality, Innovation, Productivity and Prevention)

Under normal operations, QIPP is essential to the delivery of 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 support CLCH in succeeding as a provider of choice in a more competitive market environment and create a financial contingency against future risks.

However, in the exceptional circumstances that prevailed in 20/21, the originally calculated QIPP requirement for 2020/21 of £9.7m (inclusive of contingency) based on initial planning assumptions was not required. Due to the COVID-19 pandemic, emergency funding measures were put in place though out 2020/21, and recurrent adjustments have been made to contracts to ensure that the 20/21 requirement can be written off recurrently. These measures allowed (and also required) all NHS organisations to pause QIPP delivery during 20/21.

The Trust is planning to operate to a minimal QIPP requirement in 21/22 with the first half of the year again being covered through emergency funding measures. It is vital however that 21/22 is used as period in which the Trust develops a robust set of transformation focused QIPP plans that are able to start delivering savings from the beginning of 22/23. The scale of the QIPP requirement in 22/23 can be reasonably expected to be a minimum of 2% as set within the NWL ICS plans for 21/22. It should be noted though that this has the potential to be exacerbated by the extent to which the risk on variable income comes to fruition. With the level of uncertainty on the income baseline moving into 22/23 it would be prudent for the Trust to work towards the identification of 2-4% in QIPP programmes.

4.6 Financing and investment

During 2020/21 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 2020/21 this was £9,468k (2019/20: £9,801K).
The most significant investments within this total were intangible additions of £3,984 on software and property, plant and equipment additions on these schemes:

BRE Building £274k
Backlog £288k
Elstree Way Clinic £315k
Harpenden Memorial Hospital £1,036k
Health & Safety £504k
Langley House £550k
Lisson Grove £181k
Merton Civic Centre £83k
Parsons Green HC £503k
Soho Centre - Dental £767k
Medical Devices £550k
Invest to Save £433k

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.

4.7 Political and charitable donations

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

4.8 Pension Liabilities

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

The Trust does not reflect in its financial statements any NHS Pension scheme assets or liabilities attributable to scheme members who are employed by the Trust. There is £2,750k in respect of outstanding NHS Pension contributions at 31 March 2021 (31 March 2020: £3,032k).

4.9 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.

4.10 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 10 June 2021

Mike Fox, director of finance, contracting and performance

Date 10 June 2021

STATEMENT OF COMPREHENSIVE INCOME
FOR THE YEAR ENDED 31 MARCH 2021

	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	5	291,254	262,939
Other operating income	6	27,106	10,119
Operating expenses	8,10	(319,141)	(267,025)
Operating surplus/(deficit) from continuing operations		**(781)**	**6,033**
Finance income	13	0	56
PDC dividends payable		(295)	(892)
Net finance costs		**(295)**	**(836)**
Gains / (losses) arising from transfers by absorption		0	17,593
Surplus / (deficit) for the year from continuing operations		**(1,076)**	**22,790**
Surplus / (deficit) for the year		**(1,076)**	**22,790**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments		(2,687)	0
Revaluations	14	0	3,479
Other recognised gains and losses		0	1
Total comprehensive income / (expense) for the period		**(3,763)**	**26,270**

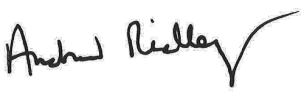
The notes on pages 85-126 form part of these financial statements.

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 2021

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	15	8,025	6,348
Property, plant and equipment	14	67,455	70,220
Receivables	16	339	1,207
Total non-current assets		75,819	77,775
Current assets			
Receivables	16	22,506	22,014
Cash and cash equivalents	18	72,424	52,418
Total current assets		94,930	74,432
Current liabilities			
Trade and other payables	19	(65,099)	(46,823)
Provisions	22	(738)	(1,241)
Other liabilities	20	(4,719)	(2,162)
Total current liabilities		(70,556)	(50,226)
Total assets less current liabilities		100,193	101,981
Non-current liabilities			
Provisions	22	(150)	(166)
Total non-current liabilities		(150)	(166)
Total assets employed		100,043	101,815
Financed by			
Public dividend capital		5,670	3,679
Revaluation reserve		19,985	22,672
Income and expenditure reserve		74,388	75,464
Total taxpayers' equity		100,043	101,815

The notes on pages 85-126 form part of these accounts.
The financial statements on pages 80-84 and accompanying notes were approved by the Audit committee on behalf of the Board on the 9 June 2021 and signed on its behalf by:



Andrew Ridley, chief executive

Date 10 June 2021

Mike Fox, director of finance, contracting and performance

Date 10 June 2021

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2021

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**3,679**	**22,672**	**75,464**	**101,815**
Surplus/(deficit) for the year	0	0	(1,076)	**(1,076)**
Impairments	0	(2,687)	0	**(2,687)**
Public dividend capital received	1,991	0	0	**1,991**
Taxpayers' and others' equity at 31 March 2021	**5,670**	**19,985**	**74,388**	**100,043**

Statement of Changes in 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**

The notes on pages 85-126 form part of these financial statements.

These financial statements have been prepared using the Department of Health and Social Care 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 and Social Care as the public dividend capital dividend. The Trust prepares the accounts in line with the Group Accounting Manual.

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 2021

	Note	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(781)	6,033
Non-cash income and expense:			
Depreciation and amortisation	8.1	7,847	6,711
Net impairments	32	22	0
Decrease in receivables and other assets		66	3,785
Increase in payables and other liabilities		23,744	5,321
Decrease in provisions		(519)	(2,939)
Net cash flows from operating activities		**30,379**	**18,911**
Cash flows from investing activities			
Interest received		0	56
Purchase of intangible assets		(3,984)	(1,856)
Purchase of PPE		(8,395)	(5,074)
Net cash flows (used in) investing activities		**(12,379)**	**(6,874)**
Cash flows from financing activities			
Public dividend capital received		1,991	2,101
PDC dividend (paid) / refunded		15	(1,171)
Net cash flows from financing activities		**2,006**	**930**
Increase in cash and cash equivalents		**20,006**	**12,967**
Cash and cash equivalents at 1 April - brought forward		**52,418**	**39,451**
Cash and cash equivalents at 31 March	18	**72,424**	**52,418**

The notes on pages 85-126 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 2020/21 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

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

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 2020-21 (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 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 2021. 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 enhancements made to its Leased Buildings during 2020/21 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.

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 2021. 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 for all freehold assets a desktop exercise.

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

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.

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.

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 Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust’s interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

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 2020/21.

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 2022. 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 re-measurement 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 2022, 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 0.91% 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 2022 for existing finance leases.

For leases commencing in 2022/23, 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 2022, 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.

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 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 10 June 2021 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, Ealing 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;
- 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;
- Walk-in and minor injury services; and

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 deficit of £1,054k which was the final position disclosed below. An allowable annual leave accrual not funded of £1,060k offsets the deficit of £1,054k to mean that a final adjusted financial performance surplus for the purpose of system achievement was made of £6k.

	Revenue from customers	Retained surplus (deficit) 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 31/3/2021	318,360	(£1,054)	0	0	7,847	(2,709)
12 months to 31/3/2020	273,058	5,197	56	0	6,711	3,479

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, Ealing 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 (2019/20 two) who individually accounted for over 10% of the Trust's turnover. These customers account for 29% (2019/20: 27%) 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	**2020/21**	**2019/20**
	£'000	**£'000**
NHS Barnet CCG		44,731
NHS West London (K&C) CCG	29,584	28,559
NHS Herts Valleys CCG	44,722	26,091
NHS Merton CCG		20,846
NHS Central London (Westminster) CCG	23,777	19,861
NHS Hammersmith and Fulham CCG	16,997	16,262
NHS Harrow CCG	10,696	10,384
NHS North Central London CCG	48,613	
NHS South West London CCG	24,438	
NHSE	28,788	11,641
Battersea Healthcare Community Interest Company (Wandsworth)	16,516	16,135
Sub Total	**244,131**	**194,510**
Income from other organisations	74,229	78,548
Total Revenue	**318,360**	**273,058**

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

	2020/21	2019/20
Income from patient care activities received from:	**£000**	**£000**
NHS England	19,068	15,160
Clinical commissioning groups	204,134	177,730
Other NHS providers	469	968
Local authorities	49,588	51,133
Injury cost recovery scheme	206	309
Non NHS: other	17,789	17,639
Total income from activities	**291,254**	**262,939**
Of which:		
Related to continuing operations	291,254	262,939

Revenue is almost exclusively from the supply of services. Revenue from the sale of goods is immaterial. No overseas income has been charged directly to overseas patients during 2020/21. Non NHS Other includes Community Adult Health Services (Wandsworth) charged to Battersea Healthcare Community Interest Company £16.5m.

Income from patient care activities (by nature)	**2020/21**	**2019/20**
	£000	**£000**
Block contract / system envelope income*	204,134	186,056
Income from other sources (e.g. local authorities)	79,115	70,049
Additional pension contribution central funding**	8,005	6,834
Total income from activities	**291,254**	**262,939**

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have 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

	2020/21			2019/20		
	Contract income £000	Non-contract income £000	Total £000	Contract income £000	Non-contract income £000	Total £000
Research and development	79	0	**79**	40	0	**40**
Education and training	3,142	0	**3,142**	4,440	0	**4,440**
Provider sustainability fund (2019/20 only)	0	0	**0**	3,221	0	**3,221**
Reimbursement and top up funding	17,725	0	**17,725**	0	0	**0**
Charitable and other contributions to expenditure	0	3,630	**3,630**	0	212	**212**
Rental revenue from operating leases	0	1,414	**1,414**	0	1,107	**1,107**
Other income	1,116	0	**1,116**	1,099	0	**1,099**
Total other operating income	**22,062**	**5,044**	**27,106**	**8,800**	**1,319**	**10,119**
Of which:						
Related to continuing operations			27,106			10,119

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

	2020/21 £000	2019/20 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	2,053	1,871

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

	2020/21 £000	2019/20 £000
Purchase of healthcare from NHS and DHSC bodies	6,518	3,017
Purchase of healthcare from non-NHS and non-DHSC bodies	7,859	4,562
Staff and executive directors costs	217,185	179,669
Remuneration of non-executive directors	102	82
Supplies and services - clinical (excluding drugs costs)	11,995	12,250
Supplies and services - general	27,605	16,410
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	1,127	1,690
Inventories written down	3,483	0
Consultancy costs	0	1,169
Establishment	3,550	5,301
Premises	7,811	4,614
Transport (including patient travel)	2,143	1,884
Depreciation on property, plant and equipment	5,540	4,204
Amortisation on intangible assets	2,307	2,507
Net impairments	22	0
Movement in credit loss allowance: contract receivables / contract assets	(238)	417
Increase/(decrease) in other provisions	(49)	(2,639)
audit services- statutory audit	63	55
other auditor remuneration (external auditor only)	0	12
Internal audit costs	130	105
Clinical negligence	605	423
Legal fees	586	368
Insurance	0	73
Education and training	1,141	3,073
Rentals under operating leases	19,395	20,535
Redundancy	137	142
Hospitality	0	6
Losses, ex gratia & special payments	6	3
Other	118	7,093
Total	**319,141**	**267,025**

8.2 Auditor remuneration

The statutory audit fee is payable to the External Auditor Net of VAT. 2020/21 £53K (2019/20 £46K).

	2020/21 £000	2019/20 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	0	0
2. Audit-related assurance services	0	12
3. Taxation compliance services	0	0
4. All taxation advisory services not 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	**0**	**12**

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

	2020/21 £000	2019/20 £000
Operating lease expense		
Minimum lease payments	19,395	20,535
Total	**19,395**	**20,535**

	31 March 2021 £000	31 March 2020 £000
Future minimum lease payments due:		
- not later than one year;	19,395	20,535
- later than one year and not later than five years;	26,386	0
- later than five years.	38,524	0
Total	**84,305**	**20,535**

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.

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.

9.2 Trust as lessor

	2020/21 £000	2019/20 £000
Operating lease revenue		
Minimum lease receipts	1,414	1,107
Contingent rent	0	0
Other	0	0
Total	**1,414**	**1,107**

	31 March 2021 £000	31 March 2020 £000
Future minimum lease receipts due:		
- not later than one year;	1,414	1,107
- later than one year and not later than five years;	0	0
- later than five years.	0	0
Total	**1,414**	**1,107**

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

	2020/21 Total £000	2019/20 Total £000
Salaries and wages	158,463	135,967
Social security costs	15,985	13,017
Apprenticeship levy	2,545	715
Employer's contributions to NHS pensions	26,385	23,021
Termination benefits	137	142
Temporary staff (including agency)	14,741	7,152
Total gross staff costs	**218,256**	**180,014**
Of which		
Costs capitalised as part of assets	934	203

During 2020/21 2 persons retired early on ill-health grounds during the financial period (2019/20: three). The associated additional accrued pension liabilities total £11K (2019/20: £152K). Permanently employed includes £1,334K (2019/20: £558k) 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 2020/21, the Trust processed £3,932k (2019/20: £1,435k) 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 2021 is based on valuation data as 31 March 2020, updated to 31 March 2021 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% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

Note 12 Better payment practice code

12.1 Measure of compliance

Non-NHS Payables	2020/21 Number	2020/21 £000	2019/20 Number	2019/20 £000
Total non-NHS trade invoices paid in the year	36,705	129,711	26,146	108,115
Total non-NHS trade invoices paid within target	33,133	121,146	20,816	87,417
Percentage of non-NHS trade invoices paid within target	90.3%	93.4%	79.6%	80.9%
NHS Payables				
Total NHS trade invoices paid in the year	578	5,743	463	4,877
Total NHS trade invoices paid within target	389	3,712	122	1,414
Percentage of NHS trade invoices paid within target	67.3%	64.6%	26.3%	29.0%

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

	2020/21 £000	2019/20 £000
Interest on bank accounts	0	56
Total finance income	**0**	**56**

No investments have been permitted to be made during 2020/21.

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 2020 - brought forward	**19,893**	**48,284**	**2,410**	**3,438**	**16,768**	**920**	**91,713**
Additions	0	4,501	0	550	433	0	**5,484**
Impairments	(65)	(3,895)	0	0	0	0	**(3,960)**
Reclassifications	0	2,410	(2,410)	0	0	0	**0**
Valuation/gross cost at 31 March 2021	**19,828**	**51,300**	**-**	**3,988**	**17,201**	**920**	**93,237**
Accumulated depreciation at 1 April 2020 - brought forward	**0**	**4,893**	**0**	**2,168**	**14,125**	**307**	**21,493**
Provided during the year	0	3,958	0	322	1,046	214	**5,540**
Impairments	0	(1,251)	0	0	0	0	**(1,251)**
Accumulated depreciation at 31 March 2021	**0**	**7,600**	**0**	**2,490**	**15,171**	**521**	**25,782**
Net book value at 31 March 2021	**19,828**	**43,700**	**0**	**1,498**	**2,030**	**399**	**67,455**
Net book value at 1 April 2020	**19,893**	**43,391**	**2,410**	**1,270**	**2,643**	**613**	**70,220**

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021							
Owned - purchased	19,828	43,700	0	1,498	2,030	399	**67,455**
NBV total at 31 March 2021	**19,828**	**43,700**	**0**	**1,498**	**2,030**	**399**	**67,455**

	Years	Years
Land	-	-
Buildings, excluding dwellings	20	65
Plant & machinery	3	15
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.

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 2021. 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 2021 with a valuation date of 31 March 2021. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. The Trust is in year four of its five yearly site visit revaluation cycle. This financial year the valuer has carried out for all freehold estate 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 2019 - as previously stated	**13,702**	**30,335**	**0**	**3,544**	**13,669**	**702**	**61,952**
Prior period adjustments	22	163	0	(606)	1,903	16	**1,498**
Valuation / gross cost at 1 April 2019 - restated	**13,724**	**30,498**	**-**	**2,938**	**15,572**	**718**	**63,450**
Transfers by absorption	6,037	11,290	378	95	-	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	**19,893**	**48,284**	**2,410**	**3,438**	**16,768**	**920**	**91,713**
Accumulated depreciation at 1 April 2019 - as previously stated	**0**	**2,659**	**0**	**2,539**	**11,353**	**159**	**16,710**
Prior period adjustments	0	365	0	(645)	1,597	16	**1,333**
Accumulated depreciation at 1 April 2019 - restated	**0**	**3,024**	**0**	**1,894**	**12,950**	**175**	**18,043**
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**	**4,893**	**0**	**2,168**	**14,125**	**307**	**21,493**
Net book value at 31 March 2020	**19,893**	**43,391**	**2,410**	**1,270**	**2,643**	**613**	**70,220**
Net book value at 1 April 2019	**13,724**	**27,474**	**0**	**1,044**	**2,622**	**543**	**45,407**

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020							
Owned - purchased	19,893	43,391	2,410	1,270	2,643	613	**70,220**
NBV total at 31 March 2020	**19,893**	**43,391**	**2,410**	**1,270**	**2,643**	**613**	**70,220**

Note 15a Intangible Non-current Assets

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2020 - brought forward	**19,088**	**19,088**
Additions	3,984	**3,984**
Valuation / gross cost at 31 March 2021	**23,072**	**23,072**
Amortisation at 1 April 2020 - brought forward	**12,740**	**12,740**
Provided during the year	2,307	**2,307**
Amortisation at 31 March 2021	**15,047**	**15,047**
Net book value at 31 March 2021	**8,025**	**8,025**
Net book value at 1 April 2020	**6,348**	**6,348**

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.

Note 15b Intangible Non-current Assets prior year

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2019 - as previously stated	**18,528**	**18,528**
Prior period adjustments	(1,296)	**(1,296)**
Valuation / gross cost at 1 April 2019 - restated	**17,232**	**17,232**
Additions	1,856	**1,856**
Valuation / gross cost at 31 March 2020	**19,088**	**19,088**
Amortisation at 1 April 2019 - as previously stated	**11,364**	**11,364**
Prior period adjustments	(1,131)	**(1,131)**
Amortisation at 1 April 2019 - restated	**10,233**	**10,233**
Provided during the year	2,507	**2,507**
Amortisation at 31 March 2020	**12,740**	**12,740**
Net book value at 31 March 2020	**6,348**	**6,348**
Net book value at 1 April 2019	**6,999**	**6,999**

Useful economic life:

Minimum life (years)	3
Maximum life (years)	10

Note 16 Trade and other receivables

	31 March 2021 £000	31 March 2020 £000
Current		
Contract receivables	12,812	15,176
Allowance for impaired contract receivables / assets	(780)	(1,022)
Prepayments (non-PFI)	2,214	1,965
PDC dividend receivable	398	708
VAT receivable	5,562	3,230
Other receivables	2,300	1,957
Total current receivables	**22,506**	**22,014**
Non-current		
Prepayments (non-PFI)	339	1,207
Total non-current receivables	**339**	**1,207**
Of which receivable from NHS and DHSC group bodies:		
Current	9,172	11,421

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	
	Contract receivables and contract assets £000	Contract receivables and contract assets £000
Allowances as at 1 April - brought forward	**1,022**	**630**
New allowances arising	780	417
Changes in existing allowances	(1,018)	0
Utilisation of allowances (write offs)	(4)	(25)
Allowances as at 31 Mar	**780**	**1,022**

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 2021	Held at amortised cost £000	Total book value £000
Trade and other receivables excluding non financial assets	12,812	**12,812**
Cash and cash equivalents	72,424	**72,424**
Total at 31 March 2021	**85,236**	**85,236**

Carrying values of financial assets as at 31 March 2020	Held at amortised cost £000	Total book value £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**

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 £5,562k (2019/20: £3,230k) 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 £2,552K (2019/20: £3,172K) and the allowance for credit losses £780k (2019/20: £1,022k) are also excluded from this note.

17.2 Financial Liabilities

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Trade and other payables excluding non-financial liabilities	48,703	**48,703**
Total at 31 March 2021	**48,703**	**48,703**

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**

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 £7,431K (2019/20: £2,900K), are not contractual and so are excluded from the disclosure.

17.3 Maturity of financial liabilities

	31 March 2021	31 March 2020 restated*
	£000	£000
In one year or less	48,703	44,580
Total	**48,703**	**44,580**

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

	2020/21 £000	2019/20 £000
At 1 April	**52,418**	**39,451**
Net change in year	20,006	12,967
At 31 March	**72,424**	**52,418**
Broken down into:		
Cash at commercial banks and in hand	33	25
Cash with the Government Banking Service	72,391	52,393
Total cash and cash equivalents as in SoFP	**72,424**	**52,418**

Note 19 Trade and other payables

	31 March 2021 £000	31 March 2020 £000
Current		
Trade payables	(1,035)	(501)
Capital payables	2,710	5,621
Accruals	55,628	39,460
Social security costs	2,756	0
Other taxes payable	1,924	0
Other payables	3,116	2,243
Total current trade and other payables	**65,099**	**46,823**
Of which payables from NHS and DHSC group bodies:		
Current	8,450	7,132

Other payables include £2,750K in respect of outstanding pension contributions at 31 March 2021 (31 March 2020: £3,032K).

Note 20 Other Liabilities

	31 March 2021 £000	31 March 2020 £000
Current		
Deferred income: contract liabilities	4,719	2,162
Total other current liabilities	**4,719**	**2,162**

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 2020	**183**	**28**	**479**	**717**	**1,407**
Arising during the year	0	19	273	0	**292**
Utilised during the year	(17)	0	(138)	(315)	**(470)**
Reversed unused	0	0	(341)	0	**(341)**
At 31 March 2021	**166**	**47**	**273**	**402**	**888**
Expected timing of cash flows:					
- not later than one year;	16	47	273	**402**	**738**
- later than one year and not later than five years;	64	0	0	**0**	**64**
- later than five years.	86	0	0	**0**	**86**
Total	**166**	**47**	**273**	**402**	**888**

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.

Note 23 Contingent liabilities and assets

NHS Resolution is holding clinical negligence provisions with a value of £4,332k (2019/20: £1,227k) and non-clinical provisions with a value of £215k (2019/20: £107k) 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 £47K (2019/20: £28K). 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 £402k (2019/20: £717k) is in respect of dilapidations provisions £402k.

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 eight non-clinical claims outstanding (2019/20: four) for which the Trust will have to pay a set excess. This excess is estimated by the NHS Resolution as £47K (2019/20: £28K). The NHS Resolution believes that it is unlikely the Trust will have to pay £7K (2019/20: £7K) excess and recommends that this amount is therefore disclosed as a contingent liability.

Note 24 Related party transactions

In financial years 2020/21 and 2019/20 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 2020/21 the Charity paid the Trust £203K for goods and services provided by CLCH (2019/20: £289K). As at 31 March 2021 the Trust had a total of £25k (2019/20: 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 North Central London CCG
NHS South East London CCG
NHS South West London CCG
NHS Brent CCG
NHS Central London (Westminster) CCG
NHS Hammersmith and Fulham CCG
NHS Harrow CCG
NHS Herts Valleys CCG
NHS West London (K&C & QPP) CCG

NHS England
Health Education England

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)
Richmond upon Thames Borough Council
Wandsworth London Borough Council
Westminster City Council
Royal Free London NHS Foundation Trust
Imperial College Healthcare 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 2021 on behalf of patients (31 March 2020: £124K).

Note 26 Losses and Special Payments

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

	2020/21		2019/20	
	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	15	4	45	25
Stores losses and damage to property	1	0	1	1
Total losses	**16**	**4**	**46**	**26**
Special payments				
Ex-gratia payments	4	6	4	2
Total special payments	**4**	**6**	**4**	**2**
Total losses and special payments	**20**	**10**	**50**	**28**

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:

	2020/21 £000	2019/20 £000
Cash flow financing	(18,015)	(10,497)
External financing requirement	**(18,015)**	**(10,497)**
External financing limit (EFL)	(2,801)	28,782
Under / (over) spend against EFL	**15,214**	**39,279**

Note 29 Breakeven performance

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	0	2,196	3,835	1,766	1,735	1,836
Breakeven duty cumulative position	0	2,196	6,031	7,797	9,532	11,368
Operating income	0	155,379	190,946	193,270	196,191	198,409
Cumulative breakeven position as a percentage of operating income	0.0%	1.4%	3.2%	4.0%	4.9%	5.7%
	2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Breakeven duty in-year financial performance	3,506	5,380	6,883	9,434	5,197	(1,054)
Breakeven duty cumulative position	14,874	20,254	27,137	36,571	41,768	40,714
Operating income	196,671	212,749	216,614	241,667	273,058	318,360
Cumulative breakeven position as a percentage of operating income	7.6%	9.5%	12.5%	15.1%	15.3%	12.8%

Note 30 Capital Resource Limit

	2020/21 £000	2019/20 £000
Gross capital expenditure	9,468	9,801
Charge against Capital Resource Limit	**9,468**	**9,801**
Capital Resource Limit	9,468	9,801
Under / (over) spend against CRL	**0**	**0**

All capital investments in 2020/21 and 2019/20 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 2021 but not yet delivered) at the statement of financial reporting date (2019/20: £0).

Note 32 Impairments of assets

	2020/21 £000	2019/20 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	22	0
Total net impairments charged to operating surplus / deficit	**22**	**0**

Impairments relate to the downward valuation of freehold estate by the valuer due to current market conditions.