Central London Community Healthcare NHS
NHS Trust
Your healthcare closer to home

Board of Directors – Annual General Meeting

Time: 1000-1100 hours Date: Thursday, 10 September 2015		Venue: Church House, Dean's Yard, London SW1P 3NZ	
			Time
1.1	Welcome, introduction[1] and apologies:	P Chesters	1000
1.2	Annual report and accounts 2014/15 – file attached	P Chesters	1005
1.3	CLCH successes, challenges and future plan 2015/16	J Reilly	1010
1.4	Quality matters	J Medhurst	1020
1.5	Key financial information	I Millar	1030
1.6	Questions from the audience / public	P Chesters	1040
1.7	Close	P Chesters	1100

'Join Us' – presentation and discussion groups	P Chesters	1105-1300

Circulation:

Board of Directors and attendees
CLCH website

[1] Note – the minutes of the AGM in 2014 were approved at the Board meeting in public on 30.09.14 and are available on the web site.

Central London Community Healthcare NHS
NHS Trust

Your healthcare closer to home

Annual Report

2014/15

Contents

1 Section One
Welcome from the Chairman and Chief Executive

There is a lot for us to be proud of from 2014/15 and we hope this annual report gives you a flavour of the great care our 3,000 staff are delivering through over two million contacts supporting over 243,000 patients across an area with a population of nearly one million people.

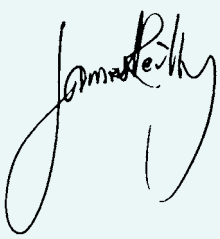
The patients that our staff care for day in, day out, range from those in the very first days of their lives, to those facing the end of their lives. We are constantly impressed by the dedication we see from our staff, the challenges they work with and the compassion with which they care for their patients. You'll see throughout this report examples of their great care. For this, and the many other examples of great care not mentioned here, we'd like to take the opportunity to say a huge thank you to all of our staff.

Working together has been a key theme in 2014/15, so much so that we rewrote our mission to emphasise it. The jargon varies, but whether we talk of integrated services or joined up working, what we mean is different professionals across primary, acute and social care supporting people and considering all their needs. It is the future of delivering great healthcare and is what patients are clamouring for and something we are fully committed to.

We put quality at the heart of everything we do and in April this year the quality of our services was scrutinised through a comprehensive Trust wide inspection by the Care Quality Commission (CQC). All our staff worked tirelessly in the run up to the inspection in April 2015 and we were bowled over by their commitment to demonstrate the effectiveness of their services and how they are addressing the inevitable challenges which arise. Once again, many thanks are due to them. We are very pleased that the CQC have recognised the quality of the care our teams provide and given us an overall rating of Good. The full results are available through our website at **www.clch.nhs.uk**. The visit itself taught us a great deal, was an immensely positive experience, and has undoubtedly helped us to improve even further on what we do and how we do it.

There is much we are determined to achieve in the years ahead, but this is dependent on us securing a sustainable position for the future. Once again in 2014/15 through efforts of our care teams, support staff and managers we delivered a solid financial position. We finished the year with our planned one per cent surplus, whilst also delivering £10.5 million in cost improvements, something very few NHS Trusts have achieved in such challenging circumstances. This gives us the stability to improve how we care for our patients and how we support our staff, thereby enabling us to grow as an organisation whilst not compromising on quality.

The highlights in this report are just the tip of the iceberg in terms of all the great care our staff provide. We're pleased to lead CLCH because we're proud to work with such a talented, dedicated and caring group of staff.



Pamela Chesters CBE
Chairman

James Reilly
Chief Executive

2 Section Two
Introducing Central London Community Healthcare NHS Trust

Central London Community Healthcare NHS Trust (CLCH) is London's largest standalone community NHS trust. We provide services to more than a million people – approximately one in every ten Londoners – predominantly those living and working in Barnet, Hammersmith and Fulham, Kensington and Chelsea and Westminster. This year we have expanded our services to support people living in Hertfordshire, Brent and Hounslow, and we have ambitious plans to deliver even more services across neighbouring boroughs and across the Home Counties.

When most people think about the NHS often it is just hospitals that spring to mind. In fact, most healthcare from the NHS is provided not by hospitals but out in the community, either through GPs or other community health services, like health visitors and district nurses.

Every day, we provide high quality healthcare to people in their homes or at clinics close to them. We currently provide nearly 70 different healthcare services from over 400 locations across the communities we serve.

Our services and our approach are driven by our vision and mission:

- Our vision: **Great care closer to home**
- Our mission: **Working together to give children a better start and adults greater independence**

In everything we do we aim to embody our values of:

- **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

Our services

We provide services which help people to stay well and take control of their own health with the support of specialist healthcare professionals working together. This means that people are not only getting the care they need, but are able to maintain greater levels of independence and avoid unplanned or unnecessary visits to hospital.

We support our patients at every stage of their lives; providing health visiting for new-born babies through to community nursing, stroke rehabilitation and palliative care for people towards the end of their lives. We also help to ease the pressure on Accident and Emergency departments by offering walk-in and urgent care centres to treat people with minor injuries.

Our range of services include:

- **Adult community nursing services** – including 24 hour district nursing, community matrons and case management.
- **Children and family services** – including health visiting, school nursing, community nursing teams, speech and language therapy, blood disorders and occupational therapy.
- **Rehabilitation and therapies** – including physiotherapy, occupational therapy, foot care, speech and language therapy, and osteopathy.
- **End of life care** – supporting people to make decisions and to receive care at the end of their life.
- **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, community dental services, sexual health and contraceptive services and psychological therapies.
- **Walk-in and urgent care centres** – providing care for people with minor illnesses, minor injuries and providing a range of health advice and information.
- **Offender healthcare services** at HMP Wormwood Scrubs.

A full directory of our services is available on our website at **www.clch.nhs.uk/services**

Increasingly, we work with other clinicians (GP, hospital and mental health teams) and social care colleagues to provide patients with joined up care that looks at all of their needs.

CLCH in numbers

WE EMPLOY AROUND
3,000
STAFF

WE HAVE
9,232
MEMBERS WITH MORE JOINING EVERY MONTH

LAST YEAR WE SAW
243,838
PATIENTS WITH OVER
2.4 MILLION
INTERACTIONS WITH THEM

WE WORK WITH
24
PARTNERS TO DELIVER CARE

45%
OF THE CARE WE GIVE TAKES PLACE IN PATIENTS' OWN HOMES

WE HAVE AN ANNUAL TURNOVER OF
£198.4m

WE PROVIDE SERVICES FROM
MORE THAN
400
LOCATIONS

Our goals

Providing the best healthcare services to patients sits at the heart of everything we do. We have six goals that guide us in delivering the best quality care for all. This report picks out examples of our achievements in 2014/15 which show how these goals are being delivered by teams across the Trust:

- **Embody the best of the NHS for our patients**; delivering great results with compassion and thoughtfulness.
- **Support people safely out of hospital**; providing safe, high quality value-for-money alternatives to hospital admissions.
- **Deliver better value than competitors in our selected markets**; securing our sustainability by providing effective and efficient services.
- **Be responsive to our patients' and partners' needs**; promoting integration and partnership by demonstrating our capacity, character and competence.
- **Employ only the best staff**; selecting staff who care and supporting them to go the extra mile for our patients.
- **Be innovation and technology pioneers**; leading the transformation of out of hospital services to empower staff and improve patient health.

Goal 1
Embodying the best of the NHS for our patients

The services we provide should capture the very best of the NHS and its values, delivering great results with compassion and thoughtfulness. Here are some of the steps we have taken in the last year to deliver on this goal.

Sign up to safety

This year we were one of the first Community Health Trusts to pledge our support and commit to the 'Sign up to Safety' initiative. It is a national programme designed to ensure the NHS is one of the safest healthcare systems in the world. We are working closely with our patients, their families and our members, to devise a plan to put five key pledges into action. These aim to deliver harm-free care for every patient, every time, everywhere.

Compassion in Care

Our Compassion in Care project, launched in 2013/14, continues to gather pace. It aims to ensure we deliver dignified and compassionate care to all our patients. Developed in partnership with City University, Compassion in Care embodies the national 6Cs (care, compassion, competence, communication, courage and commitment), and helps provide our frontline staff with skills and knowledge to most effectively support patients at all stages of their life. We now have 50 named Compassion in Care Champions who support other staff and the project has captured the interest of the Department of Health and the Chief Nurse for England.

15 Steps Challenge

The 15 steps challenge is based on the idea that a patient can tell what kind of care they will receive within 15 steps of entering a care setting. It continues to provide an important tool for staff and patients to work together to improve patient experience. The 15 steps challenge helps us to see the care we give from the perspective of our patients, and helps us to determine whether a service is welcoming, safe, caring, well-organised and calm.

A specialist team including members of our Board, patient representatives, staff and our wider membership list visit sites, evaluate what they find and develop recommendations for improvements. In 2014/15 our team visited two of our rehabilitation units and our intermediate care unit in Charing Cross. The recommendations have helped us to create more homely and friendlier environments for patients of these services. In 2015/16 we are planning visits to our walk-in centres to help us better understand how patients feel when they visit these often busy and crowded environments.

Spotlight on Marjory Warren Intermediate Care Unit

Our Marjory Warren Intermediate Care Unit at Charing Cross Hospital plays an important role in relieving the winter pressures on the NHS and social services. The unit is a specialist 'step up, step down' ward for people who are medically well enough not to be in acute hospital care, but who still need some support or assessment before returning home. The ward was featured on Sky News as part of a news item looking at the value of these units for vulnerable patients.

The unit was visited by our 15 steps challenge team, and whilst patients praised the care they received, they also felt that the environment was quite sterile and very similar to a traditional ward. Following the visit the ward's dining area was redesigned to create a more homely and social environment, helping patients to feel more at home whilst they recover.

Patient stories

During 2014/15 our patient experience team collected over 100 patient stories, helping us to stay connected to the patients and communities we serve. Patient stories help us to better understand the experiences of people using our services, learn lessons and adapt our services to better meet the needs of patients. Every meeting of our Board begins with a patient story from one of our services. This gives Board members a chance to hear the views of our patients in their own words. Our Quality Account provides a number of the stories collected in 2014/15.

Continuous Improvement Programme

CLCH is committed to developing an organisation which holds quality at the heart of everything we do. The Continuous Improvement programme has been designed to give our staff the confidence, tools and know-how to tackle complex problems in the workplace effectively and efficiently. The skills they learn help us to continuously improve the services we provide and resolve frustrating problems that may initially seem impossible to crack.

Programme graduates use the skills that they have learned to make ongoing improvements to the quality and effectiveness of their service. It is an essential part of helping teams to action the issues highlighted through our patient stories and wider feedback on patient experience. Examples of projects in 2014/15 include reducing 'Did not attend' rates in dental and musculoskeletal services, reducing waiting times in dental services, and reducing medication incidents.

Clinical outcomes

We have a programme in place to ensure services measure their performance against what is most important, i.e. the clinical outcomes for the patients they see. All services have been tasked to identify at least three clinical outcomes to evidence the effectiveness of their care. To date 75% have done so and are regularly recording the data to evidence good practice and drive further improvement. As national benchmarks for clinical outcomes in community services are developed we will use the information to identify areas where we could learn from others and improve.

Hello my name is…

We supported the launch of a new social media movement called 'Hello my name is…' designed to improve the experience of patients by encouraging staff to introduce themselves to those they are caring for. Described as 'the first rung on the ladder to providing compassionate care', the campaign has secured a wide range of support from well-known figures including David Cameron, Jeremy Hunt, Bob Geldof and Drew Barrymore.

Goal 2
Supporting people safely out of hospital

One of our biggest roles is to support people safely through services provided in their homes and community settings – providing effective alternatives to hospital care. We are proud to be taking on this important role, which is now widely recognised as being key to transforming the NHS and ensuring it can continue to provide high quality care in the face of growing demand and tight financial constraints.

Bringing services together

We have been at the heart of developing new plans to bring together health and social care services for people across central London. The Community Independence Service (CIS), which we will deliver alongside partners including Imperial College Healthcare NHS Trust, social care and voluntary organisations, will give patients the chance to retain their independence by improving links between related services.

Giving people across London the chance to be as healthy and independent as possible, the new CIS will offer:

- rapid response – for urgent help
- in-reach – giving the help people need to return home from hospital quicker
- rehabilitation – the care (medical and social) needed to get well at home
- reablement – supporting people to remain at home and be independent.

The new service was commissioned in 2014/15 during which time a huge amount of work has been put in by our staff to design the service. It has been rolled out from April 2015, with patients being given a single contact for any questions they may have about their health and social care needs.

Proactive Care Homes

Our Proactive Care Homes project has also been a key element of helping to keep people out of hospital. Shortlisted for the Health Service Journal 2014 awards, the project which was developed with a number of local clinical commissioning groups, was recognised by the judges for helping to bring together services to better meet patients' needs. Through working closely with the residents and the care teams within residential and nursing homes across London we were able to reduce falls, improve prescriptions given to patients and reduce the number of emergency A&E admissions.

Emergency Care Service

The Health Service Journal's 'Value in Healthcare' awards recognised the great work of our redesigned emergency care pathway, developed with Chelsea and Westminster Hospital and local clinical commissioning groups. The programme was acknowledged as the best example of patient care across organisational boundaries.

The GP-led programme was drawn up with GE Healthcare Performance Solutions, along with other key partners (London Ambulance, social services and commissioners) to:

- reduce emergency admissions by 5 per cent on the previous year
- deliver earlier supported discharge and rehabilitation
- keep patients safely at home.

Rapid access acute medical and surgical clinics were developed, offering an alternative to patients requiring urgent care. This helped towards around 1,500 (6.5%) fewer emergency admissions at the hospital trust year-on-year and excess bed days reducing by 30%.

We also undertook a detailed analysis of patients who regularly attended or were admitted to the hospital. Only 40 per cent were already known to us, and, on average, from seven to 17 hospital beds were taken up at Chelsea and Westminster by such patients, equating to a potential £972,000 in savings to the NHS.

The HSJ award judges said: "The winner offered an excellent and grounded piece of work, demonstrating solid outcomes. The plan was well integrated and recognised the need for close system working and effective partnership."

Driving better diabetes care

Our community diabetes team in Barnet held a special event to raise awareness of the condition and to promote the role of a healthy lifestyle in helping to keep it in check. Over 140 members of the local community came along, as well as the Deputy Mayor for Barnet, David Longstaff, and Deputy Mayoress, Ms Gillian Griffiths.

As part of the activities, guests had the opportunity to take part in a diabetes food quiz, which participants could apply to their own diet to help measure their risk of developing the condition. An alarming 50% scored as moderate or high risk, all of whom were offered an initial test for the condition at the event and advice on ways to reduce their risk level.

Children's community nurses

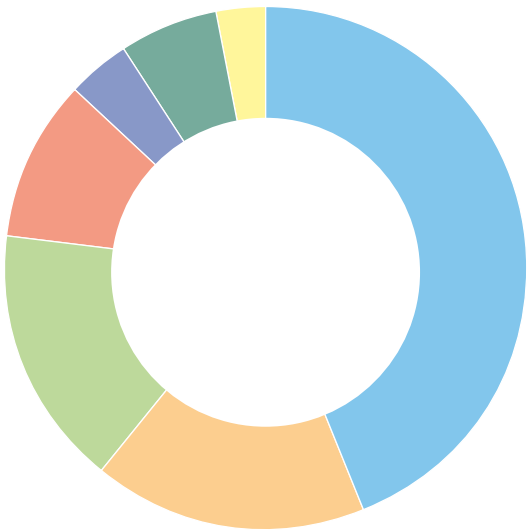
Our Children's Community nurses work closely with teams from Great Ormond Street Hospital, Chelsea and Westminster Hospital, the Royal Marsden, and St Mary's Hospital, to deliver specialist care to children and young people with leukaemia and other cancers. Under the umbrella of 'shared care' our team work with children and their families to reduce the amount of time they need to stay in hospital by providing care and treatment at home or in school where possible. The team are also on hand to offer practical information and support on how to care for a sick child, as well as providing training to parents, extended family and even teachers who might also be involved in looking after the child.

The service continues to be well received by parents, with one family saying 'they make life at home manageable' and another 'the seven day a week service is great'.

Goal 3
Delivering better value than our competitors

NHS commissioners and local authorities, the organisations who pay us to provide care to patients, expect to see both quality and value from everything we do. Better value means the finite resources of the NHS can pay for more healthcare. By providing the best value to our commissioners we can be confident we will have a secure future and that we are supporting the wider health service to be the best it can be.

Sources of income



Our income

In 2014/15 we received an income of £198 million – a small increase on the previous year's total of £196 million. Around 61 per cent of our income came from the clinical commissioning groups (CCGs) looking after the four main boroughs we work in. We also received income from NHS England, local authorities, CCGs in other parts of London and the Home Counties, and from some other NHS Trusts who we work with.

Our contracts

In line with all community trusts, our main NHS contracts came to an end last year. As is standard across the NHS we now work in accordance with 12 month contracts, with the exception of Barnet who have agreed a two year contract from 1 April 2015.

Improving efficiency

We have a strong and stable financial background, with a solid track record for consistently delivering savings above target. In 2014/15 we delivered £10.5 million from cost improvement plans and met our overall financial target to deliver a 0.9 per cent surplus. This is thanks to the commitment of staff across all our services in identifying and implementing better ways of working that release savings whilst maintaining the quality of care they provide.

In 2014/15 we launched a procurement exercise to establish a strategic partnership to deliver some of our corporate services and help us grow and improve. The partnership is designed to improve the efficiency of some back office functions and help us to protect investment in frontline services. We will be concluding the procurement and going live with a partnership in 2015/16. It means a big change for some of our staff and we are enormously grateful for their continued commitment throughout the process.

Responsive to commissioners' needs

Key to delivering value for commissioners is delivering what they want. Sometimes this is about changing how we work so we can offer greater flexibility and responsiveness for commissioners. To help build clinical leadership within the Trust and to be more responsive to commissioners and patients we have introduced Clinical Business Units (CBUs). These new units have enabled our frontline managers to have much greater autonomy, allowing them to design their services in the right way to meet the needs of commissioners and patients. 23 of our 24 service areas are now led by a clinical manager. This is helping to ensure we keep patient needs at the core of the services we design to meet what commissioners want.

Ambitions for growth

Delivering great value will help us achieve our ambition to expand and offer more services both to existing commissioners and by taking on work from new commissioners. Growing as an organisation will benefit patients. Delivering services across a wider area will drive adoption of best practice and plans to secure new business will help drive the need to deliver high quality trusted services in order to convince new commissioners to work with us. Larger organisations also benefit from economies of scale within management and corporate support services, allowing them to spend a greater proportion of their budgets on clinical services. Critical to this success is the ability to provide consistently high quality services at great value, with our frontline clinicians playing a key role in the design and delivery of all our services. The greater clinical leadership delivered through our new clinical business units, together with our growing reputation as a high quality community healthcare provider, has helped us to secure new contracts including:

- enhanced community respiratory services in Hertfordshire
- sexual health services in Hertfordshire
- school nursing in Brent
- diabetes services in Hounslow.

Goal 4
Being responsive to our patients' and partners' needs

To provide the best service to our patients and partners it is vital that we understand and evolve to meet their changing needs. Our commitment to listening to the needs of our patients and partners has driven many new projects throughout the year.

Providing a 'healthy start'

Our dietetics team were at the heart of a new drive to give children and babies a better start by increasing the uptake of free vitamin D tablets available to new and expectant mothers. Children's clinics and health centres from across Hammersmith and Fulham, Westminster and Kensington and Chelsea took part in our Healthy Start campaign, which devised new ways of encouraging people to take advantage of the free vitamins through specially designed posters and information sessions. The campaign saw up to a 56 per cent increase in the number of vitamins given out by our teams.

A garden for body and mind

Our work supporting people with dementia took a big step forward thanks to the opening of a specially designed garden and room at our Princess Louise nursing home in Kensington. The garden, which was opened by the Chelsea Pensioners, helps to provide a stimulating sensory experience for those living with the progressive condition and was funded thanks to a £180,000 grant from the Secretary of State for Health.

Young mothers and family nurse partnership

Four young mothers from Barnet were amongst the first to graduate after completing our Family Nurse Partnership programme. Open to all mothers under the age of 20, the specially designed programme allows our teams to work closely with young expectant mothers to support them in making decisions that will increase their chances of a healthy pregnancy, managing labour, improving child development, building a positive relationship with their babies and helping them plan for the future. The programme, which originated in the United States, has been shown not only to improve antenatal health but also reduce non-accidental injury and child protection cases.

Donna Thornley, Family Nurse Supervisor at our Graeme Park clinic explains: "Between 60-70% of the mothers who take part in the programme go back into education, which is really encouraging to see.

"When the mums start out with us they're extremely vulnerable, so it's very rewarding to see them so much more self-sufficient by the time they finish the programme. We're proud of each and every one of them."

Working with businesses for healthier choices

Working in partnership with the Royal Borough of Kensington and Chelsea, we have been working with businesses to involve them in our Healthier Catering Commitment (HCC). We have been working with cafes and businesses across the borough to help them offer their customers greater and better menu options. To achieve the HCC, food businesses need to meet at least eight of 24 criteria to improve the nutrition of their food - by reducing fat, salt and sugar and promoting fresh food.

New breastfeeding support service

We have launched an important breastfeeding support service for new mothers in Barnet. As well as benefitting from peer support and local support groups, our team also provide new mothers with the help and encouragement they need to start and keep on breastfeeding.

Accessible for all

Our Homeless Health team provides important support, information and treatment to a vulnerable group of people who often struggle to get the care they need. Following a drop in the number of people accessing the service from day centres in Westminster, the team has taken a direct approach to delivering care to homeless people in central London. Our team have gone out into the community and now work in a variety of locations including hostels and day centres, allowing them to reach out to many more people. The team has also built strong links with GPs and teams from outer London boroughs, making it easier for people who use our service to get the support they need.

Goal 5
Employing only the best staff

Great community healthcare is all about great staff both the clinicians and all the support teams that make our services tick.

This is why we aim to employ only the best staff by selecting people who are passionate about caring for our patients, and why we work hard to provide our staff with the support they need to go the extra mile for our patients.

Staff awards

In September 2014 we held our annual staff awards ceremony, which honours and recognises the dedication and achievements of our 3,000 staff. A record number of nominations were received from patients and carers as well as staff, acknowledging individuals, teams and our partners who have all made an outstanding contribution to the lives of our patients. At the centre of our awards, sit our three quality priorities – a positive patient experience, preventing harm and smart, effective care.

The winners were:

- Improving the patient or user experience: **Dr Roman Raczka**
- Innovation for smart, effective care: **The Care Navigator team and the Proactive Falls Prevention Care Home Pilot team**
- Patient safety and preventing harm award: **Esther George and Oluremi Ilesanmi**
- Healthcare professional of the year (children): **Sandra Hall**
- Healthcare professional of the year (adults): **Emily Karugaba**
- Receptionist or administrator of the year: **Alma Sinanovic**
- Healthcare support worker of the year: **Naulda Iglesias**
- Corporate services worker or team of the year: **Neal Gething**
- Patient award: **Funmilola Fawi**
- Partner award: **Catherine Pymar of Open Age**
- Compassion in care award: **Princess Louise Kensington Dementia Unit**
- Outstanding service delivery award: **Claire Gregory**
- Emerging leader award: **Layla Begum**
- Supervisor, team leader or manager of the year: **Glenda Esmond**
- Educator or mentor of the year: **Richard Watts**
- Team of the year: **Homeless Health Team, Looked After Children team, Public Health Nutrition team**
- Bringing our values to life award: **David Woods**

Leading the way with national recognition

Our staff lead the way in providing expert and innovative care in the community, working closely with other professional bodies to transform the care people receive. Here are just some of the ways the expertise and dedication of our staff has been recognised nationally:

- **Jumoke Oladipupo**, Team Leader for our Universal Children Service, was invited to join the prestigious Institute of Health Visiting's Fellowship programme. Jumoke is one of a few selected health visitors sitting on a specialist group helping to transform the lives of children and their families across the country.

- Two of our nurses at Wormwood Scrubs Prison, **Esther George** and **Oluremi Ilesanmi**, have been officially commended for their role in helping to save a prisoner's life after a suicide attempt. A consultant treating the patient confirmed that the quick actions of our staff that fought for 15 minutes to save him, had 'without doubt, saved his life'.

- Our **Specialist Weight Management Service** team received a best practice award from the Association for the Study of Obesity (ASO). The ASO commended the team for their significant contribution to the treatment of overweight and obese individuals – as well as playing a vital role in obesity prevention.

- **Kyle Gibbens**, one of our clinical support workers, was commended by the Health Service Journal as one of 25 exemplary role models working in the NHS who identify as Lesbian, Gay, Bisexual and Transgender and help promote greater inclusion for all.

- Our Deputy Head of Equality and Human Rights, **Melissa Berry**, was named as one of the 50 Health Service Journal Pioneers. The panel commended Melissa for her work in helping Black and Minority Ethnic (BME) staff to overcome barriers to career progression. As a role model to many BME staff, the panel also recognised the work Melissa and her team are doing in delivering our equality agenda.

- **Yvette Bynoe**, one of our school nurses based at the Medical Centre at Woodfield Road, picked up an award at the annual Community Practitioner and Health Visitor 2015 (CPHVA) award ceremony in Central London. Yvette was described as "a leader that gives her time to listen and offers full-hearted advice. She knows how to delegate well and follows guidelines and protocols in detail. She is a very good example of the professional standard of nursing that needs to be illustrated to any new team member".

A positive, progressive place to work

We want to make sure we thank our staff for the work they do by providing a supportive and positive environment. Here are just some of the steps we have taken to making this happen:

- We are listed as one of the top 100 Best Places to Work in an independent survey carried out by the Health Service Journal of over 500 NHS organisations.

- We are ranked 3rd in the health category of Stonewall's Top 100 places to work in 2015 – coming 40 out of 397 organisations overall across the UK.

- We have been recognised for our work in streamlining the application process for temporary and agency staff wishing to join us on a permanent basis.

Staff survey results

Like many parts of the NHS there has been an increase in the number of people using our services and as we rise to meet this increasing challenge, our staff are committed to giving their patients the best care possible. Our latest staff survey paints an encouraging picture about the dedication of our staff despite increasing pressures:

- nine in ten (92 per cent) of our staff feel their role makes a difference to the lives of their patients
- 88 per cent of staff are happy with the level of care they give to their patients
- seven in ten (71 per cent) of our staff feel they are able to directly contribute to improving the way we work
- 68 per cent of our staff feel enthusiastic about their job
- encouragingly, 97 per cent of our staff feel they know and understand our values, whilst almost nine in ten (87 per cent) feel able to demonstrate those values in their daily jobs.

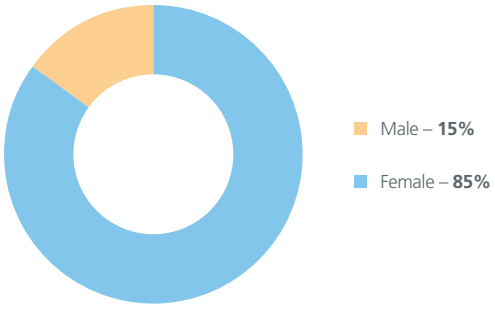
Over the next year we will continue to work closely with our staff to continue to create a positive and rewarding work environment; providing staff with greater opportunity to get involved and shape how we deliver services to our patients in the future.

Whilst our staff survey highlights lots of areas we can be proud of, there are some areas that we need to improve. Over the next year we will take active steps to address issues around bullying, harassment and discrimination, improving communications from senior management, as well as increasing the number of staff participating in the survey so that we get the best possible picture of working life at CLCH.

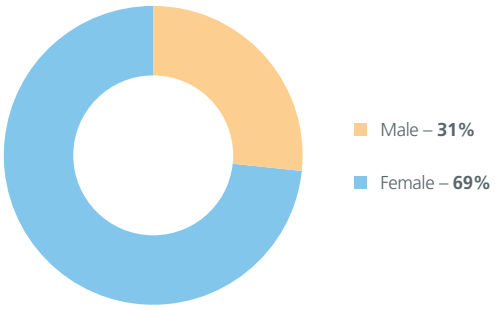
Equality and diversity

We believe that employing a workforce that reflects the diverse nature of the communities we serve will make us better at meeting the needs of our patients. Equally, all our staff need an environment of fairness, dignity and respect in which they are able to meet their personal and professional potential.

Male/female employee split

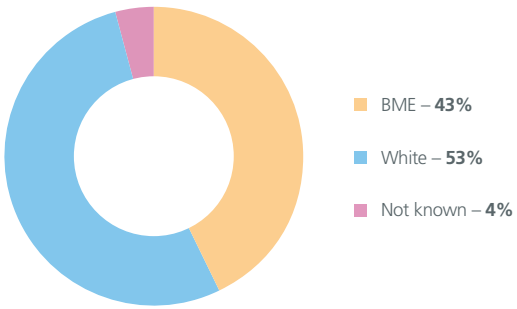


Male/female senior employee split



For the first time our Board Members undertook Equality and Diversity training. This included all members of the Board making personal pledges to support the Equality and Diversity agenda and taking on specific actions. Since this training two members of the board have become mentors to members of staff from a BME background. In 2014/15 we developed an initiative with Deloitte to appoint a new Associate Non-Executive to the Board and in May 2015 welcomed Hani Girgis to the Board.

BME background of staff



Empowering staff from black and minority ethnic (BME) backgrounds to take the next steps in their career with us remains key. We have a target to have 30% of staff in roles graded Band 7 and above from BME backgrounds. We are achieving this in two clinical divisions but have further work to do in corporate services and the other two clinical divisions. To help address this we run a specialist leadership programme, open to all staff, but with a focus on those from a BME background, to help people progress with us. Of the 89 people who have completed this programme, over a third have achieved a promotion and two have reached a senior level with us. Over the next year we will continue to work closely with our staff from a BME background to increase their involvement in this programme.

It is vital that all our staff have an understanding of equality and diversity issues and we take active steps to make sure that everyone undertakes specialist training to support relationships with both patients and colleagues.

Our *Diversity and Inspire* network for BME staff and *Rainbow* network for LGBT staff also play a key role in providing direct support to staff.

We pay specific attention to equality during proposed change programmes and carry out bespoke equality analysis assessments to check that no groups of staff or patients are disproportionately affected.

Staff involvement and consultation

Building strong relationships and engaging with our staff is vitally important. We inform and involve staff through many different channels, including our formal Joint Staff Consultative Committee meetings between union representatives and management. We run the annual NHS staff survey as well as quarterly local Pulse Surveys. Our Chief Nurse and Director of Quality, Louise Ashley, does a weekly clinical day where she visits and helps to deliver services. Medical Director, Joanne Medhurst, is also establishing regular clinical days within our services and other executive directors and senior managers visit our many sites and services. We also have staff newsletters, regular workshop sessions for our senior managers and a staff intranet.

Goal 6
Being innovation and technology pioneers

Using the most innovative technology can make a clear difference to the lives of the patients we support. To ensure the best possible experience for all our patients, it is vital that we embrace the latest technology. Through innovation we are leading the transformation of out of hospital services, empowering our staff to deliver the best possible care.

One system, one record

One of the biggest transformations to patient care this year has been our move to SystmOne, an intelligent medical record keeping system used in many General Practices across the country. As one of the first community trusts in England to move from the now dated RiO system, which has no connection to GP systems, our staff are able to share vital medical information with other health professionals improving the care our patients receive. Many of our staff work closely with general practice teams on a daily basis so it makes perfect sense that the systems they use to record the care patients receive are linked.

Already in operation across many of our services, SystmOne also allows us to better understand how patients are using our services and will make it easier for us to plan our services to meet the shifting and growing needs of patients.

Going mobile

With many of our staff working in the community and often in patients' homes, we want to make sure they feel connected to us at all times. By equipping our staff with mobile devices that allow them to access our clinical systems, as well as phone and email, we can better involve our patients in helping to set a care plan as well as making sure that records and notes made during visits are updated quickly and accurately.

The early stages of this work have been particularly encouraging and in September staff from across our Westminster and Kensington and Chelsea Community Rehabilitation teams, presented two papers on the success of our project at the International Digital Health and Care Congress organised by the King's Fund. At the congress the team not only shared their experiences of mobile working in a busy and challenging environment, but presented two thought leading sessions to 500 delegates from across the globe.

Apportunity for all

We want to make sure we capture the views of all our patients; especially those who might have more difficulty in expressing their opinions.

Our Consultant Lead Clinical Psychologist, Dr Roman Raczka, has been at the centre of an acclaimed new project with the University of East London to develop an app to help adults with learning disabilities share their experiences of the care they receive.

Funded by NHS England as a Pathfinder Project, it is a partnership between CLCH, Hammersmith & Fulham Clinical Commissioning Group, Hammersmith & Fulham Mencap, and Safety Net People First advocacy group. The 'My Health, My Say' patient app uses animations, voice overs and colour coded cartoons that allow adults with learning disabilities to easily complete the Friends and Family Test (which asks whether they would recommend the service they received to friends and family).

As a result of this new technology we can begin to build a more accurate picture about how some of our more vulnerable groups view our services.

Investing for the future

One year after the launch of our £21.38m, five-year IT strategy, we have already delivered a number of important improvements that are helping us to improve how we work to deliver the best services to our patients. Our progress includes:

- Electronic automation (60% complete) of the child health system that allows our services to receive information from colleagues in acute hospital settings in real time.
- Development of mobile working across clinical teams continues. We have issued 165 smart devices to physiotherapists, speech therapists, health visitors, community nurses and occupational therapists.
- Introduction of video conferencing and virtual meeting rooms, allowing our staff to connect to each other with ease – cutting time spent travelling and helping to maximise time for patient care.
- Migrated servers and data storage space to a specialist secure data centre making our network more reliable and more efficient, helping to minimise disruption to clinical activity.
- Improved bandwidth and introduced more reliable Wi-Fi networks to a number of our sites.
- Staff now have access to diary, email and ordering through the internet on the move.
- Introduced more robust electronic document management system.

Ian Millar, our Director of Finance, Performance and Corporate resources, explains:

"It's vital that the NHS moves with the times and developments in technology are extremely important for our clinicians, who see so many of our patients out in the community, often in their own homes. We have to ensure that all our record keeping of patient information is secure but also the way in which we capture it is agile and modern to ensure our patients receive the best possible NHS care."

Our performance in 2014/15

Our overall performance for 2014/15 was positive with solid financial performance and our quality of care confirmed by the Care Quality Commission inspection which took place in early April 2015.

To make sure we provide the best possible services to our patients we also set ourselves a challenging range of targets each year. For a number of these we have set stretch targets, aiming higher than the minimum requirement of nationally set targets.

In 2014/15 we set ourselves 27 targets, also known as key performance indicators (KPIs), which link closely to our 6 goals. Of the 27 targets 5 were fully met, 8 were not achieved but only narrowly missed and 14 were missed. This is for overall performance across the year. Every month we review our progress against these targets to provide a full picture on our effectiveness and efficiency. The in-month position as published as part of our regular public Board meetings.

We believe it is important to set targets that truly stretch us to make significant improvements, so whilst we're disappointed about the targets we have missed we are confident that progress is being made across all areas. In most of the areas were we have missed local stretch targets our actual performance falls in line with the national average and reflects the difficulties facing all NHS Trusts; for example sickness rates, vacancy rates, use of interim staff and the need to deliver efficiencies.

Achieved targets

- Hand hygiene audit
  We exceeded the target in every quarter of the year.

- Bedded units achieving minimum staffing levels
  We achieved consistently high performance across the year.

- Services capturing Patients' Clinical Outcomes
  We exceeded our target of 66% and expect all services to have defined clinical outcomes by the end of 2015/16.

- Complaints resolved within timescales agreed by complainant
  We achieve 100% in every month of the year.

- Quality Governance Assurance Framework score
  This is an independent assessment on a scale of 1-5 (1 being high), we achieved our target of 3 which is widely regarded as a good standard.

Narrowly missed targets

- Staff appraisal rates
  Performance improved in the final quarter of the year, but overall we missed the 90% target by 8.1%. Improved systems are being put in place for 2015/16.

- Patients agreeing they were treated with dignity and respect
  We met the target of 95% in two months of the year but overall narrowly missed with 93.7%.

- Patients with no new harms identified
  We achieved 96.6%, exceeding the national target of 96% but narrowly missing our internal stretch target of 98%.

- Staff complying with statutory and mandatory training
  We met our monthly trajectories for 11 months of the year but narrowly missed the overall target of 90% by 0.3%.

- Friends and family test (CLCH methodology)
  The target of 85% was missed by 2.6%.

- Staff feeling satisfied with the care they give to patients and service users
  We met the target in quarter three but overall missed the 85% target by 2.6%.

- Incidents affecting patients that did not cause harm
  Performance fluctuated in the first half of the year, linked to performance in our target for pressure ulcers. Performance stabilised in the second half and we met the target for the last two months of the year.

- **Staff from BME backgrounds at Band 7 and above**
  We continue to prioritise work to improve diversity of our senior leadership. The monthly trajectory was met in three months of the year, bit overall we missed the target of 34% by 3.1%.

Not achieved targets

- **Friends and family test (national methodology)**
  Our performance improved in the last quarter having fluctuated through the year.

- **Appointments cancelled by CLCH**
  We compare favourably with other similar organisations and performance improved in the final quarter of 2014/15.

- **Reduction in the incidence of pressure ulcers**
  Our rates are similar to other trusts based on national data however we continue to set stretching local targets to maintain a focus on reducing pressure ulcers.

- **Staff recommending CLCH as a place to work**
  We compare with other Community NHS Trusts based on results from the annual NHS staff survey. In January 2015 we were ranked 40th in Stonewall's Top 100 Employers index. In 2014/15 and 2015/16 we feature in the Health Service Journal's Best Places to Work list.

- **Ratio of clinical bank to agency staff hours worked**
  We compare with the average performance for London Trusts but missed an internal stretch target.

- **Staff sickness rate**
  We achieved 4.2%, performing better than the 4.4% average for other Community NHS Trusts but missed an internal stretch target of 3.5%.

- **Staff vacancy rates**
  We had a 15.3% vacancy rate at the end of 2014/15, similar to other London Trusts but missing an internal stretch target of 11%.

- **Staff completing the continuous improvement programme**
  Despite missing the target we continue to priorities and invest in training staff in the continuous improvement methodology.

- **Innovation committee taking forward projects as pilots**
  Whilst the innovation committee approved fewer projects than planned there is wider evidence of innovation and improvement happening within teams.

- **Recurrent Quality, Innovation, Productivity and Prevention plans (QIPPs) achieved**
  We delivered £10.5million savings in 14/15 with £10.4 being recurrent savings.

- **QIPPs achieving the planned level of savings**
  We discontinued or reduced some planned savings following stringent quality reviews to ensure efficiencies do not impact on quality of clinical care.

- **Securing new business**
  A strategic decision during the year not to compete to renew nursing home contracts meant we missed this internal target.

- **Complaints resolved within 25 days of receipt**
  This is a local target to support the national complaints target which we did achieve. By reviewing internal processes in year we saw significant improvement. In March 2015 we met 100%.

- **KPIs rated green for confidence in data quality**
  Despite missing our internal target we continue to put significant effort into improving data quality across the Trust. The introduction of a new clinical software system was a key step forward in 2014/15.

Where we have failed to meet our targets we have undertaken an in-depth analysis of the challenges in each area, and sought to make improvements throughout the year.

Performance against all of our targets in 2014/15 has been reviewed and discussed by our Board, and the outcomes of these discussions fed into shaping how we have set equally challenging targets for the year ahead as shown in the following section.

Our targets for 2015/16

Looking ahead, we have an ambitious set of targets to achieve by the end of 2015/16. They are a mix of our own goals as well as national targets and once again we are setting ourselves stretching targets beyond the minimum requirements of some national targets.

Goal one: Embody the best of the NHS for our patients – delivering great results with compassion and thoughtfulness:

- A friends and family test net promoter score of 85 per cent
- 95 per cent of patients agreeing with the statement 'I was treated with dignity and respect'
- 85 per cent of staff agreeing with the statement 'I am satisfied with the quality of care I give to patients/ service users'
- A ratio of 60:40 by month 12 for clinical bank to agency staff, calculated in hours worked.

Goal two: Support people safely out of hospital providing safe, high quality value for money alternatives to hospital admissions:

- 98 per cent of patients treated with no new harms identified
- 97 per cent or better hand hygiene audit score
- 100 per cent minimum staff achieved by bedded units
- 90 per cent of staff up to date with statutory and mandatory training
- No new (CLCH acquired) pressure ulcers grade 3/4 in bedded units.

Goal three: Deliver better value than competitors in our selected markets – securing our sustainability by providing effective and efficient services:

- Winning £22m of net new business
- 100 per cent of services capturing patents' clinical outcomes
- Increasing the percentage of incidents affecting patients that did not cause harm to 54 per cent.

Goal four: Be responsive to our patients' and partners' needs - promoting integration and partnership by demonstrating our capacity, character and competence:

- At least 90 per cent of all complaints resolved within 25 days of receipt
- 100 per cent of complaints resolved within the timescale agreed with the complainant
- Cancelling no more than 2.5 per cent of appointments.

Goal five: Employ only the best staff – selecting staff who care and supporting them to go the extra mile for our patients:

- 62 per cent of staff recommending CLCH as a place to work
- 90 per cent of staff receiving appraisals
- Staff sickness at a rate of no more than 4 per cent
- Vacancy level of no more than 14 per cent
- 34 per cent of staff at bands 7 and above from black and minority ethnic (BME) backgrounds.

Goal six: Be innovation and technology pioneers – leading the transformation of out-of-hospital services to empower staff and improve patient health:

- 100 per cent of recurrent QIPPs achieved
- 100 per cent of QIPP plans achieving their target
- 100 per cent of relevant staff using mobile technology
- 85 per cent of key performance indicators rated green for confidence in data quality
- Continuous Improvement model being used in 80 per cent of services.

Quality

We are committed to providing safe, effective high quality care to all our patients. Our patients drive everything we do and we have worked hard to improve the quality of our services to make sure we deliver the best possible care to all.

Our work to deliver excellent care to patients is underpinned by our three year quality strategy, which is built upon three basic priorities:

- Positive patient experience
- Preventing harm
- Smart, effective care

Understanding quality

Our work to improve quality is supported by our Quality Stakeholder Reference Group, made up of patients, members of our local Healthwatch and the wider community. The group gives an important insight into how our services are seen.

Highlights

- Each month over 90 per cent of patients rate their overall experience with us as excellent or good, with 94 per cent of patients saying 'yes, definitely' to being treated with respect and dignity by our staff.

- Clinical recording keeping by staff has improved. In 2014/15, 87 per cent of all records audited met our standards.

- Our Compassion in Care project, designed to deliver compassionate and dignified care to patients at the end of their lives, has delivered 50 Compassion in Care Champions who are actively working to introduce local Compassion in Care projects across our services.

More information

As an NHS healthcare provider, we publish an annual Quality Account explaining how we have performed against our quality priorities and national requirements. The Quality Account includes information about the standard of our services in three areas defined by the Department of Health; safety, clinical effectiveness and patient experience.

The Quality Account includes our annual report on complaints and compliments. The NHS complaints procedure adheres to the Principles for Remedy published by the Parliamentary and Health Service Ombudsman.

This annual report highlights a range of improvements during 2014/15. However, the Quality Account provides a more in-depth review of how our services have worked to improve quality. A copy is available at **www.clch.nhs.uk/aboutus/our-publications** or email **communications@clch.nhs.uk** to request a copy.

Our journey to become a foundation trust

At the heart of our desire to deliver the best possible care to patients is our journey to becoming a foundation trust.

A foundation trust explained

It is national policy that all NHS provider trusts become foundation trusts. Put simply, a foundation trust is a not for profit organisation that exists to support the interests of the community and is accountable to that community through a Council of Governors.

We believe that by becoming a foundation trust we will have a greater ability to provide the best and most efficient services for patients and commissioners.
We want a secure future and to be a flexible and responsive provider of healthcare to the communities we serve. The freedom that being a foundation trust brings would allow us to grow, create our own success and achieve the financial independence we need to deliver an even better service to our patients. Becoming a foundation trust will help us to work more closely with other local health and social care providers and to reinvest any financial surplus in enhancing patient care.

The next steps in our journey

Our application to become a foundation trust was paused last year as we awaited details of a new-style inspection by the Care Quality Commission (CQC). All aspiring foundation trusts must now undergo a formal CQC inspection before submitting their application to the regulator, Monitor. Securing a rating of Good from our Care Quality Commission inspection in April was a key milestone for proceeding with our application.

Ahead of the CQC inspection, during 2014/15 our preparations to become a foundation trust have progressed:

- We have refreshed our five year plan to improve and develop our services
- External assessments of our quality and Board governance have been passed successfully
- We have consulted with patients and members to understand what makes a good patient experience and how our services are seen.

We are now heading towards the final stages of our journey and pending the result of the CQC inspection, and a successful application to Monitor, it is anticipated that we will become a foundation trust in the summer of 2016.

Engaging our members and communities

Part of becoming a foundation trust involves establishing a membership, from which the Council of Governors will be appointed. Our members play an important part in keeping us connected to the communities we serve. We have a clear plan, driven by three key principles – inform, involve and influence – that helps us to reach out to a broad range of people in our communities.

Inform

Keeping our members informed about our work is the foundation of our relationship. Our quarterly magazine, *The NHS in your Neighbourhood*, is sent out to all members as well as being available online and across our network of clinics and walk-in centres. As well as showcasing the latest developments across our services, the magazine also shines a spotlight on the important role our members have played in shaping future services, provides healthcare advice and highlights the ways people can get more involved.

Our website is also an essential part of helping to keep members and the wider community up to date on our services and activities. A specialist section of the website, developed for members, showcases upcoming events as well as focusing on how individual members are actively helping to shape services in their area.

Involve

Central to involving members in our work are bi-monthly listening events. These provide an opportunity to members to give their views and discuss topics of relevance to the Trust's future and the care we provide.

Early in 2015, our members were invited to join us for a series of Sign Up to Safety events. Linked to the national *Sign Up to Safety* campaign, these events gave us the chance to work closely with our patients, carers, members and the wider public in setting the foundations for a new campaign to improve patient safety. Discussion at these events was invaluable – particularly those focusing on the use of technology – and will now help to form the basis of our future work.

We also held a series of Medicine for Members events that focussed on issues our members told us were important to them including public health, stroke and falls. These events gave us the chance to not only highlight some of the services we provide to help people manage these conditions, but also to share and discuss important health information.

Full details of all our events are reported in our magazine *The NHS in your Neighbourhood* for those who were unable to attend.

Influence

Our members also play an important part in helping to make sure we are faithful to our values and have continued to take on an active role in this area during 2014/15. Members, staff, patients and the wider community were asked to help us define what our quality priorities for the coming year should be. Over 130 people responded with the majority of these coming from either members or patients – helping to ensure they influence the direction of our work.

We are also working actively with members to involve them in the Patient Led Assessment of the Care Environment (PLACE) as assessors at our rehabilitation and continuing care homes. This important scheme puts patients, carers and their families at the heart of examining where we provide treatment. The role of a patient assessor is vital and provides an objective and unbiased view of the way we deliver our care.

We have had a strong response from our members and now have over 30 people trained and carrying out assessments across our services.

Over the next year we are looking to build even further on this important platform and will be recruiting more assessors and undertaking mystery shopper exercises that will help identify ways in which we can further improve the care we provide and the environments of the clinics and health centres where people are treated.

Our membership

We have two membership constituencies – a public constituency and a staff constituency. The public constituency is divided into five areas: the London Boroughs of Barnet, Hammersmith and Fulham, Kensington and Chelsea and Westminster, and the 'rest of England'. This allows everyone over the age of 16 who uses or who has an interest in our services to become a member irrespective of where they live in England.

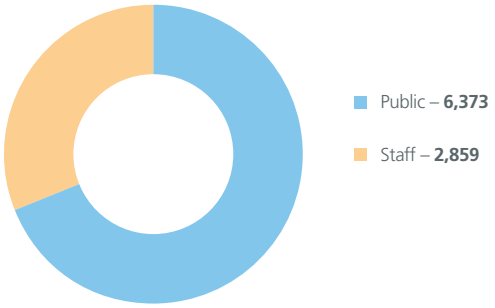
Our staff constituency is divided into two sections, clinical staff (including non-qualified health care assistants) and non-clinical staff (administration staff, professional support staff and managers). Staff are eligible to become members if they have either a permanent contract or a fixed-term contract of 12 months or more.

In 2014/15 we made good progress in recruiting new members, beating the target we set ourselves. By the end of March 2015 we had 9,232 members, of which 6,373 were public members and 2,859 were staff.

Our membership is broadly representative of the population we serve, however there is some under representation in the following groups:

- Ethnicity – White British and White Other
- Gender – Males

Membership



As part of our ongoing work to make sure our membership is representative of the communities we serve we ran a targeted campaign to recruit new public members from our inner boroughs through our walk-in / urgent care centres and other community settings. This led to over 300 people signing up.

Over the next year we will continue to take active steps to address areas of under-representation.

We actively write to our patients inviting them to become members – more than one in 20 sign up as a result. We also work to recruit members from those who contact our customer service teams and by contacting new recruits and volunteers.

3 Section Three
Directors' Report
Meet our Board

Our Board of Directors has overall responsibility for setting the strategy of CLCH, as well as monitoring performance, finance and maximising the efficiency of services provided by the organisation. The Board works collaboratively and meets at least 10 times a year to discuss issues, challenges and strategy.

How our Board works

Our Board meets in public, however, when discussing issues of confidentiality, it excludes members of the public in accordance with the Public Bodies (Admission to Meeting) Act 1960. Our standing orders and standing financial instructions includes the scheme of delegation and decisions reserved for the Board. Our Board has a majority of Non-Executive Directors (six including the Chairman).

Non-Executive Board members
* committee chair

Pamela Chesters CBE
Chairman

Pamela spent nearly twenty years with BP, latterly as chief executive of Duckhams Oils, before moving to the public sector. She was health advisor to London Mayor Boris Johnson and is a former Camden Councillor and Leader of the Opposition. She has previously chaired the Royal Free Hospital NHS Trust, Action for Children, English Churches Housing Group and PRIME. In addition to chairing CLCH, Pam currently chairs Anchor Trust.

Committee membership:
People and Remuneration* (to 1 September 2014), Quality, Finance, Resources and Investments, Workforce (from 1 September 2014), Remuneration (from 1 September 2014).

Anne Barnard
Vice Chair/Senior Independent Director

Anne has 20 years' experience in public and private sector broadcasting. Between 1994 and 2009, she held a number of positions at the BBC, most recently as Managing Director BBC World News Limited, the BBC's commercial international news channel.
Anne is a qualified chartered accountant with significant expertise in applying commercial principles and robust financial control to organisations with public objectives whilst ensuring the maintenance of strong values and integrity.

Committee membership: Audit (*to 1 September 2014), People and Remuneration (to 1 September 2014), Charitable Funds*, Finance, Resources and Investment (*from 1 September 2014).

Julia Bond
Non-Executive Director

Julia Bond has extensive experience in capital markets within the investment banking sector gained over 27 years; first with Bank of America followed by 22 years with Credit Suisse where she joined as a Vice President before becoming Managing Director in 1997. Julia established herself as a market leader in dealing with the $7t public sector investor institutions around the world and led global client service teams as well as co-heading Non Japan Asia.
Throughout her career, Julia has been involved in numerous strategic initiatives around clients, leadership, human capital management, branding, diversity, strategy and governance.

Committee membership: Quality Committee*, Charitable Funds, Audit (to 1 September 2014).

Tony Brown

Non-Executive Director

A partner at Nexus Corporate Finance LLP, Tony specialises in the healthcare services market. As a member of the editorial advisory panel for Health Investor magazine and as acting company secretary for Primary Health Properties PLC, he has a strong understanding of the market in which NHS bodies operate. Previously, Tony was also a non-executive director for NHS Barnet Primary Care Trust, Walk Health Ltd and Catalyst Healthcare, a PFI consortium.

Committee membership: Finance, Resources and Investment (*to 1 September 2014), Audit (*from 1 September 2014), People and Remuneration (to 1 September 2014).

Professor David Sines CBE

Non-Executive Director

David has a clinical background in providing frontline, board level and senior academic nursing expertise. During his career he has had responsibility for the delivery of health and social care-related education to a range of prestigious hospitals and community services including: Imperial College, Great Ormond Street Hospital, Guys & St Thomas' and nine primary care trusts. David is a Consultant Workforce and Education Advisor to Health Education North West London. He has held four Secretary of State positions and was a Nursing Member for England for the Nursing & Midwifery Council until 2006. He is also a fellow of the Royal College of Nursing, and until recently was Pro Vice Chancellor and Executive Dean, Society and Health at Buckinghamshire New University.

Committee membership: Quality, Workforce (*from 1 September 2014), Remuneration (*from 1 September 2014).

Dr Carol Cole

Non-Executive Director

Dr Carol Cole is a consultant psychologist specialising in organisation and management development. Originally trained as a Clinical Psychologist, she worked as a Change Management Consultant with the NHS and with Royal Dutch Shell. She now consults, coaches and lectures on organisation design, strategy, change management and leadership, applying psychology to enhance organisational and team effectiveness. She has also been a Non-Executive Director of Hounslow and Richmond Community Health NHS Trust and is a Trustee of Action on Hearing Loss.

Committee membership: Quality, Workforce (from 1 September 2014), Remuneration (from 1 September 2014), Audit.

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

- Anne Barnard
- Tony Brown

Executive Board members

James Reilly

Chief Executive

James Reilly is the Chief Executive of Central London Community Healthcare NHS Trust. He is a member of the Imperial College Health Partner Board and of Community Healthcare Networks. He has 25 years of experience in local government, having worked in Brent, Hackney and Hammersmith and Fulham primarily in services to adults and also with children's services. James is an Associate Member of Association of Adult Directors of Social Services and was the former Chair of the London Network of Directors of Adult Social Services and Chair of the Adult Social Care Joint Improvement Programme. He has pioneered extra care sheltered accommodation, providing an alternative to residential care and is the trustee of Standing Together Against Domestic Violence.

Committee membership: Finance, Resources and Investments and Workforce.

Richard Milner

Deputy Chief Executive (Operations)

Richard Milner oversees the clinical services provided for adults and children across the four London boroughs served by CLCH. Richard's priorities include: improving performance and transforming health and care for patients, in collaboration with partner organisations.

Prior to joining CLCH, Richard was Director of Service Development at North Middlesex University Hospital NHS Trust (NMUH); and before that was Director of Operations and Performance at Harrow Primary Care NHS Trust. His career began in management consulting, working at Booz Allen Hamilton.

Committee membership: Finance, Resources and Investments and Quality.

Ian Millar

Director of Finance, Performance and Corporate Resources

Ian Millar has substantial experience in both public and private sectors, combining the best of both cultures in the NHS, non-departmental public bodies, charities, housing, utilities and local government.

Prior to joining us, Ian advised Surrey & Sussex Commissioning Support Unit as their Strategic and Commercial Director and was Director of Resources and Performance at West Sussex County Council. Ian has also held non-executive directorships with Age UK Brighton, London housing provider Family Mosaic and Brighton & Hove City Housing.

Committee memberships: Finance, Resources and Investments and Workforce.

Louise Ashley

Chief Nurse and Director of Quality Governance

Louise Ashley trained as a general nurse at Chase Farm Hospital, as a children's nurse at Great Ormond Street Hospital, and as a health visitor in Tower Hamlets. She has worked across London at a variety of Trusts for the past 30 years, both in clinical and managerial roles. Louise has been a Director of Nursing/Chief Nurse since 2001 in a number of NHS Trusts and private healthcare providers. Louise completed her Masters Degree at the Tavistock Clinic in London in 2003. She is passionate about improving the quality of care for patients and enabling staff to work to their full potential. Louise is a Visiting Professor of Nursing at Bucks New University.

Committee membership: Quality and Workforce.

Dr Joanne Medhurst

Medical Director

Dr Joanne Medhurst was appointed as Medical Director in December 2012. Her previous role was as the Joint Managing Director and Medical Director of NHS South East London Bexley Business Support Unit. As well as overseeing the day-to-day running of the organisation, Joanne's specific areas of responsibility included clinical redesign, governance, safeguarding, medicines management, commissioning and the GP leadership.

Joanne is also a GP and has worked in Bexley for 17 years. She trained at Guy's Hospital and carried out her GP training in Bexley. She is interested in quality improvement and the role clinical leaders have in making quality improvement successful and sustainable.

Committee membership: Quality and Charitable Funds.

4 Section Four
Governance and Financial Review

Annual governance statement – 2014/15

1 Introduction

The NHS Trust Development Authority (TDA) Chief Executive, in his capacity as Accounting Officer for the NHS TDA, requires the Accountable Officer for Central London Community Healthcare NHS Trust (CLCH) to give assurance about the stewardship of the organisation. This annual governance statement will be included in the CLCH 2014/15 Annual Report and Accounts.

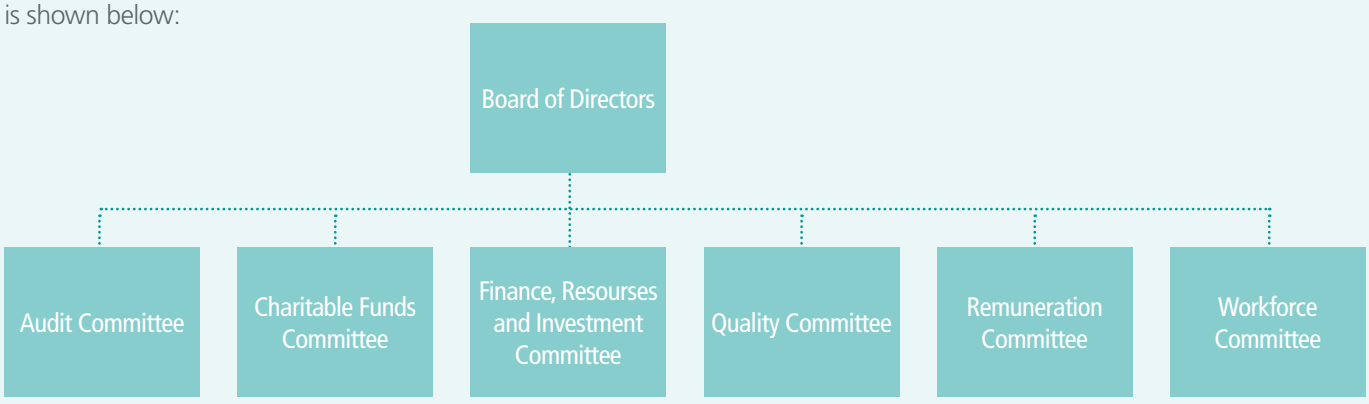
For CLCH the Accountable Officer is James Reilly, Chief Executive.

2 Scope of responsibility

The Board is ultimately responsible for internal control. As Accountable Officer and Chief Executive of the Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

3 Corporate governance framework

The board governance structure is shown below:



CLCH has sought to develop a positive relationship with local stakeholders, including the clinical commissioning groups and our partner organisations in order to provide high quality patient care. The Trust has worked closely with the TDA which is responsible for overseeing the performance management and governance of NHS Trusts, including clinical quality, and managing their progress towards foundation trust status. Performance against the national priorities set out in Delivering for Patients: the 2014/15 Accountability Framework for NHS trust boards is discussed at monthly integrated delivery meetings (IDM). Throughout the year, feedback from the TDA has remained very positive and agreed actions have been completed.

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 of Directors; minutes from Committees are included with Board papers and, where appropriate, published at **www.clch.nhs.uk**

All Committees have an agreed programme of work for the year.

Central London Community Healthcare NHS Trust is the Corporate Trustee of the CLCH NHS Trust Charity having been appointed on 22 December 2011. The Trust Board has devolved responsibility for the on-going management of funds to the Charitable Funds Committee, which administers the funds on behalf of the Corporate Trustee.

Issues highlighted by Committees of the Board during the year include issues in relation to:

Quality Committee:
Safety and Quality
The prevention and management of pressure ulcers; clinical record-keeping; waiting times by service; omitted doses; health and safety risk management and governance arrangements and vacancies particularly in relation to the delayed transfer of the nursing homes to a new provider.

Finance, Resources and Investment Committee:
Finance and Performance
Implementation of SystmOne; net new business; data quality and availability of information at a clinical business unit level; corporate and clinical transformation; capital expenditure; controls in relation to interim usage and other workforce key performance indicators; and delivery of cost improvement savings.

* The Board generally meets in public. When this is not possible due to reasons of confidentiality it excludes members of the public pursuant to the Public Bodies (Admission to Meetings) Act 1960. In their meetings, the Board of Directors regularly consider strategic, operational and assurance issues, including risk management. CLCH standing orders and standing financial instructions include the scheme of delegation and decisions reserved for the Board. The Board has had a full complement of substantive Executive and Non-Executive Directors throughout the year, with the exception of one NED post which was vacant from 28 March 2014 to 1 August 2014.

3.1 Board performance and development

In early 2015, Board members participated in a self-assessment showing good progress on the previous year; results will be used to inform the Board's development plan to support Board effectiveness which will remain a priority in 2015/16. Internal and external Board development and evaluation over the past two years has demonstrated a strong commitment to maintaining an engaged and effective Board.

Development during 2015 will build on this work, specifically in relation to the foundation trust curriculum, including:

- Stakeholder perceptions and unitary board (Excellence in Leadership)
- Preparation for authorisation
- Post authorisation development
- External stakeholder engagement
- Developing a positive organisational culture (ref King's Fund, Nov 2014).

The Board is compliant with the Code of Conduct and Code of Accountability for NHS Boards and Cabinet Office Corporate Governance Code and continues to work towards compliance with Monitor's Code of Governance in support of future foundation trust status.

A register of relevant and material Board member interests is maintained and published at www.clch.nhs.uk. Board and Committee meeting agendas routinely include an opportunity for members to declare any interests in agenda items, which are recorded in the minutes of the meeting and in a separate register. There have been no occasions during the year where a member has had to withdraw from the discussion or decision taken.

3.2 The role of the Board's Committees

3.2.1 Audit Committee

The Audit Committee is a standing committee of the Board. The role of the Committee is to support the Board of Directors and the Accounting Officer by reviewing the comprehensiveness, reliability and integrity of 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 2014/15:

- The Board Assurance Framework (BAF)
- IT infrastructure
- Monitoring the effectiveness of controls established for the on-going management of property assets transferred to CLCH and associated risks
- Implementation of the clinical business units
- The effectiveness of the programme management office
- Continuing to monitor the implementation of the data quality strategy and achievement of strategic aims.

3.2.2 Charitable Funds Committee

The Charitable Funds Committee has been established by the Board to make and monitor arrangements for the control and management of Trust's charitable funds. This work has been supported by an external review and training. 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 1993.

3.2.3 Finance, Resources and Investment Committee

The Finance, Resources and Investment Committee is responsible for seeking assurance regarding the control and management of the Trust's performance, finances, resources and investments. Duties of the Committee include: consideration of the finance strategy (revenue and capital) and overseeing the implementation of the Trust's procurement strategy, together with monitoring the key financial outcomes at business unit level.

3.2.4 Quality Committee

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 pillars of quality: safety; patient experience; and effectiveness and includes clinical risk management (monitoring risks to quality) and service user safety. As part of this, the Committee reviews and agrees the annual clinical audit plan, quality account and clinical framework.

3.2.5 Remuneration Committee

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 leadership team capable of achieving our objectives for performance. The Committee has oversight of succession planning and senior staff pay and contractual arrangements.

3.2.6 Workforce Committee

The Workforce Committee was established in October 2014 and is responsible for seeking assurance on the appropriateness of the workforce strategy and its implementation in support of NHS service modernisation.

3.3 Board and Committee attendance

Summary attendance by members of Board and Committee meetings during 2014/15 is shown in table 1 below[1]:

In August 2014, we welcomed Dr Carol Cole to the Board as a Non-Executive Director. There have been no other changes to the composition of the Board during 2014/15 and there are no vacancies.

The Executive Leadership 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.

Each Committee is required to consider how well it has performed during the year against the objectives as set out in their terms of reference and annual work plan.

3.4 Quality governance

The Trust's Clinical Framework provides a plan for the way in which services will be delivered over the next few years. The Trust recognises that it must change its models of care to continue to meet the needs of the patients and commissioners. The Quality Strategy supports the Trust's objectives and Clinical Framework by clearly defining our vision and success criteria for maintaining and improving quality through all our services. The annual Quality Account, published in June annually, defines the Trust's annual quality objectives, linked to the objectives in Quality Strategy, and provides a public report on the success year on year of our plans. We have commissioned an external audit of our 2014/15 Quality Account and this work will be undertaken in July 2015 for report to the Quality Committee and Audit Committee.

Table 1

	Board of Directors	Audit Committee	Charitable Funds Committee	Finance, Resources and Investment Committee	Quality Committee	Remuneration Committee	Workforce Committee [2]
April 2014	10/11*	3/3	-	4/6	5/7*	-	-
May 2014	10/11*	-	-	6/6	6/7*	-	-
June 2014	10/11*	3/3	-	5/6	3/7*	3/3	-
July 2014	10/11*	-	-	6/6	-	-	-
August 2014	-	-	5/5	-	6/7	-	-
September 2014 [3]	11/11	-	-	-	-	-	-
September 2014	11/11	3/3	3/5	6/6	7/7	-	-
October 2014	10/11	-	-	5/6	6/7	2/3	5/6
November 2014 [4]	9/11	-	-	-	-	-	-
November 2014	8/11	3/3	-	6/6	6/7	-	-
December 2014	-	-	5/5	-	-	-	-
January 2015	9/11	3/3	-	6/6	7/7	-	-
February 2015	10/11	-	-	5/6	6/7	3/3	5/6
March 2015	10/11 [5]	-	4/5	6/6	7/7	-	-

[1] Part-attendance at meetings is included

* NED vacancy from April – August 2014

[2] Established October 2014

[3] Annual General Meeting – 18.09.14

[4] Extraordinary Board meeting – 20.11.14

[5] One member was unable to stay for the confidential meeting – therefore there were two directors absent

There are three quality 'Campaigns for Action'

- **Campaign One:** A Positive Patient Experience
- **Campaign Two:** Preventing Harm – including lessons from incidents
- **Campaign Three:** Smart, Effective Care – including clinical audit

These campaigns are directly linked to the Quality Committee's 'sub-groups': Patient Experience Group, Patient Safety and Risk Group and the Clinical Effectiveness Group.

During September 2014, Niche Consulting undertook an external assessment of the Trust's quality governance assurance framework (QGAF), scoring the Trust at 3.0. This meets the requirements of the assessment process for authorisation as a foundation trust. The Trust publishes the patient safety – serious incident report with every set of Board papers. This report includes action taken in response to serious incident investigation.

A revised, national, never events policy and framework was published in March 2015. CLCH 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. 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.

During the year the main area of concern was the number of grade 3 and 4 pressure ulcer cases, occurring among CLCH patients which is being actively managed.

3.5 Statutory duties

In addition to external audit, the Trust agreed a number of internal audits during the year to provide assurance in support of statutory functions and legal compliance, including: information governance, risk management, service transformation, cost improvement, clinical audit, data quality, workforce and financial reporting systems.

4 The risk and control framework

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. The risk management strategy was revised in 2014. Risk is considered from the perspectives of clinical risk, organisational risk and financial risk.

The Trust's risk management strategy sets out a plan for a standardised approach to 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. Risk assessment and grading of risks is based on the Trust risk matrix adapted for use from the AS/NZS 4360:1999 risk matrix and approved by the National Patient Safety Association (NPSA).

This evaluates 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 12 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 BAF.

The Board reviews the risk register (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.

The Executive Leadership Team (ELT) receives a monthly report on Board Assurance Framework risks and risks of 15 and above. The Patient Safety Group, which includes representatives from all divisions, reviews all risks 12 and above including ratification, updates and closure.

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 and five-year integrated business 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.

Major strategic risks in 2014/15 included: the risk of not developing new business and growth, failure to achieve cost improvement plans, risks to quality and specific risks related to the implementation of the electronic healthcare record.

The BAF is reviewed regularly by ELT and considered quarterly by both the Audit Committee and Trust Board. Strategic risks, for example risks to the achievement of foundation trust status, are allocated to specific Executive Directors who have responsibility for ensuring that controls to mitigate these risks are effective,

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

5 Risk assessment

Risk management sits within the quality governance structure of the Trust.

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.

For the period - 1 April 2014 to 31 March 2015, 145 new risks were identified (compared to 486 in 2013/2014) and 231 risks were closed (compared to 204 in 2013/2014). This reflects the significant work undertaken to improve and embed our risk management arrangements.

Currently there are 13 BAF risks opened on the risk register, 3 of which were opened in the period 2014/15.

New Risks Opened (excludes BAF)

Category	Total
Clinical (this includes Infection Prevention (4), Medicines Management (2) and Safeguarding (0)	72
Environment	3
Finance, Performance, Contracts and Strategy	25
Fire, Health and Safety	12
Information Governance	5
Information Management and Technology	11
Medical Directorate	1
Reputational	6
Workforce	10
Total	**145**

Risks Closed

Category	Total
Clinical (this includes Infection Prevention (4), Medicines Management (2) and Safeguarding (0)	90
Environment	2
Finance, Performance, Contracts and Strategy	2
Fire, Health and Safety	63
Information Governance	13
Information Management and Technology	4
Medical Directorate	11
Reputational	10
Workforce	36
Total	**231**

BAF Risks Opened

Category	Total
Clinical	1
Information Governance	1
Workforce	1
Total	**3**

5.1 Summary of data security lapses, including any that were reported to the Information Commissioner

There have been 7 data security incidents during the year compared to 8 in 2013/14. Four of these relate to information being disclosed to an unintended recipient and 3 relate to the inadequate protection of information. These 7 incidents were of a severity that required reporting to the Information Commissioner's Office (ICO).

In the summer of 2014, CLCH invited the Information Commissioner's Office (ICO) to carry out a voluntary data protection audit of our systems for managing and storing personal data and records management. The result of the audit was a finding of limited assurance, however with some areas of good practice and some areas for improvement. Following the audit we put in place a robust action plan to ensure consistently good systems are in place across the Trust and our actions have been commended by the ICO's office - *"We are very pleased to note the significant progress made by CLCH in meeting and in many areas completing or exceeding the action plan…. To have made so much progress in such a short space of time is to CLCH's credit"*.

We remain committed to maintaining and further improving our information governance systems, building on this positive outcome.

6 Review of the effectiveness of risk management and internal control

In addition to the role of the Board 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 internal audit undertook a review of the Trust's Board Assurance Framework which confirmed substantial assurance with positive risk management findings at both a strategic and operational level.

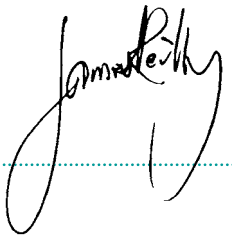
The Head of Internal Audit Opinion is provided annually and comments on the audit programme for the year. During 2014/15 an opinion of "reasonable assurance" was provided.

In its Annual Report the Audit Committee indicated 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 and noted continued improvement in the active monitoring of the BAF and risk register.

As Accountable Officer, my conclusion is that the risk management process is effective and has been improved by the recommendations identified within the internal audit report.

7 Significant issues

There have been no significant issues raised by internal audit during the year.



Signed
James Reilly

Date: 2 June 2015

Sustainability Report

We are committed to delivering a clear programme of sustainable development across our services. Our plan takes its cue from the Good Corporate Citizenship (GCC) model to developing a comprehensive and balanced approach that covers:

- Transport
- Procurement
- Facilities management
- Employment and skills
- Community engagement
- New buildings

A sustainability policy is agreed by our Board, and our sustainability steering group, meets quarterly to support and monitor the implementation of the plan.

We will continue to implement our sustainability plan through the recruitment of sustainability champions. These champions will help to not only raise awareness of sustainability in their own service areas, but help to promote these values across our network. Being focussed on community healthcare, travel to patients' homes is a key part of what we do and we are developing a 'green travel plan' that will help to reduce our overall carbon footprint.

A number of core transformation projects underway across the trust will help us to address sustainability issues, including:

- Estates reviews to reduce the Trust's overall footprint and make better use of the sites we either own or lease.

- Mobile working programme which will improve how staff can work whilst away from their work base and reduce the amount of travel. Video conferencing systems have also been set up to help reduce travel between our key sites.

- A managed print service which will co-ordinate a consistent and efficient approach to the use of printers and external design/print services across the Trust.

NHS Property Services Ltd provides facilities services and property management to the majority of our estates. NHS Property Services has a clear focus on sustainability and we at CLCH benefit from its national initiatives and investment.

Emergency Preparedness

The Trust has a dedicated team which leads on resilience issues and working with colleagues across CLCH they have taken forward our emergency planning, resilience and response work in the last year. Specific activities include:

- Participating in the NHS England assurance process 2014, receiving positive feedback on our arrangements with an overall result of substantial assurance
- Development of a Business Continuity e-form in order for services to complete Business Impact Analyses to aid and inform the development of service Business Continuity Plans
- Successfully utilising and updating the Trust's all staff emergency notification system, meaning all CLCH mobile phones are now on the contact list and all staff who volunteer to have their personal mobile phone added will also receive messages in an emergency
- Delivering Executives' Awareness, Tactical Support Adviser and internal on-call training to key staff, including the Chief Executive Officer, Trust Secretary and members of the Director and Senior Manager on-call rotas
- Working with Human Resources and Operations colleagues in planning for and responding to NHS industrial action.
- Working with the Infection Prevention team on the Ebola Virus Disease management plan and reporting to NHS England.

Financial overview

CLCH, as a publicly funded organisation, has a responsibility to demonstrate value for money in its activities by focusing resources in expenditures and investments that;

- guarantee quality at the most affordable cost;
- ensure that services that the public and our commissioners want are delivered safely and efficiently; and
- give children a better start and adults greater independence.

Our Earnings before Interest Tax Depreciation and Amortisation (EBITDA) for the year ended 31 March 2015 were £6,400k which equates to a 3.2% gross margin (2013/14: £4,595k, 2.3% gross margin). The increase of £1,805k in our current year EBITDA over the previous year is as a result of £2,218k increase in revenue which is offset by £413k further costs of generating this additional revenue. Also, our gross margin has increased during the year when compared to previous year as we continued to improve our business to ensure that we offer a high quality and safe service that can successfully compete in the healthcare marketplace.

The Trust had capital and reserves totalling £42,183k at 31 March 2015 (2013/14: £39,895k). Our capital and reserves have risen by £2,288k during the year; the increase is attributable to net profit retained for the year (£1,836k) and a gain on the revaluation of our land and buildings.

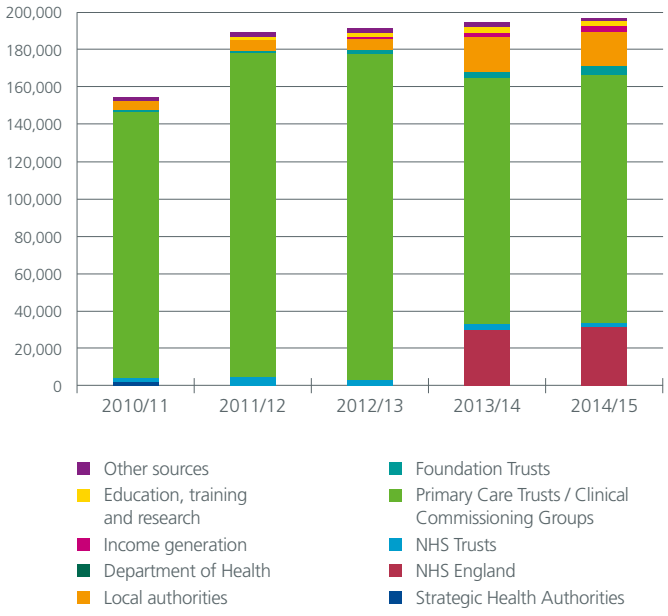
The Trust delivered a full year surplus of £1,836k (2013/14: £1,915k), £3k (or less than 1%) more than set out in our annual plan for the year. This surplus was possible as a result of the innovation and diligence shown by the Trust's staff against a back drop of ongoing corporate and clinical transformation programmes as we continue to restructure frontline and corporate services within the Trust and is a testament to the commitment shown by the Trust's staff to making every penny spent count whilst delivering the best possible care. We will continue to monitor all known cost pressures, notably around agency costs, improving staff productivity through the transformation programme and better purchasing by using our buyers to renegotiate more favourable prices from suppliers.

The Trust's working capital remains a source of strength and ensures that the Trust is both a good place 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 our future. At 31 March 2015 the Trust had cash balances of £24,034k (2013/14: £13,968k), sufficient to pay for 45 days of the Trust's operating expenditure. The increase in cash position from the prior year is temporary and has arisen as a result of unpaid rent due to on-going discussions with our landlord on providing information to validate charges. During the year the Trust continued to carefully manage its working capital, outstanding receivables and payables. This management enabled the Trust to invest £6,933k during 2014/15 (2013/14: £7,264k) in information technology infrastructure, estates maintenance and medical equipment used by our clinical and support staff.

Income

Our operating income (which excludes interest income) for the year to 31 March 2015 was £198,409k (2013/14: £196,191k) which came from the following sources:

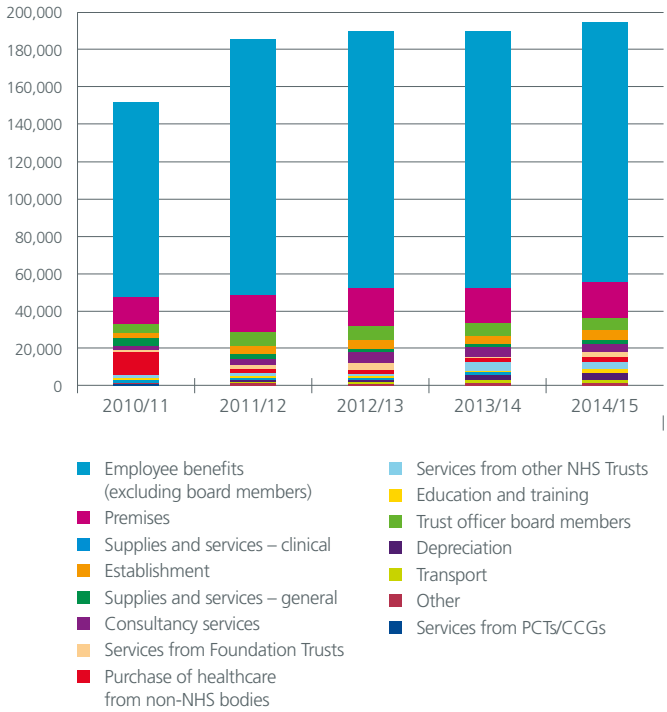
Source of Trust Income, £000



Expenditure

Our operating expenditure (which does not include financing costs) for the year to 31 March 2015 was £196,016k (2013/14: £194,326k) and was spent in the following areas:

Source of Trust Expenditure, £000



We have no income due from private patients ordinarily resident in the UK but we generate income from overseas patients without reciprocal agreements.

Treasury policies and objectives and liquidity of the Trust

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

The Trust's treasury philosophy is that the security and safety of public funds is paramount. Within this secure environment, the Trust ensures that it manages public funds to provide liquidity to discharge its obligations on a timely basis. Only when these two objectives are achieved can the Trust invest surplus funds. Our performance in paying our liabilities as they fall due has improved significantly from the previous year and can be seen in our performance against the targets set by the Better Payment Practice Code, which is detailed below in our Financial Statements. This performance gives the Trust confidence that it understands the timing of its payables and that they can be discharged when they fall due.

Our working capital management performance against target:

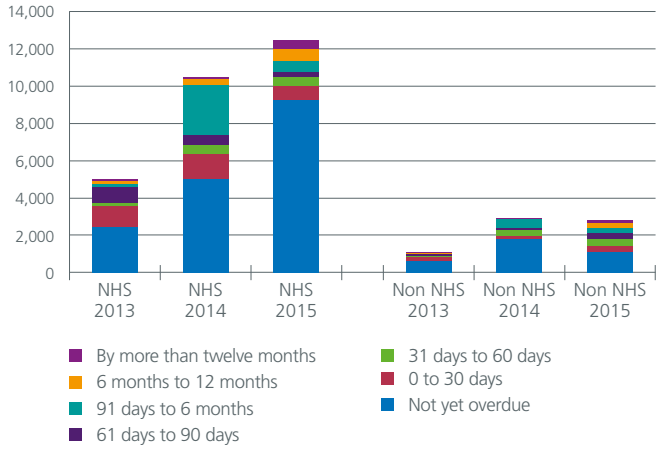
	31 March 2015	31 March 2014	Target
Receivables uncollected over 90 days past due	9%	27%	5%
Payables unpaid over 90 days past due	37%	10%	5%

We acknowledge that whilst it remains reasonable when benchmarked against the performance of our peers, we did not achieve the target on the percentage % of Receivables uncollected over 90 days past due and Payables unpaid over 90 days past due. The Receivables uncollected over 90 days past due is due to delays in payment by CCGs for Walk-in-Centre and Urgent Care Centre charges due to the time it takes to provide them with information to validate charges, long overdue payments from an NHSFT for PACE invoices and Local Authorities taking longer to pay their SLA invoices due to restructuring. We have a plan in place to further improve our performance during 2015/16. The underperformance on Payables unpaid over 90 days past due is as a result of unpaid rent invoices due to on-going discussions with our land lord on providing information to validate their charges.

CLCH has a track record of recovering amounts owed. During 2014/15 the Trust wrote off £4k (2013/14: £1k) of amounts due as at 31 March 2015 and has a provision against unrecoverable debts of £438k (2013/14: £344k). The Trust had a robust cash position throughout the year which enabled it to invest surplus funds and accrue interest. Interest earned during 2014/15 totalled £79k (2013/14: £55k). Much of the cash balance brought forward is allocated to meet existing financial commitments and fund future service developments.

The Trust has £14,250k receivable from NHS and non-NHS bodies at 31 March 2015 (31 March 2014: £13,726k). The age of this debt is as follows:

Age of outstanding receivables at 31 March



This chart reflects an overall increase in our NHS debtors when compared to previous years. This is as a result of invoices which were not yet due for payment at the time of reporting and for which we have plans in place to collect in 2015/16. Increase in Non-NHS receivables is due to more services being commissioned from Non-NHS commissioners.

Key Metric – Continuity of Service Risk Rating

From 1 October 2013 the Compliance Framework was replaced by the Risk Assessment Framework. In this Monitor has simplified its approach to focus on risk of financial failure, rather than overall financial position of organisations. They have also made this risk assessment more explicitly forward-looking. The Continuity of Services Risk Rating ("CSRR") comprises two equally weighted financial metrics:

- **Liquidity:** This ratio indicates whether the provider can meet its operational cash obligations, i.e. its liquidity (expressed in days of liquid assets i.e. net assets/cash*365); and

- **Capital Servicing Capacity ("CSC"):** This ratio indicates whether the provider can meet its financing obligations, i.e. its ability to service debts or other financing obligations (including PDC dividends, interest and debt repayment and Private Finance Initiative capital and interest payments. It is calculated as EBITDA / (PDC dividend + finance interest)).

The Trust achieved the maximum financial risk rating of '4' out of '4' for both individual metrics, plus the overall weighted rating throughout 2014/15.

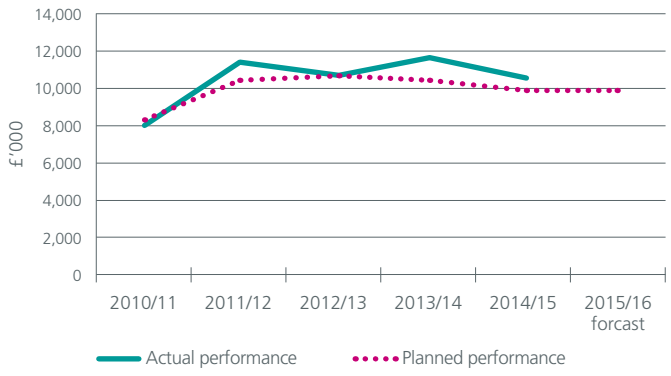
Cost Improvement Programme and Transformation programme (Quality, Innovation, Productivity and Prevention – QIPP)

The QIPP target for 2014/15 was £11,958k gross and £9,932k net of planned contingency (2013/14: £10,421k) representing 5.5% (2013/14: 5.5%) of total operating expenditure for the financial year. The Trust initially identified potential QIPP schemes with a value of £12,700k, which were put through a rigorous quality and risk assessment process leading to some of the initially identified schemes not being implemented. In total the Trust delivered £10,578k of QIPP during the year meaning it has achieved its target net of planned contingency. Of this, £8,800k has been achieved through recurrent schemes (which have a full year recurrent value of £10,427k), with the remainder being delivered on a non-recurrent basis. The gap in recurrent QIPP achievement is being addressed in business planning for 2015/16.

Areas of significant improvements in the financial year include estates rationalisation (£1,200k), staff productivity review (£4,000k), transformation of frontline services (£2,400k) and improved purchasing (£1,600k).

In the Trust's fifth year of existence we have again demonstrated an ability to safely deliver substantial cost savings and will do so in the future. It is anticipated that a further £11m of efficiencies will be delivered over the next financial year as we continue to make the Trust as efficient as possible.

Cost Improvemet Programme: Actual v Plan



The Cost Improvement programme is essential to deliver services within the financial revenues agreed with commissioners and to deliver a surplus that will be reinvested in developments in line with our service strategy. It will support us to succeed as a provider of choice in a more competitive market environment. It will also create a financial contingency against the risks which we face. The 2015/16 programme comprises of Trust wide transformational initiatives focusing on estates rationalisation, mobile working and workforce modernisation. This will be supplemented by local directorate schemes all of which should enhance efficiency and effectiveness at lower costs with minimal reduction in income. This programme will be delivered whilst maintaining the safety or quality of our services which is assured by our process of Quality Impact Assessments undertaken by the Trust Medical Director and Chief Nurse and Director of Quality Governance.

Financing and investment

During 2014/15 we made significant investments in a new Patient Administration System (PAS), in information technology infrastructure and carried out backlog maintenance in our clinical areas. These investments are core to how we will achieve our QIPP programme over the coming years. It will demonstrably improve our productivity and free both clinical time and financial resources to focus on improving patient care. Our 2014/15 investment programme totalled £6,933k (2013/14: £7,264k). The most significant investments were:

- £1,032k spend on improvements to the Trust's estates and in ensuring that the clinical areas are compliant with requirements to deliver our services to safe standards while still complying with the requirements of the Care Quality Commission (CQC);
- £2,621k in replacing our core Patient Administration System and £566k in creating a scalable interoperable solution across core CLCH PAS and PAS of major partners across the boroughs we currently serve;
- £827k in providing secure WAN and WIFI infrastructure across CLCH sites and £187K in connecting services at Hertfordshire to the CLCH IT infrastructure;
- £668k expenditure on pilot phase of mobile computing infrastructure to ensure clinical and support staff can easily access fast wireless internet connection via various devices while working in a mobile or remote manner; and
- £236k spend on modern medical devices including ultrasound scanners, bladder scanners, falls monitoring equipment and micro loop spirometers.

We have identified a number of areas where future investment will help us achieve our objectives and meet the aspirations of all of our stakeholders. These areas include mobile working infrastructure, Voice-Over-Internet-Protocol (VOIP), estates backlog maintenance, completion of SystmOne deployment across the Trust and creating an interoperable platform between our PAS and those used by our healthcare partners (CCGs, GPs and other providers).

Political and charitable donations

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

Pension Liabilities

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

The Trust does not reflect in its financial statements any NHS Pension scheme assets or liabilities attributable to scheme members who are employed by the Trust. There is £1,511k in respect of outstanding NHS Pension contributions at 31 March 2015 (31 March 2014: £1,668k).

Disclosure of information to Auditors

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

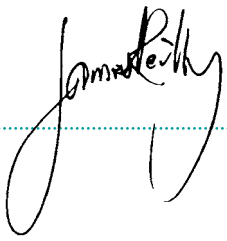
Our annual accounts

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

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

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

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



James Reilly
Chief Executive

Ian Millar
Director of Finance,
Performance and Corporate Resources

Remuneration 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 2015.

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.

Remuneration Committee

The Remuneration Committee is made up of the Chairman and two Non-Executive Directors of the Trust Board as voting members: the Head of Human Resources and Chief Executive are attendees. The Committee meets as necessary to advise the Board on the appropriate remuneration and terms of service for the Chief Executive and Executive Directors.

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 are set out below.

Basic Salary

Executive Directors and senior managers with remuneration set by the Very Senior Managers' Pay Framework

The remuneration of all executive directors and co-opted directors with continuing service with the Trust is set by the Very Senior Managers' Pay Framework.

The reward package set by the Very Senior Managers' Pay Framework is as follows:

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

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

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

Executive Directors and senior managers with remuneration paid via an agency

The Trust paid the remuneration of no board member via an agency during 2014/15 (2013/14: 0).

Executive Directors and senior managers with remuneration set by Agenda for Change, the national pay and terms and conditions framework for the NHS

During 2014/15 no Executive Director's remuneration was set by Agenda for Change, the national pay and terms and conditions framework for the NHS (2013/14: one).

Agenda for Change Handbook and the Very Senior Managers Framework are available to the general public on the Department of Health website.

Incentive Arrangements

During 2008/09 the Department of Health implemented a performance related pay scheme for Very Senior Managers' contracts (VSM).

As part of these pay arrangements those CLCH employees on a VSM contract are eligible to be considered for a performance related bonus scheme. The Trust has opted for a policy not to make performance payments.

No performance bonuses awards were paid by CLCH during 2014/15 or 2013/14.

NHS Pension Entitlement

All staff including senior managers are eligible to join the NHS Pensions Scheme. The Scheme has fixed the employer's contribution at 14% (2013/14: 14%) of the individual's salary as per the NHS Pension Agency Regulations. Employee contribution rates for Trust officers and practice staff, and the prior year comparators, are as follows:

Tier	Annual Pensionable Pay (full time equivalent)	Contribution Rate 2014/15	Contribution Rate 2013/14
1	Up to £15,431.99	5.3%	5.0%
2	£15,432.00 to £21,387.99	5.6%	5.3%
3	£21,138.00 to £26,823.99	7.1%	6.8%
4	£26,824.00 to £49,472.99	9.3%	9.0%
5	£49,473.00 to £70,630.99	12.5%	11.3%
6	£70,631.00 to £111,376.99	13.5%	12.3%
7	£111,377.00 plus	14.5%	13.3%

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

Service Contracts

Each of the Executive 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:

Director	Role	Contract Date	Leave date
Jon Bell (a)	Director Finance and Performance	4/01/2010	30/09/2013
Mark Hirst (b)	Director of Human Resources and Organisational Development	1/09/2008	31/03/2014
Dr. Joanne Medhurst	Medical Director	14/01/2013	-
Ian Millar (c)	Director of Finance, Performance and Corporate Resources	22/08/2013	-
Satish Mathur (d)	Director of Corporate Services	4/02/2013	30/06/2013
Richard Szadziewski (d)	Director of Corporate Services	1/07/2013	31/08/2013
Richard Milner	Deputy Chief Executive	28/01/2013	-
Louise Ashley (e)	Chief Nurse and Director of Quality Governance	21/11/2012	-
James Reilly	Chief Executive	14/02/2011	-

a) Mr Jon Bell left the Trust on 30 September 2013.

b) Mr Mark Hirst left the Trust on 31 March 2014.

c) Ian Millar joined the Trust on 22 August 2013 as the Director of Finance, Performance and Corporate Resources, combining the duties previously performed by the Director of Finance and Performance, the Director of Strategy and Business Development and the Director of Corporate Services.

d) Mr Satish Mathur left the Trust on 30 June 2013 and was replaced by Mr Richard Szadziewski. Mr Richard Szadziewski joined the Trust on 1 July 2013 as acting Director of Corporate Services until 31 August 2013.

e) Louise Ashley joined the Trust as a substantive Director from 1 April 2013. Prior to this date she was a Director of the Trust but employed via an employment agency.

None of the service contracts for Executive Directors or senior managers make any provision for compensation outside of the national pay and remuneration guidelines or NHS Pension Scheme Regulations.

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.

Salaries direct to limited companies

The Trust has a policy that all substantive staff are paid through the payroll. During 2014/15, no Board member's remuneration was paid direct to a limited company wholly or partly owned by the member (2013/14: one). The Trust paid the remuneration of the Director of Corporate Services direct to a limited company wholly or partly owned by him during the financial year 2013/14.

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 2014/15 was £165,000 to £170,000 (2013/14: £170,000 to £175,000). The reduction was due to salary sacrificed under the leased car scheme. This was five times (2013/14: five times) the median remuneration of the workforce, which was £30,925 (2013/14: £31,679).

In 2014-15, no employee (2013-14: nil) received remuneration in excess of the highest-paid director. The highest paid Director during 2014/15 was the Trust's Chief Executive. Remuneration paid to employees during 2014/15 ranged from £19,000 to £167,000 (2013/14 £19,000 to £175,000).

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.

Non-Executive Directors

Non-Executive Directors do not have service contracts. They are appointed by the NHS Trust Development Authority 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 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 Date	Leave date
Anne Barnard	Non-Executive Director	1/04/2010	-
Julia Bond	Non-Executive Director	17/12/2009	-
Tony Brown	Non-Executive Director	28/04/2011	-
Pamela Chesters	Board Chairman	1/06/2012	-
Alexa McCulloch (a)	Non-Executive Director	17/12/2009	31/03/2014
David Sines	Non-Executive Director	27/06/2012	-
Carol Cole (b)	Non-Executive Director	1/08/2014	-

a) Alexa McCulloch left the Trust on 31 March 2014; and

b) Carol Cole joined the Trust as a Non-executive Director on 1 August 2014.

Directors' and Very Senior Managers' Salaries and allowances – audited

Name and Title	2014/15					2013/14				
	Salary (bands of £5,000)	Bonus payments (bands of £5,000)	Benefits in Kind (bands of £100)	Other Remuneration (bands of £5,000)	Total (bands of £5,000)	Salary (bands of £5,000)	Bonus payments (bands of £5,000)	Benefits in Kind (bands of £100)	Other Remuneration (bands of £5,000)	Total (bands of £5,000)
Executive Directors										
Louise Ashley (Chief Nurse and Director of Quality Governance)	110-115	0	0	0	110-115	110-115	0	0	0	110-115
Mark Hirst (Director of Human Resources & Organisational Development)	0	0	0	0	0	105-110	0	0	0	105-110
James Reilly (Chief Executive from 15 February 2011)	165-170	0	0	0	165-170	170-175	0	0	0	170-175
Jon Bell (Director of Finance and Performance)	0	0	0	0	0	60-65	0	0	0	60-65
Satish Mathur (Director of Corporate Services)	0	0	0	0	0	60-65	0	0	0	60-65
Richard Milner (Deputy Chief Executive and Director of Operations)	110-115	0	0	0	110-115	125-130	0	0	0	125-130
Dr. Joanne Medhurst (Medical Director from 15 January 2013) (a)	75-80	0	0	0	75-80	65-70	0	0	0	65-70
Ian Millar (Director of Finance, Performance and Corporate Resources from 22 August 2013)	125-130	0	0	0	125-130	75-80	0	0	0	75-80
Non-Executive Directors										
Tony Brown (Non-Executive Director)	5-10	0	0	0	5-10	5-10	0	0	0	5-10
Alexa McCulloch (Non-Executive Director)	0	0	0	0	0	5-10	0	0	0	5-10
Pam Chesters (Board Chairman)	20-25	0	0	0	20-25	20-25	0	0	0	20-25
Anne Barnard (Non-Executive Director and Chairman of the Audit Committee)	5-10	0	0	0	5-10	5-10	0	0	0	5-10
Julia Bond (Non-Executive Director)	5-10	0	0	0	5-10	5-10	0	0	0	5-10
Professor David Sines (Non-Executive Director)	5-10	0	0	0	5-10	5-10	0	0	0	5-10
Dr. Carole Cole (Non-Executive Director)	0-5	0	0	0	0-5	0	0	0	0	0

a) Dr Joanne Medhurst works part-time for the Trust and this is reflected in her salary banding.

Directors' and Very Senior Managers' Pension Benefits – unaudited

Name and Title	Real increase/ (decrease) in pension at age 60 (bands of £2,500)	Real increase/ (decrease) in pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2015 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2015 - £'000 (Note d)	Cash Equivalent Transfer Value at 31 March 2014 (Noted)	Real increase/ (decrease) in Cash Equivalent Transfer Value £000 (Note e)	Employer's contribution to stakeholder pension (£000)	Total pension entitlement at 31 March 2015 (Bands of £5,000)
Dr. Joanne Medhurst (Medical Director from 15 January 2013)	0-2.5	0-2.5	15-20	50-55	315	289	19	0	15-20
Richard Milner (Deputy Chief Executive and Director of Operations)	0-2.5	0-2.5	15-20	50-55	247	157	9	0	15-20
James Reilly (Chief Executive from 15 February 2011)	2.5-5	0	5-10	0	95	16	38	0	5-10
Ian Millar (Director of Finance, Performance and Corporate Resources from 22 August 2013)	0-2.5	0	5-10	0	47	0	30	0	5-10
Louise Ashley (Chief Nurse and Director of Quality Governance)	0-2.5	0-2.5	20-25	65-70	416	0	0	0	20-25

Notes

a) Mr Ian Millar and Mr James Reilly are in the 2008 NHS pension scheme and do not automatically accrue a lump sum on retirement.

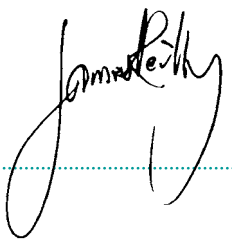
b) Non-Executive members do not receive pensionable remuneration. There are no payments in respect of pensions for Non-Executive members (2013/14: £nil).

c) During 2014/15 the Trust paid no employer's contribution into Director's personal pension plans (2013/14: £nil).

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

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

f) The 2014/15 Pension, Lump Sum and CETV for Dr Joanne Medhurst exclude Practitioner (i.e. GP) pension benefits. Prior year figures (Pension £35k, Lump Sum £104k and CETV £588k) have been restated to reflect this adjustment.



Signed
James Reilly

Date: 2 June 2015
(On behalf of the Board)

Financial statements
For the 12 months ended 31 March 2015

Foreword to the accounts

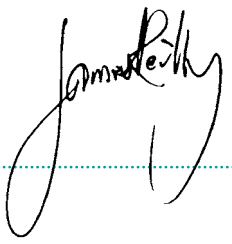
These accounts for the 12 months ended 31 March 2015 have been prepared by the Central London Community Healthcare NHS Trust under Section 98 (2) of the National Health Service Act 1977 in the form which the Secretary of State has, with the approval of the Treasury, directed.

Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers' Memorandum issued by the Chief Executive of the NHS Trust Development Authority. 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 with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

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



Signed
James Reilly

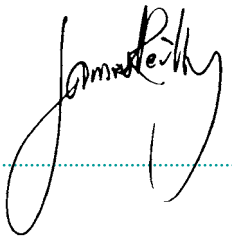
Date: 2 June 2015

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 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 judgements 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.



Signed
James Reilly

Date: 2 June 2015

Signed
Director of Finance, Performance and Corporate Resources

Date: 2 June 2015

Independent Auditor's Report to the Board of Directors of Central London Community Healthcare NHS Trust

We have audited the financial statements of Central London Community Healthcare NHS Trust for the year ended 31 March 2015 on pages 19 to 57. These financial statements have been prepared under applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England. We have also audited the information in the Remuneration Report that is subject to audit.

This report is made solely to the Board of Directors of Central London Community Healthcare NHS Trust, as a body, in accordance with Part II of the Audit Commission Act 1998. 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.

Respective responsibilities of Directors and auditor

As explained more fully in the Statement of Directors' Responsibilities set out on page 15, the Directors are responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Directors; and the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2015 and of the Trust's expenditure and income 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 relevant to NHS Trusts in England.

Opinion on other matters prescribed by the Code of Audit Practice 2010 for local NHS bodies

In our opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England; and
- the information given in the Strategic Report and Director's Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Code of Audit Practice 2010 for local NHS bodies requires us to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with the NHS Trust Development Authority guidance;
- any referrals to the Secretary of State have been made under section 19 of the Audit Commission Act 1998; or

- any matters have been reported in the public interest under the Audit Commission Act 1998 in the course of, or at the end of the audit.

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Respective responsibilities of the Trust and auditor

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

We report if significant matters have come to our attention which prevent us from concluding that the Trust has put in place 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 its use of resources are operating effectively.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our work in accordance with the Code of Audit Practice 2010 for local NHS bodies, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2014, as to whether the Trust has proper arrangements for:

- securing financial resilience; and
- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those necessary for us to consider under the Code of Audit Practice 2010 for local NHS bodies in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2015.

We planned and performed our work in accordance with the Code of Audit Practice 2010 for local NHS bodies. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all material respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2014, we are satisfied that, in all material respects, Central London Community Healthcare NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2015.

Certificate

We certify that we have completed the audit of the accounts of Central London Community Healthcare NHS Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission.

Signed

Neil Hewitson
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
15 Canada Square
London
E14 5GL
2 June 2015

Statement of Comprehensive Income for the year ended 31 March 2015

	Notes	2014/15 £'000	2013/14 £'000
Revenue			
Revenue from patient care activities	5	**192,054**	189,289
Other operating revenue	6	**6,355**	6,902
Employee benefits	7/9	**(140,124)**	(142,755)
Other operating expenses	7	**(55,892)**	(51,571)
Operating surplus/(deficit)		**2,393**	1,865
Finance income/(costs)			
Investment revenue	12	**79**	55
Other gains and losses		**(4)**	0
Finance costs	13	**(6)**	(5)
Surplus/(deficit) for the financial year		**2,462**	1,915
Public dividend capital dividends payable		**(626)**	0
Retained surplus/(deficit) for the year		**1,836**	1,915
Other comprehensive income			
Net gain/(loss) on revaluation of property, plant, equipment	14	**452**	872
Total comprehensive income for the year		**2,288**	2,787

The notes on pages 62 to 92 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 2015

	Notes	31-Mar-15 £'000	31-Mar-14 £'000
Non-current assets:			
Property, plant, and equipment	14	**35,928**	35,551
Intangible assets	15	**6,842**	3,893
Trade and other receivables	16	**0**	0
Total non-current assets		**42,770**	39,444
Current assets:			
Inventories		**0**	0
Trade and other receivables	16	**18,291**	15,107
Cash and cash equivalents	18	**24,034**	13,968
Total current assets		**42,325**	29,075
Total assets		**85,095**	68,519
Current liabilities:			
Trade and other payables	19	**(37,304)**	(23,223)
Provisions	21	**(4,983)**	(4,769)
Total current liabilities		**(42,287)**	(27,992)
Net current assets		**38**	1,083
Total assets less current liabilities		**42,808**	40,527
Non-current liabilities:			
Provisions	21	**(625)**	(632)
Total non-current liabilities		**(625)**	(632)
Total assets employed:		**42,183**	39,895
Financed by: Taxpayers' equity			
Public Dividend Capital		**202**	202
Retained Surplus		**33,536**	31,700
Revaluation Reserve		**8,445**	7,993
Total taxpayers' equity		**42,183**	39,895

The notes on pages 62 to 92 form part of these accounts.

The financial statements on pages 56 to 92 and accompanying notes were approved by the Board on the 2nd June 2015 and signed on its behalf by:

Signed
James Reilly

Date: 2 June 2015

Signed
Director of Finance,
Performance and Corporate Resources

Date: 2 June 2015

Statement of changes in Taxpayers' Equity for the year ended 31 March 2015

	PDC £'000	Retained Surplus £'000	Revaluation Reserve £'000	Total Reserves £'000
Balance at 31 March 2014	**202**	**31,700**	**7,993**	**39,895**
Retained surplus/(deficit) for the year	0	1,836	0	1,836
Net gain/ (loss) on revaluation of property, plant and equipment	0	0	452	452
Revaluation reserves	0	0	0	0
New PDC received - Items paid by Department of Health	0	0	0	0
Transfers between reserves in respect of modified absorption - PCTs & SHAs	0	0	0	0
Movements between reserves	0	0	0	0
Balance at 31 March 2015	**202**	**33,536**	**8,445**	**42,183**

The notes on pages 62to 92 form part of these financial statements.

These financial statements have been prepared using the NHS Manual of Accounts.

Retained Surpluses reflect the accumulated surpluses of CLCH since its inception plus those inherited from Barnet Community Service, Barnet PCT, Hammersmith and Fulham PCT, Kensington and Chelsea PCT and Westminster PCT.

Statement of Cash Flows for the year ended 31 March 2015

	2014/15 £'000	2013/14 £'000
Cash flows from operating activities		
Operating surplus/(deficit)	**2,393**	1,865
Depreciation and amortisation	**4,007**	2,730
Dividends (paid)/refunded	**(728)**	0
(Increase)/decrease in trade and other receivables	**(3,184)**	(6,013)
Increase/(decrease) in trade and other payables	**13,621**	6,883
Provisions utilised	**(3,336)**	(1,305)
Increase/(decrease) in provisions	**3,537**	1,246
Net cash inflow/(outflow) from operating activities	**16,310**	5,406
Cash flows from investing activities		
Interest received	**79**	55
Payments for property, plant and equipment	**(2,904)**	(3,622)
Payments for intangible assets	**(3,481)**	(3,406)
Proceeds of disposal of assets held for sale (PPE)	**48**	0
Rental revenue	**14**	33
Net cash inflow/(outflow) from investing activities	**6,244**	6,940
Net cash inflow/(outflow) before financing	**10,066**	(1,534)
Net cash inflow/(outflow) from financing		
Public Dividend Capital received	**0**	202
Net Cash inflow/(outflow) from financing activities	**0**	202
Net increase / (decrease) in cash and cash equivalents	**10,066**	(1,332)
Period opening cash and cash equivalents	**13,968**	15,300
Period closing cash and cash equivalents	**24,034**	13,968

The notes on pages 62 to 92 form part of these financial statements.

Notes to the accounts

Note 1 Principal Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the NHS Trusts Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2014-15 NHS Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual 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 NHS Trusts Manual for Accounts permits a choice of accounting policy, the accounting policy which 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 by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1 Movement of assets within the DH Group

Transfers as part of reorganisation are to be accounted for by use of absorption accounting in line with the Treasury 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 Statement of Changes in Taxpayers' Equity (SOCITE), and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS20 and similarly give rise to income and expenditure entries.

2 Accounting convention

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

3 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.

4 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from commissioners for healthcare services. The Trust has no partially completed spells at the financial reporting date.

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

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

5 Critical accounting judgments 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.

5a Critical judgments 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.

Provisions

The Trust's provisions at the balance sheet date relate to: redundancy costs arising due to a restructuring of the Trust's service delivery and clinical support functions; a provision for costs relating to the exit of an uneconomical contract; and a provision for future injury benefits payable to staff previously employed by the Trust. The Board does not believe these provisions are subject to the use of material judgments or estimation.

Leases

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.

5b 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.

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.

Provisions

The Trust's provisions at the balance sheet date relate to: redundancy costs arising from a restructuring of the Trust's service delivery and clinical support arrangements; to costs relating to the exit of an uneconomical contract; and a provision for future injury benefits payable to staff previously employed by the Trust. The Board does not believe these provisions are subject to the use of significant judgments or estimation. The Trust does not believe that it has material estimation uncertainty over the completeness of its provisions.

6 Inventories

Stocks comprise raw materials and consumables and are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to current cost due to the high turnover of stocks.

Work-in-progress comprises goods in intermediate stages of production.

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula.

7 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

8 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).

9 Clinical Negligence Costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust.

10 Employee benefits

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.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

11 Other Operating Expenses

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

12 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 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.

Until 31 March 2008, the depreciated replacement cost of specialised buildings was estimated for an exact replacement of the asset in its present location. 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.

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new 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 an 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.

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.

13 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), 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.

14 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.

The Trust as lessee

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

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

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated. Leased land is treated as an operating lease. Leased buildings are assessed as to whether they are operating or finance leases.

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.

15 Contingencies

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.

16 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 present value of those cash flows using HM Treasury's discount rate of 2.7% in real terms.

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

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

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

17 Financial Instruments

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.

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.

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.

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.

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.

18 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.

19 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.

20 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.

21 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.

22 Research and development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Operating Cost Statement on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

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.

24 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.

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

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2014/15. The application of the Standards as revised would not have a material impact on the accounts for 2014/15, were they applied in that year:

- IFRS 9 Financial Instruments – subject to consultation; and
- IFRS 13 Fair Value Measurement - subject to consultation.

Note 2 Authorisation of the Financial Statements

These financial statements were authorised for issue on 2 June 2015 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 healthcare to the population of the London Boroughs of Hammersmith and Fulham, Kensington and Chelsea, Westminster and Barnet and Hertfordshire. Community healthcare covers a wide range of services, including:

- Adult community nursing services, including 24 hour district nursing, community matrons and case management;
- Child and family services, including health visiting, school nursing, children's community nursing teams, speech and language therapy, haemaglobinopathy nursing and children's occupational therapy;
- Rehabilitation and therapies, including physiotherapy, occupational therapy, podiatry, speech and language therapy and osteopathy;
- Palliative care services;
- Offender health services;
- Continuing care services;
- Specialist services, including elements of long term condition management (diabetes, COPD, tissue viability, continence), phlebotomy, community dental services, diabetic retinal screening and sexual health & contraceptive services;
- Walk-in and minor injury services; and
- PMS and GPWSI (dermatology and musculo-skeletal).

The segment has been determined by the information presented to Trust's chief decision making body so that it can assess the financial performance of the Trust's business activities. The Trust's chief decision making body is the Board. 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.

	Revenue from customers £'000	Retained surplus for the period £'000	Interest revenue £'000	Interest expense £'000	Depreciation and amortisation £'000	Net gain/(loss) on revaluation of property, plant, equipment £'000
12 months to 31/3/2015	198,409	1,836	79	(6)	4,007	452
12 months to 31/3/2014	196,191	1,915	55	(5)	2,730	872

All income is earned in the provision of community healthcare to the population of the London Boroughs of Hammersmith and Fulham, Kensington and Chelsea, Westminster and Barnet and Hertfordshire.

No geographical analysis of income or expenditure has been prepared as income and expenditures earned and spent outside of the Trust's five core boroughs is not significant.

The Trust has five customers who individually account for over 10% of the Trust's turnover. These customers account for 78% 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:

	2014/15 £'000	2013/14 £'000
Barnet CCG	**33,669**	34,279
Central London (Westminster) CCG	**29,681**	29,428
Hammersmith And Fulham CCG	**20,644**	20,944
NHS England	**31,000**	29,456
West London (K&C & QPP) CCG	**36,996**	38,555

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

The Trust management reported to the Board, the chief decision making body, an aggregate surplus of £1,836K which was the final position disclosed above.

Note 4 Income generating activities

The Trust undertakes limited non-patient activity mainly relating to the provision of interpreting and occupational health services to public sector bodies, including Clinical Commission 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

	2014/15 £'000	2013/14 £'000
NHS England	**31,339**	29,764
NHS Trusts	**2,221**	3,830
Clinical Commission Groups/Primary Care Trusts	**134,465**	133,059
Foundation Trusts	**4,713**	2,513
Local Authorities	**18,850**	19,656
Department of Health	**42**	2
NHS other	**0**	0
Non-NHS:		
Injury cost recovery	**291**	257
Overseas patients (non-reciprocal)	**133**	208
	192,054	189,289

Revenue is almost exclusively from the supply of services. Revenue from the sale of goods is immaterial.

Overseas patient income relates to income received for treating overseas patients at the Trust's Walk in Centres.

Note 6 Other operating revenue

	2014/15 £'000	2013/14 £'000
Patient transport services	**0**	0
Education, training and research	**3,216**	3,226
Charitable and other contributions to expenditure	**115**	77
Non-patient care services to other bodies	**0**	0
Receipt of grants for capital acquisitions	**0**	180
Income generation	**2,352**	1,451
Rental revenue from finance leases	**0**	0
Rental revenue from operating leases	**14**	33
Other revenue	**658**	1,935
	6,355	6,902

Other income relates to income earned through the recharging of costs associated with speech and language therapists working in local schools, prescription charge income, and other miscellaneous income.

Note 7 Operating Expenses

7.1 Analysis of other operating expenses

	2014/15 £'000	2013/14 £'000
Services from other NHS Trusts	**3,799**	4,850
Services from Foundation Trusts	**3,172**	361
Purchase of healthcare from non NHS bodies	**2,665**	2,326
Trust chair and non-executive directors	**52**	54
Employee benefits – non board member	**139,110**	141,331
Employee benefits – board member	**1,014**	1,424
Supplies and services - clinical	**6,993**	7,319
Supplies and services - general	**1,983**	1,352
Consultancy services	**4,433**	5,410
Establishment	**5,033**	4,670
Transport	**1,814**	1,579
Premises	**18,791**	18,481
Hospitality	**13**	15
Insurance	**244**	236
Legal Fees	**256**	121
Provision for impairment of receivables	**98**	186
Depreciation	**2,475**	2,064
Amortisation	**1,532**	666
Audit fees	**69**	71
Other auditor's remuneration	**107**	158
Clinical negligence	**337**	411
Education and Training	**1,789**	957
Other	**237**	284
	196,016	194,326

Other costs incurred during 2014/15 relate to interpreting cost and other miscellaneous costs. Other auditor's remuneration relates to the cost of internal audit and local counter fraud services in 2014/15.

Note 8 Operating leases

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 following organisations:

- Westminster City Council, which leases CLCH its administrative headquarters at 64 Victoria Street, London, SW1E 6QP;
- Community Health Partnerships, which leases CLCH a number of properties in the London Borough of Barnet which are used for the provision of healthcare, including Finchley Memorial Hospital and Vale Drive Clinic; and
- NHS Property Services, which leases CLCH a number of properties which are used for the provision of healthcare, including Edgware Community Hospital, Grahame Park Health Centre, St Charles Hospital Urgent Care Centre and Princess Louise Nursing Home.

The lease between CLCH and Westminster City Council is a 10 year lease, running until 2019/20, with one rent review during its term. From March 2013 either party can exit the lease with six months' notice.

The Trust has no contingent rentals as the rental costs on all the properties occupied by CLCH as a lessee have been agreed. There are no unusual or onerous renewal restrictions within CLCH leases.

CLCH has also leased a small number of cars for its employees during the period. These leases were on an ad hoc basis and there is no material liability outstanding at the reporting date.

8.1 Trust as lessee

	2014/15 £'000	2013/14 £'000
Payments recognised as an expense:		
Minimum lease payments	**16,018**	11,685
Contingent rents	**0**	0
Sub-lease payments	**0**	0
Total	**16,018**	11,685
Payable:		
No later than one year	**16,354**	11,290
Between one and five years	**3,298**	4,054
After five years	**0**	0
Total	**19,652**	15,344

8.2 Trust as lessor

	2014/15 £'000	2013/14 £'000
Recognised as revenue	**14**	33
Rental revenue	**0**	0
Contingent rents	**0**	0
Total	**14**	33
Receivable:		
No later than one year	**14**	32
Between one and five years	**61**	144
After five years	**0**	0
Total	**75**	176

CLCH owns the freehold of nine properties and leasehold on eleven properties. CLCH is the landlord for other tenants in these properties. The tenancy agreements with the tenants on these properties are yet to be formalised. Rental income from these properties is based on the rates charged by the legacy PCTs from which CLCH inherited the properties on 1 April 2013. CLCH does not charge contingent rents on these properties and there are no unusual or onerous restrictions within the agreements with these tenants.

Note 9 Employee benefits and staff numbers

9.1 Employee Benefits

	2014/15			2013/14		
	Total £'000	Permanently Employed £'000	Other £'000	Total £'000	Permanently Employed £'000	Other £'000
Salaries and wages	**119,223**	90,831	28,392	121,154	96,103	25,051
Social security costs	**7,932**	7,445	487	8,416	7,907	509
Employer contributions to NHS Pensions scheme	**11,758**	11,242	516	12,365	11,826	539
Other pension costs	**0**	0	0	0	0	0
Other post-employment benefits	**0**	0	0	0	0	0
Other employment benefits	**0**	0	0	0	0	0
Termination benefits	**1,251**	1,251	0	1,184	1,184	0
TOTAL - including capitalised costs	**140,164**	**110,769**	**29,395**	**143,119**	**117,020**	**26,099**
Costs capitalised as part of assets	**40**	40	0	364	364	0
Total employee benefits (excluding capitalised staff costs)	**140,124**	**110,729**	**29,395**	**142,755**	**116,656**	**26,099**

9.2 Staff numbers

	2014/15			2013/14		
	Total Number	**Permanently Employed Number**	**Others Number**	**Total Number**	**Permanently Employed Number**	**Others Number**
Medical and dental	**107**	72	35	119	77	42
Ambulance staff	**0**	0	0	0	0	0
Administration and estates	**758**	668	90	790	695	95
Healthcare assistants and other support staff	**78**	78	0	74	73	1
Nursing, midwifery and health visiting staff	**1,408**	1,204	204	1,477	1,222	255
Nursing, midwifery and health visiting learners	**52**	0	52	0	0	0
Scientific, therapeutic and technical staff	**570**	438	132	635	477	158
Social Care Staff	**2**	2	0	2	2	0
Other	**0**	0	0	0	0	0
Total staff numbers	**2,975**	**2,462**	**513**	**3,097**	**2,546**	**551**

Staff (WTE) engaged in capital projects included above 1 (2013/14: 8)

9.3 Exit Packages agreed for staff

2014/15

Exit /package cost band (including any special payment element)	**Number of compulsory redundancies, Number**	**Cost of compulsory redundancies, £'000**	**Number of other departures agreed, Number**	**Cost of other departures agreed, £'000**	**Total number of exit packages by cost band, Number**	**Total cost of exit packages by cost band, £'000**
Less than £10,000	3	18	0	0	3	18
£10,001 - £25,000	13	200	0	0	13	200
£25,001 - £50,000	13	519	0	0	13	519
£50,001 - £100,000	12	914	0	0	12	914
£100,001 - £150,000	5	652	0	0	5	652
£150,001 - £200,000	3	532	0	3	3	532
>£200,000	1	219	0	0	1	219
Total	**50**	**3,054**	**0**	**0**	**50**	**3,054**
Total number of special payments (and total cost of special payment element)				**0**	**0**	

2013/14

Exit /package cost band (including any special payment element)	Number of compulsory redundancies, Number	Cost of compulsory redundancies, £'000	Number of other departures agreed, Number	Cost of other departures agreed, £'000	Total number of exit packages by cost band, Number	Total cost of exit packages by cost band, £'000
Less than £10,000	6	26	0	0	6	26
£10,001 – £25,000	9	139	0	0	9	139
£25,001 – £50,000	10	322	0	0	10	322
£50,001 – £100,000	9	592	0	0	9	592
£100,001 – £150,000	2	210	0	0	2	210
Total	**36**	**1,289**	**0**	**0**	**36**	**1,289**
Total number of special payments (and total cost of special payment element)				**0**	**0**	

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.

9.4 Sickness Absences

During the 2014/15 financial year the Trust's staff took a total of 23,411 days (2013/14: 24,990 days) of sickness absence. This is an average of 9.1 (2013/14: 9.6) days per staff member. These amounts are for the calendar year 2014.

9.5 Retirements due to ill-health

During 2014/15 seven persons retired early on ill-health grounds during the financial period (2013/14: two). The associated additional accrued pension liabilities total £244K (2013/14: £126K).

Note 10 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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 the scheme liability is carried out annually by the scheme actuary 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 are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015 is based on valuation data as 31 March 2014, updated to 31 March 2015 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. 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 scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.
The formal valuation to assess the contribution rates to be used from 1 April 2015 was carried out as at March 2012.

c) Scheme provisions

The NHS Pension Scheme provides defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVCs run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

Note 11 Better Payment Practice Code

	2014/15		2013/14	
	Number	**£'000**	**Number**	**£'000**
Non-NHS Payables				
Invoices Paid in the Year	50,369	84,189	48,014	76,176
Invoices Paid Within Target	49,992	83,833	45,673	74,325
Invoices Paid Within Target - %	**99.3**	**99.6**	**95.1**	**97.6**
NHS Payables				
Invoices Paid in the Year	614	8,592	1,254	18,964
Invoices Paid Within Target	597	8,558	1,173	18,303
Invoices Paid Within Target - %	**97.2**	**99.6**	**93.5**	**96.5**

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

Note 12 Investment Revenue

	2014/15 £'000	**2013/14 £'000**
Interest earned from monies held on deposit at the National Loans Fund.	79	55

Note 13 Finance Costs

	2014/15 £'000	**2013/14 £'000**
Unwinding of discount	6	5

Financing costs relate to the unwinding of the discount inherent in the Trust's injury benefit provision.

Note 14a Property plant and equipment

	Land £'000	Buildings excl Dwellings £'000	Plant & Machinery £'000	Information Technology £'000	Furniture & Fittings £'000	Total £'000
Opening Valuation at 1 April 2014	**12,892**	**17,681**	**2,271**	**7,563**	**36**	**40,443**
Additions Purchased	0	1,032	236	1,184	0	**2,452**
Disposals other than for sale	0	0	(164)	0	0	**(164)**
Reclassifications	0	0	0	0	0	**0**
Revaluation	920	70	0	0	0	**990**
Impairments/negative indexation charged to reserves	0	(538)	0	0	0	**(538)**
Valuation at 31 March 2015	**13,812**	**18,245**	**2,343**	**8,747**	**36**	**43,183**
Opening depreciation at 1 April 2014	0	(512)	(1,255)	(3,101)	(24)	**(4,892)**
Disposals other than for sale	0	0	112	0	0	**112**
Revaluation	0	0	0	0	0	**0**
Charged During the Year	0	(664)	(301)	(1,507)	(3)	**(2,475)**
Depreciation at 31 March 2015	**0**	**(1,176)**	**(1,444)**	**(4,608)**	**(27)**	**(7,255)**
Net Book Value at 1 April 2014	12,892	17,169	1,016	4,462	12	35,551
Net Book Value at 31 March 2015	**13,812**	**17,069**	**899**	**4,139**	**9**	**35,928**
Source of asset:						
Purchased at 31 March 2014	12,892	17,169	1,016	4,462	12	35,551
Purchased at 31 March 2015	**13,812**	**17,069**	**899**	**4,139**	**9**	**35,928**
Asset Financing:						
Owned at 31 March 2014	12,892	17,169	1,016	4,462	12	35,551
Owned at 31 March 2015	**13,812**	**17,069**	**899**	**4,139**	**9**	**35,928**

	Land £'000	Buildings excl Dwellings £'000	Plant & Machinery £'000	Information Technology £'000	Furniture & Fittings £'000	Total £'000
Attributable revaluation reserve: Revaluation Reserve Balance for Property, Plant & Equipment:						
As at 1 April 2014	**4,635**	**3,972**	**6**	**0**	**(620)**	**7,993**
Impairments in the year	0	0	0	0	0	0
Revaluations in the year	920	(468)	0	0	0	452
Other movements	0	(614)	(6)	0	620	0
As at 31 March 2015	**5,555**	**2,890**	**0**	**0**	**0**	**8,445**
Useful economic life:						
Minimum life (years)		20	3	3	2	
Maximum life (years)		65	15	15	15	452

All assets are initially recognised at purchase cost plus any incremental costs to bring the asset into its operational location and condition and depreciated over its estimated useful economic life to £nil residual value. Thereafter assets are held at cost less depreciation recognised since purchase plus any previously recognised upwards indexation (revaluation) as this is estimated to be not materially different to fair value.

At the balance sheet date the Trust continues to use assets with a gross book value of £3,708K (2013/14: £2,982K) that have no net book value. There are no temporarily idle assets.

Note 14b Property plant and equipment prior year

	Land £'000	Buildings excl Dwellings £'000	Plant & Machinery £'000	Information Technology £'000	Furniture & Fittings £'000	Total £'000
Opening Valuation at 1 April 2012	0	0	1,315	3,808	23	5,146
Additions Purchased		148	367	1,887	0	2,402
Disposals other than for sale		0	0	(36)	0	(36)
Valuation at 31 March 2013	**0**	**148**	**1,682**	**5,659**	**23**	**7,512**
Transfers under Modified Absorption Accounting - PCTs*	12,289	14,377	205	0	633	27,504
Restated Opening Valuation at 1 April 2013*	**12,289**	**14,525**	**1,887**	**5,659**	**656**	**35,016**
Additions Purchased	0	2,294	361	1,900	0	4,555
Disposals other than for sale	0	0	0	0	0	0
Reclassifications	(179)	152	23	4	0	0
Upward revaluation/positive indexation	782	710	0	0	0	1,492
Impairments/negative indexation charged to reserves	0	0	0	0	(620)	(620)
Valuation at 31 March 2014	**12,892**	**17,681**	**2,271**	**7,563**	**36**	**40,443**
Opening depreciation at 1 April 2012	0	0	(806)	(810)	(20)	(1,636)
Disposals other than for sale	0	0	0	0	0	0
Charged During the Year	0	0	(154)	(1,037)	(1)	(1,192)
Depreciation at 31 March 2013	0	0	(960)	(1,847)	(21)	(2,828)
Disposals other than for sale	0	0	0	0	0	0
Charged During the Year	0	(512)	(295)	(1,254)	(3)	(2,064)
Depreciation at 31 March 2014	**0**	**(512)**	**(1,255)**	**(3,101)**	**(24)**	**(4,892)**
Net Book Value at 31 March 2012	0	0	509	2,998	3	3,510
Net Book Value at 31 March 2013	0	148	722	3,812	2	4,684
Net Book Value at 1 April 2013*	12,289	14,525	927	3,812	635	32,188
Net Book Value at 31 March 2014	**12,892**	**17,169**	**1,016**	**4,462**	**12**	**35,551**
Source of asset:						
Purchased at 31 March 2013	0	148	722	3,812	2	4,684
Purchased at 1 April 2013*	12,289	14,525	927	3,812	635	32,188
Purchased at 31 March 2014	**12,892**	**17,169**	**1,016**	**4,462**	**12**	**35,551**
Asset Financing:						
Owned at 31 March 2013	0	148	722	3,812	2	4,684
Owned at 1 April 2013*	12,289	14,525	927	3,812	635	32,188
Owned at 31 March 2014	**12,892**	**17,169**	**1,016**	**4,462**	**12**	**35,551**

Note 15 Intangible Non-current Assets

	Computer Software Purchased £'000	Total £'000
Cost at 1 April 2014	**4,951**	**4,951**
Additions Purchased	**4,481**	**4,481**
Disposals other than for sale	**0**	**0**
Cost at 31 March 2015	**9,432**	**9,432**
Amortisation at 1 April 2014	**(1,058)**	**(1,058)**
Disposals other than for sale	**0**	0
Charged During the Year	**(1,532)**	(1,532)
Amortisation at 31 March 2015	**(2,590)**	**(2,590)**
Net Book Value at 31 March 2014	3,893	3,893
Net Book Value at 31 March 2015	**6,842**	**6,842**
Source of asset:		
Purchased at 31 March 2014	3,893	3,893
Purchased at 31 March 2015	**6,842**	**6,842**
Asset Financing:		
Purchased at 31 March 2014	3,893	3,893
Purchased at 31 March 2015	**6,842**	**6,842**
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 is depreciated over its estimated useful economic life to £nil residual value. All assets thereafter are held at cost less depreciation recognised since purchase as this is estimated to be not materially different to fair value.

At the balance sheet date the Trust continues to use assets with a gross book value of £579K (2013/14: £356K) that have no net book value. There are no temporarily idle assets.

Note 15b Intangible Non-current Assets prior year

	Computer Software Purchased £'000	Total £'000
Cost at 1 April 2012	**583**	**583**
Additions Purchased	1,665	1,665
Disposals other than for sale	(6)	(6)
Cost at 31 March 2013	**2,242**	**2,242**
Additions Purchased	2,709	2,709
Disposals other than for sale		
Cost at 31 March 2014	**4,951**	**4,951**
Amortisation at 1 April 2012	**(183)**	**(183)**
Disposals other than for sale	0	0
Charged During the Year	(209)	(209)
Amortisation at 31 March 2013	**(392)**	**(392)**
Disposals other than for sale		
Charged During the Year	(666)	(666)
Amortisation at 31 March 2014	**(1,058)**	**(1,058)**
Net Book Value at 31 March 2013	1,850	1,850
Net Book Value at 31 March 2014	**3,893**	**3,893**
Source of asset:		
Purchased at 31 March 2013	1,850	1,850
Purchased at 31 March 2014	**3,893**	**3,893**
Asset Financing:		
Owned at 31 March 2013	1,850	1,850
Owned at 31 March 2014	**3,893**	**3,893**
Useful economic life (years):	**3**	

Note 16 Trade and other receivables

	Current 2014/15 £'000	Non-current 2014/15 £'000	Current 2013/14 £'000	Non-current 2013/14 £'000
NHS receivables - revenue	**11,369**	**0**	11,516	0
NHS prepayments and accrued income	**2,945**	**0**	163	0
Non-NHS receivables - revenue	**2,881**	**0**	2,210	0
Non – NHS prepayments & other accrued income	**336**	**0**	318	0
PDC Dividend prepaid to DH	**102**	**0**	0	0
Provision for the impairment of receivables	**(438)**	**0**	(344)	0
VAT	**515**	**0**	771	0
Other Receivables	**581**	**0**	473	0
Total	**18,291**	**0**	15,107	0

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

During the period under review the majority of CLCH trade was with NHS England and Clinical Commissioning Groups, as commissioners of NHS patient care services. As these organisations were funded by the Government to buy NHS patient care services, no credit scoring of them was considered necessary. The only other material receivable counterparties are London Borough and City Councils. 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 Receivables past their due date but not impaired

	2014/15 £'000	2013/14 £'000
By up to three months	**3,511**	3,146
By three to six months	**666**	3,214
By more than six months	**1,083**	519
Total	**5,260**	6,879

16.2 Provision for impairment of receivables

	2014/15 £'000	2013/14 £'000
Balance as at 1April	**(344)**	(158)
Amount written off during the year	**4**	0
Amount recovered during the year	**190**	(186)
(Increase)/decrease in receivables impaired	**(288)**	0
Balance at 31 March	**(438)**	(344)

The Trust has a risk based approach to receivable impairment provision, where previous experience highlights the expected future recoverability of different non NHS receivable categories (non NHS, and private patients and staff).

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 principally 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

	At Fair Value Through Profit and Loss £'000	Loans and Receivables £'000	Available for Sale £'000	Total £'000
Embedded Derivatives	0	0	0	**0**
Receivables - NHS	0	11,369	0	**11,369**
Receivables - non NHS	0	3,462	0	**3,462**
Cash at Bank and in Hand	0	24,034	0	**24,034**
Other Financial Assets	0	0	0	**0**
Total at 31 March 2015	**0**	**38,865**	**0**	**38,865**

	At Fair Value Through Profit and Loss £'000	Loans and Receivables £'000	Available for Sale £'000	Total £'000
Embedded Derivatives	0	0	0	**0**
Receivables - NHS	0	11,516	0	**11,516**
Receivables - non NHS	0	2,683	0	**2,683**
Cash at Bank and in Hand	0	13,968	0	**13,968**
Other Financial Assets	0	0	0	**0**
Total at 31 March 2014	**0**	**28,167**	**0**	**28,167**

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 £515k (2013/14: £771k) 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 £781k (2013/14: £481k) and the bad debt provision £438k (2013/14: £344k) are also excluded from this note.

17.2 Financial liabilities

	At Fair Value Through Profit and Loss £'000	Other £'000	Total £'000
Embedded Derivatives	0	0	**0**
Payables - NHS	0	12,421	**12,421**
Payables - non NHS	0	21,004	**21,004**
Other Borrowings	0	0	**0**
Other Financial Liabilities	0	0	**0**
Total at 31 March 2015	**0**	**33,425**	**33,425**

	At Fair Value Through Profit and Loss £'000	Other £'000	Total £'000
Embedded Derivatives	0	0	**0**
Payables - NHS	0	5,943	**5,943**
Payables - non NHS	0	13,040	**13,040**
Other Borrowings	0	0	**0**
Other Financial Liabilities	0	0	**0**
Total at 31 March 2014	**0**	**18,983**	**18,983**

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 £3,811K (2013/14: £4,066K), are not contractual and so are excluded from the disclosure.

17.3 Maturity of financial liabilities

	2014/15 £'000	2013/14 £'000
In one year or less	**33,425**	18,983
In more than one years but not more than two years	**0**	0
In more than two years but not more than five years	**0**	0
In more than five years	**0**	0
Total	**33,425**	18,983

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

	2014/15 £'000	2013/14 £'000
Opening balance at 31 March	**13,968**	15,300
Net change in year	10,066	(1,332)
Closing balance at 31 March	**24,034**	**13,968**
Comprising:		
Cash with Government Banking Service	**512**	13,944
Liquid deposit with National Loan Fund	**23,500**	0
Cash in hand	**22**	24
Total	**24,034**	13,968

Note 19 Trade and other payables

	Current 2014/15 £'000	Non-current 2014/15 £'000	Current 2013/14 £'000	Non-current 2013/14 £'000
NHS payables - revenue	**11,025**	**0**	5,943	0
NHS - accruals and deferred income	**1,396**	**0**	0	0
Non-NHS trade payables - revenue	**2,132**	**0**	1,090	0
Non NHS – accruals and deferred income	**16,407**	**0**	9,945	0
Non NHS – capital creditors	**2,465**	**0**	2,005	0
Tax	**1,070**	**0**	1,179	0
Social Security Costs	**1,144**	**0**	1,219	0
Other Payables	**1,665**	**0**	1,842	0
Total	**37,304**	**0**	23,223	0

Other payables include £1,511K in respect of outstanding pension contributions at 31 March 2015 (31 March 2014: £1,668K).

Note 20 Borrowings

Central London Community Healthcare NHS Trust has no borrowings at the balance sheet date.

Note 21 Provisions for liabilities and charges

	Injury and Sickness Benefits £'000	Legal Claims £'000	Other £'000	Restructuring £'000	Total £'000
Balance as at 31 March 2013	**282**	**621**	**0**	**4,172**	**5,075**
Transfers under Modified Absorption Accounting - PCTs	**0**	**0**	**380**	**0**	**380**
Restated Opening Valuation at 1 April 2013	**282**	**621**	**380**	**4,172**	**5,455**
Arising During the Year	**0**	**83**	**0**	**1,184**	**1,267**
Utilised During the Year	**(16)**	**0**	**0**	**(1,289)**	**(1,305)**
Reversed Unused	**0**	**(21)**	**0**	**0**	**(21)**
Unwinding of Discount	**5**	**0**	**0**	**0**	**5**
Balance as at 31 March 2014	**271**	**683**	**380**	**4,067**	**5,401**
Arising During the Year	0	60	2,226	1,251	**3,537**
Utilised During the Year	(16)	(266)	0	(3,054)	**(3,336)**
Reversed Unused	0	0	0	0	**0**
Unwinding of Discount	6	0	0	0	**6**
Balance as at 31 March 2015	**261**	**477**	**2,606**	**2,264**	**5,608**
Expected Timing of Cash Flows as at 31 March 2015					
No Later than One Year	16	477	2,226	2,264	**4,983**
Later than One Year and not later than Five Years	80	0	380	0	**460**
Later than Five Years	165	0	0	0	**165**
	261	**477**	**2,606**	**2,264**	**5,608**
Expected Timing of Cash Flows as at 31 March 2014					
No Later than One Year	19	683	0	4,067	4,769
Later than One Year and not later than Five Years	104	0	380	0	484
Later than Five Years	148	0	0	0	148
	271	683	380	4,067	5,401

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. 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.

The NHS Litigation Authority (NHSLA) is holding clinical negligence provisions with a value of £477K (2013/14: £745K) and non-clinical provisions with a value of £400K (2013/14: £409K) 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 £82K (2013/14: £121K). This excess is fully provided for within the provisions for Legal Claims. The NHSLA has estimated a probability that the Trust will have to pay this excess.

Other provisions include the sum of £2,082k in respect of disputed invoices with two suppliers.

The restructuring provision in place at the balance sheet dates related to those staff whose existing post is at risk under various clinical and corporate transformation restructures that will be implemented during 2015/16.

Note 22 Contingent liabilities and assets

The NHS Litigation Authority (NHSLA) 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 NHSLA. CLCH has ten non-clinical claims outstanding (2013/14: thirteen) for which the Trust will have to pay a set excess. This excess is estimated by the NHSLA as £82K (2013/14: £121K).

The NHSLA believes that it is unlikely the Trust will have to pay £19K (2013/14: £26K) excess and recommends that this amount is therefore disclosed as a contingent liability.

Note 23 Related Party Transactions

In financial years 2014/15 and 2013/14 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 2014/15 the Charity paid the Trust £115K for goods and services provided by CLCH (2013/14: £76K). As at 31 March 2015 the Trust had a total of £38K (2013/14: £nil) receivable from the Charity in respect of payments made by the Trust on behalf of the Charity for refurbishments of a Nursing Home.

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. These transactions are as follows:

	Payable as at 31/3/2015 £'000	Receivable as at 31/3/2015 £'000	Revenue in the 12 months to 31/3/2015 £'000	Expenditure in the 12 months to 31/3/2015 £'000
Department of Health	0	0	42	0
Other NHS bodies*	11,025	11,369	172,738	24,404

*Material related party transactions with NHS bodies are listed below:

	Payable as at 31/3/2015 £'000	Receivable as at 31/3/2015 £'000	Revenue in the 12 months to 31/3/2015 £'000	Expenditure in the 12 months to 31/3/2015 £'000
Barnet CCG	3	1,227	33,669	0
Brent CCG	0	377	2,910	0
Camden CCG	0	140	770	0
Central London (Westminster) CCG	7	2,075	29,681	0
City And Hackney CCG	0	1	186	0
Ealing CCG	0	44	654	0
Enfield CCG	0	5	436	0
Hammersmith And Fulham CCG	0	644	20,644	0
Haringey CCG	0	106	399	0
Harrow CCG	0	32	620	0
Herts Valleys CCG	0	368	2,226	0
Hounslow CCG	0	88	277	0
Islington CCG	0	119	259	0
Lambeth CCG	0	9	281	0
Southwark CCG	0	14	156	0
Tower Hamlets CCG	0	86	155	0
Wandsworth CCG	0	58	285	0
West London (K&C & Qpp) CCG	53	1,532	36,996	0
NHS Litigation Authority	0	0	0	337
Care Quality Commission	0	0	0	72
Community Health Partnerships	1,777	0	0	3,806
NHS Property Services	6,564	0	0	9,074
NHS England (London Regional Office)	0	1,704	31,000	0
Barnet and Chase Farm Hospitals NHS Trust (Dissolved on 01/07/14)	0	0	0	341
Barnet, Enfield and Haringey Mental Health NHS Trust	84	49	0	241
Imperial College Healthcare NHS Trust	625	79	1,016	738
London Ambulance Service NHS Trust	217	0	1	1,323
West London Mental Health NHS Trust	113	0	6	382
Central And North West London MH NHS Foundation Trust	577	515	652	3,819
Chelsea And Westminster Hospital NHS Foundation Trust	450	0	496	692
Kings College Hospital NHS Foundation Trust	152	0	0	167
Royal Free London NHS Foundation Trust	1,130	1,494	3,515	1,082

Note 24 Intra-Government Balances

	Current receivables £'000	Non-current receivables £'000	Current receivables £'000	Non-current receivables £'000
Balances with other Central Government Bodies	0	0	2,214	0
Balances with Local Authorities	1,455	0	0	0
Balances with NHS bodies inside the Departmental Group	14,486	0	12,421	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Total Intra-Government balances	**15,941**	0	**14,635**	0
Balances with bodies external to government	2,350	0	22,669	0
At 31 March 2015	**18,291**	0	**37,304**	0

	Current receivables £'000	Non-current receivables £'000	Current receivables £'000	Non-current receivables £'000
Balances with other Central Government Bodies	9,741	0	7,471	0
Balances with Local Authorities	2,038	0	0	0
Balances with NHS Trusts and Foundation Trusts	1,938	0	2,537	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Total Intra-Government balances	**13,717**	0	**10,008**	0
Balances with bodies external to government	1,390	0	13,215	0
At 31 March 2014	**15,107**	0	**23,223**	0

Note 25 Third party assets: patients' monies

The Trust held £244K cash at bank and in hand at 31 March 2015 on behalf of patients (2013/14: £233K).

Note 26 Third party assets: Integrated Care Pathway Project

During 2011/12 a number of NHS, local government, GP, and third sector bodies formed an unincorporated Trust called the NHS North West London Integrated Care Pilot (ICP). As an unincorporated Trust, the ICP has no existence or personality separate from its individual members. The membership is as follows:

- 50% North West London GPs;
- 25% Acute Providers, including Chelsea and Westminster and Imperial;
- 10% Third Sector Representatives;
- 5% Community Health Providers, including CLCH;
- 5% North West London Local Authority Providers; and
- 5% Mental Health Providers.

CLCH has agreement with the ICP members to host the ICP staff (all ICP staff are either on fixed term contracts or seconded from another NHS body for a defined period), provide IT and other logistical support such as IT hardware and software and process routine payable and receivable financial transactions.

These transactions have been excluded in full from the Trust's financial statements. As at 31 March 2015 the Trust is holding £3,728K (2013/14: £5,407K) of cash on behalf of the ICP members. This is cash received from the CCGs who have funded the ICP but has not yet been spent. During 2014/15 the Trust received cash totalling £541K (2013/14: £3,708K) and made payments totalling £1,981K (2013/14: £3,164K) on behalf of the ICP. The Trust is fully indemnified against the risk of financial loss from providing these services.

Note 27 Losses and Special Payments

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

	2014/15 £	2014/15 Number	2013/14 £	2013/14 Number
Fruitless payments	**240**	**1**	270	5
Salary overpayment	**0**	**0**	410	3
Bad debts and abandoned claims	**4,843**	**1**	0	0
Loss of personal effects	**0**	**0**	400	1
Other Negligence and Injury	**3,700**	**2**	0	0
Other Payments	**506**	**1**	0	0

Note 28 Events after the reporting date

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

Note 29 External Financing Limit

	2014/15 £'000	2013/14 £'000
External Financing Limit	**3,661**	6,498
Cash Flow Financing	**(10,066)**	1,332
Unwinding of Discount Adjustment	**0**	5
Other Capital Receipts	**0**	0
External Financing Requirement	**(10,066)**	1,337
Under/(Over) Spend against EFL	**13,727**	5,161

Note 30 Breakdown performance

	2014/15	2013/14	2012/13	2011/12	2010/11
Turnover, £'000	198,409	196,191	193,270	190,946	155,379
Retained surplus/(deficit) for the year, £'000	1,836	1,915	1,826	3,835	2,196
Break-even in-year position, £'000	1,836	1,915	1,826	3,835	2,196
Break-even cumulative position, £'000	11,608	9,832	7,917	6,031	2,196
Break-even in-year position as a percentage of turnover	0.93%	0.98%	0.94%	2.01%	1.41%
Break-even cumulative position as a percentage of turnover	5.85%	5.01%	4.10%	3.16%	1.41%

Note 31 Capital Resource Limit

	2014/15 £'000	2013/14 £'000
Gross capital expenditure	6,933	7,205
Less: book value of assets disposed of	0	0
Less: capital grants	0	(180)
Less: donations towards the acquisition of non-current assets	0	0
Charge against the capital resource limit	**6,933**	7,025
Capital resource limit	**7,123**	7,209
(Over)/underspend against the capital resource limit	**190**	**184**

All capital investments in 2014/15 were funded from the Trust's internally generated cash reserves. The capital grant in 2013/14 was received from the Department of Health for the creation of Dementia Friendly Environment within the Trust's clinical areas to improve the experience of dementia patients using the Trust's facilities.

Note 32 Capital Commitments

The Trust had no capital commitments (amounts ordered at 31 March 2015 but not yet delivered) at the statement of financial reporting date (2013/14: £0).

Off-payroll engagements

Following on from the Review of Tax Arrangements of Public Sector Appointees published by Her Majesty's Treasury on 23 May 2012, NHS bodies are required to disclose specific information about off-payroll engagements. Her Majesty's Treasury recommends that public sector bodies report arrangements whereby individuals are paid £220 or more per day through their own companies and so are responsible for their own tax and NI arrangements.

The following tables disclose the number of employees affected by this recommendation and other details surrounding their employment:

Table 1: For off-payroll engagements as of 31 March 2015, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2015	65
for less than one year at the time of reporting	44
for between one and two years at the time of reporting	20
for between 2 and 3 years at the time of reporting	1
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

Table 2: For all new off-payroll engagements between 1 April 2014 and 31 March 2015, for more than £220 per day and more than 6 months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015	22
Number of new engagements which include contractual clauses giving Central London Community Healthcare NHS Trust the right to request assurance in relation to income tax and National Insurance obligations	22
Number for whom assurance has been requested	22
Of which:	
assurance has been received	18
assurance has not been received^	4
engagements terminated as a result of assurance not being received	0

^These contracts were coming to a natural end as at reporting date.

Table 3: Board members, and/or senior officers with significant financial responsibility paid via off-payroll engagements between 1 April 2014 and 31 March 2015

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year*	0
Number of individuals that have been deemed "board members, and/or senior officers with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements*	5

*The Trust paid the remuneration of no director to a limited company wholly or partly owned by him during the financial year 2014/15 (2013/14: one).

Notes

Notes