NHS
Central London
Community Healthcare
NHS Trust

Annual Report
2017/18

Section 1 – Performance report

Section 2 – Accountability report

Section 3 – Financial statements

1 Overview

The purpose of the 2017/18 annual report is to provide the Chief Executive, Andrew Ridley and the Chairman, Angela Greatley's perspective on the performance of the the organisation over 2017/2018. The report also highlights, through the 'about us' section, the purpose and the activities of Central London Community Healthcare NHS Trust.

Under the 'Performance analysis' section of the report a summary of the Trust's performance is provided alongside a statement of the key issues and risks that could affect the Trust in the delivery of its objectives as we move into the 2018/19 financial year.

2 Foreword

As a community trust the vast majority of our care is provided one-to-one by clinicians working in patients' homes or from local clinics; backed up by all our essential support teams. Our strong performance again this year is a credit to our excellent workforce. Their continued commitment to delivering great care for all our patients is what makes Central London Community Healthcare NHS Trust (CLCH) the high quality trust that we are so proud to be part of.

Following our strong performance in 2016/2017, we immediately followed this up as the Care Quality Commission (CQC) inspection team visited us in September and October 2017. After an extremely positive visit by the CQC to a wide-range of our teams and services, we were rated as 'Good' in all domains – a fantastic achievement by everyone involved and a true reflection of the excellent practice we provide here.

In summary, we were awarded Good in 38 out of 40 separate ratings and across five inspection domains (safe, caring, effective, responsive and well-led). CQC ratings use a four point scale of Inadequate, Requires Improvement, Good, and Outstanding. As well as our 38 'Goods', we achieved one outstanding and one finding of 'Requires Improvement'. The report highlighted the way in which we are working with our patients on our journey to becoming an outstanding organisation and is a true testament to the work we do here.

We have seen our staff at their very best over the last year, the response to both the Grenfell Tower fire tragedy and the terrorist attack at Parsons Green tube station was exceptional and we are incredibly proud of how all those involved worked so tirelessly to support those impacted by these incidents.

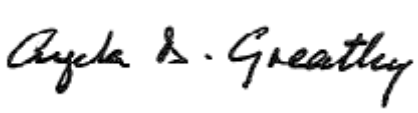
During a busy but exciting autumn period of 2017, we welcomed new services to the Trust as we became the provider of adult services in Wandsworth and just over 200 staff transferred to us from St George's University Hospitals NHS Trust. It was also in October that we began providing new sexual health services across Merton, Richmond and Wandsworth which built on our already extensive sexual health services provided across Hertfordshire. The new services are part of an award winning London sexual health transformation programme that is a unique collaboration of 29 London boroughs transforming the way sexual health services are organised and provided.

At the start of 2018 we welcomed health visitors from Wandsworth and Richmond to our organisation, which saw nearly 150 staff join us representing a significant expansion to the organisation and our children's division in particular.

In summary, 2017/18 has been a strong year of good quality service delivery, sound financial management, and targeted growth, innovation and organisational development. We reviewed and updated some of our Board level key performance indicators, grouping them under five strategic objectives: Quality, Operations, Workforce, Finance and Strategy Implementation.

The Trust Board monitored 21 KPIs throughout 2017/18. Of these KPIs 9 improved, 8 were maintained, and 4 reduced from month one to month twelve. We have also forged a number of strong partnerships with GPs, other NHS trusts, social care and voluntary sector partners, as we drive forward work on integrating care across all areas.

We very much look forward to embracing the challenges that the exciting year ahead is likely to bring.



Angela Greatley, OBE
Chair

Andrew Ridley
Chief Executive

As with our 2016/17 report we are producing this statutory annual report alongside an annual review; published as the autumn 2018 edition of our quarterly stakeholder magazine.

3 About us

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

In 2017/18 we provided a broad range of services in ten different London boroughs plus specialist sexual health and respiratory services in Hertfordshire.

3.1 Our range of services includes:

- **Adult community nursing** including district nursing, community matrons and case management.
- **Children and family services** including health visiting, school nursing, community nursing, speech and language therapy, blood disorders and occupational therapy.
- **End of life care** supporting people to make decisions and receive the care they need at the end of their life.
- **Long-term condition management** supporting people with complex ongoing health needs caused by disability or chronic illness.
- **Rehabilitation and therapies** including physiotherapy, occupational therapy, foot care, speech and language therapy and osteopathy.
- **Specialist services** including delivering care for people living with diabetes, heart failure, Parkinson's and lung disease, homeless health services, community dental services, sexual health and contraceptive services and psychological therapies.
- **Walk-in and urgent care centres** providing care for 226,000 people with minor illnesses and injuries and providing a range of health advice and information.

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

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

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

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

4 Performance analysis

We are a high performing Trust that puts quality of care at the heart of everything we do. Our most recent CQC inspection took place in September 2017. During the visit CLCH hosted a team of 28 CQC inspectors and specialist advisors, who assessed four of our care services: children's; adults; inpatient and end of life care. The team visited 17 sites, in six boroughs, where they talked to over 150 staff, carers, patients and service users about their experience of CLCH and observed the care that CLCH provides. They also reviewed our documentation and patient notes, evaluated our systems and processes and assessed the environment in which we provide care. A focus group was also held with some of our Black, Asian and Minority Ethnic staff. We welcomed the opportunity that the visit provided to highlight the work our clinical services deliver.

Following the 2017 inspection, we were pleased to receive an overall 'Good' rating in February 2018.

	Safe	Effective	Caring	Responsive	Well led	Overall
Community dental services	Good	Good	Good	Good	Good	Good
Community end of life care	Good	Good	Good	Good	Good	Good
Community health inpatient services	Good	Good	Good	Good	Good	Good
Community health services for adults	Good	Good	Good	Good	Outstanding ☆	Good
Community health services for children, young people and families	Requires improvement	Good	Good	Good	Good	Good
Urgent care services	Good	Good	Good	Good	Good	Good

4.1 Quality strategy 2017-2020

During 2017/18 we have built on the successes of 2016/17 when our quality strategy 'Simply the Best, Every Time' was developed. The 2017-2020 strategy was published in February 2017 and its aim is to move us from *Good* to *Outstanding.* It introduces three new quality campaigns alongside the three which continue from the 2013-2016 strategy. These campaigns provide a focus for everything we do and cover all aspects of delivering high quality, safe, effective and efficient care. They are:

- **Positive patient experience**
  Changing behaviours and care to enhance the experience of our patients and service users
- **Preventing Harm**
  Reducing unwarranted variations in care and increasing diligence in practice
- **Smart, Effective Care**
  Ensuring patients and service users receive the best evidence based care, every time
- **Modelling the Way**
  Providing world class models of care, education and professional practice
- **Here, Happy, Heard and Healthy**
  Recruiting and retaining an outstanding workforce
- **Value added care**
  Using enhanced tools, technology and lean methodologies to manage resources well.

To deliver the quality strategy objectives we established a new *shared governance* approach to driving improvement across the Trust. This allows frontline staff to drive through the improvements they know need to be made. Thirteen quality councils have been set up across our four divisions and are chaired by junior members of staff. Each council has identified improvement projects and are working together with patient representatives to deliver changes that benefit patients and staff.

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

4.2 2017/18 performance

Each year the Board of Directors sets a suite of key performance indicators (KPIs) to track our performance in priority areas. We monitor performance against these KPIs monthly both within our clinical divisions and at the Board. Progress throughout the year is published in our integrated finance and performance report which is part of the papers for monthly public Board meetings, available at www.clch.nhs.uk/boardpapers.

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

We have increased the number of Patient Reported Experience Measures (PREMS) responses returned and the scores for these have improved this year. In safety we have continued to perform well in the NHS Safety Thermometer. We are also pleased to note that we have maintained hand hygiene compliance in the community and improved our response rates to

national patient safety alerts. Full details of our quality performance are published in our Quality Account, available on our website at www.clch.nhs.uk/publications

For 2017/18 we reviewed and updated some of our Board level key performance indicators, grouping them under five strategic objectives: Quality, Operations, Workforce, Finance and Strategy Implementation.

The Board monitored 21 KPIs throughout 2017/18. Of these KPIs nine improved, eight were maintained and four reduced from month one to month twelve.

4.2.1 Quality

Proportion of clinical incidents that do not cause harm (moderate to catastrophic categories)
This KPI compares like for like incidents across the Trust that were reported as moderate or above, against a target of 96% the Trust achieved 96.8%.

Deaths in community hospitals as a percentage of all discharges (excluding palliative care and end of life)
This KPI measures the percentage of unexpected deaths in inpatient community settings. Against a target of 3.8% or below the Trust achieved 0.3%.

Friends and family test - percentage of people that would recommend our services
The calculation of this KPI reflects the percentage of those respondents that gave either an "extremely likely" or "likely" response to the survey question 'How likely is it that you would recommend this service to a friend or family if they needed it', minus those who would not recommend. Against a target of 95% the Trust achieved 92%.

Patients agreeing with the statement "I was treated with dignity and respect"
This KPI is taken from the monthly patient experience survey and reflects the percentage of respondents choosing the 'Yes, definitely' category when answering the question "Did the staff treat you with dignity and respect?" Against a target of 95% the Trust achieved 97.6%.

Proportion of services with reported clinical outcomes
This KPI represents the percentage of services within the Trust which have identified clinical outcomes and are able to collect and report manually extracted data. Against a target of 75% the Trust achieved 29.5%. This will be addressed through development of the reporting infrastructure and reporting processes.

Delivery of Quality Strategy outcome measures for 2017/18
This KPI is a monthly measure and shows the percentage of the 33 Quality KPIs that are being met.

4.2.2 Operations

Complaints resolved within 25 days of receipt
This KPI reflects the number of low/moderate graded complaints (to which a 25 day completion deadline applies) which are dealt with within 25 days. 100% of complaints were resolved within 25 working days, against a target of 95% or more.

Contract Performance Notices
This KPI measures the number of contract performance notices received from the Trust's commissioners. Four performance notices were received throughout 2017/18.

Waiting time of 18 weeks from point of referral to treatment (RTT)
Against a target of 92% the Trust achieved 98.2%.

Accident and Emergency (Walk-in/Urgent Care Centre) maximum waiting time of 4 hours from arrival to treatment/transfer/ discharge
Against a target of 95% the Trust achieved 99%.

Implementation of the Trust's new data warehouse and information reporting programme.
This KPI measures the percentage of delivered milestones on the plan for the delivery of the 2017/18 data warehouse and information reporting programme. Against a target of 100% the Trust achieved 97.9%.

4.2.3 Workforce

Percentage of staff that recommend the Trust as a place to work
This KPI is collected quarterly via the Trust's Pulse Survey for Q1, Q2 and Q4 with the national staff survey covering Q3. The measure reflects those staff who agree or strongly agree with the question asking staff whether they would recommend the Trust as a place to work, 52.3% of our staff would recommend the Trust as a place to work against a target of 62%.

Vacancy level – clinical staff
This KPI reflects the vacant full time equivalent (less frozen posts) divided by the budgeted establishment. Through the 2017/18 year the Trust's mean clinical vacancy rate has been 14.5% against a target of 12% or less.

Turnover rate – clinical staff
This KPI shows a rolling 12 month % rate of leavers by headcount / average of start and end of month headcount [for voluntary reasons for leaving only]. Through the 2017/18 year the Trust's mean clinical staff turnover rate has been 15.3% against a target of 12% or less.

Staff appraisal rate
This KPI shows the number of staff assignments appraised as a percentage of the number due for appraisal in the same period. 85.3% of staff have had their appraisal across 2017/18 against a target of 90%.

Staff from Black, Asian and Minority Ethnic (BAME) backgrounds at bands 8a and above
Across the Trust 29.9% of BAME staff are at an 8a level and above against a target of 33%.

4.2.4 Finance

Percentage of actual delivered savings compared to plan, net of contingency
This KPI shows the forecast end of year recurrent QIPP position (including any contingency in reserve) as a percentage of the end of year QIPP target. Against a target of 100% across the 2017/18 year the Trust achieved 98% of actual delivered QIPP compared to plan.

Percentage of recurrent value of savings delivered
This KPI reflects the financial position of the year to date 'actual' QIPPS achieved as a percentage of the year to date planned position. Against a target of 100% across the 2017/18 year the Trust achieved 84.4%.

Income and expenditure performance
Against a year-end target of £5,013K the Trust achieved an income and expenditure surplus of £5,337k.

Cash balance performance
Against a year-end target of £7,983k, the Trust ended the year with a £22,709k cash balance compared to plan.

4.2.5 Strategy implementation

Sustainability and Transformation Plan (STP) engagement
This KPI has been measured by three components:

1) CLCH attendance at Sustainability and Transformation Plan meetings in the areas where we provide services.
2) Performance against the national CQUIN objectives for STP engagement as defined by the Trust's commissioners.
3) Quarterly Trust Board qualitative review of STP engagement. Against an annual target of 80% the Trust has achieved 90% engagement.

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the adaptation reporting requirements are complied with.

The Trust, as part of its business assurance framework, has considered the key strategic issues and risks that could affect the delivery of our objectives; these have been set out in section 2 of this report.

5 Trust strategy

We were established in 2008 as a provider of community services for Hammersmith and Fulham, Kensington and Chelsea and Westminster. Since then we have grown exponentially and we now provide services across each of the following boroughs and Hertfordshire:

- Richmond
- Merton
- Wandsworth
- Brent
- Barnet
- Harrow
- Hounslow

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

Sustainability and Transformation Partnerships (STPs) indicate a future that is based on closer collaboration between health providers and with social care. We now operate in four STP areas: North Central London, North West London, South West London and Hertfordshire and West Essex. The STPs bring organisations together to take collective responsibility and to plan improvements. Working within these STPs is a complex challenge and to be an effective partner in each STP we need to be able to focus and commit time and resources.

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

Our new strategic direction covers what we do, where we work and how we work with partners. You can find our Trust strategy at https://www.clch.nhs.uk/application/files/7415/2603/5098/Strategic_Direction_for_2017-20.pdf

Following a refresh of the Trust's core strategy for 2017-2020 we set five strategic priorities for 2017/18. There five strategic priorities were:

- Strategy Implementation - implement strategic priorities of integration and place

- Quality - maintain and improve the quality of services delivered by CLCH moving from good to outstanding

- Finance - seliver the 17/18 financial plan

- Operations - deliver all NHS constitutional and contractual standards

• Workforce - make CLCH a great place to work.

5.1 What we do

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

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

In all cases services need to be founded on evidence, best practice and shared learning and we need to engage with the full range of resources in the statutory and non-statutory sector.

The essence of our services will remain very personal and based on the skilful face-to-face engagement of our staff with patients and their families. We will however, increasingly adopt new technologies that make access to our services easier and help people to do more for themselves.

5.2 Where we work

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

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

During the year the Trust Board agreed to support the formal developments of integrated care partnerships in Hammersmith and Fulham and Harrow.

5.3 How we work with partners

The NHS England's *Five Year Forward View* which can be found online includes a range of integration solutions, but there is no blueprint and integration will take many different forms. We will consider the needs of each local area and offer appropriate solutions.

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

5.4 Engaging with local systems

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

5.5 Re-shaping our services

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

5.6 Developing our workforce

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

5.7 Deploying new technologies

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

6 Our staff

We employ 2,287 full-time staff, 1,191 part-time staff and we have another 1,233 people registered on our staff bank for temporary work. Our workforce is made up of:

- 78% clinical roles
- 86.6% women
- 42% Black, Asian and Minority Ethnic (BAME) backgrounds
- 64% aged 40+

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

Expenditure relating to consultancy is disclosed in our financial statements. Exit package payments are disclosed in the remuneration and staff report. Our Board gender breakdown is as follows: six male, five female.

6.1 Supporting a healthy workforce

We invest heavily in the health and wellbeing of our staff so our absence from sickness is significantly below the NHS and public sector averages, at 3.61%.

We have continued to be committed to helping all of our staff maintain and improve their wellbeing. We appreciate that working in healthcare can sometimes be stressful and we work

hard to provide help and support for our staff. During 2017/18 we developed initiatives for physical and mental wellbeing including:

6.1.1 The London Healthy Workplace Charter

The Mayor's office created the London Healthy Workplace Charter which is a voluntary assessment process by which organisations within London are supported to develop their Health and Wellbeing services for staff. In June 2017, CLCH were assessed as having reached the second of three levels. We are one of relatively few NHS trusts to have reached this level. Our aim is to now progress to the final level, "Excellence" during 18/19.

6.1.2 The Global Corporate Challenge

93 teams of seven staff took part in this international initiative to boost physical exercise and improve mental wellbeing, funded generously from the Trust's Charitable Funds. The challenge ran for 100 days during which everyone aimed to take at least 10,000 steps each day, improve their diet, address stress and improve sleep. Together CLCH staff walked 556,260,981 steps which equalled 221,213 miles. It was great to see that 66% of participants following the challenge reported feeling less stressed.

6.1.3 Transport for London Cycle Scheme

We partnered with Transport for London (TFL) to offer free sessions for staff at Parsons Green on how to cycle safely, how to ensure their bicycle was safe by having it checked by a mechanic and the chance for people who hadn't cycled before to go out on an hour's introductory lesson.

6.1.4 Time to Change

In September 2017, the Trust signed the 'Time to Change' pledge which committed the Trust to reduce stigma around mental health. Sarah Kell, an occupational health nurse established a mental health blog as a vehicle for staff to share their experiences of mental health. Workshops on "how to look after your mental health" were run for staff in areas which showed an above average score for stress in the staff survey.

6.1.5 Rapid Access Physiotherapy

Access to physiotherapy was provided from the South Westminster Centre to make it easier for staff in the south and centre of the Trust to access the service.

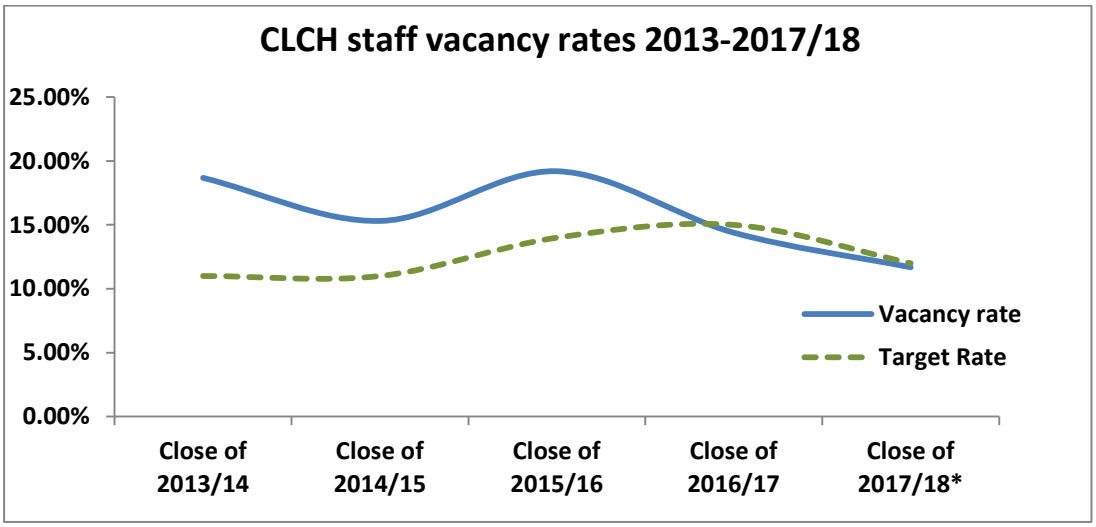
6.1.6 Muskuloskeletal (MSK) Workshops

Our in-house physiotherapist and the lead for moving and handling ran several workshops for staff on how to look after yourself better and prevent MSK injury. They have targeted teams who have scored above average in the staff survey, showing a higher than average level of MSK injury.

6.2 Recruitment and Retention

Like many parts of the NHS we have significant challenges around recruitment and retention with national shortages of several professions we rely on including health visiting, district nursing, school nursing, occupational therapy, physiotherapy and emergency nurse practitioners. Within community nursing services there are also longer-term challenges of an aging workforce to plan for.

In 2017/18 we continued to make good progress in recruitment. Following improvements to the recruitment process, this has significantly reduced the time it now takes to fill vacancies. We instigated a robust oversight of recruitment activity under the recruitment and retention group chaired by an Executive Director. The overall rates were reduced to the lowest level for five years and we are looking to reduce this even further moving into 2018/19.



Some specific projects to support our recruitment and retention work include:

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

- **International recruitment**
  During 2017/18 we recruited 32 nurses from the Philippines and have an ongoing programme for 2018/19.

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

- **Nursing associate pilots**
  The Trust continues to be involved in the national pilot sites with the first groups of nursing associates due to qualify in January 2019.

Recruitment and retention has remained a priority throughout 2017/18 and will continue to do so.

6.3 Recognising quality

We are extremely proud of the work our staff do, and it is always great to see that work acknowledged through national award schemes. In 2017/18 the work of our staff/teams was highlighted in:

6.3.1 Health Service Journal's (HSJ) Awards 2017 - Provider Trust of the Year - shortlisted

This award recognises providers which are offering excellent, patient-centric care built on strong engagement between clinicians within and beyond the organisation.

6.3.2 Health Service Journal's (HSJ) Patient Safety Awards 2017 - Care of Older People category - Impact of Proactive Care Homes Pharmacists - shortlisted

This award recognises projects that improve the safety of older people in primary, acute or community settings.

6.3.3 Health Service Journal's (HSJ) Patient Safety Awards 2017 - Improving Safety in Medicines Management category - Impact of Proactive Care Homes Pharmacists – shortlisted

This award recognised organisations that have reduced or eliminated drug errors – from minor to those with serious and even fatal consequences.

6.3.4 Health Service Journal's (HSJ) Partnership Awards 2017/2018 - Property and Estates Management Service of the Year - Central London Community Healthcare NHS Trust partnership with Capita – shortlisted

This award recognised organisations who helped NHS trusts make the most of their current estate or had innovative solutions to help it develop new properties – often within tight budgets – or a mixture of both.

6.3.5 Health Service Journal's (HSJ) Partnership Awards 2017/2018 – Recruitment Services Provider of the Year - Central London Community Healthcare Trust partnership HR and recruitment service – shortlisted

This award recognised partnerships that provided a cost-effective service which helped NHS organisations with hard-to-fit gaps in its workforce, or have provided a service which reduced the cost of using temporary staff.

6.3.6 X-Pert Health Award's – Hounslow Diabetes service nominated for various awards

The Hounslow Diabetes service came second in the 'greatest improvement in glycated haemoglobin' category and third in the 'greatest number of participants to attend X-PERT' category. They were also highly commended for 'weight loss data at six months and 12 months for the largest impact on body weight and waist circumference' and Rupindar Sahota, Diabetes Specialist Dietitian in the service, was also awarded second place for the 'X-PERT best educator award 2017'.

6.3.7 CLCH staff awards

Our own annual staff awards were held in October 2017 at Porchester Hall and recognised the excellent work of our staff with winners and commendations across 18 different categories. Of the 18 awards available, an unbelievable 400 nominations were received and close to 300 staff attended on the night.

6.4 Staff survey results

Our response rate to the 2017 NHS staff survey was 42.3% (1,215 staff).

Compared with other community trusts across the 32 indicators in the survey we were best in the country for two indicators: quality of non-mandatory training and the percentage of staff and colleagues reporting their most recent experience of violence; at or better than average in 24 indicators (significantly better in 11); slightly worse than average in five indicators and significantly worse than average (compared to other community trusts across the country) in one indicator relating to perception of equality of opportunity for career progression of promotion. Compared to our 2016 results we improved in 23 indicators, remained the same in five and dropped in four, although none of these declined by a statistically significant amount.

Key themes in 2017 show:

- Improved scores for staff recommendation of the Trust as a place to work or receive treatment, the level of appraisals, staff satisfaction with resourcing and support, staff satisfaction with the opportunity for flexible working patterns and the organisation and management interest and action on health and wellbeing

- A worsened position of staff experiencing harassment, bullying or abuse from patients, relatives of the public in the last 12 months.

The full and summary reports of our 2017 results are available at http://www.nhsstaffsurveys.com

6.5 Equality and diversity

Research evidence shows that how NHS staff are treated has a substantial impact on how patients are cared for. This principle is the driving force behind the NHS Workforce Race Equality Standard (WRES) against which the Trust has been working to improve both the representation of Black, Asian and Minority Ethnic (BAME) staff at all grades of its workforce and also the experience of BAME staff as reported through the annual staff survey.

The CLCH annual BAME staff conference was held in November 2017 focusing on career development and this led to a further event in March 2018 which enabled BAME staff from across the organisation to be involved in influencing the nature of the staff development opportunities being offered within the Trust.

One of the areas of improvement identified was the need to strengthen the existing BAME Staff Network to enable BAME staff to play a more effective part in the Trust's WRES action

plans and also to be more effective in being able to offer development opportunities for BAME staff from within its own membership. This is being taken forward incorporating best practice from other NHS trusts.

The Trust has a thriving LGBTQ Rainbow staff network which meets formerly every quarter. The network help to arrange activities and events to celebrate PRIDE each year as we did as a Trust in 2017.

In 2017 the Trust signed up as 'Disability Confident Committed' to the government's Disability Confident Scheme. This replaced the government's previous Two Ticks Symbol and sets out a range of standards for the Trust to achieve regarding:

- recruitment processes which are inclusive and accessible for job applicants with disabilities.
- the support of new and existing staff with disabilities through providing of reasonable adjustments to equipment and working arrangements.

Work continues to ensure that new initiatives being introduced, such as apprenticeships, are designed to provide a suitable pathway for people with disabilities to secure employment within the Trust.

The Trust ensures that staff with a disability are not treated less favourably through the application of HR policies. The Trust has a range of policies and support available to staff with disabilities plus recruitment processes to ensure we treat all applicants fairly; available from our HR team. Also, the use of the change management policy will consider the needs of staff with disabilities when restructuring proposals are considered. These policies are tested through the HR policy group comprising of management and staff representatives and other appropriate forums (eg Health and Safety Committee) before being signed off through CLCH's policy reference group. CLCH has signed up to the disability confident scheme which helps to improve how we can attract, recruit and retain disabled workers.

Self-reporting of disability by staff to the HR team is at 2.7% which is lower than is indicated by the annual staff survey. There is 28.4% non-response rate regarding disability (NHS national non-response rate 30.7%). We welcome the introduction of the NHS Workforce disability equality standard which is due to be implemented from August 2018 which will help us to improve our self-reporting of disability and to enable us to gain a better picture of the representation and experience of our staff with disabilities. In line with legal requirements, the Trust reported on its gender pay gap in March 2018. The gender pay gap does not demonstrate any equal pay concerns as equal pay is where men and women are paid the same for like work whereas the gender pay gap is the difference between the hourly earnings for both men and women across an organisation. It is encouraging to see that our gender pay gap (8.99%) is smaller than the UK average (18.1%) but this reflects the representation of men and women throughout the organisation as shown in the table below:

Grade	Female number	Male number	Female %	Male %
Bands 1-4	907	143	86.38%	13.62%
Band 5	485	59	89.15%	10.85%
Band 6	732	69	91.39%	8.61%
Band 7	597	91	86.77%	13.23%
Band 8a	164	40	80.39%	19.61%
Band 8b 8c	67	30	69.07%	30.93%
Band 8d, 9 VSM**	22	17	56.41%	43.59%
Medical/Dental staff	38	17	69.09%	30.91%
Total	3012	466	86.60%	13.40%

6.6 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 take part in the annual NHS staff survey as well as quarterly local pulse surveys. We also have staff newsletters, regular workshop sessions for our senior managers, open staff meetings hosted by the chief executive are regularly held across the Trust, staff are invited to present at the Trust Board meetings and a staff intranet.

6.7 Shared governance

The model of shared governance aimed to set up 12 quality councils across the Trust in the first year, currently we are ahead of schedule with 13 quality councils in situ, nine of these with patient representatives as part of their membership. Each council is working in alignment with one of the quality campaigns outlined in the 2017-2020 quality strategy.

Following their introduction staff feedback reports demonstrate higher engagement with the quality strategy and quality improvement across the Trust. Staff report that they feel listened to and welcome the opportunity to take on a role outside their normal scope of daily practice, particularly enjoying the engagement with senior management across the Trust and the opportunities for mentorship and education this provides.

6.8 Anti-slavery / anti-bribery

CLCH as with all NHS organisations has a statutory duty under the Modern Slavery Act 2015 to cooperate with reporting cases of trafficking / modern day slavery in line with the statutory requirements of the Modern Slavery Act.

CLCH is committed to ensuring that there is no modern slavery or human trafficking in any part of its business activity and so far as is possible to holding our suppliers to account to do likewise. The Trust ensures that slavery and human trafficking does not take place in our supply chain through the use of approved procurement frameworks and standard NHS/public

sector contracts for all major spends which require suppliers to take account of anti-slavery, anti-bribery and other statutory requirements. We are taking steps to put standard terms and conditions onto all purchase orders which will cover anti-bribery and anti-slavery; which will cover all spend regardless of the size of contracts.

All CLCH staff have mandatory safeguarding training which includes awareness on Modern Slavery. Additionally our clinical staff attend mandatory level 3 face-to-face training and CLCH has surpassed the NHS England compliance target of 85% for all eligible clinical staff by 31st March 2018.

CLCH provided assurance to commissioners and Clinical Commissioning Groups (CCGs) that our staff fulfil their statutory duty to identify and report concerns about suspected cases of modern slavery or human trafficking.

7 Service changes

The community health market continues to be characterised by a significant amount of competitive tender activity. During 2017/18 CLCH mobilised several new services as follows, following successful competitive tenders.

- On 1st June we launched the new Brent 0-19 children's service which added health visiting to our existing school nursing service in the borough
- On 1st October the new Wandsworth adult community service went live. The service is part of the new Wandsworth multi-specialty community provider led by the GP Federation, Battersea Health CIC.
- On 1st October we went live with the new South West London sexual health service, covering Wandsworth, Merton and Richmond. The service provides integrated sexual health prevention and treatment services and is delivered in partnership with Chelsea and Westminster Hospital NHS Foundation Trust.
- On 2nd January we launched a new health visiting service in Wandsworth and Richmond.

Other service developments included the opening of a new intermediate care bed facility, Adams Ward, serving Barnet. The ward which is at Finchley Memorial Hospital provides rehabilitation therapy services.

We also lost some services through the competitive tender process. When we lose a service CLCH always works diligently with the commissioner and the new provider to ensure that the service is handed over in a manner that causes least possible disruption to service users and staff. The services we lost in 2017/18 consisted of:

- Barnet contraceptive and sexual health
- Hounslow school nursing
- Barnet oral health promotion
- Ruby Ward serving Harrow patients – Care UK will provide intermediate care beds to Harrow and CLCH will support with therapy services only and not in the delivery of a bedded unit.

As well as services being retendered we have also seen some commissioners reducing their spending on a number of our services for 2017/18. In some cases services are being decommissioned altogether and in other cases we are working with the commissioners to redesign services to match their lower level of spending.

There will be significant changes in the three inner London boroughs (Hammersmith and Fulham, Kensington and Chelsea and Westminster). This is because NHS Clinical Commissioning Groups reduced our contract by £2.5m (circa 5%) in 2017/18. To achieve this, the CCGs are decommissioning some services and asking us to change how we deliver others.

In Barnet we are working with the CCG commissioner to deliver a significant reconfiguration of district nursing and intermediate care facilities to streamline pathways and improve care. These changes should come into effect in the second half of 2018/19.

8 Value for money

8.1 Financial Sustainability

During 2017/18 the Trust achieved a surplus on operating expenditure of £3.3m (£0.2m above target) thus securing a further £2.1m of Sustainability and Transformation Funding (STF) from central Government, this was based on a total Trust turnover of £215m (£213m 2016/17). The Trust financial performance was driven by continual improvements in the control of spend on temporary staffing, delivery of significant operation clinical efficiencies and the continued delivery of our corporate transformation programme which resulted in management costs reducing by 4% in 2017/18 (5% excluding inflation) from £4.9m in 2016/17 to £4.7m in 2017/18.

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

8.2 Quality, Innovation, Productivity and Prevention (QIPP) plans

Recognising the need to deliver value for money we have consistently delivered QIPP savings each year for the past six years. In 2017/18 we delivered a broad programme of savings projects with a total value of £9.1m. The estates savings highlighted below are an example of where we are looking to maximise value in ways which have minimal impact of the frontline services caring for patients. Our cost improvement work has totalled approximately £75m since 2011. For the year ahead we have another challenging target of £9.5m (which is in addition to the contract reductions mentioned above).

8.3 Estates rationalisation

The cost of managing/renting our various health centres and office bases is the Trust's second biggest expense, after pay costs. Throughout 2017/18 we worked on a number of projects to get better value for money from the estate we use to ensure full utilisation. Within the current Trust estate there is a significant amount of void space. Consolidation of services will increase

space utilisation and enable some properties to be released from the estate. Key projects and the savings they released in 2017/18 included:

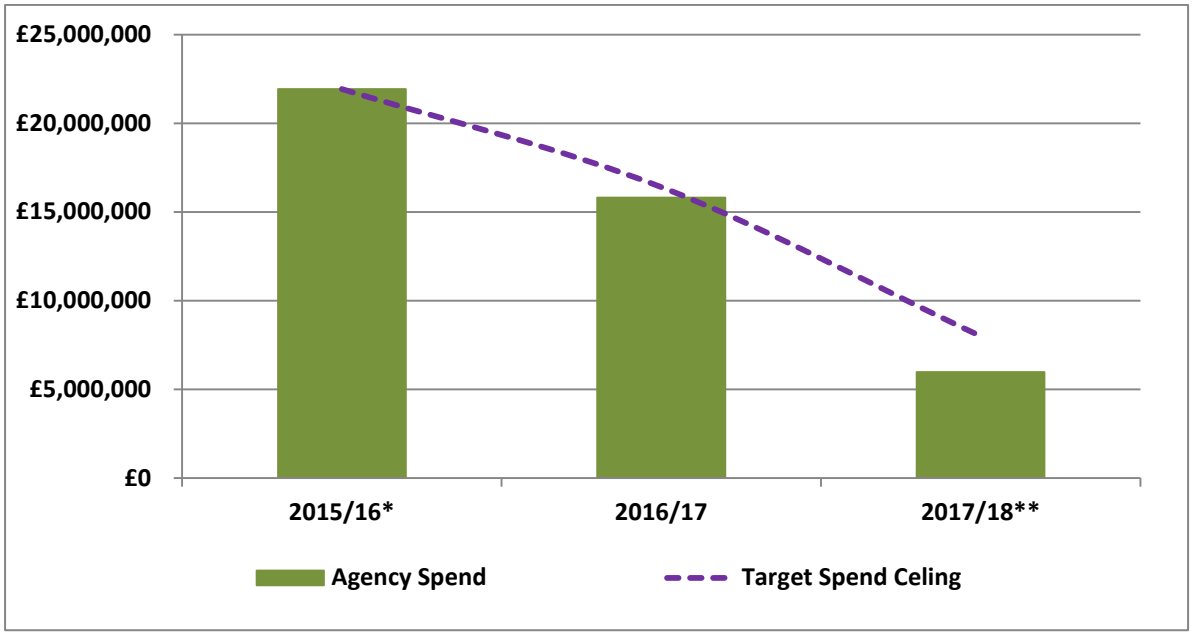
- Rationalisation of non-patient facing space at Edgware Community Hospital into Westgate House (£400,000)
- Rationalisation project for Merton estate, with closure of some sites and multiple reorganisations (£1.1m) which included the move to the Merton Civic Centre
- Vacation of Marylebone Health Centre (£15,000)
- Vacation of Berkely Centre into Heston Health Centre (£120,000)
- Hertfordshire strategic estate rationalisation (£30,000)
- Closure of Victoria Street offices which served as the Trust headquarters (£500,000).

CLCH commenced estate works at Parsons Green Health Centre in March 2017, this work will allow Lillyville Practice to enter the building and support an integrated healthcare model with our walk in centre.

Work continues to develop the asset optimisation plans for the Trust's freehold estate for the 2018/19 efficiency programme.

8.4 Agency spend

Building on the significant success in 2016/17, the Trust continued to target lower agency usage and an internal stretch target of £8 million was applied. We have managed to reduce a spend of circa £22 million in 2015/16 to £15.8 million at the close of 2016/17 and are forecast to be under our stretch target of £8 million at the close of 2017/18.



*no set ceiling in 2015/16

Replacing agency staff with permanent staff is good for patients and for taxpayers. It improves value for money but also improves quality of care through greater continuity of care (patients

seeing the same clinicians) and a stronger commitment to and understanding of the Trust by permanently employed staff.

9 Board of Directors

Our Board of Directors has overall responsibility for setting the strategy of CLCH, as well as monitoring performance, finance and maximising the efficiency of services provided by the organisation.
The Board meets in public at least ten times a year to discuss performance, challenges and strategy. When discussing issues of a confidential nature it excludes members of the public in accordance with the Public Bodies (Admission to Meeting) Act 1960. Our standing orders and standing financial instructions includes the scheme of delegation and decisions reserved for the Board. The Board has a majority of non-executive directors.

9.1 Information Governance

Incidents with a severity level of two or above are classed as serious incidents and must be externally reported to the Information Commissioner's Office (ICO) via the information governance toolkit incident reporting tool.

During the period of 01.04.17 to 31.03.18 a total of eight serious incidents (level two) were reported to the ICO, one incident was later withdrawn as the investigation revealed that there was no breach as the data was never accessed. This is an increase from the previous year (2016/17) when a total of five incidents were reported.
Seven incidents have been investigated by the ICO, and have been closed with no further action required.

The information governance team is supported by the Caldicott Guardian. The Quality Committee receives an annual report from the Caldicott Guardian, including issues raised / reported to the Information Commissioner's Office.

9.2 Changes on our Board

During 2017/18 there has been a change to the membership of our Board:

9.2.1 Director of improvement

James Benson, previously a divisional director of operations was appointed as the director of improvement and formally took up the role in May 2017.

9.3 Board members

The table below details our Board members' positions at 31 March 2018 on the formal sub-committees of the Board. Profiles of our Board members are available at www.clch.nhs.uk/ourboard

Non-executive team	Committee membership (* Chair)
Anne Barnard	Audit Charitable Funds Finance, Resources and Investment*
Jitesh Chotai	Audit* Finance, Resources and Investment
Dr Carol Cole	Charitable Funds* (to 03.12.17) Quality Remuneration Workforce
Angela Greatley OBE, Chair	Finance, Resources and Investments Quality Remuneration Workforce
Professor David Sines CBE	Quality Remuneration* Workforce*
Clive Sparrow	Audit Charitable Funds* (from 04.12.17) Quality
Executive Board members	
Louise Ashley, Chief Nurse and Chief Operating Officer	Quality Workforce
James Benson, Director of Improvement (from 01.05.17)	Finance, Resources and Investment Quality
Mike Fox, Director of Finance, Contracting and Performance	Charitable Funds Finance, Resources and Investment
Dr Joanne Medhurst, Medical Director	Charitable Funds Quality
Andrew Ridley, Chief Executive	Finance, Resources and Investment Workforce
Associate Non-executive	
Paula Constant	Attends various committees

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

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

Annual governance statement 2017/18

10 Scope of responsibility

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

11 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Central London Community Healthcare NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Central London Community Healthcare NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

12 Capacity to handle risk

Risk management sits within the quality governance structure of the Trust, led by the Chief Nurse and Chief Operating Officer.

The Trust has a risk management strategy in place which sets out the key responsibilities and accountabilities to ensure that risk is identified, evaluated and controlled. Risk is considered from the perspectives of clinical risk, organisational risk and financial risk. The risk management strategy was revised and reviewed by the Audit Committee in October 2017.

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

12.1 The risk and control framework

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 Board Assurance Framework (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 quarterly report on BAF risks and risks of 15 and above which subsequently goes to Board. ELT also receive a weekly update on new risks at 15 or above. The Patient Safety and Risk Group, which includes representatives from all divisions, reviews all risks of 12 and above including ratification, updates and closure.

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.

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

12.1.1 Single Oversight Framework

The Board receives a quarterly update on compliance with the Single Oversight Framework; with the exception of 'use of data', all areas are classified as 'green', including condition 4

'fit and proper persons'. All Board members have provided self-certification and employment contracts which have been updated to include a clause that gives the Trust the ability to dismiss 'unfit persons'. 'Use of data', action plans are progressing and have been brought together into a single informatics improvement plan.

12.1.2 Data Security

In October 2017 the Department of Health (DH) issued the 2017/18 Data Security and Protection Requirements. The Board has considered the Trust's position in relation to the 10 data security standards recommended by the National Data Guardian. The data security standards are monitored by the Executive team as part of monthly performance monitoring meetings and presented to the Finance, Resources and Investment Committee as part of the annual review process.

Information Security and IM&T systems are now managed by our partner Capita. This arrangement provides significant assurance of the Trust's preparedness to combat cyber security threats. Compliance is monitored monthly to identify any potential threats and to determine the required steps to mitigate risks; more urgent updates would be risk assessed and applied immediately as required. This response is monitored at the monthly operations group and discussed at service operational quarterly review meetings. The Board will monitor cyber security as a key performance indicator (KPI) in 2018/19.

Capita will be introducing, building and implementing an Information Security Management System (ISMS) compliant against ISO/IEC27001:2015 standards in 2018 [note: ISMS is a set of policies and procedures for systematically managing an organisation's sensitive data. This is based on a risk approach which enables management to establish, implement, operate, monitor, review, maintain and continually improve information security within the Trust].

Information Security is a component of information governance (IG) within the IG Toolkit for which an annual report is made to the Board.

12.2 Risk assessment

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

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

For the period – 01.04.17 to 31.03.18, 167 new risks were identified and approved (excluding BAF risks) and 175 approved risks were closed - risk categories are shown in

tables 1 and 2 below.

There are currently 10 BAF risks on the risk register; two of these risks were opened in the period 2017/18 and 5 were closed* – see tables 3- 5 below.

New risks opened and approved (excluding BAF risks) in 2017/18

Category	*Total*
Clinical	40
Environment	2
Finance, Performance, Contracts and Strategy	60
Fire, Health and Safety	5
Information Governance	4
Information Management and Technology	32
Medical Directorate	4
Reputational	6
Security	1
Workforce	13
Total	**167**

Table 1

Risks closed (excluding BAF risks) in 2017/18

Category	*Total*
Clinical	54
Environment	5
Event	1
Finance, Performance, Contracts and Strategy	42
Fire, Health and Safety	8
Information Governance	2
Information Management and Technology	31
Medical Directorate	3
Reputational	14
Workforce	15
Total	**175**

Table 2

BAF risks opened and approved

Category	*Total*
Workforce	1
Information Governance	1
Total	**2**

Table 3

BAF risks closed or removed from the BAF register[1]

Category	*Removed from BAF*	*Closed*	*Total*
Clinical	1	1	2
Workforce	1		1
Finance, Performance, Contracts and Strategy		1	1
Information Management and Technology	1		1
Total	**3**	**2**	**5**

Table 4

[1] *Risks that were removed from the BAF register in the 2017/28 period (but continued to be managed as part of the Trust's risk register) are included in this figure*

Major strategic risks to Trust priorities in 2017/18 included:

ID	Risk	Trust Objective
930	BAF Risk: Poor track record in developing collaborative partnerships with other providers to respond to new models of commissioning which may compromise the Trust's future viability. Principal Assurance Committee: FRIC	*Strategy Implementation* - Implement strategic priorities of integration and place
1154	BAF Risk: Failures in adherence to Information Governance national standards can lead to reputational damage, conflict with regulatory compliance and undermine the quality of Trust service delivery. Principal Assurance Committee: Quality	*Quality* - Maintain and improve the quality of services delivered by CLCH moving from good to outstanding
1218	BAF Risk: Currently the Trust's business information and analytics function is under-performing, providing inconsistent contractual information requirements. There are also variable sign-off arrangements for data submission externally. This represents a reputational risk with commissioners and regulators. There is also a financial risk through loss/failure to win contracts and inability to recover income that is due through poor/no information. Principal Assurance Committee: FRIC	*Operations* - Deliver all NHS constitutional and contractual standards
1598	BAF Risk: Sustainability and Transformation Plan (STP) Resource. Risk that the Trust has not allocated adequate resources to the engagement with the STP process in the four geographies where CLCH provides services - NWL, NCL, SWL, Herts. This could mean that the Trust's strategic interests and the interests of community healthcare are not sufficiently represented in the development of the STPs. Principal Assurance Committee: FRIC	*Finance* - Deliver the 17/18 financial plan
1797	BAF Risk: Risk that the Trust will have less flexibility to enter into New Care Models/Joint Ventures as it is not an FT and there is a national pause in FT programme. Principal Assurance Committee: FRIC	*Strategy Implementation* - Implement strategic priorities of integration and place
1960	BAF Risk: Medium to long term changes in workforce (nursing & therapies) presents a risk that CLCH will not be able to recruit and retain suitably qualified clinical staff to deliver a safe and effective service. Principal Assurance Committee: Workforce	*Quality* - Maintain and improve the quality of services delivered by CLCH moving from good to outstanding, *Workforce* - Make CLCH

		a great place to work
1961	BAF Risk: Weaknesses in NHS cyber security identified at national level may put the Trusts data (staff, patient and business related) at risk which could result in IG breaches, loss of reputation and risk for staff & patients Principal Assurance Committee: Quality (from 2018/19 FRIC)	*Operations* - Deliver all NHS constitutional and contractual standards
831	BAF Risk: Failure to deliver the 2017/18 QIPP (£9.5m) results in a reduced surplus or a deficit which could affect our NHSI segment 1 status. Principal Assurance Committee: FRIC	*Finance* - Deliver the 17/18 financial plan
833	BAF Risk: Risk of our failure to maintain commissioner satisfaction with Trust delivery - through shortfalls in stakeholder engagement, contract delivery or perceived misalignment of Trust services with commissioners' intentions - leads to commissioner discontent and risk of lost income. Principal Assurance Committee: FRIC	*Finance* - Deliver the 17/18 financial plan
866	BAF Risk: Failure to compete results in a failure to increase or maintain Trust market share in our core services and STPs. Principal Assurance Committee: FRIC	*Finance* - Deliver the 17/18 financial plan

Table 5

12.3 Quality governance

The Trust's Clinical Framework provides a plan for the way in which services will be delivered and sits at the heart of the work of the organisation in support of the Organisational Strategy. The Trust recognises that it will need to continuously update its models of care to meet the needs of patients, commissioners and sustainability and transformation plans (STP) in a changing environment.

The quality account, published in June annually, defines the Trust's annual quality objectives, linked to the objectives in the quality strategy, and provides a public report on the success year on year of the Trust's plans. The Quality Strategy supports the Trust's objectives and Clinical Framework by clearly defining the vision and success criteria (campaigns) for maintaining and improving quality through all Trust services. In December 2016 the Board approved a new quality strategy incorporating the innovative shared governance model. Governance arrangements for the 6 campaigns: a positive patient experience; preventing harm; smart, effective care; modelling the way; here, happy, healthy and heard; value added care, are defined in the quality strategy together with clearly defined measures of success each year until 2019/2020.

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

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

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

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

For a second year, CLCH has remained in segment 1 (providers with maximum autonomy) and we were delighted to maintain our rating of 'good' following assessment by the CQC in October 2017. Feedback from NHSI throughout the year 2017/18 NHSI has been supportive and positive.

12.4 Corporate governance framework

The Board governance structure is shown in figure 1 below.

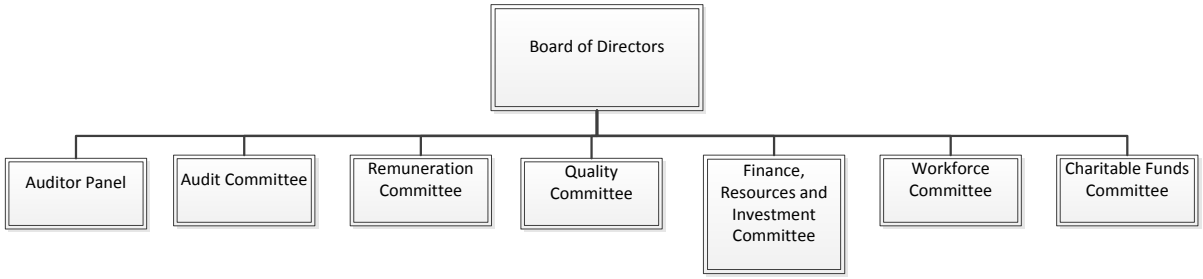


Figure 1

12.5 The role of the Board's Committees

12.5.1 Auditor Panel – meetings arranged as required

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

12.5.2 Audit Committee – minimum of 4 meetings per year

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

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

In addition to its core responsibilities, the Audit Committee has focused on the following areas as part of its programme of work during 2017/18:

- To continue to monitor progress against the implementation of the data quality strategy to gain assurance on the accuracy, timeliness and relevance of key performance data sets.
- To continue to gain assurance on the governance and processes in place to bring new contracts on board successfully, delivering to the satisfaction of commissioners and achieving business plan.
- To gain assurance that the Trust has a system of controls for the management and development of significant supplier contracts including controls of contractual changes and the monitoring of the delivery of contractual obligations.
- To receive internal audit reports, monitor and gain assurance that recommendations are being complete in a timely manner.

- To ensure that the Trust has a robust system for identifying and reducing instances of fraud.

12.5.3 Remuneration Committee - minimum of 3 meetings per year

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

12.5.4 Quality Committee – minimum of 9 meetings per year

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

12.5.5 Finance, Resources and Investment Committee – minimum of 10 meetings per year

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

12.5.6 Workforce Committee – minimum of 3 meetings per year

The Workforce Committee is responsible for seeking assurance on the appropriateness of the people strategy and its implementation across the Trust and strategic partnership. Similar to the Remuneration Committee, the Committee is mindful of the need to improve the diversity of the workforce so that it better reflects the populations which the Trust serves.

12.5.7 Charitable Funds Committee - minimum of 3 meetings per year

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

12.6 Board and Committee attendance

Summary attendance by members of Board and Committee meetings during 2017/18 is

shown in table 6 below[2] - please note that the Associate Non-Executive Director is a non-voting member of the Board.

	Board of Directors, including non-voting members[3]	Auditor Panel	Audit Committee	Remuneration Committee	Quality Committee	Finance, Resources and Investment Committee (FRIC)	Workforce Committee	Charitable Funds Committee
April 2017	11/12^{ANV}	-	3/3	-	5/6	5/5	-	-
May 2017	11/12^{ANV}	-	2/3	-	6/7*	5/6*	-	-
June 2017	8/12^{ANV}	-	-	2/3	3/7	4/6	3/5	-
July 2017	10/12	-	3/3	-	4/7	5/6	-	3/5^{DDO}
August 2017	-	-	-	-	-	-	-	-
September 2017 (AGM)	11/12	-	-	-	-	-	-	-
September 2017	11/12	-	-	-	7/7	6/6	-	-
October 2017	9/12	-	3/3	-	7/7	6/6	-	-
November 2017	10/12	-		3/3	7/7	6/6	4/5	-
December 2017	-	-	3/3	-	-	-	-	5/5
January 2018	11/12	-	-	-	7/7	5/6	-	-
February 2018	8/12	-	-	3/3	7/7	5/6	4/5	5/5
March 2018	11/12	-	3/3	-	-	4/6	-	-

Table 6

Key	
ANV	Associate Non-Executive Director vacancy
DDO	Divisional Director vacancy
EV	Executive Director vacancy
*	In May 2017, the Director of Improvement joined the membership of the Quality Committee and FRIC

The Executive Director Leadership (ELT) 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. There is a weekly meeting of ELT which includes the Divisional Directors of Operations.

Each Committee is required to consider how well it has performed during the year against their terms of reference and annual work plan. The Audit Committee, Finance, Resources

[2] Board attendance is based on the meeting in public, part-attendance at meetings is included
[3] Associate Non-Executive Director

and Investment Committee and Workforce Committee also agree specific annual objectives.

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

12.7 Committee programmes and issues reported to the Board

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

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

CLCH is the Corporate Trustee of the CLCH NHS Trust Charity having been appointed on 22 December 2011. The Board has devolved responsibility for the on-going management of funds to the Charitable Funds Committee, which administers the funds on behalf of the Corporate Trustee.
Issues highlighted by Committees of the Board during the year include matters in relation to the following:

12.7.1 Auditor Panel

KPMG were recommended in 2016 as the Trust's external auditor from 01.04.17. There have been no meetings of the panel in 2017/18.

12.7.2 Audit Committee

The Committee has highlighted matters in relation to: risk management; progress against the internal audit and counter fraud plan; policy management; procurement; internal audit tender and the management of tender waivers.

Following the Committee's recommendations to the Board, the process to identify and report internal audits has been strengthened, including sharing reports with the relevant Board committee and presentation of limited assurance report findings by responsible executive leads as appropriate.

A number of control issues in relation to the South Division advisory audit were identified during the year and reported to the Board.

The Committee has emphasised the need for management to provide comprehensive and unambiguous responses to internal audit recommendations which address the risks identified for all internal and advisory audits.

12.7.3 Remuneration Committee

During the year a number of important issues have been managed on behalf of the Board, including: phase II of the executive team restructure; very senior manager (VSM)

appointments and remuneration; Board vacancies and succession planning.

The Committee has also considered severance arrangements and noted the effectiveness of proactive redeployment initiatives - minimising costs and, importantly, the impact on staff.

12.7.4 Quality Committee

The Committee has routinely considered assurance reports in support of the quality strategy and has highlighted a number of innovative developments in support of patient care[4], for example the quality development units and the range and richness of methodology in support of hearing the patient voice. Issues in relation to quality action teams (QAT) and workforce action teams (WAT) have also been brought to the attention of the Board, together with matters in relation to the modernisation of Trust wide in-patient rehabilitation services and the transfer of services and mobilisation of new services.
A number of annual reports have been scrutinised in support of the Board, for example: the quality account; safeguarding; medicines management; infection management and prevention, together with a new policy entitled 'learning from deaths'.

The Committee has also considered, in detail, limited assurance report recommendations in relation to The National Institute for Health and Care Excellence (NICE) and clinical audit.

12.7.5 Finance, Resources and Investment Committee

The Committee has highlighted issues in relation to: performance (operational and financial); post investment reviews (transformation projects and new services); financial plans and risks; delivery of savings plans and the challenges of mobilising and demobilising services.

Progress against the estates, procurement and IM&T strategies has been monitored, together with regular review of the business information and performance analytics (BIPA) rectification and service improvement plans – against which progress has been demonstrated.

A deep dive into the South Division financial position was undertaken in January 2018 with a number of control issues reported to the Board see section 7 - below.

12.7.6 Workforce Committee

Issues brought to the attention of the Board have included: clinical workforce transformation, leadership, education and training, progress in implementing the people strategy; performance monitoring and exception reporting, together with national directives in relation to gender pay.

Control issues in relation to HR processes have been actively monitored with a recommendation for further review in 2018/19.

[4] And our ambitions to move from CQC 'good' to 'outstanding'

12.7.7 Charitable Funds Committee

On behalf of the Corporate Trustee, the Committee approved an updated fundraising strategy. Risks have been closely monitored and the Corporate Trustee has been made aware that the Charity will need to use capital as well as income to fund initiatives while fundraising initiatives are embedded.

12.7.8 Board of Directors

The Board generally meets in public. When this is not possible, due to reasons of confidentiality, it excludes members of the public pursuant to the Public Bodies (Admission to Meetings) Act 1960. In their meetings, the Board regularly considers strategic, operational and governance issues, including the assurance framework and risk management. CLCH standing orders and standing financial instructions include the scheme of delegation and decisions reserved for the Board. There have been a number of changes to the membership and composition of the Board during the year as shown in table 7 below, including a new executive director post for 2018/19.

Board membership and composition	Post holder	Notes
Chief Nurse and Chief Operating Officer	From 08.07.17 Louise Ashley, substantive	From 01.01.17 to 07.07.17 Louise Ashley was Chief Nurse and Acting Chief Operating Officer
Director of Improvement	From 01.05.17 James Benson, substantive	New post introduced in 2017
Non-Executive Director	From 01.04.17 Clive Sparrow	
Senior Independent Director	To 31.03.18 Anne Barnard	From 01.04.18 David Sines
Deputy Chair	To 31.03.18 Anne Barnard	From 01.04.18 Carol Cole
Associate Non-Executive Director	From 08.06.17 Paula Constant	Non-voting position 18 month duration
Director of People and Communications (new position for 2018/19)	From 01.04.18 Louella Johnson, substantive	Non-voting position

Table 7

With the exception of the Director of Improvement position, the Board has had a full complement of substantive Executive and Non-Executive Directors since April 2017.

12.7.9 Committee Chair arrangements

Committee	Chair	Notes
Auditor Panel	To 31.03.18 Jitesh Chotai	From 01.04.18 Clive Sparrow
Audit Committee	To 31.03.18 Jitesh Chotai	From 01.04.18 Clive Sparrow
Remuneration Committee	David Sines	

Quality Committee	Carole Cole	
Finance, Resources and Investment Committee	To 31.03.18 Anne Barnard	From 01.04.18 Jitesh Chotai
Workforce Committee	David Sines	
Charitable Funds Committee	To 03.12.17 Carol Cole	From 04.12.17 Clive Sparrow

Table 8

12.8 Board performance and development

In May 2018, Board members participated in a self-assessment showing sustained / good progress on the previous year; results will be used to inform the Board's development plan to support Board effectiveness during 2018/19. Internal and external Board development over the past few years has demonstrated a strong commitment to maintaining an engaged and effective Board.

Development during 2018 will support the Trust's organisational strategy and the well-led framework domains in relation to appropriate and accurate information being effectively processed, challenged and acted on and robust systems and processes for learning, continuous improvement and innovation.

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

A register of relevant and material Board member interests is maintained and published on the Trust's website. Board and Committee meeting agendas routinely include an opportunity for members to declare any interests in agenda items. Any such interests are recorded in the minutes of the meeting as well as 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 at any Board or Committee meeting.

12.9 Statutory duties

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

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

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

accordance with the timescales detailed in the Regulations.

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

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the adaptation reporting requirements are complied with.

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

We are proud to have maintained high quality services and to have achieved our target surplus for a seventh consecutive year.

We have implemented a number of major transformation schemes and the majority of schemes in the 2017/18 Quality, Innovation, Productivity and Prevention plan relate to the efficient use of resources rather than reductions in staff numbers. This programme has been delivered whilst maintaining the safety and quality of services which is assured by a process of quality impact assessments undertaken by the Trust medical director and chief nurse and chief operating officer. However not all related cost improvement plan targets were achieved on a recurrent basis in-year.

In addition to external audit, the Trust agreed a number of internal audits during the year to provide assurance in support of statutory functions. Core audits have included: the BAF and financial ledger and feeder systems (including payroll) and information governance together with cost improvement and financial reporting and budgetary management.

In November 2017, a use of resources assessment was introduced as part of the single oversight framework. While this applies only to acute providers, the Trust has been engaged with the Carter review and some early work on the development of the use of resources assessment to community trusts and a summary of the use of resources metrics will be included in quarterly reports to the Board with an initial indication of the metrics that would apply to CLCH and which we could start to monitor in shadow form in 2018/19.

14 Information governance

Incidents with a severity level of two or above are classed as serious incidents and must be externally reported to the Information Commissioner's Office (ICO) via the information governance toolkit incident reporting tool.

During the period of 01.04.17 to 31.03.18 a total of eight serious incidents (level two) were

reported to the ICO, one incident was later withdrawn as the investigation revealed that there was no breach as the data was never accessed. This is an increase from the previous year (2016/17) when a total of five incidents were reported.

Seven incidents have been investigated by the ICO, and have been closed with no further action required.

The information governance team is supported by the Caldicott Guardian. The Quality Committee receives an annual report from the Caldicott Guardian, including issues raised / reported to the Information Commissioner's Office.

15 Annual quality account

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

The draft Quality Account is scrutinised by the Quality Committee on behalf of the Board. Recommendations from our external auditor in relation to previous voluntary audits of the Quality Account have been implemented in full.

15.1 Quality and accuracy of elective waiting time data

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

The Trust follows national guidance on submission of RTT reports. Reports are issued through the NHS UNIFY2 system. The reports are generated via the informatics team and are scheduled for deployment in the new data warehouse due in July 2018. Information is extracted directly from CLCH clinical systems.

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

16 Review of effectiveness

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

During the year 2017/18 internal audit undertook a review of the Trust's BAF which confirmed 'substantial assurance' following a period of significant development.

The Head of Internal Audit Opinion is provided annually to contribute to the assurances available to the Accounting Officer and the Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control. During 2017/18, an overall opinion of "reasonable assurance" was provided.

Of the 12 internal audits reported during the year, four reports confirmed substantial assurance, five reasonable assurances, with three limited assurance opinions. There was one advisory report.

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

Clinical audit

- While the Trust had participated in three mandatory national audits, the full audit cycle for one of these audits was not completed
- There was a backlog of recommendations and actions identified from completed audits for 2015/16 and 2016/17
- The clinical audit database, policy and other documents were not up-to-date

NICE

- There was no evidence to support action plans developed in the baseline assessment forms for NICE guidance
- While regular meetings were held, not all meetings were quorate
- Guidelines were not always successfully disseminated and implemented
- The policy was inconsistent with agreed key performance indicators
- Problems in implementing changes were not always escalated effectively.

Records management and archiving

- Inadequate supporting information to provide assurance for the management of the archiving arrangements for both services
- There was no evidence that the minimum retention period for paper records of the services audited or justifiable business reasons for not destroying records older than the eight years retention period stipulated in the records management policy (RMP)
- The clinical business unit manager advised that the 'change of location form' stipulated in the policy was completed for all four sites where the two services were provided this could not be evidenced
- The first batch of archiving took place in July 2017 and another batch in October 2017, however, there were more than 100 boxes to be archived at the time of audit fieldwork in April 2018
- No evidence was provided to show that the decommissioning of the 2 services and archiving of records had been reported to a Committee of the Board, or that lessons learnt had been formally shared within the Trust.

During the year TIAA Ltd undertook a detailed follow-up exercise of the recommendations in relation to the clinical audit and NICE limited assurance reports. They have concluded that all of the recommendations have been successfully implemented by the Trust. The records management and archiving report was issued at the end of the year, therefore progress against the recommendations made will be monitored during 2018/19.

While there have been three limited assurance reports, the Trust has a risk based approach to preparing the internal audit plan – focusing on areas where further assurance is required in order to identify necessary change or improvement. The clinical audit and NICE limited assurance reports have been considered in detail by the Quality Committee.
There were 5 overdue internal audit recommendations at year-end – these relate to the advisory report in relation to the South Division. All recommendations will be completed (to strengthen controls) when the upgrade to the finance system is complete.

Some control issues, in relation to the South Division, have been identified by the management team during the year for which an internal review, advisory audit and external review have been undertaken. The review findings have been considered by the Board and a comprehensive action plan has been agreed.

A summary of issues identified and action taken is shown in **table 9** below.

Summary control issue	Action taken
Weaknesses in financial management – lack of clarity regarding how savings for the year would be achieved and lack of transparency about the financial position in first quarter of the year	Internal review and advisory audits arranged in September 2017, issues identified now fully addressed.
Weaknesses in establishment change control- recruitment to vacant posts without transforming the model of care led to a significant over establishment	Recovery plan implemented to re-model the services within safer staffing requirements to remove over established posts. Independent review undertaken in February

and overspend position	2018, actions identified now being addressed.

Table 9

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

17 Conclusion

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

There have been no significant internal control issues raised by internal audit during the year. Control issues identified by the management team in relation to the South Division during the year are detailed above.

Andrew Ridley, Chief Executive

Date: 23 May 2018

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

The chief executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the chief executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum.*

These include ensuring that:

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

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

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

Andrew Ridley, Chief Executive

Date:.23 May 2018

19 Statement of directors' responsibilities in respect of the accounts

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

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts;
- assess the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error, and for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.
The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

Andrew Ridley, Chief Executive
Date:.23 May 2018

Mike Fox, Director of Finance, Contracting and Performance
Date:.23 May 2018

20 Remuneration and Staff Report 2017/18

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 2018.

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.

20.1 Remuneration Committee

The Remuneration Committee is made up of the Chairman and two Non-Executive Directors of the Trust Board as voting members: the director of HR and chief executive are attendees. The Committee meets as necessary to advise the Board on the appropriate remuneration and terms of service for the chief executive and directors.

20.2 Remuneration policy

The Committee's deliberations are carried out within the context of national pay and remuneration guidelines, local comparability and taking account of independent advice regarding pay structures.

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

20.2.1 Basic Salary

Directors and senior managers with remuneration set by the Very Senior Managers' (VSM) Pay Framework

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

The reward package set by the VSM Pay Framework is as follows:

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

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

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

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

The 2013 VSM Framework for Community Trusts is available to the general public on the Department of Health website.

Directors and senior managers with remuneration paid via an agency

The Trust did not pay the remuneration of any Board members via an agency during 2017/18 (2016/17: 1).

20.2.2 Incentive arrangements

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

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

No performance bonus awards were paid by CLCH during the year relating to 2017/18. Two performance related bonuses were paid in 2017/18 that related to 2016/17. These were agreed and approved during 2017/18 and so were not presented in the 2016/17 remuneration report. These figures have been updated in the 2016/17 performance pay and bonuses below.

20.2.3 NHS Pension entitlement

All staff including senior managers are eligible to join the NHS Pension Scheme. The Scheme has fixed the employer's contribution at 14.3% (2016/17: 14.3%) of the individual's salary as per the NHS Pension Agency Regulations. Employee contribution rates for Trust employees and practice staff, and the prior year comparators, are as follows:

Tier	Annual Pensionable Pay (full time equivalent)	Contribution Rate 2017/18	Contribution Rate 2016/17
1	Up to £15,431.99	5.0%	5.0%
2	£15,432.00 to £21,477.99	5.6%	5.6%
3	£21,478.00 to £26,823.99	7.1%	7.1%
4	£26,824.00 to £47,845.99	9.3%	9.3%
5	£47,846.00 to £70,630.99	12.5%	12.5%
6	£70,631.00 to £111,376.99	13.5%	13.5%
7	£111,377.00 and over	14.5%	14.5%

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

20.2.4 Service contracts

Each of the directors and very senior managers listed below has or has had a substantive or fixed term contract which can be terminated by either party giving between three and six 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 start Date	Leave date
Andrew Ridley	Chief Executive	01/10/2016	-
Dr Joanne Medhurst	Medical Director	14/01/2013	-
Mike Fox	Director of Finance, Contracting and Performance	12/12/2016	-
Louise Ashley	Chief Nurse and Director of Quality Governance	21/11/2012	01/01/2017
Louise Ashley	Acting Chief Nurse and Chief Operating Officer	01/01/2017	07/07/2017
Louise Ashley	Chief Nurse and Chief Operating Officer	07/07/2017	-
James Benson (a)	Director of Improvement	01/05/2017	-

a) James Benson commenced the role of Director of Improvement on 1 May 2017.

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

20.2.5 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.

20.2.6 Salaries direct to limited companies

The Trust has a policy that all substantive staff are paid through the payroll. The Trust paid the remuneration of no Director to an associated limited company during the financial year 2017/18 (2016/17: 0).

20.2.7 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 2017/18 was £165,000 to £170,000 (2016/17: £275,000 to £280,000). The reason that 2016/17 was higher than 2017/18 was because the upper limit of the highest remuneration paid during 2016/17 reflected the full year effect of three months' fees paid to agency for the service of an interim Chief Executive Officer between 1 April 2016 and 30 June 2016 while recruiting a substantive replacement. This was 5 times (2016/17: nine times) the median remuneration of the workforce, which was £31,333 (2016/17: £32,088).

In 2017/18 two employees received remuneration higher than the highest paid Director (2016/17: nil), both of these employees were temporary Medical staff. The highest paid Director during 2017/18 was the Trust's Chief Executive. Remuneration paid to employees during 2017/18 ranged from £13k to £208k (2016/17 £19kk to £279k). The upper limit of the highest remuneration paid during 2016/17 reflects the full year effect of three months' full time remuneration and not the actual remuneration of any single individual.
The VSMs in post on 1st April 2017 received a pay increase in line with NHSI guidance in relation to 1% of the average VSM salary in CLCH during 2017/8.

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.

20.2.8 Non-Executive Directors

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

Non-Executive Directors are paid a fee set nationally. Travel and subsistence fees incurred in respect of official business are payable in accordance with nationally set rates. Non-Executive

Directors are also able to reclaim expenses related to all necessary carer 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	01/04/2010	31/03/2018
Jitesh Chotai	Non-Executive Director	01/06/2016	-
Angela Greatley	Chair of the Board	01/04/2016	-
David Sines	Non-Executive Director	27/06/2012	-
Carol Cole	Non-Executive Director	01/08/2014	-
Clive Sparrow	Non-Executive Director	01/04/2017	-

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

	2017/18					2016/17				
Name and Title	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	Total (bands of £5,000)	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	Total (bands of £5,000)
Executive Directors										
Andrew Ridley (Chief Executive)	165-170	0	0	0	165-170	80-85	0	0	0	80-85
Dr Joanne Medhurst (Medical Director) (a) (c)	105-110	0	0	0	105-110	105-110	0	0-5	0	105-110
Ian Millar (Director of Finance, Performance and Corporate Resources from 22 August 2013 to 16 September 2016)	0	0	0	0	0	55-60	0	0	0	55-60
Louise Ashley (Chief Nurse and Chief Operating Officer) (c)	120-125	0	0	0	120-125	110-115	0	0-5	0	115-120
Mike Fox (Director of Finance, Contracting and Performance) – from 12 December 2016)	115-120	0	0	0	115-120	35-40	0	0	0	35-40
Peter Coles (Interim Chief Executive from 11 January 2016 to 30 June 2016) (b)	0	0	0	0	0	65-70	0	0	0	65-70
Richard Milner (Deputy Chief Executive and Director of Operations) to 31 December 2016	0	0	0	0	0	125-130	0	0	0	125-130

James Benson (Director of Improvement) from 1 May 2017	95-100	0	0	0	95-100	0	0	0	0	0
Non-Executive Directors										
Angela Greatley (Non-Executive Director)	30-35	0	0	0	30-35	30-35	0	0	0	30-35
Anne Barnard (Non-Executive Director)	5-10	0	0	0	5-10	5-10	0	0	0	5-10
Carole Cole (Non-Executive Director)	5-10	0	0	0	5-10	5-10	0	0	0	5-10
Jitesh Chotai (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) to 31 March 2017	0	0	0	0	0	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
Clive Sparrow (Non-Executive Director) from 1 April 2017	5-10	0	0	0	5-10	0	0	0	0	0

a) Dr Joanne Medhurst works part-time for the Trust - 4.5 days per week. This is reflected in her salary banding.

b) Peter Coles was employed as an interim chief executive via an agency.

c) Louise Ashley and Dr Joanne Medhurst both received a performance related bonus that was agreed and paid in 2017/18 due to their performance in 2016/17.

Directors' and Very Senior Managers' Pension Benefits – audited

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 2018 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2018 - £'000 (Note d)	Cash Equivalent Transfer Value at 31 March 2017 (Note d)	Real increase/ (decrease) in Cash Equivalent Transfer Value £000 (Note e)	Employer's contribution to stakeholder pension (£000)	Total pension entitlement at 31 March 2018 (Bands of £5,000)
Dr Joanne Medhurst (Medical Director)	0-2.5	0-2.5	20-25	55-60	421	383	37	0	20-25
Louise Ashley (Chief Nurse and Chief Operating Officer)	2.5-5	7.5-10	25-30	85-90	579	490	90	0	25-30
Mike Fox (Director of Finance, Contracting and Performance)	2.5-5	5-7.5	25-30	65-70	360	286	74	0	25-30
James Benson (Director of Improvement)	0	0	15-20	40-45	205	0	0	0	15-20

Notes

a) Non-Executive members do not receive pensionable remuneration. There are no payments in respect of pensions for Non-Executive members (2016/17: £nil).

b) During 2017/18 the Trust paid no employer's contribution into director's personal pension plans (2016/17: £nil).

c) 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.

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

e) The 2017/18 and 2016/17 Pension, Lump Sum and CETV for Dr Joanne Medhurst exclude Practitioner (i.e. GP) pension benefits.

f) James Benson's pension disclosure does not include the real increase in pension, real increase in pension lump sum and real increase in CETV as he was appointed to the Board during 2017/18 and his 2016/17 data was not available.

21 Staff Report

The profile of CLCH has altered throughout the year with movement of services into and out of the organisation in line with the commissioning intentions and outcomes of competitive tender processes. Key services to leave CLCH's portfolio in 17/18 have included sexual health services in Inner London, parts of the dental service and parts of the Inner London school nursing units. Meanwhile health visiting services in Brent, Richmond and Wandsworth, sexual health services in South West London, and community adults services covering all of Wandsworth have been key additions to CLCH's portfolio in 17/18. Fewer variations in service are expected in 18/19 though school nursing services in Hounslow and Harrow, and small elements of Barnet children's therapies are confirmed to be moving out of the portfolio.

Staff sickness absences rates are within targeted tolerances closing at a 12 month rolling position of 3.65%.

Expenditure relating to consultancy is disclosed in note seven of the financial statements. Exit package payments are disclosed below (subject to audit).

The head count split of individuals paid through CLCH payroll at 31 March 2018 was (13%) male to (87%) female (31 March 2017: 13% male to 87% female). Our Board Management gender breakdown as at 31 March 2018 was as follows: six male, five female (31 March 2017 was as follows: four male, six female).

21.1 Average number of employees (WTE basis – subject to audit)

	2017/18			2016/17		
	Permanent Number	Other Number	Total Number	Permanent Number	Other Number	Total Number
Medical and dental	30	6	**36**	74	13	87
Ambulance staff	-	-	**-**	-	-	-
Administration and estates	583	92	**675**	602	54	656
Healthcare assistants and other support staff	406	54	**460**	31	1	32
Nursing, midwifery and health visiting staff	1,188	209	**1,397**	1,349	345	1,694
Nursing, midwifery and health visiting learners	-	-	**-**	-	-	-
Scientific, therapeutic and technical staff	476	63	**539**	483	129	612
Healthcare science staff	-	-	**-**	-	-	-
Social care staff	-	-	**-**	3	-	3
Other	9	3	**12**	-	-	-
Total average numbers	**2,692**	**427**	**3,119**	**2,542**	**542**	**3,084**
Of which:						
Number of employees (WTE) engaged on capital projects	5	-	**5**	8	-	8

21.2 Exit packages agreed for staff

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages	Total cost of exit packages
	Number	Number	Number	£000
Exit package cost band				
<£10,000	-	-	-	-
£10,001 - £25,000	2	-	2	24
£25,001 - 50,000	4	-	4	171
£50,001 - £100,000	1	-	1	69
£100,001 - £150,000	1	-	1	107
£150,001 - £200,000	-	-	-	-
>£200,000	-	-	-	-
Total number of exit packages by type	**8**	**-**	**8**	**371**

Reporting of compensation schemes - exit packages 2016/17

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages	Total cost of exit packages
	Number	Number	Number	£000
Exit package cost band				
<£10,000	6	-	**6**	35
£10,001 - £25,000	2	-	**2**	22
£25,001 - 50,000	-	-	**-**	-
£50,001 - £100,000	1	-	**1**	100
£100,001 - £150,000	-	-	**-**	-
£150,001 - £200,000	-	-	**-**	-
>£200,000	-	-	**-**	-
Total number of exit packages by type	**9**	**-**	**9**	**158**

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.

21.3 Sickness absences

During the 2017/18 financial year the Trust's staff took a total of 21,876 days (2016/17: 19,328 days) of sickness absence. This is an average of 8 days (2016/17: 7.6) per staff member. These amounts are for the calendar year 2017.

21.4 Retirements due to ill-health

During 2017/18, 4 persons retired early on ill-health grounds during the financial period (2016/17: 2 persons). The associated additional accrued pension liabilities total £212K (2016/17: £19K).

21.5 Staff policies applied during the financial year

The Trust has policies which have consideration for the following:

- Giving full and fair consideration to applications for employment by the Trust made by disabled persons, having regard to their particular aptitudes and abilities
- Continuing the employment of, and for arranging appropriate training for, employees of the Trust who have become disabled persons during the period when they were employed by the Trust
- The training, career development and promotion of disabled persons employed by the Trust.

These policies are all published on the Trust's website at https://www.clch.nhs.uk/

Andrew Ridley, Chief Executive - on behalf of the Board

Date: 23 May 2018

Independent auditor's report to the board of directors of Central London Community Healthcare NHS Trust

Report on the audit of the financial statements

Opinion

We have audited the financial statements of Central London Community Healthcare NHS Trust ("the Trust") for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note one.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as being relevant to NHS Trusts in England and included in the Department of Health Group Accounting Manual 2017/18.

Basis for opinion

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

Going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements. We have nothing to report in these respects.

Other information in the Annual Report

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

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

in the other information. In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health Group Accounting Manual 2017/18. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health Group Accounting Manual 2017/18.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 46, the directors are responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity . As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on page 45 the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

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

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

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

As explained in the statement set out on page 45, the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved

from the resources available to the Trust. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

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

Statutory reporting matters

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

- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

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

This report is made solely to the Board of Directors of Central London Community Healthcare NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Board of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

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

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

25 May 2018

22 Financial overview

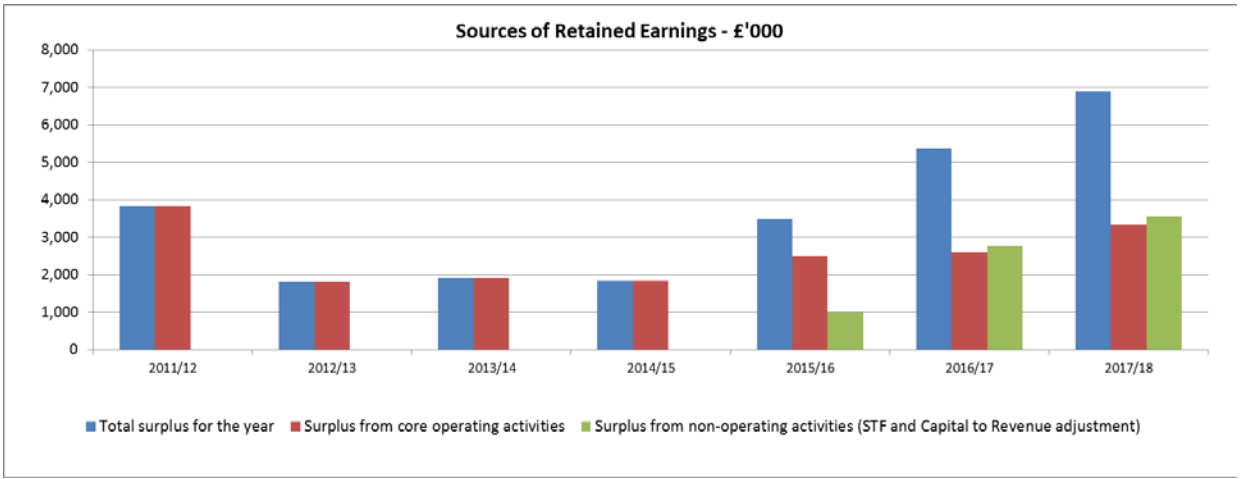
In 2017/18 the Trust achieved all key financial targets agreed with the Department of Health and NHS Improvement at the start of the financial year. These achievements include

- Achieving a surplus of £6,883k against plan of £5,013k
- Investing £7,166k of Capital in IT, Estates and Medical Equipment (£27k lower than our Capital Resource Limit)
- Cash on hand was £22,709k at the end of March 2018 (£13,9k higher than plan)
- Reducing reliance on high cost temporary staffing resulting in agency spend to £6,434k in 17/18 being £9,458k lower than the £15,892k reported in 2016/17. This means that the Trust has achieved the cap on agency spend set by NHSI ; and
- Achieving 'Segment 1' status on the Single Oversight Framework performance indicator instituted by NHS Improvement.

Our Earnings before Interest Tax Depreciation and Amortisation (EBITDA) for the year ended 31 March 2018 were £14,233k which equates to a 6.6% gross margin (2016/17: £11,714k, 5.5% gross margin). The increase of £2,519k in our current year EBITDA over the previous year is mainly as a direct result of the impact of Sustainability and Transformation Funding (STF) from NHS Improvement (£3,550k) which CLCH was not permitted to spend as well as improved operational efficiency in the Trust.

The Trust had capital and reserves totaling £63,449k at 31 March 2018 (2016/17: £53,627k). Our capital and reserves have risen by £9,822k during the year; the increase is attributable to net surplus retained for the year of £6,883k, public dividend capital (PDC) granted of £794k for Parsons Green development and an increase in the revaluation reserve of £2,145k.

The Trust delivered a full year surplus of £6,883k (2016/17: £5,380k), £1,870k (37.3%) more than plan due to £1,708k of STF received above plan from NHS Improvement for meeting key performance indicators (£3, 550k in total) and the Trust having a £162k surplus higher than plan. The Trust surplus consisted of £3,333k generated from operating activities and £3,550k of STF. The surplus generated by our operating activities was mainly driven by increased efficiency in services and reductions in spend on high cost agency staffing.

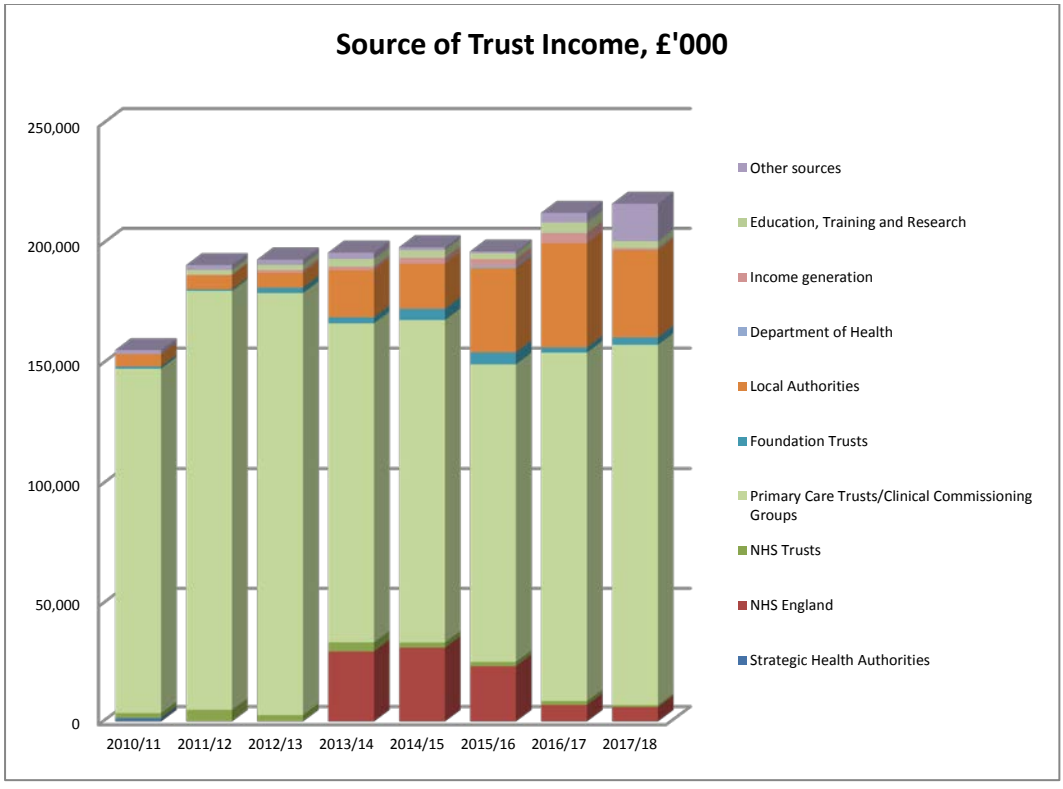


The Trust's working capital remains a source of strength and ensures that the Trust is both a good organisation for stakeholders to do business (as we pay our bills on time and in full) and provides a stable platform on which we can make the investment decisions needed to secure the future of the essential services we deliver. At 31 March 2018 the Trust had cash balances of £22,709k (2016/17: £11,346k), sufficient to pay for over 40 days of the Trust's operating expenditure. During the year the Trust continued to carefully manage its working capital, outstanding receivables and payables. A significant driver of our improved cash position is as a result of difficulties in agreeing payments to several significant suppliers.

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

23 Income

Our operating income (which excludes interest earned) for the year to 31 March 2018 was £216,614k (2016/17: £212,749k) which came from the following sources:

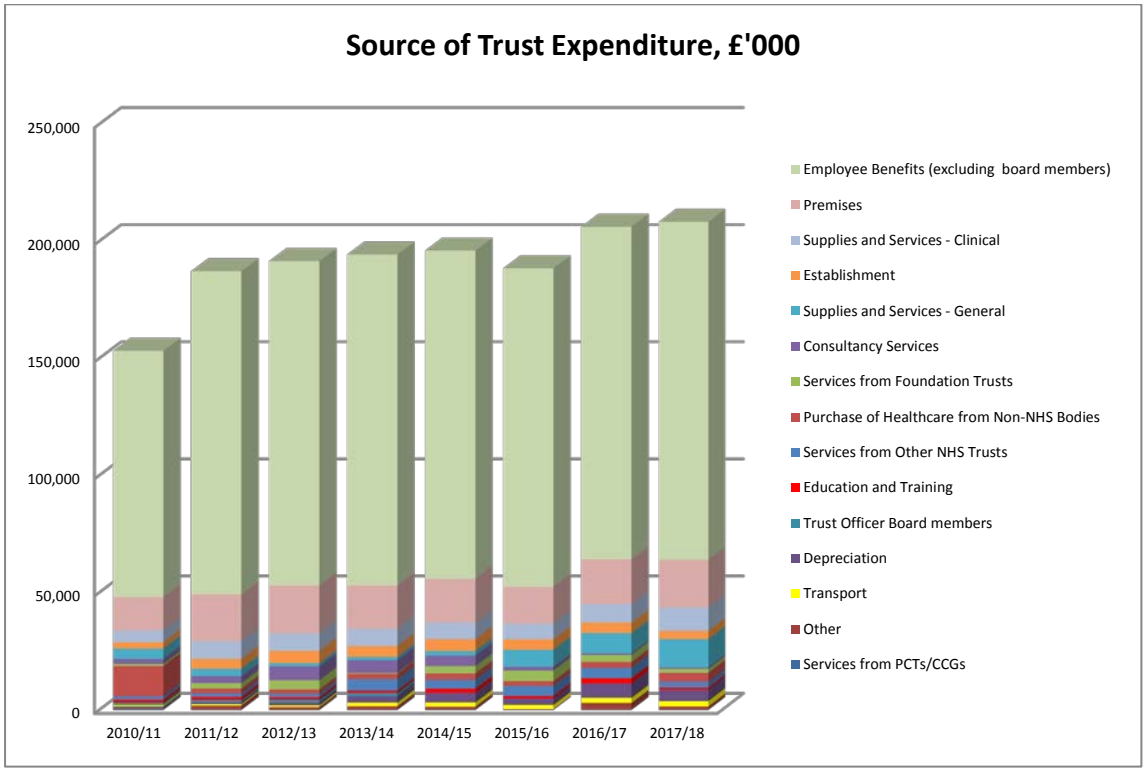


Income increased by 2% or £3.9m due to net gain in business as the profile of CLCH has altered throughout the year with movement of services into and out of the organisation in line with the commissioning intentions and outcomes of competitive tender processes. Key services to leave CLCH's portfolio in 17/18 have included sexual health services in Inner London, parts of the dental service and parts of the Inner London school nursing units. Meanwhile health visiting services in Brent, Richmond and Wandsworth, sexual health services in South West London, and community adults services in Wandsworth have been

key additions to CLCH's portfolio in 17/18. Fewer variations in service are expected in 18/19 though school nursing services in Hounslow and Harrow, and small elements of Barnet children's therapies are confirmed to be moving out of the portfolio.

24 Expenditure

Expenditure increased by 1% or £2.1m primarily due to increased activities. Our operating expenditure (which does not include financing costs) for the year to 31 March 2018 was £208,273k (2016/17: £206,178k) and was spent in the following areas:



25 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.

26 Our Better Payment Practice Code (BPPC) performance against target:

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

	Q1	Q2	Q3	Q4	YTD	Target
2017/18	93%	95%	95%	92%	94%	95%

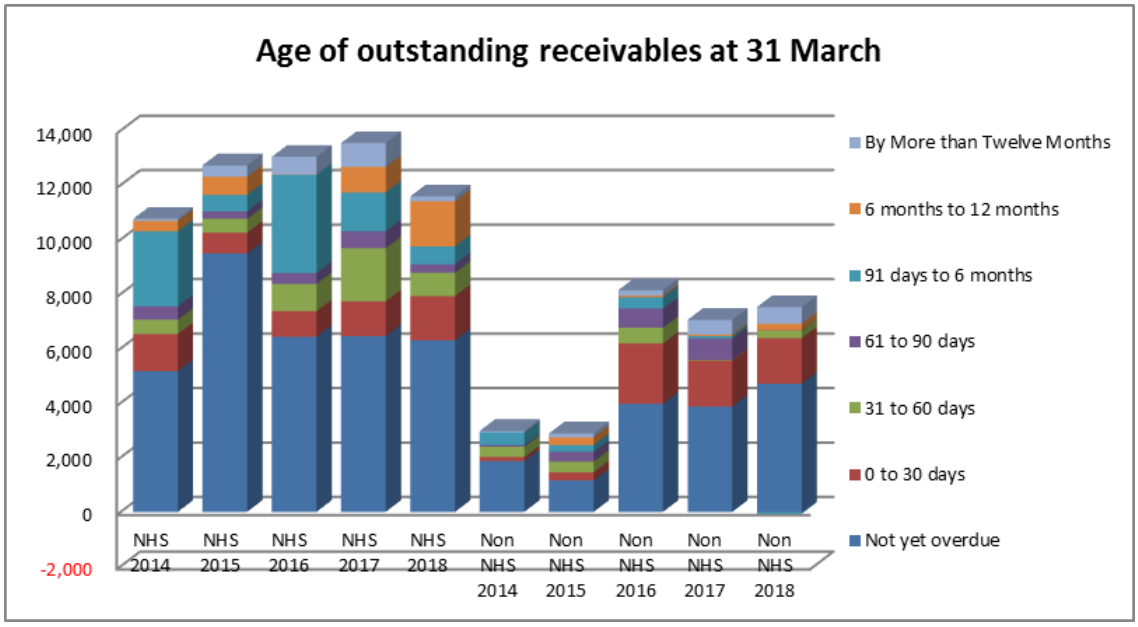
Our working capital management performance against target:

	31-Mar-18	31-Mar-17	Target
Receivables uncollected over 90 days past due	17%	13%	5%
Payables unpaid over 90 days past due	91%	23%	5%

We did not achieve the targets for the percentage of Receivables uncollected over 90 days past due and Payables unpaid over 90 days past due. The Receivables uncollected over 90 days past due is due to delays in payment by CCGs for Walk-in-Centre/Urgent Care Centre charges due to delays in commissioners validating information, long overdue payments from one NHS Trust and Local Authorities taking longer to pay their SLA invoices due to restructuring and longer payment terms. We have a plan in place to further improve our performance during 2018/19. The underperformance on Payables unpaid over 90 days past due is as a result of unpaid invoices due to a small number of organisations where ongoing queries are being resolved

CLCH has a track record of recovering amounts owed. During 2017/18 and 2016/17 the Trust did not write-off any debt of amounts due and has a provision against unrecoverable debts of £259k (2016/17: £1,332k). The Trust had a healthy cash position throughout the year relative to plan which enabled it to mobilise new services without recourse to external sources of finance. Much of the cash balance carried forward to 2018/19 is allocated to meet existing financial commitments and fund future service developments.

The Trust has £19,023k aged receivable from NHS and non-NHS bodies at 31 March 2018 (31 March 2017: £19,929k). The age of this debt is as follows:



This chart reflects an overall reduction in our receivables outstanding for more than 90 days when compared to previous years. Non-overdue NHS receivables have increased whilst old NHS debts have broadly remained the same level. Overall, debt recovery in 2017/18 has improved when compared to prior year as this activity was prioritised during the financial year. The Trust has plans in place to collect these debts in 2018/19.

27 Key Metric – Single Oversight Framework

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

- **Capital Servicing Capacity ("CSC"):** The degree to which the organisation's generated income covers its financing obligations. This ratio indicates whether the provider can meet its financing obligations, i.e. its ability to service debts or other financing obligations (including PDC dividends, interest and debt repayment and Private Finance Initiative capital and interest payments. It is calculated as EBITDA / (PDC dividend + finance interest)). The Trust achieved a score of 1 out of 4 in this category with an EBITDA of 9.8 times its CSC compared with 2.5 times required to achieve score of 1 out of 4
- **Liquidity:** days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown, i.e. its liquidity (expressed in days of liquid assets i.e. net assets/cash*365). The Trust achieved a score of 1 out

of 4 in this category with liquidity days of 8.4 days at year end compared with 0 days minimum requirement to achieve score of 1 out of 4

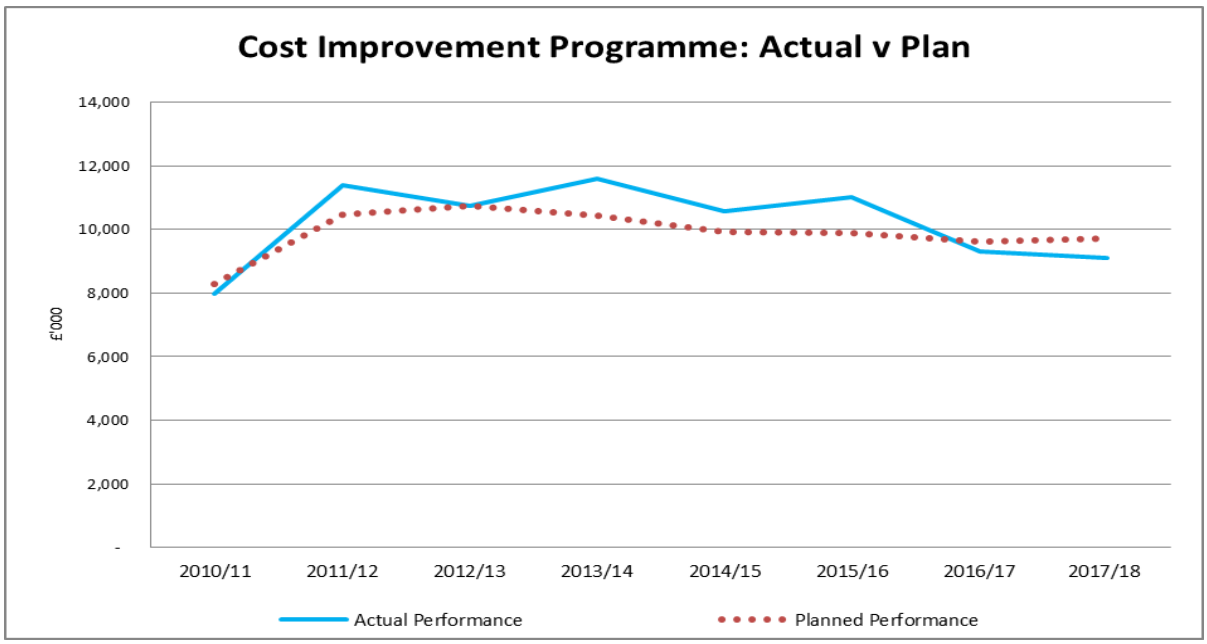
- **Income and Expenditure (I&E) Margin:** the degree to which the organisation is operating at a surplus/deficit - the Trust achieved a score of 1 out of 4 in this category, ending the year with 5.51% gross margin (EBITDA) which is 4.51% greater than the threshold of 1% required to be assessed a 1 for this criteria
- **Distance from Financial Plan in Relation to I&E Margin:** variance between the Trust's planned I&E margin in its annual forward plan and its actual I&E margin within the year. The Trust achieved a score of 1 out of 4 in this category, as the Trust achieved its planned surplus in addition to receiving bonus STF fund of £0.6m for achieving all key financial indicators
- **Agency Cap:** distance from provider's cap - the Trust achieved a score of 1 out of 4 in this category, ending the year with £9.8m less in agency spend than plan of £16.3m agreed with NHS Improvement.

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

28 QIPP (Quality, Innovation, Productivity and Prevention)

The QIPP requirement for 2017/18 was £9.7m (excluding identified contingency).

The Trust achieved £9.1m QIPP for 2017/18 which represented a £0.6m adverse variance against plan.



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

The QIPP requirement for 2018/19 is £9.5m (excluding identified contingency), as of month 1 £5.8m of schemes have been identified. The programme comprises of Trust wide transformational initiatives focusing on reducing use of agency, estates rationalisation, corporate review 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.

The majority of the schemes in the 2018/19 QIPP plan relate to the efficient use of resources and estate rather than reductions in staff numbers. This programme will be delivered whilst maintaining the safety and quality of services which is assured by a process of quality impact assessments undertaken by the Trust medical director and director of nursing (quality and safety).

29 Financing and investment

During 2017/18 we made significant investments in various capital projects. Some of these investments were to complete projects that began during 2016/17 such as IT equipment and infrastructure, EMIS Patient Administration System, service mobilisations and estates backlog maintenance. These investments are core to how we will achieve our QIPP programme over the coming years and maintain our financial sustainability. Our 2017/18 capital investments totaled £7,166k (2016/17: £7,839k). The most significant investments were:

- £2,739k invested in various estates related projects including the new GP practice (LileyVille) at Parsons Green, Woodfield Road to provide new efficient open-plan office accommodation, The Parkinson Unit, the creation of additional clinical rooms.
- £2,863k spend to provide new community services across Wandsworth and South West London sexual health service estates mobilisation
- £1,054 spend on assistive technologies and clinical system development to utilize available technologies in both clinical services and administrative activities sites to reduce the Trust's estate footprint while ensuring that all CLCH site remain compliant with Care Quality Commission (CQC) and Health and Safety Executive (HSE) requirements
- The rest spend on modern medical devices including, ECG Arthythmia Detection Device, Bladder Scanner, SonoSite M-Turbo Ultrasound Scanner and other.

We have identified a number of areas where future investment will help us to achieve service quality and technological growth and therefore will allow us to maintain our financial sustainability and provide excellent service to our patients. We have identified areas of investments that will allow us to achieve our goals including further investment in IMT mobile and scheduling technology, upgrade our networks and further move towards digitalisation for example single point of access (SPAs). For our estates investments we have identified schemes primarily to focus on achieving financial efficiency and investment in backlog of existing estate for example Inner London estate rationalisation. We will also be investing in providing one single hub for SWL sexual health services in very convenient location which will allow to grow service to reach wider South West London population. Our

backlog investment will continue to ensure that all CLCH site remain compliant with CQC and HSE requirements.

30 Political and charitable donations

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

31 Pension Liabilities

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

The Trust does not reflect in its financial statements any NHS Pension scheme assets or liabilities attributable to scheme members who are employed by the Trust. There is £2,009k in respect of outstanding NHS Pension contributions at 31 March 2018 (31 March 2017: £1,767k).

32 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.

33 Our annual accounts

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

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

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to

ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Andrew Ridley
Chief Executive

Mike Fox
Director of Finance, Contracting and Performance

Date: 23 May 2018 … Date: 23 May 2018

STATEMENT OF COMPREHENSIVE INCOME
FOR THE YEAR ENDED 31 MARCH 2018

	Note	2017/18 £000	2016/17 £000
Revenue from patient care activities	5	206,263	200,841
Other operating revenue	6	10,351	11,908
Employee benefits	7, 9	(144,698)	(142,910)
Other Operating expenses	7	(63,575)	(63,268)
net operating surplus		**8,341**	**6,571**
Finance Income	12	0	16
Other gains / (losses)		(5)	(11)
Surplus / (deficit) for the financial year		**8,336**	**6,576**
Public Dividend Capital dividends payable	30	(1,453)	(1,196)
Retained surplus / (deficit) for the year		**6,883**	**5,380**
Other comprehensive income			
Net gain/(loss) on revaluation of property, plant, equipment	13	2,145	(577)
Total comprehensive income for the year		**9,028**	**4,803**

The notes on pages 77 to 113 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 2018

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	14	8,338	9,088
Property, plant and equipment	13	44,701	40,538
Total non-current assets		**53,039**	**49,626**
Current assets			
Trade and other receivables	15	26,948	25,308
Cash and cash equivalents	17	22,709	11,346
Total current assets		**49,657**	**36,654**
Current liabilities			
Trade and other payables	18	(36,616)	(29,981)
Provisions	20	(2,426)	(1,822)
Total current liabilities		**(39,042)**	**(31,803)**
Total assets less current liabilities		**63,654**	**54,477**
Non-current liabilities			
Provisions	20	(205)	(850)
Total non-current liabilities		**(205)**	**(850)**
Total assets employed		**63,449**	**53,627**
Financed by			
Public dividend capital		996	202
Revaluation reserve		13,148	11,003
Retained surplus		49,305	42,422
Total taxpayers' equity		**63,449**	**53,627**

The notes on pages 77 to 113 form part of these accounts.

The financial statements on pages 72 to 76 and accompanying notes were approved by the Audit committee on behalf of the Board on the 23 May 2018 and signed on its behalf by:

Andrew Ridley……
Chief Executive

Date: 23 May 2018
……..

Mike Fox……
Director of Finance, Contracting and Performance

Date: 23 May 2018
……

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY
FOR THE YEAR ENDED 31 MARCH 2018

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

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**202**	**11,580**	**37,042**	**48,824**
Surplus/(deficit) for the year	0	0	5,380	**5,380**
Revaluations	0	(577)	0	**(577)**
Taxpayers' equity at 31 March 2017	**202**	**11,003**	**42,422**	**53,627**

The notes on pages 77 to 113 form part of these financial statements.

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

STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED 31 MARCH 2017

	2017/18	2016/17
	£000	£000
Cash flows from operating activities		
Operating surplus / (deficit)	8,341	6,571
Non-cash income and expense:		
Depreciation and amortisation	5,892	5,143
(Increase) / decrease in receivables and other assets	(1,640)	1,496
Increase / (decrease) in payables and other liabilties	4,689	(6,077)
Increase / (decrease) in provisions	(41)	(479)
Net cash generated from / (used in) operating activities	**17,241**	**6,654**
Cash flows from investing activities		
Interest received	0	16
Purchase of intangible assets	(1,635)	(3,718)
Purchase of property, plant, equipment and investment property	(3,838)	(5,189)
Sales of property, plant, equipment and investment property	0	28
Cash movement from disposals	1	0
Net cash generated from / (used in) investing activities	**(5,472)**	**(8,863)**
Cash flows from financing activities		
Public dividend capital received	794	0
PDC dividend (paid) / refunded	(1,200)	(1,307)
Net cash generated from / (used in) financing activities	**(406)**	**(1,307)**
Increase / (decrease) in cash and cash equivalents	**11,363**	**(3,516)**
Cash and cash equivalents at 1 April - brought forward	**11,346**	**14,862**
Cash and cash equivalents at 31 March	**22,709**	**11,346**

The notes on pages 77 to 113 form part of these financial statements.

NOTES TO THE ACCOUNTS

Note 1 Principal Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Accounting Manual 2017-18, issued by the Department of Health.

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

1.1 Going concern

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

Movement of assets within the DH Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury Financial Reporting Manual 2017-18 (FReM). The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCI, and is disclosed separately from operating costs.

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

1.2 Accounting convention

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

Accruals

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

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

Material entities over which the Trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate

adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust or where the subsidiary's accounting date is not co-terminous.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

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

1.4 Critical accounting judgements and key sources of estimation uncertainty

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

1.4.1 Critical judgements in applying accounting policies

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

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.

1.4.2 Key sources of estimation uncertainty

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

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.

Valuation of Land and Buildings (Owned)
This is based on the professional judgement of the Trust's Independent Valuer with extensive knowledge of the physical estate and market factors.

Valuation of Buildings (Leased)
This is based on the BCIS Tender Price Indices as provided by the Trust's Independent Valuer.

1.5 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.

1.6 Employee Benefits

1.6.1 Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.6.2 Retirement benefit costs

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

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

1.7 Other expenses

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

1.7.1 Value Added Tax

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

1.8 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised if:

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

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

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

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

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

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

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

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

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

Operational land and buildings owned by CLCH are held at Current Values. The effective date of revaluation of land and buildings owned by the Trust is 31 March 2018. The revaluation was carried out by Gareth Palmer MRICS, a Senior Surveyor (RICS registered valuer) with the DVS property services arm of the Valuation Office Agency, using the market and cost approach valuation techniques to determine the Current Value of land and buildings owned by the Trust. The Trust has a full revaluation every five years with Desktop revaluations in the intervening years.

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

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

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

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

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

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

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

1.9 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

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

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

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

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

1.10 Leases

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

1.10.1 The Trust as lessee

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

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

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

1.10.2 The Trust as lessor

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

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

1.11 Inventories

The Trust does not hold any inventories.

1.12 Cash and cash equivalents

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

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

Cash and bank balances are measured at current value.

1.13 Provisions

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

1.14 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.

1.15 Contingent liabilities and contingent assets

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

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

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

1.16 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred. Financial assets are initially recognised at fair value. Financial assets are classified into the following categories: financial assets 'at fair value through profit and loss'; 'held to maturity investments'; 'available for sale' financial assets and 'loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

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

1.16.1 Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or those that do not fall within any of the other three financial asset classifications. They are measured at fair value, determined by the future cash flows associated with the asset and with changes in value taken to the revaluation

reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to the statement of comprehensive income on de-recognition.

1.17 Loans and receivables

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

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

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

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

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

1.18 Financial liabilities

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

1.18.1 Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.19 Public Dividend Capital (PDC) and PDC dividend

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

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

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

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

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

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

1.20 Foreign currencies

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

1.21 Third party assets

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

1.22 Research and Development

The Trust does not carry out Research and Development expenditure.

1.23 Non-clinical risk pooling

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

1.24 Losses and special payments

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

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

The DH GAM does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 and IFRS 17 still subject to HM Treasury consideration.

● IFRS 9 *Financial Instruments* – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted

● IFRS 15 *Revenue from Contracts with Customers* – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

● IFRS 16 *Leases* – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

● IFRS 17 *Insurance Contracts* – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

● IFRIC 22 *Foreign Currency Transactions and Advance Consideration* – Application required for accounting periods beginning on or after 1 January 2018.

● IFRIC 23 *Uncertainty over Income Tax Treatments* – Application required for accounting periods beginning on or after 1 January 2019.

Note 2 Authorisation of the financial statements

These financial statements were authorised for issue on 23rd May 2018 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, Hounslow, Richmond, Harrow, Brent, Merton, Barnet, Hertfordshire and Wandsworth. 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;

- Long-term condition management supporting people with complex and substantial ongoing health needs caused by disability or chronic illness;
- Specialist services including delivering parts of long term condition management for people living with diabetes, heart failure, Parkinson's and lung disease, homeless health services, community dental services, sexual health and contraceptive services and psychological therapies;
- Walk-in and minor injury services; and
- PMS and GPWSI (dermatology and musculo-skeletal).

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

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

The Trust management reported to the Board an aggregate surplus of £5,337k which was the final position disclosed below.

	Revenue from customers	Retained surplus for the year	Interest revenue	Interest expense	Depreciation and amortisation	Net gain/(loss) on revaluation of property, plant, equipment
	£'000	£'000	£'000	£'000	£'000	£'000
12 months to 31/3/2018	216,614	6,883	0	0	5,892	2,145
12 months to 31/3/2017	212,749	5,380	16	0	5,143	(577)

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

The Trust has three customers (2016:17 three) who individually accounted for over 10% of the Trust's turnover. These customers account for 41% (2016/17: 39%) of the Trust's turnover on aggregate. The significant sources of external income, including those sources that account for at least 10% of the Trust's total external income, are as follows:

Organisation name	2017/18	2016/17
	£'000	£'000
NHS Barnet CCG	38,405	35,077
NHS West London (K&C) CCG	26,842	27,416
NHS Merton CCG	22,805	21,341
NHS Central London (Westminster) CCG	17,843	0
NHS Hammersmith and Fulham CCG	15,819	0
NHS Harrow CCG	11,886	0
NHSE	9,662	0
Battersea Healthcare Community Interest Company (Wandsworth)	7,811	0
Sub Total	**151,073**	**83,834**
Income from other organisations	65,541	128,915
Total Revenue	**216,614**	**212,749**

Income from NHS Central London (Westminster) CCG £17,843k, NHS Hammersmith and Fulham CCG £15,819k, NHS Harrow CCG £11,886k, NHS England £9,662k and Battersea Healthcare Community £7,811k are individually less than 10% of the Trust's aggregate turnover in 2017/18.

Note 4 Income generating activities

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

Note 5 Revenue from patient care activities

Income from patient care activities received from:	2017/18	2016/17
	£000	£000
NHS England	6,071	6,984
Clinical commissioning groups	150,736	145,788
NHS Foundation Trusts	3,086	2,169
NHS Trusts	850	1,637
Local authorities	36,432	43,545
Non-NHS: overseas patients (chargeable to patient)	0	447
Injury costs recovery	327	271
Non NHS: other	8,761	0
Total income from activities	**206,263**	**200,841**

Revenue is almost exclusively from the supply of services. Revenue from the sale of goods is immaterial. Overseas patient income relates to income received for treating overseas patients at the Trust's Walk in Centres which has been charged to Clinical commissioning groups in 2017/18. No overseas income has been charged directly to overseas patients during 2017/18. Non NHS Other includes Community Adult Health Services (Wandsworth) charged to Battersea Healthcare Community Interest Company £7.8m, Speech and Language £0.3m and other £0.7m.

Note 6 Other operating revenue

	2017/18	2016/17
	£000	£000
Education and training	2,897	4,419
Charitable and other contributions to expenditure	193	277
Sustainability and transformation fund income	3,550	2,778
Rental revenue from operating leases	1,330	60
Income generation	762	4,233
Other income	1,619	141
Total other operating income	**10,351**	**11,908**

Sustainability and transformation fund income relates to non-recurrent income from NHS England / NHS Improvement to support investments in various transformation programmes in the Trust. Other income relates to income earned through the recharging of costs associated with prescription charge income, and other miscellaneous income. Rental revenue has been reclassified from other income in 2016/17 to rental revenue in 2017/18.

Note 7 Operating expenses

7.1 Analysis of other operating expenses

	2017/18	2016/17
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	4,192	7,497
Purchase of healthcare from non-NHS and non-DHSC bodies	3,838	2,514
Staff and executive directors costs	144,291	142,910
Chair and non-Executive Directors' Costs	69	69
Supplies and services - clinical (excluding drugs costs)	8,374	6,385
Supplies and services - general	12,010	8,693
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	1,579	1,525
Consultancy services	584	575
Establishment	3,582	4,455
Premises	4,221	1,961
Transport (including patient travel)	2,276	2,175
Depreciation on property, plant and equipment	3,507	2,947
Amortisation on intangible assets	2,385	2,196
Increase/(decrease) in provision for impairment of receivables	(1,073)	977
Audit fees payable to the external auditor		
audit services- statutory audit	58	62
other auditor remuneration (external auditor only)	12	12
Internal Audit Expenditure	105	78
Clinical negligence	416	369
Legal fees	364	403
Insurance	71	1
Education, Training and Conferences	830	2,129
Rentals under operating leases	16,142	17,105
Redundancy	407	0
Hospitality	5	5
Other	28	1,135
Total	**208,273**	**206,178**

7.2 Auditor remuneration

The statutory audit fee is payable to the External Auditor Net of VAT. 2017/18 £49K (2016/17 £52K).

	2017/18	2016/17
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	0	0
2. Audit-related assurance services	12	12
3. Taxation compliance services	0	0
4. All taxation advisory services not falling within item 3 above	0	0
5. Internal audit services	0	0
6. All assurance services not falling within items 1 to 5	0	0
7. Corporate finance transaction services not falling within items 1 to 6 above	0	0
8. Other non-audit services not falling within items 2 to 7 above	0	0
Total	**12**	**12**

7.3 Limitation on auditor's liability

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

Note 8 Operating leases

8.1 Trust as lessee

	2017/18	2016/17
	£000	£000
Operating lease expense		
Minimum lease payments	16,142	17,105
Total	**16,142**	**17,105**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease payments due:		
- not later than one year;	15,596	16,526
- later than one year and not later than five years;	507	0
- later than five years.	0	0
Total	**16,103**	**16,526**

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

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

8.2 Trust as lessor

	2017/18	2016/17
	£000	£000
Operating lease revenue		
Rental Revenue	1,330	60
Total	**1,330**	**60**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	0	58
- later than one year and not later than five years;	0	211
- later than five years.	0	0
Total	0	**269**

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

Note 9 Employee benefits

9.1 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	110,982	104,349
Social security costs	11,333	10,378
Apprenticeship levy	536	0
NHS Pension Costs	13,400	12,525
Redundancy	407	0
Temporary staff (external bank)	1,698	0
Temporary staff (including agency)	6,434	15,892
Total gross staff costs	**144,790**	**143,144**
Less Costs Capitalised	92	234
Total net staff costs	**144,698**	**142,910**

During 2017/18 four persons retired early on ill-health grounds during the financial period (2016/17: two). The associated additional accrued pension liabilities total £212K (2016/17: £19K).

Permanently employed includes £1,292k (2016-17: £1,321k) in respect of cost of staff seconded into the Trust from other NHS organisations. The Trust processes the cost of some temporary staff through a third party payroll bureau. In 2017-18, the Trust processed £1,698k (2016-17: £1,246k) through this bureau.

Note 10 Pension costs

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

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

a) Accounting valuation

b) A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Note 11 Better payment practice code

11.1 Measure of compliance

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	23,287	89,962	42,555	94,904
Total non-NHS trade invoices paid within target	22,057	84,551	30,741	74,149
Percentage of non-NHS trade invoices paid within target	94.7%	94.0%	72.2%	78.1%
NHS Payables				
Total NHS trade invoices paid in the year	489	6,964	420	5,945
Total NHS trade invoices paid within target	232	3,250	180	1,528
Percentage of NHS trade invoices paid within target	47.4%	46.7%	42.9%	25.7%

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

Note 12 Investment revenue

	2017/18 £'000	2016/17 £'000
Interest earned from monies held on deposit at the National Loans Fund.	0	16

Note 13a Property plant and equipment

	Land	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**13,920**	**23,757**	**2,563**	**11,934**	**115**	**52,289**
Additions Purchased	0	3,467	521	1,089	454	**5,531**
Revaluations	0	891	0	0	0	**891**
Reclassifications	0	0	0	0	0	0
Disposals other than for sale	0	(6)	0	0	0	**(6)**
Valuation/gross cost at 31 March 2018	**13,920**	**28,109**	**3,084**	**13,023**	**569**	**58,705**
Accumulated depreciation at 1 April 2017 - brought forward	**0**	**1,732**	**1,924**	**8,045**	**50**	**11,751**
Charged during the year	0	1,254	292	1,946	15	3,507
Revaluations	0	(1,254)	0	0	0	(1,254)
Disposals other than for sale	0	0	0	0	0	0
Accumulated depreciation at 31 March 2018	**0**	**1,732**	**2,216**	**9,991**	**65**	**14,004**
Net book value at 31 March 2018	**13,920**	**26,377**	**868**	**3,032**	**504**	**44,701**
Net book value at 1 April 2017	**13,920**	**22,025**	**639**	**3,889**	**65**	**40,538**

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

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

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

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

At the balance sheet date the Trust continues to use assets with a gross book value of £1,020K (2016/17: £6,044K) that have no net book value. There are no temporarily idle assets.

Operational land and buildings owned by CLCH are held at Current Values. The effective date of revaluation of land and buildings owned by the Trust is 31 March 2018. The revaluation was carried out by Gareth Palmer MRICS, a Senior Surveyor (RICS registered valuer) with the DVS property services arm of the Valuation Office Agency, using the market and cost approach valuation techniques to determine the Current Value of land and buildings owned by the Trust.

Note 13b Property plant and equipment prior year

	Land	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**13,969**	**22,245**	**2,441**	**10,709**	**67**	**49,431**
Additions Purchased	0	2,628	221	1,225	48	**4,122**
Revaluations	(49)	(1,116)	0	0	0	**(1,165)**
Reclassifications	0	0	0	0	0	0
Disposals other than for sale	0	0	(99)	0	0	**(99)**
Valuation/gross cost at 31 March 2017	**13,920**	**23,757**	**2,563**	**11,934**	**115**	**52,289**
Accumulated depreciation at 1 April 2016 - brought forward	**0**	**1,337**	**1,688**	**6,390**	**36**	**9,451**
Charged during the year	0	**983**	**295**	**1,655**	**14**	**2,947**
Revaluations	0	(588)	-	0	0	**(588)**
Disposals other than for sale	0	-	(59)	0	0	**(59)**
Accumulated depreciation at 31 March 2017	**0**	**1,732**	**1,924**	**8,045**	**50**	**11,751**
Net book value at 31 March 2017	**13,920**	**22,025**	**639**	**3,889**	**65**	**40,538**
Net book value at 1 April 2016	**13,969**	**20,908**	**753**	**4,319**	**31**	**39,980**

	Land	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017						
Owned - purchased	13,920	22,025	639	3,889	65	**40,538**
NBV total at 31 March 2017	**13,920**	**22,025**	**639**	**3,889**	**65**	**40,538**

	Land	Buildings excluding Dwellings	Plant & Machinery	Information Technology	Furniture & Fittings	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Attributable revaluation reserve:						
Revaluation Reserve Balance for Property, Plant & Equipment:						
As at 1 April 2016	**5,601**	**5,979**	**0**	**0**	0	**11,580**
Impairments in the year	0	0	0	0	0	0
Revaluations in the year	(49)	(528)	0	0	0	(577)
Other movements	0	0	0	0	0	0
As at 31 March 2017	**5,552**	**5,451**	**0**	**0**	**0**	**11,003**

Note 14a Intangible non-current assets

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**15,911**	**15,911**
Additions	1,635	1,635
Disposals other than for sale	0	0
Gross cost at 31 March 2018	**17,546**	**17,546**
Amortisation at 1 April 2017 - brought forward	**6,823**	**6,823**
Charged during the year	2,385	2,385
Disposals other than for sale	0	0
Amortisation at 31 March 2018	**9,208**	**9,208**
Net book value at 31 March 2018	**8,338**	**8,338**
Net book value at 1 April 2017	**9,088**	**9,088**

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

All assets are initially recognised at purchase cost plus any incremental costs to bring the asset into its operational location and condition and amortised over its estimated useful economic life to £nil residual value. All assets thereafter are held at cost less amortisation recognised since purchase as this is estimated to be not materially different to fair value. At the balance sheet date the Trust continues to use assets with a gross book value of £857K (2016/17: £3,347K) that have no net book value. There are no temporarily idle assets.

Note 14b Intangible non-current assets prior year

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2016 - brought forward	**12,193**	**12,193**
Additions	3,718	3,718
Disposals other than for sale	0	0
Gross cost at 31 March 2017	**15,911**	**15,911**
Amortisation at 1 April 2016 - brought forward	4,627	4,627
Charged during the year	2,196	2,196
Disposals other than for sale	0	0
Amortisation at 31 March 2017	**6,823**	**6,823**
Net book value at 31 March 2017	**9,088**	**9,088**
Net book value at 1 April 2016	**7,566**	**7,566**

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

Note 15 Trade and other receivables

	31 March 2018	31 March 2017
	£000	£000
Current		
NHS receivables - revenue	11,452	13,546
NHS prepayments and accrued income	5,113	2,740
Non-NHS receivables - revenue	7,571	6,383
Non NHS prepayments and accrued income	1,235	2,895
Provision for impaired receivables	(259)	(1,332)
VAT receivable	1,044	361
Other receivables	792	715
Total current trade and other receivables	**26,948**	**25,308**

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

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

15.1 Receivables past their due date but not impaired

	31 March 2018	31 March 2017
	Trade and other receivables	Trade and other receivables
Ageing of non-impaired financial assets past their due date	**£000**	**£000**
0 - 30 days	3,292	0
30-60 Days	1,133	0
60-90 days	327	2,409
90- 180 days	589	1,521
Over 180 days	2,432	2,410
Total	**7,773**	**6,340**

15.2 Provision for impairment of receivables

	31 March 2018	31 March 2017
	Trade and other receivables	Trade and other receivables
Ageing of impaired financial assets	**£000**	**£000**
0 - 30 days	0	0
30-60 Days	0	0
60-90 days	0	0
90- 180 days	0	0
Over 180 days	259	1,332
Total	**259**	**1,332**

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). The Trust has reduced its bad debt provision in year as debt resolutions have allowed unpaid invoices to be paid.

Note 16 Financial instruments

Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with commissioners and the way the commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

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

Currency risk

The Trust is 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.

16.1 Financial Assets

	Loans and receivables	Assets at fair value through the I&E	Available-for-sale	Total book value
	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2018				
Embedded derivatives	0	0	0	0
Trade and other receivables excluding non financial assets	20,917	0	0	**20,917**
Cash and cash equivalents at bank and in hand	22,709	0	0	**22,709**
Total at 31 March 2018	**43,626**	0	0	**43,626**

	Loans and receivables	Assets at fair value through the I&E	Available-for-sale	Total book value
	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2017				
Embedded derivatives	0	0	0	0
Trade and other receivables excluding non financial assets	20,644	0	0	**20,644**
Cash and cash equivalents at bank and in hand	11,346	0	0	**11,346**
Total at 31 March 2017	**31,990**	0	0	**31,990**

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 £1,044k (2016/17: £361k) 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 £5,468K (2016/17: £5,635k) and the bad debt provision £259k (2016/17: £1332k) are also excluded from this note.

16.2 Financial Liabilities

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018			
Trade and other payables excluding non financial liabilities	33,637	0	**33,637**
Total at 31 March 2018	**33,637**	0	**33,637**

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Trade and other payables excluding non financial liabilities	25,424	0	**25,424**
Total at 31 March 2017	**25,424**	0	**25,424**

Financial liabilities are defined by IAS 32 as contractual obligations to pay out cash in the future. Balances that arise through statute, for example tax, social security costs and pension contributions £2,009K (2016/17: £4,557K), are not contractual and so are excluded from the disclosure.

16.3 Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	33,637	25,424
Total	**33,637**	**25,424**

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

Note 17 Cash and cash equivalents

	2017/18	2016/17
	£000	£000
At 1 April	**11,346**	**14,862**
Net change in year	11,363	(3,516)
At 31 March	**22,709**	**11,346**
Broken down into:		
Cash at commercial banks and in hand	21	18
Cash with the Government Banking Service	22,688	11,328
Total cash and cash equivalents as in SoFP	**22,709**	**11,346**

Note 18 Trade and other payables

	31 March 2018	31 March 2017
	£000	£000
Current		
NHS payables - revenue	163	7,139
NHS - accruals and deferred income	10,908	8,520
Non - NHS trade payables - revenue	(270)	474
Non - NHS accruals and deferred income	20,904	8,364
Non NHS - Capital creditors	2,620	927
Tax	1	1,113
Social security costs	7	1,528
PDC dividend payable	253	0
Other payables	2,030	1,916
Total current trade and other payables	**36,616**	**29,981**

Other payables include £2,009K in respect of outstanding pension contributions at 31 March 2017 (31 March 2017: £1,767K).

Note 19 Borrowings

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

Note 20 Provisions for liabilities and charges

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

	Early Departure Costs	Clinical negligence	Redundancy	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2016	**245**	**375**	**1,339**	**1,192**	**3,151**
Arising during the year	0	27	495	346	**868**
Utilised during the year	(8)	0	(1,339)	0	**(1,347)**
Reversed unused	0	0	0	0	**0**
At 31 March 2017	**237**	**402**	**495**	**1,538**	**2,672**
Expected timing of cash flows:					
- not later than one year;	16	402	495	909	**1,822**
- later than one year and not later than five years;	16	0	0	0	**16**
- later than five years.	205	0	0	629	**834**
Total	**237**	**402**	**495**	**1,538**	**2,672**

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 £1000k (2016/17: £420k) and non-clinical provisions with a value of £202k (2016/17: £241k) on behalf of the Trust at the reporting date. Should these claims prove successful the Trust will incur a liability excess payable to NHS Litigation Authority of £63K (2016/17: £49K). This excess is fully provided for within the provisions for 'Legal' above. The NHSLA has estimated a probability that the Trust will have to pay this excess.

Other provisions of £1,302k (2016/17: £1,532k) is in respect of dilapidations provisions £402k and overseas recruitment £900k.

Note 21 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 seven non-clinical claims outstanding (2016/17: seven) for which the Trust will have to pay a set excess. This excess is estimated by the NHSLA as £63K (2016/17: £49K). The NHSLA believes that it is unlikely the Trust will have to pay £27K (2016/17: £13K) excess and recommends that this amount is therefore disclosed as a contingent liability.

Note 22 Related party transactions

In financial years 2017/18 and 2016/17 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 2017/18 the Charity paid the Trust £146K for goods and services provided by CLCH (2016/17: £277K). As at 31 March 2018 the Trust had a total of £18k (2016/17: £nil) receivable from the Charity.

The Department of Health is regarded as the parent department of CLCH NHS Trust. During the year CLCH had a number of material transactions with entities controlled by the Department, and other entities for which the Department is regarded as the parent. These transactions are as follows:

Material related party transactions with NHS bodies are listed below where income or expenditure is over £500k:

Organisation name	Income	Expenditure	Receivables	Payables
	£'000	£'000	£'000	£'000
NHS Barnet CCG	38,405	0	3,304	0
NHS West London (K&C & Qpp) CCG	26,842	0	1,687	0
NHS Merton CCG	22,805	0	596	0
NHS Central London (Westminster) CCG	17,843	182	868	12
NHS Hammersmith and Fulham CCG	15,819	0	769	0
NHS Harrow CCG	11,886	0	927	0
NHS England	9,662	0	2,579	19
NHS Herts Valleys CCG	3,799	0	578	0
NHS Brent CCG	3,307	0	428	0
NHS Hounslow CCG	2,804	0	190	0
Royal Free London NHS Foundation Trust	1,948	1,207	1,100	996
NHS Camden CCG	941	0	267	0
Chelsea and Westminster NHS Foundation Trust	914	1,327	446	505
NHS Ealing CCG	765	0	88	0
NHS Enfield CCG	554	0	46	0
West Hertfordshire Hospitals NHS Trust	78	677	15	0
Hounslow and Richmond Community Healthcare NHS Trust	15	1,244	9	0

Note 23 Third party assets: patients' monies

The Trust held £126K cash at bank and in hand at 31 March 2018 on behalf of patients (31 March 2017: £128K).

Note 24 Losses and special payments

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

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Bad debts and claims abandoned	0	0	1	0
Total losses	0	0	**1**	**0**
Special payments				
Compensation under court order or legally binding arbitration award	2	8	0	0
Ex-gratia payments	5	1	6	17
Total special payments	**7**	**9**	**6**	**17**
Total losses and special payments	**7**	**9**	**7**	**17**

Note 25 Events after the reporting date

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

Note 26 External financing limit

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

	2017/18	2016/17
	£000	£000
Cash flow financing	(10,569)	3,516
External financing requirement	(10,569)	3,516
External financing limit (EFL)	8,149	5,697
Under / (over) spend against EFL	18,718	2,181

Note 27 Breakeven performance

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	0	2,196	3,835	1,766	1,735	1,836	3,506	5,380	6,883
Breakeven duty cumulative position	0	2,196	6,031	7,797	9,532	11,368	14,874	20,254	27,137
Operating income	0	155,379	190,946	193,270	196,191	198,409	196,671	212,749	216,614
Cumulative breakeven position as a percentage of operating income	0.00%	1.41%	3.16%	4.03%	4.86%	5.73%	7.56%	9.52%	12.53%

Note 28 Capital resource limit

	2017/18	2016/17
	£000	£000
Gross capital expenditure	7,166	7,839
Less: Disposals	(6)	(39)
Less: Donated and granted capital additions	0	0
Plus: Loss on disposal of donated/granted assets	0	0
Charge against Capital Resource Limit	7,160	7,800
Capital Resource Limit	7,187	7,920
Under / (over) spend against CRL	27	120

All capital investments in 2017/18 and 2016/17 were funded from the Trust's internally generated cash reserves.

Note 29 Capital commitments

The Trust had no capital commitments (amounts ordered at 31 March 2018 but not yet delivered) at the statement of financial reporting date (2016/17: £0).

Note 30 Annual capital cost absorption rate

	2017/18	2016/17
	£'000	£'000
Dividends on Public Dividend Capital	1,453	1,196
Opening Capital and Reserves (Total Assets Employed)	53,627	48,824
Adjustment to closing balances re Q4 Sustainability Transformation Fund	(558)	
Opening Relevant Net Assets	**53,069**	**48,824**
Closing Capital and Reserves (Total Assets Employed)	63,449	53,627
Closing adjustment- Incentive & Bonus STF	(1,708)	(558)
Closing Relevant Net Assets	**61,741**	**53,069**
Sum of Opening/Closing Relevant Net Assets	114,810	101,893
Initial Average Relevant Net Assets	57,405	50,947
Average Daily Cleared Balances in GBS/NLF	(15,899)	(16,765)
Final Average Relevant Net Assets	**41,506**	**34,182**
Full Year Effect for Part Year Trusts	**1,453**	**1,196**
Capital Cost Absorption Rate (%)	**3.5**	**3.5**