NHS
Central London
Community Healthcare
NHS Trust

Annual Report
2016/17

Your healthcare closer to home

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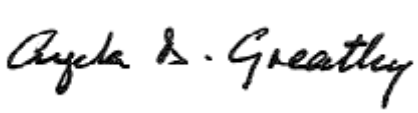
1. Foreword

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 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.

2016/17 was another strong year for CLCH. We delivered against a wide range of quality targets including measures of safety, effectiveness and patient experience. Alongside this we found more than £10m in cost improvements and finished the year with a positive financial position. We have made good progress in a number of critical areas and in particular recruitment and reducing spending on agency staff. Alongside this we have published a new quality strategy for 2017-2020 which will build on the great work of the past and take us from good to outstanding in terms of Care Quality Commission ratings.

The board has seen a number of changes during the year (detailed in section 8) and with a permanent chief executive in post from October 2016 we've made good progress agreeing a new strategic direction that is closely aligned to the current national agenda for the NHS. Moving forward we intend to be strong and effective partners in the four sustainability and transformation plan (STP) areas we work in and to focus on building partnerships and integrated services for the benefit of patients.

Finances remain tight for the NHS and as you'll see from this report we are working both internally and with our commissioners to transform and improve value for money in our services to ensure we can deliver the very best care within the resources we have. In some areas this means changing how we work in ways which does impact on staff and patients. We acknowledge that these changes can be tough but we are confident in the professionalism and commitment of all our staff to continue delivering high quality care to all our patients.



Angela Greatley, OBE
Chair

Andrew Ridley
Chief Executive

For 2016/17 we are producing this statutory annual report alongside an annual review; published as the autumn 2017 edition of our quarterly stakeholder magazine. You'll find more of the personal stories of our teams and individual staff in the annual review and we strongly encourage you to read both.

2. About us

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 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 2016/17 we provided a broad range of services in nine different London boroughs plus specialist sexual health and respiratory services in Hertfordshire.

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 people with minor illnesses and injuries and providing a range of health advice and information.

Several 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

3. Quality & performance

We are a high performing trust that puts quality of care at the heart of everything we do. We are rated *Good* by the Care Quality Commission (CQC) which together with strong financial management has placed us in *Segment 1* of NHS Improvement's new single oversight framework, published in November 2016.

Quality strategy 2017-2020

During 2016/17 we developed a new quality strategy to build on the work of the previous three-year strategy which helped secure our CQC rating in 2015. The 2017-2020 strategy was published in February 2017 and aims 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 objectives of the quality strategy we have established a new approach to driving improvement across the trust. We are introducing a model of 'shared governance' which lets frontline staff drive through the improvements they know need to be made. Quality councils are being set up across our four divisions and will be chaired by junior members of staff. Each council will identify improvement projects and work together with patient representatives to deliver changes that benefit patients and staff.

2016/17 was a development year for our shared governance model and focused on setting the ground work and recruiting staff and patients onto the quality councils. There has been an enthusiastic response and eight councils will begin their work from April 2017. Over the life of the quality strategy we intend to establish 24 councils covering the six quality campaigns in each of our four clinical divisions.

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

2016/17 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.

Achieved in full

- **Staff satisfied with the care they give to patients**
  86% of staff said they were satisfied with the care they were able to give (from the 2016 annual NHS staff survey), against a target of 85% or more.

- **Patients receiving harm free care**
  98.6% of patients were treated without any harm being caused by the care we provided, against a target of 98% or more.

- **Hand hygiene**
  99.3% of clinical staff were compliant with our hand hygiene policy at monthly audits, against a target of 97% or more.

- **Minimum staffing levels on bedded units**
  100% of our bedded units achieved minimum staffing levels in every month of the year.

- **Statutory and mandatory training**
  92% of staff were compliant against a target of 90% or more.

- **Information governance training**
  96.2% of staff were compliant against a target of 95% or more.

- **Patients recommending our services**
  91.3% of patients would recommend our services to friends and family, against a target of 90% or more.

- **Deaths in community hospitals**
  There were 0.4% deaths in our community hospitals as a percentage of all discharges (excluding palliative and end of life care), against a target of 3.8% or less which is well within the expected range.

- **Spend on agency staff**
  £15.8m was spent on agency staff, against our internal target of £15.9m or less and a nationally set cap of £16.4m.

- **Complaints**
  100% of complaints were resolved within 25 working days, against a target of 95% or more.

- **Cancelled appointments**
  1.8% of appointments were cancelled by CLCH, against a target of 2.5% or less.

- **Staff sickness**
  Staff absence due to sickness was 3.26%, against a target of 4% or less.

- **Vacancy level**
  At the end of 2016/17 the trust vacancy rate was 14.4% against a target of 15% or less.

- **Vacancy level at band 7 and above**
  At the end of 2016/17 this vacancy rate was 9.0%, against a target of 10% or less.

- **Turnover rate**
  At the end of 2016/17 staff turnover was 12.73%, against a target of 15% or less.

- **Workforce diversity**
  32.7% of our staff at band 8a and above are from BME backgrounds, against a target of 30% or more.

- **Recurrent savings**
  100% of the recurrent value of savings plans were delivered.

Partially achieved

- **Incidents affecting patients that did not cause harm**
  95% of patients received harm free care against a target of 96% or more based on incidence, however the trust achieved 98.9% harm free care as measured using the national NHS Safety Thermometer. The main area of harm for patients is pressure ulcers acquired in the community setting.

- **Patients treated with dignity and respect**
  94.5% of patients agree they were treated with dignity and respect, against a target of 95% or more.

- **Data quality**
  91.6% of patient records had key content complete, against a target of 95% or more.

- **Staff recommending CLCH as a place to work**
  60% of staff said they would recommend the trust as a place to work (from the 2016 annual NHS staff survey), against a target of 62% or more.

- **Appraisal**
  At the end of 2016/17 87.8% of staff had an appraisal, against a target of 90% or more.

- **Actual savings**
  97% of actual savings were delivered compared to plan, net of contingency, against a target of 100%.

- **Pressure ulcers**
  We remain committed to minimising pressure ulcers and set ourselves a zero tolerance target for grade three/four pressure ulcers in bedded units. We had 4 ulcers this year against a total of 8 in 2015/16.

- **Waiting times**
  We have been developing our reporting processes for waiting times through 2016/17. All services where specific waiting time targets are set routinely measure this and report performance to their divisional management teams.

- **Services capturing patents' clinical outcomes**
  We achieved our 100% target for all clinical teams to have three clinical outcomes identified, however, the associated data collection processes for reporting still need to be developed in a number of areas.

- **Continuous improvement**
  55% of our continuous improvement programme graduates have participated in an improvement project in the past 12 months, against a target of 80% or more.

- **New business**
  In 2016/17 the value of contracts lost outweighed new contracts gained and we missed our target of £10m of net new business.

- **Delivery of reports to commissioners**
  84.3% of reports were submitted on time to commissioners, against a target of 100%.

In addition to these board level key performance indicators we routinely monitor a range of other quality indicators. Compared to 2015/16 we maintained or improved performance in 19 out of 20 quality indicators. We continue to have a relatively low level of complaints and all complaints have been answered within 25 days. 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

2017/18 targets

We refreshed our overall trust strategy at the end of 2016/17 (see section 4 below) and we have taken the opportunity to also review and update some of our Board level key performance indicators, grouping them under five strategic objectives:

Quality

- Proportion of clinical incidents that do not cause harm (moderate to catastrophic categories)
- Deaths in community hospitals as a percentage of all discharges (excluding palliative care and end of life)
- Friends and family test - percentage of people that would recommend our services
- Patients agreeing with the statement "I was treated with dignity and respect"
- Proportion of services with reported clinical outcomes
- Delivery of Quality Strategy outcome measures for 2017/18

Operations

- Complaints resolved within 25 days of receipt
- Contract Performance Notices
- Maximum waiting time of 18 weeks from point of referral to treatment (RTT)
- A&E (Walk-in/Urgent Care Centre) maximum waiting time of 4 hours from arrival to treatment/transfer/ discharge
- Delivery of Business Intelligence and Performance Analytics (BIPA) transformation plan

Workforce

- Percentage of staff that recommend the trust as a place to work
- Vacancy level – clinical staff
- Turnover rate – clinical staff
- Staff appraisal rate
- Staff from Black and Minority Ethnic (BME) backgrounds at bands 8a and above

Finance

- Percentage of actual delivered savings compared to plan, net of contingency
- Percentage of recurrent value of savings delivered
- Income and expenditure performance
- Cash balance performance

Strategy implementation

- Sustainability and Transformation Plan (STP) engagement

4. Trust strategy

During 2016/17 we refreshed our overarching trust strategy. We wanted to make sure it was aligned to the national direction for the NHS as set out in the *Five Year Forward View* and being taken forward through local Sustainability and Transformation Plans (STPs). This section provides a summary of a more detailed strategy document which is available on our website.

We were established in 2008 as a provider of community services for Hammersmith & Fulham, Kensington & Chelsea, and Westminster. Up to now our strategic objectives have been to build a strong, independent and sustainable trust. A commitment to quality has always been our first priority but alongside this there has been a strong focus on income growth and the pursuit of efficiencies; which has driven our geographical expansion into nine London boroughs and Hertfordshire.

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.

The establishment of 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 & West Essex. The STPs bring organisations together to take collective responsibility and to plan improvements. It 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.

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.

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 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.

How we work with partners

The *Five Year Forward View* 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.

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.

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.

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.

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.

This new strategic direction is based on our strong desire to collaborate on a local basis to achieve more for patients and families and to contribute to making local systems sustainable. It has been developed in discussion with staff and partners and we have sought feedback from our membership group which includes patients from across all the geographies we work in. The response to it has been very positive.

5. Our staff

At the end of March 2017 we employed 2,000 full-time staff, 1,200 part-time staff and had another 900 people registered on our staff bank for temporary work. Our workforce is made up of:

- 76% clinical roles
- 87% women
- 38% Black and Minority Ethnic (BME) backgrounds
- 60% 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.

The profile of CLCH has altered throughout the year with movement of services into and out of the organisation. This will continue to be the case moving into 2017/18 with a number of services set to join and leave the trust through the year.

Staff sickness absences rates are within targeted tolerances closing at a 12 month rolling position of 3.26%.

Expenditure relating to consultancy is disclosed in note 7.1 of the financial statements. Exit package payments are disclosed in remuneration and staff report. Our board management gender breakdown as at 31 March 2017 was as follows: 4 male, 6 female.

Supporting a healthy workforce

We are committed to helping all of our staff maintain and improve their wellbeing. We know working in healthcare can sometimes be stressful and we work hard to provide help and support for our staff. During 2016/17 we developed initiatives for physical and mental wellbeing including:

- **The global corporate challenge**
  700 of our staff took part in this international initiative to boost physical exercise and improve mental wellbeing. 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 we walked more than nine times round the world taking over 586 million steps. We were the eighth most active of 54 healthcare / medical organisations. 74% of staff reported decreased stress, 63% lost weight and 65% met the 10,000 steps a day target.

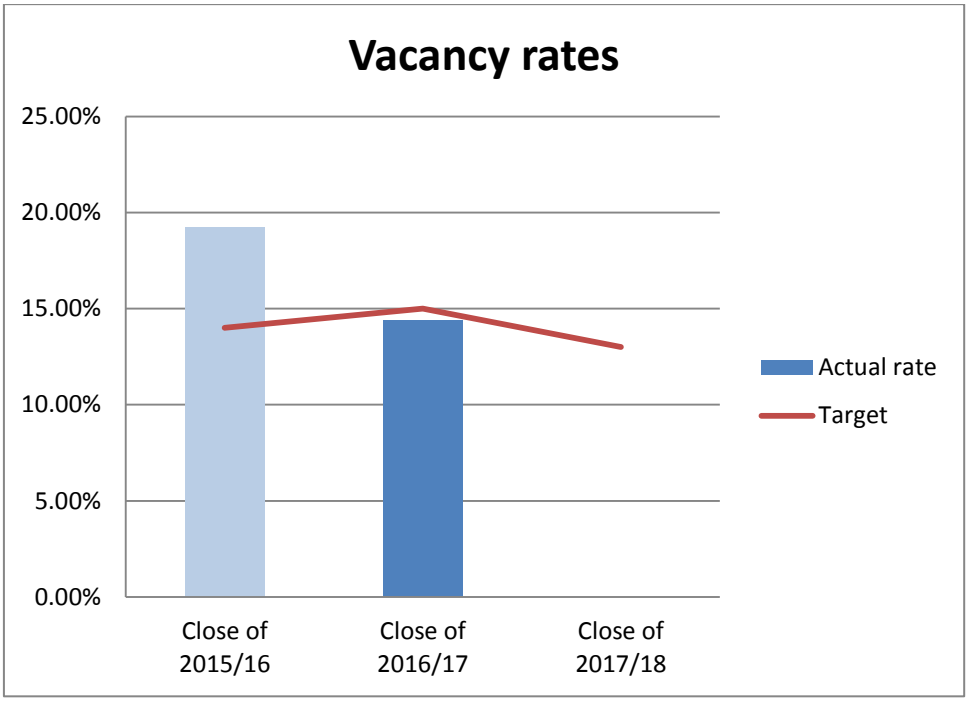
- **Wellbeing champions**
  In 2016/17 we trained a team of six staff to be wellbeing champions. They work in a broad range of our services and come from both clinical and non-clinical backgrounds. The champions have been trained to offer simple confidential advice on health and wellbeing and to help signpost others to the support available both within the trust and externally. They are supported by our occupational health psychologist.

- **Mental health awareness training**
  We rolled out training on mental health awareness to over 170 managers and team leaders across the trust. The training looked at the impact of stress on individuals and teams and explained how to identify stress in individuals and support them to manage it.

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 2016/17 we made good progress in recruitment with improvements to the process bringing down the time it takes to fill roles and a reduction in the overall vacancy levels to 14% in March 2017 (down from over 22% in the early part of the year). Lower turnover rates have also helped to reduce our vacancy levels. However, we continue to have high vacancy rates within some specific services/roles and have a range of programmes underway to address these.



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

- **Fast track nursing**
  We have 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 is 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 2016/17 we recruited 47 nurses and occupational therapists from the Philippines and have an ongoing programme for 2017/18. The standard of both professions in the

Philippines is excellent and we have been extremely impressed with the quality and commitment of the staff joining us.

- **Capital nurse programme**
  We are active members of this London initiative to secure a sustainable nursing workforce for London. It is a collaboration between Directors of Nursing and HR Directors from service providers, Health Education, NHS England, NHS Improvement, universities, education providers, CCGs, trade union and professional organisations.

- **Nursing associate pilots**
  We are part of the national pilots for nurse associate roles. These are a new role to help bridge the gap between health care assistants and qualified nurses and it is hoped they will add to the skill mix options for building the best possible teams to support patients. There are 11 pilot areas across the country which will begin training 1,000 nursing associates. We are part of three London based pilots.

- **Shared governance**
  The model of shared governance which we are using to support delivering our 2017-2020 quality strategy has proven to be highly effective in boosting staff engagement where it has been used both here in the UK and in America. We are confident that it will help a wide range of staff to feel more engaged in their work and empowered to drive improvements which in turn will improve retention rates and build the trust's reputation and our ability to attract new recruits.

Recruitment and retention remains a top priority for 2017/18. Our commitment to clinical leadership and our achievements as a community healthcare trust send a strong signal to potential recruits that their professions are the leaders of our organisation and we offer them the best opportunities to thrive in their chosen field and develop their careers.

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 2016/17 the work of our staff/teams was highlighted in:

- **Health Service Journal Awards 2016 – workforce category – shortlisted**
  Sarah Childs, Principal Speech and Language Therapist, developed a programme to support newly qualified therapists to learn and share experiences about the reality of working with children and their families. The programme builds on the theory that therapists learn as students giving them practical support through their first year of working in the speech and language therapy service. Sarah's work was shortlisted alongside some of the major acute trusts and national organisations like NHS Blood and Transplant.

- **Pharmacy Management National Forum on Medicines Optimisation – Best Medicines Optimisation in Primary Care – winner**
  Our medicines management team work with care homes and general practice in Hammersmith & Fulham and Kensington & Chelsea to make sure that residents get

medicines reviews and that they are taking the right range of medication at the right times. The team also support the staff in care homes with education and training; and their work has been shown to deliver significant cost savings by reducing inappropriate medication.

- **Royal College of Nursing Institute Nurse Awards 2016 – Child Health Award – winner**
  Ruth Butler from our school nursing service won one of the top prizes in the RCNi's annual awards for her work developing the Healthmatters website for young people. The site originally focused on school aged children in our Inner London boroughs and we are now developing it to cover our 0-19 services (health visiting and school nursing) across all areas. Ruth's work on Healthmatters was also recognised as runner-up in the Innovation in School Nursing category at the Cavell Nurses Trust awards.

- **CLCH staff awards**
  Our own annual staff awards were held in September 2016 and recognised the excellent work of our staff with winners and commendations across 19 different categories. Full details of the winners were published in the Winter 2016 edition of our @CLCH magazine which is available on our website at www.clch.nhs.uk/publications

Staff survey results

Our response rate to the 2016 NHS staff survey was 44% (1250 staff). Despite a significant period of change between the 2016 survey and the previous survey our results remained largely consistent.

Compared with other community trusts across the 32 indicators in the survey we were best in the country for quality of non-mandatory training; at or better than average in 22 indicators; slightly worse than average in seven indicators and significantly worse than average (compared to other community trusts across the country) in two indicators relating to equality of opportunity and discrimination. Our scores in these two areas are consistent with other London trusts. Compared to our 2015 results we improved in 11 indicators, remained the same in seven and dropped in 14; although only two of these declined by a statistically significant amount.

Key themes in 2016 show:

- **Improved scores** for: senior management communication, staff motivation, opportunities for flexible working, organisation interest in wellbeing, reporting incidents of harassment/bullying/abuse, and appraisal completion.

- **Significantly declining scores** for: reporting of violence (though actual incidents reduced since 2014) and reporting of errors/near misses.

The full and summary reports of our 2016 results are available on our website at www.clch.nhs.uk/publications

Equality and diversity

We believe that employing a workforce that reflects the diverse nature of the communities we serve will make us better at meeting the needs of our patients. Equally, to be able to deliver great care, all our staff need a working environment where they are able to be themselves and are treated with fairness and respect.

The trust is keen to improve its performance in respect of the national Workforce Race Equality Standard and has started to show some improvements in relation to the success of Black and Minority Ethnic (BME) staff at the shortlisting stage and appointments at a senior level. In 2016/17 we had a board level target to have 30% of staff in roles graded band 8a and above from BME backgrounds, against a backdrop of 38% of our staff being from a BME background. We exceeded this target with a final figure of 32.65% in March 2017, which compares favourably to other London NHS Trusts. In November 2016 we held a successful BME staff conference. We also ran an in-house empowerment programme for BME staff at bands 2-7 and have a BME staff network.

In recent years the trust has regularly featured in the Stonewall top 100 employers and the trust has a well-established Rainbow network for LGBT staff. We also have a disability staff network in the trust and for 2017 we are exploring developing a *Women in leadership* network. The training sessions on mental health awareness aimed to improve the support offered to staff suffering from mental health difficulties and reduce the stigma associated with mental illness.

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 Human Resources team.

Staff involvement and consultation

Building strong relationships and engaging with our staff is vitally important. We inform and involve staff through many different channels, including our formal Joint Staff Consultative Committee meetings between union representatives and management. We run the annual NHS staff survey as well as quarterly local pulse surveys. We also have staff newsletters, regular workshop sessions for our senior managers and a staff intranet. In 2016/17 we also developed the shared governance approach to involving more staff in improving quality within the trust.

6. Service changes

In 2016/17 we completed the mobilisation of new services in Merton and Harrow. Both were large and complex mobilisations with over 400 staff joining the trust. Feedback about the mobilisation has been positive from staff and commissioners and through 2016/17 we have begun the work to transform these services to meet the requirements of commissioners and patients. Both mobilisations have resulted in CLCH taking on new core clinical IT systems with the trust having migrated Harrow onto the EMIS system and in Merton taking on the services' existing RiO system. The safe and successful transition of IT systems means as a trust we are now experienced in running multiple core clinical IT systems in order to improve our links with GP clinical systems.

Competitive tendering by commissioners continues to have a significant impact on our work. During 2016/17 a number of our existing services were retendered and we bid for new work in new areas. As is to be expected we lost some services whilst gaining others. The services we lost at the end of 2016/17 consisted of around 140 staff:

- Barnet community dental
- Inner London sexual health
- Child health information service
- School nursing for Kensington & Chelsea and Westminster boroughs
- Community Independence Service, Inner London

We are also welcoming some new services for 2017/18. The health visiting services for Brent will join the school nursing teams which are already part of CLCH. Around 100 health visiting staff will be joining us in June 2017. Also joining our north division from April 2017 will be a stroke support service in Barnet and a falls prevention service in Brent. Later in 2017 adult community services for Wandsworth will join the trust as will sexual health services in Richmond and Wandsworth.

As well as services being retendered we have also seen some commissioners reducing their spending on a number of our services for 2017/18 and we have worked hard through 2016/17 to prepare for these changes. In some cases services are being decommissioned altogether and in other cases we are working with the commissioners to redesign services to match the lower level of spending they have committed to.

The significant changes are in the three inner London boroughs (Hammersmith & Fulham, Kensington & Chelsea and Westminster), where:

- **Clinical Commissioning Groups** have reduced our contract by £4.5m (9%) in 2017/18 (with another similar decrease to come in 2018/19). To achieve this, the CCGs are decommissioning some services and asking us to change how we deliver others.

- **Local authorities** have reduced our children's speech and language therapy (SLT) contract by £1m (15%) in 2017/18 and health visiting contracts are also expected to see a significant reduction. To achieve this, during 2016/17 we worked with SLT staff to design a new service model and began a transformation programme for health visiting services.

7. Value for money

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 2016/17 we delivered a broad programme of savings projects with a total value of £10.7m. 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 £65m since 2011. For the year ahead we have another challenging target of £10m (which is in addition to the contract reductions mentioned above).

Estates rationalisation

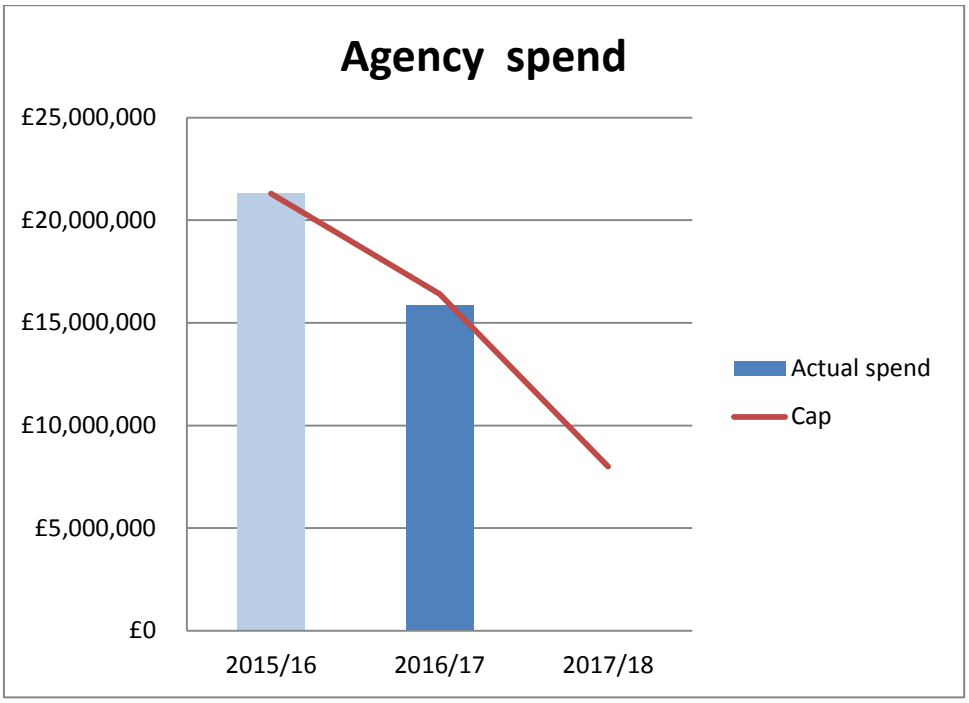
The cost of managing/renting our various health centres and office bases is the trust's second biggest expense, after pay costs. Throughout 2016/17 we worked on a number of projects to get better value for money from the estate we use. Key projects and the savings they have released include:

- Relocation of teams from Stamford Brook and Milson Road health centres (£380,000)
- Relocation of corporate teams and trust headquarters from 64 Victoria Street (approx. £700,000)
- Vacation of Maida Vale Health Centre (£107,000)
- Rationalisation of space at Soho Centre for Health (£195,000)
- Vacation of 215 Lisson Grove (£56,000)

Further cost reductions on our estates will continue into the future. In April 2017 we completed the vacation of 120 The Broadway in Merton, moving our teams to be co-located with council services at the civic centre. As well as supporting more effective joint working the move will save approximately £600,000.

Agency spend

Another significant piece of work to improve value for money in 2016/17 was the continued work to reduce the use of agency staff. The Government set all NHS trusts targets to significantly reduce spend on agency staff in 2016/17. Thanks to a concerted effort from all services we finished the year with an agency spend of £15.8m against our cap of £16.4m. Our spend on agency equates to 11.1% of our total pay bill. Work in this area continues and there is another significant reduction required to meet a 2017/18 target we have set ourselves of no more than £8m on agency staff.



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.

8. 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 10 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.

Changes on our board

During 2016/17 there were a number of changes to the membership of our board.

Chief executive

Andrew Ridley joined the trust as our new permanent chief executive in October 2016. Prior to that, our deputy chief executive (Richard Milner) was acting-up between 1 July and 30 September. From April to June 2016 we had an interim chief executive, Peter Coles.

Director of finance, performance and corporate resources

Ian Millar left the trust in September 2016 and following a restructure of the executive team we appointed Mike Fox, previously divisional director of resources and performance, to the new role of director of finance, performance and contracting in December 2016. We thank Ian for all his work during his time with the trust.

Deputy chief executive & director of operations

Richard Milner left this role in January 2017. The role has not been recruited to and Louise Ashley, chief nurse has taken on an acting chief operating officer role in addition to her existing position. We thank Richard for all his work during his time with the trust.

Director of improvement

This new role was recruited to in March 2017. James Benson, one of our existing divisional directors of operations was appointed and formally took up the role in May 2017.

Non-executive changes

Jitesh Chotai joined the trust as a non-executive and chair of the audit committee on 1 June 2016.

Julia Bond left the trust on 31 March 2017 having served as a non-executive director since the trust was established. We would like to formally thank Julia for her commitment and the contributions she has made to strengthen the organisation throughout her time with us.

Hani Girgis, associate non-executive left the trust on 2 March 2017. We would like to thank Hani for his commitment in what was a newly created role of associate non-executive, specifically developed with the audit and consultancy company Deloitte to help us improve the diversity of our board. The role is being replaced through another placement from Deloitte in 2017.

Board members

The table below details our board members' positions at 31 March 2017 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)
Angela Greatley OBE, Chair	Quality Finance, Resources and Investments Workforce Remuneration
Anne Barnard	Audit Audit* (from 01/04/2016 - 31/05/2016) Charitable Funds Finance, Resources and Investment*
Julia Bond (left the trust on 31/03/2017	Quality * Audit
Jitesh Chotai (joined the trust on 01/06/2016)	Finance, Resources and Investment Audit*
Professor David Sines CBE	Quality Workforce* Remuneration*
Dr Carol Cole	Quality Workforce Remuneration Charitable Funds*
Hani Girgis, Associate Non-Executive (left the trust on 02/03/2017)	Finance, Resources and Investment
Executive board members	
Andrew Ridley, Chief Executive (joined the trust on 01/10/2016)	Finance, Resources and Investment Workforce
Richard Milner, Deputy Chief Executive/Director of Operations (left the Trust on 31/12/2016) Also Acting Chief Executive from 01/07/2016 to 30/09/2016	Quality Finance, Resources and Investment
Peter Coles, Interim Chief Executive (left the trust on 30/06/2016)	Finance, Resources and Investment Workforce
Louise Ashley, Chief Nurse and Director of Quality Governance Also Acting Chief Operating Officer from 11/01/2017	Quality Workforce
Dr Joanne Medhurst, Medical Director	Quality Charitable Funds
Ian Millar, Director of Finance, Performance and Corporate Resources (left the trust on 16/09/2016)	Finance, Resources and Investment Workforce

Mike Fox, Director of Finance, Contracting and Performance (joined the Board from 09/12/2016) Also Acting Director of Finance from 17/09/2016 to 08/12/2016	Finance, Resources and Investment Charitable Funds

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

Anti-slavery / anti-bribery

The trust ensures that slavery and human trafficking is not taking 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.

Annual governance statement

1 Introduction

The Chief Executive of NHS Improvement (NHSI), in his capacity as the Accounting Officer for the NHS Trust Development Authority legal entity, requires NHS Trust Accountable Officers to give assurance about the stewardship of the organisation.

This annual governance statement will be included in the Central London Community Healthcare NHS Trust (CLCH) 2016/17 Annual Report and Accounts.

For CLCH the Accountable Officer is Andrew Ridley, Chief Executive.

2 Scope of responsibility

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

CLCH has sought 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, designed to help NHS providers attain and maintain, Care Quality Commission (CQC) ratings of 'good' or 'outstanding' was introduced during the year. Trusts have been segmented according to the level of support each trust needs across 5 themes of: quality of care, finance and use of resources, operational performance, strategic change and leadership and improvement capability. CLCH was placed, and remains, in segment 1 (providers with maximum autonomy). Throughout the year, feedback from NHSI has remained supportive and positive.

3 Corporate governance framework

The Board governance structure is shown in figure 1 below.

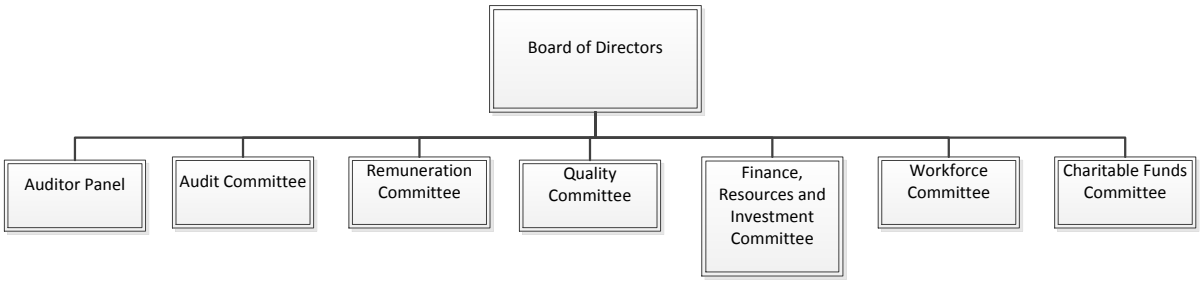


Figure 1

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.

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

3.1.1 Auditor Panel

At the recommendation of the Auditor Panel the appointment of KPMG LLP as the Trust's external auditor from 01.04.17 was approved.

3.1.2 Audit Committee

The committee has highlighted matters in relation to risk management and incident processes; progress against the internal audit and counter fraud plan and recommendations; policy management; procurement; counter fraud tender; management of tender waivers and commercial and procurement lessons learned from the SystmOne implementation.

An additional meeting of the Committee was arranged in November 2016 to review the data quality strategy.

The Committee made a recommendation to the Board that significant projects / business cases should include the proactive involvement of procurement at the appropriate level and the internal auditors have been asked to routinely build lessons learned from post project / investment evaluation into relevant audits.

3.1.3 Remuneration Committee

During the year a number of important issues have been managed on behalf of the Board, including: very senior manager (VSM) appointments and remuneration; Board vacancies; succession planning and the executive team structure.

The Committee has also considered severance arrangements and, given the difficulties recruiting clinical staff and the transfer of undertakings (TUPE) arrangements, has expressed its concern that redundancies have been necessary, as a result of commissioning decisions. As a result, the Trust has changed its policy - moving to a more proactive redeployment approach.

3.1.4 Quality Committee:

The Committee has routinely considered assurance reports in support of the quality strategy and has highlighted a number of innovative developments, including the shared governance approach and red flag system - to identify and mitigate risks to quality. Issues in relation to quality action teams (QAT) have also been brought to the attention of the Board, together with matters in relation to the transfer of services and mobilisation of new services.

Work in support of reducing agency usage, and thus improving the quality of services provided, has been closely monitored and the Committee has been assured that efforts will continue to reduce vacancies as far as possible over the coming year.

3.1.5 Finance, Resources and Investment Committee:

The Committee has highlighted issues in relation to performance (and exception reports); post investment reviews (transformation projects and new services); delivery of savings plans; processes used to cost significant business cases for both investments and new business tenders; business intelligence and the viability of individual service lines.

Key lessons from post investment reviews have included: co-ordination of clinical and corporate functions in delivering change projects, effective and expert project planning, the need to evaluate and validate the effectiveness of communication to ensure organisational awareness and preparedness for change and rapid transition from project to business as usual support.

3.1.6 Workforce Committee

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

Following the establishment of an operational workforce group, the Committee will have a more strategic role in support of the Board.

3.1.7 Charitable Funds Committee

On behalf of the Corporate Trustee, the Committee approved a fundraising strategy and recommended an increase in fundraising resources (manager appointed and new community fundraiser agreed for one year). Risks have been closely monitored, including those in relation to the investment portfolio, given the uncertainty of the future and a potential decline in growth. The Corporate Trustee has been made aware that the Charity will need to use capital to fund initiatives while fundraising initiatives are embedded.

3.1.8 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 consider 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 composition of the Board during the year as shown in table 1 below.

Board composition			
Chairman	To 31.03.16 Pamela Chesters	From 01.04.16 Angela Greatley	
Non-executive Director (Audit Committee Chair)	To 31.03.16 Tony Brown	From 01.04.16 to 31.05.16 Anne Barnard	From 01.06.16 Jitesh Chotai
Chief Executive	To 30.06.16 Peter Coles, Interim	From 01.07.16 to 30.09.16 Richard Milner, Acting	From 01.10.16 Andrew Ridley, Substantive
Director of Finance	To 16.09.16 Ian Millar	From 17.09.16 to 09.12.16 Mike Fox, Acting	From 10.12.16 Mike Fox, Substantive
Deputy CEO / Director of Operations	To 30.06.16 Richard Milner	From 01.07.16 to 30.09.16 James Benson	From 01.10.16 to 31.12.16 Richard Milner
Acting Chief Operating Officer	From 01.01.17 Louise Ashley has been Chief Nurse and Acting Chief Operating Officer		
Director of Improvement (new Board position for 2017/2018)	From 01.05.17 James Benson, substantive		

Table 1

With the exception of the Director of Improvement position, the Board has had a full complement of substantive Executive and Non-Executive Directors since December 2016.

The position of Chair of the Audit Committee was filled on a temporary basis by another Non-Executive Director with financial expertise, from 01.04.16 to 01.06.16 before the new Audit Committee Chair commenced.

3.1 Board performance and development

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

In March 2017, 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; a priority for 2017/18. Internal and external Board development over the past few years has demonstrated a strong commitment to maintaining an engaged and effective Board.

Development during 2017 will support the Trust's organisational strategy, including events funded by NHSI, drawing on the experience of Trusts rated good and outstanding by the CQC as well as linking with external stakeholders to help understand regulators' perspectives.

Topics for 2017-2019 include:

- Developing an effective and compassionate unitary board
- Developing a positive organisational culture
- Relationships and external stakeholder engagement
- The external environment (landscape)
- Leadership (informed by the well-led framework)

The Board is compliant with the Code of Conduct and Code of Accountability for NHS Boards and has undertaken comparisons with the 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, which 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.

3.2 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 in the data warehouse based on information extracted directly from CLCH clinical systems.

There are scheduled data quality checks to find distinct data issues within the waiting times data. For example, patient visits that have not been linked to appointments and where contact methods have not been completed. The reports are available on the Trust's 'Hub' Intranet. The Business Intelligence unit has developed a waiting time and RTT dashboard which is available to clinical units. The clinical 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.

Where errors are identified they are corrected and the process is then updated to address the underlying issue / risk. The Trust is extending the range of data quality reports available and strengthening governance arrangements and oversight of data quality.

3.3 The role of the Board's Committees

3.3.1 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.

3.3.2 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 2016/17:

- Monitoring progress against the implementation of the data quality strategy to gain assurance on the accuracy, timeliness and relevance of key performance data sets
- Assurance that the strategic partnership has appropriate and resilient governance and management processes in place to ensure delivery of the contract
- Through the establishment of an Auditor Panel to initiate and manage the process for tendering and appointing new auditors for the Trust
- 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 the business plan.

3.3.3 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.

3.3.4 Quality Committee – minimum of 10 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 pillars of quality: safety; patient experience; and effectiveness and includes clinical risk management (monitoring risks to quality) and service user safety. As part of this, the Committee reviews and agrees the annual clinical audit plan and quality account.

3.3.5 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 the implementation of the Trust's procurement strategy, together with monitoring the key financial outcomes.

3.3.6 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.

3.3.7 Charitable Funds Committee - minimum of 3 meetings per year

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

3.4 Board and Committee attendance

Summary attendance by members of Board and Committee meetings during 2016/17 is shown in table 2 below[1] - please note that the Associate Non-Executive Director is a non-voting member of the Board and the Finance, Resources and Investment Committee.

There have been a number of changes to the composition of the Board and thus Committee membership, see table 1 above.

	Board of Directors	Auditor Panel	Audit Committee	Remuneration Committee	Quality Committee	Finance, Resources and Investment Committee (FRIC)	Workforce Committee	Charitable Funds Committee
April 2016	11/12	2/3[NV]	2/3[NV]	-	7/7	6/7[NV]	-	4/4
May 2016	10/12	-	-	-	7/7	4/7[NV]	-	-
June 2016	12/12	-	3/3	3/3	5/7	4/7	5/6	-
July 2016	9/12	-	2/3	-	5/7	6/7	-	3/5
August 2016	-	-	-	-	-	-	-	-
September 2016[2]	8/12	-	-	-	-	-	-	-
September 2016	8/12	-	-	-	6/7	6/7	-	-
October 2016[3]	11/12	-	-	-	-	-	-	-
October 2016	8/12	3/3	3/3	-	7/7	5/7	-	-
November 2016	11/12	-	3/3	3/3	7/7	5/7	3/6	-
December 2016	10/12	-	-	-	-	-	-	4/5
January 2017	11/12[EV]	-	3/3	-	4/7[EV]	5/7[EV]	-	-
February 2017	10/12[EV]	-	-	3/3	3/7[EV]	5/7[EV]	5/6	3/5
March 2017	9/12[EV, ANV]	-	-	-	5/7[EV]	4/7[EV, ANV]	-	-

Table 2

Key	
EV	Executive Director vacancy
NV	Non-Executive Director vacancy
ANV	Associate Non-Executive Director vacancy

The Executive Director 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 the Executive Leadership Team (ELT).

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 and Finance, Resources and Investment Committee also agree specific annual objectives.

[1] Part-attendance at meetings is included – Board attendance is based on the meeting in public

[2] Annual General Meeting – 21.09.16

[3] Extraordinary Board meeting convened on 17.10.16 to consider sustainability and transformation plans

3.5 Quality governance

The Trust's Clinical Framework provides a plan for the way in which services will be delivered over the next few years. The Trust recognises that it 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 strategy supports the Trust's objectives and Clinical Framework by clearly defining the vision and success criteria 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.

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. At the recommendation of the Audit Committee, an external audit of the 2016/17 quality account has been commissioned for report to the Quality Committee and Audit Committee.

There were three quality 'Campaigns for Action' in 2016/17

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

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

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. 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.

3.6 Statutory duties

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

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 Board assurance framework (BAF) and financial ledger and feeder systems (including payroll) and information governance.

4 The risk and control framework

The Trust has a risk management strategy in place which sets out the key responsibilities and accountabilities to ensure that risk is identified, evaluated and controlled. The risk management strategy was revised and reviewed by the Audit Committee in 2015. Risk is considered from the perspectives of clinical risk, organisational risk and financial risk.

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

This evaluates likelihood of exposure and the consequences if exposed. Likelihood is the probability of an event occurring; consequences are the outcomes that result if the risk occurs. Likelihood and consequence are combined to calculate the risk grading. Risks scoring 12 and above are included in the 'corporate' risk register.

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

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

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

The Executive Leadership Team (ELT) receives a quarterly report on BAF risks and risks of 15 and above which subsequently goes to Board. ELT 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.

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

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

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

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.

5 Risk assessment

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

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

For the period – 01/04/16 to 31/03/17, 194 new risks were identified (excluding BAF risks) and 213 risks were closed - risk categories are shown in tables 3 and 4 below.

There are currently 13 BAF risks on the risk register; 3 of these risks were opened in the period 2016/17 and 2 were closed – see tables 5- 7 below.

New risks opened (excluding BAF risks) in 2016/17

Category	Total
Clinical	67
Environment	7
Event	6
Finance, Performance, Contracts and strategy	30
Fire, health and safety	10
Information governance	7
Information management and technology	38
Medical directorate	3
Reputational	12
Workforce	14
Total	**194**

Table 3

Risks closed (excluding BAF risks) in 2016/17

Category	Total
Clinical	78
Environment	4
Equality and Diversity	2
Finance, Performance, Contracts and strategy	51
Fire, health and safety	12
Information governance	5
Information management and technology	39
Medical directorate	1
Reputational	5
Workforce	16
Total	**213**

Table 4

BAF risks opened

Category	Total
Finance, performance, contracts and strategy	3
Total	**3**

Table 5

BAF risks closed

Category	Total
Finance, performance, contracts and strategy	2
Total	**2**

Table 6

Major strategic risks to Trust priorities in 2016/17 included:

BAF risks in relation to:	CLCH 2016/17 priority
Staff vacancies	Quality
New clinical services and compliance	Quality
FT authorisation	Leadership and governance
Information governance compliance	Leadership and governance
Performance management framework	Leadership and governance
Delivery of the cost improvement programme	Value for money
Use of mobile working technology to drive clinical and operational innovation	Value for money
Collaborative partnerships	Transformation and growth
Stakeholder engagement	Transformation and growth
Contract competition	Transformation and growth
Service redesign	Transformation and growth

Table 7

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

During the period of 01.04.16 to 31.03.17 a total of 6 serious incidents (level 2) were reported to the Information Commissioner's Office (ICO). Incidents with a severity level of 2 or above are classed as serious incidents and are required to be externally reported to the ICO via the information governance toolkit incident reporting tool. This is a decrease from the previous year (2015/16) when a total of 7 incidents were reported.

All 6 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.

6 Review of the effectiveness of risk management and internal control

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 2016/17 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 and comments on the audit programme for the year. During 2016/17 an opinion of "reasonable assurance" was provided.

Of the 13 internal audits reported during the year, 3 reports confirmed substantial assurance, 6 reasonable assurances, with 4 limited assurance opinions. There was one advisory report.

A summary of the key findings from each of the 4 limited assurance reports is provided below:

HR – probationary period

- The Trust did not have an overarching recruitment and selection policy in place at the time of the fieldwork
- Only 42% of the sample tested was compliant with the Trust's probationary period operational framework in terms of conducting mid-year reviews
- Only 41% of the sample tested had evidence of an "end of induction and probationary review" and evidence of monitoring and compliance was found to be weak
- Recruitment files (either electronic or hardcopy) could not be located for five out of 19 (26%) appointments selected by audit for testing.

Non-electronic medical records

- The Trust did not have a clinical record keeping lead to champion and promote records management practice
- The operational arrangements for record keeping management within directorates required review
- Outcomes from annual record management audits had not been followed-up with appropriate action plans
- The approach to the clinical audit for non-electronic record keeping was not informed by health record risks and incidents
- Directorates lacked a single point of contact for local medical records management.

Strategic partnership – change control notices

- Although the governance structure for the partnership and for the management of change control notices (CCNs) had been formalised, further work was required to improve compliance levels for the management of CCNs
- Findings showed that there were instances where CCNs had been raised retrospectively
- There was a backlog of CCNs to be processed and 4 of the 10 CCNs sampled were not signed off by both parties within 60 days as required
- Despite the CCN log being a standing agenda item on the operations board agenda, the item was not discussed regularly during 2016/17

Data quality governance

- The data quality control cycle prescribed in the data quality strategy had not been executed across all of the Trust's divisions
- There were a number of reporting issues relating to the Business Intelligence function
- At the time of audit fieldwork, there was no designated officer with operational responsibility for data quality within the Trust (this is now the responsibility of Director of Improvement)
- There was no documented data quality assurance framework in place which raised concerns that not all data quality issues would be adequately addressed
- A review of the performance information data quality oversight group minutes of meetings indicated that there was no detailed monitoring of data quality reviews or key performance indicators.
- The data quality policy needed to be updated to reflect the new data quality strategy.

Detailed remedial plans have been agreed with the management team and will be followed-up during the year.

While there have been 4 limited assurance reports, the Trust has a risk based approach to preparing the internal audit plan – focusing on areas where further assurance is required in order to identify necessary change or improvement.

There are currently 3 urgent outstanding recommendations and a revised implementation date has been agreed in relation to the overdue HR recommendation and 2 other recommendations in relation to the strategic partnership and data quality governance are due to be closed in the near future.

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 and noted continued improvement in the active monitoring of the BAF and risk register.

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.

7 Significant issues

There have been no significant issues raised by internal audit during the year, however towards the end of the year the Trust identified some significant issues in relation to business intelligence and performance analytics arrangements. These relate to the delayed implementation of a new data warehouse solution and the impact on the Trust's ability to make reports to commissioners. These are being addressed with the Trust's strategic partner, Capita.

Andrew Ridley, Chief Executive
Central London Community Healthcare NHS Trust
Date: 31 May 2017

Remuneration and Staff Report

This report is made by the Board on the recommendation of the Remuneration Committee in accordance with Chapter 6 of Part 15 of the Companies Act 2006 and Schedule 8 of SI 2008 no 410. The first part of the report provides details of remuneration policy; the second part provides details of the remuneration and pensions of our senior managers for the year ended 31 March 2017.

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

Remuneration Committee

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

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.

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 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 paid the remuneration of one board member, the interim Chief Executive via an agency during 2016/17 (2015/16: 1).

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 2016/17 or 2015/16.

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% (2015/16: 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 2016/17	Contribution Rate 2015/16
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.

Service Contracts

Each of the Directors and Very Senior Managers listed below has or has had a substantive or fixed term contract which can be terminated by either party giving between 3 and 6 months' written notice. The Trust can request that the senior manager either works his or her notice or be paid an amount in lieu of notice.

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

Director	Role	Contract start Date	Leave date
Andrew Ridley (a)	Chief Executive	01/10/2016	-
Dr. Joanne Medhurst	Medical Director	14/01/2013	-
Ian Millar (b)	Director of Finance, Performance and Corporate Resources	22/08/2013	16/09/2016
Louise Ashley	Chief Nurse and Director of Quality Governance	21/11/2012	-
Mike Fox (b)	Director of Finance, Contracting and Performance	12/12/2016	-
Peter Coles (c)	Chief Executive (Interim)	11/01/2016	30/06/2016
Richard Milner (d)	Deputy Chief Executive	28/01/2013	31/12/2017

a) Andrew Ridley joined the Trust on 1 October 2016 as substantive Chief Executive as a result of the substantive Chief Executive retiring early due to ill health. Prior to his appointment as substantive Chief Executive, Richard Milner acted as Chief Executive between 1 July 2016 and 30 September 2016.

b) Ian Millar left the Trust on 16 September 2016 and Mike Fox served as acting Director of Finance until 12 December 2016 when he was appointed as substantive Director of Finance, Contracting and Performance.

c) Peter Coles served as Interim Chief Executive of the Trust until 30 June 2016 whilst a permanent Chief Executive was being recruited for the Trust following the departure of James Reilly, former substantive Chief Executive of the Trust, who left the Trust on 29 February 2016, retiring early due to ill health.

d) Richard Milner is currently seconded to Barnet Enfield and Haringey NHS trust. His appointment is due to end on 31 December 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.

Termination Arrangements

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

Salaries direct to limited companies

The Trust has a policy that all substantive staff are paid through the payroll. The Trust paid the remuneration of no Director to an associated limited company during the financial year 2016/17 (2015/16: 0).

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 2016/17 was £275,000 to £280,000 (2015/16: £350,000 to £355,000). This is the full year effect of three months' fees paid to an agency for the service of the interim Chief Executive Officer between 1 April 2016 and 30 June 2016 while recruiting a substantive replacement. The costs include agency commission and non-recoverable VAT. This was nine times (2015/16: eleven times) the median remuneration of the workforce, which was £32,088 (2015/16: £31,349).

In 2016/17, no employee (2015/16: nil) received remuneration in excess of the highest-paid director. The highest paid Director during 2016/17 was the Trust's interim Chief Executive. Remuneration paid to employees during 2016/17 ranged from £19,000 to £279,000 (2015/16 £19,000 to £324,000). The upper limit of the highest remuneration paid during 2016/17 and 2015/16 reflects the full year effect of three months' full time remuneration and not the actual remuneration of any single individual.

The Trust appointed a substantive Chief Executive on 1 October 2016. His salary is in the £165,000 to £170,000 band. This equates to five times the median remuneration of the workforce.

The VSMs in post on 1st April 2016 received a pay increase in line with NHSI guidance in relation to 1% of the average VSM salary in CLCH during 2016/7.

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

Non-Executive Directors

Non-Executive Directors do not have service contracts. They are appointed by 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	-
Julia Bond	Non-Executive Director	17/12/2009	31/03/2017
Jitesh Chotai	Non-Executive Director	01/06/2016	-
Angela Greatley	Board Chairman	01/04/2016	-
David Sines	Non-Executive Director	27/06/2012	-
Carol Cole	Non-Executive Director	01/08/2014	-

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

		2016/17					2015/16				
Name and Title		Salary (bands of £5,000)	Bonus payments (bands of £5,000)	Benefits in Kind (bands of £100)	Other Remuneration (bands of £5,000)	Total (bands of £5,000)	Salary (bands of £5,000)	Bonus payments (bands of £5,000)	Benefits in Kind (bands of £100)	Other Remuneration (bands of £5,000)	Total (bands of £5,000)
Executive Directors											
Andrew Ridley (Chief Executive)		80-85	0	0	0	80-85	0	0	0	0	0
Dr Joanne Medhurst (Medical Director)		105-110	0	0	0	105-110	90-95	0	0	0	90-95
Ian Millar (Director of Finance, Performance and Corporate Resources from 22 August 2013 to 16 September 2016)		55-60	0	0	0	55-60	125-130	0	0	0	125-130
James Reilly (Chief Executive from 15 February 2011 to 29 February 2016)		0	0	0	0	0	195-200	0	3,900-4,000	0	200-205
Louise Ashley Chief Nurse and Director of Quality Governance)		110-115	0	0	0	110-115	110-115	0	0	0	110-115
Mike Fox (Director of Finance, Contracting and Performance) – from 12 December 2016)		35-40	0	0	0	35-40	0	0	0	0	0
Peter Coles (Interim Chief Executive from 11 January 2016 to 30 June 2016)		65-70	0	0	0	65-70	80-85	0	0	0	80-85
Richard Milner (Deputy Chief Executive and Director of Operations)		125-130	0	0	0	125-130	115-120	0	0	0	115-120
Non-Executive Directors											
Angela Greatley (Non-Executive Director)		30-35	0	0	0	30-35	0	0	0	0	0
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	0	0	0	0	0
Julia Bond (Non-Executive Director)		5-10	0	0	0	5-10	5-10	0	0	0	5-10
Pam Chesters (Chairman from 1 June 2012 to 31 March 2016)		0	0	0	0	0	20-25	0	0	0	20-25
Professor David Sines (Non-Executive Director)		5-10	0	0	0	5-10	5-10	0	0	0	5-10

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

b) Louise Ashley will receive a pay increase to reflect the additional responsibilities following the secondment of the Deputy CEO /COO backdated to 1 January 2017. This is still subject to NHSI approval.

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 2017 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2017 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2017 - £'000 (Note d)	Cash Equivalent Transfer Value at 31 March 2016 (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 2017 (Bands of £5,000)
Dr Joanne Medhurst (Medical Director)	f	0-2.5	0-2.5	20-25	50-55	383	336	47	0	20-25
Ian Millar (Director of Finance, Performance and Corporate Resources)	a	0-2.5	0-2.5	5-10	0	96	78	18	0	5-10
James Reilly (Chief Executive)	a, g	0	0	0	0	0	98	0	0	0
Louise Ashley (Chief Nurse and Director of Quality Governance)		0-2.5	5-7.5	25-30	75-80	490	445	44	0	25-30
Mike Fox (Director of Finance, Contracting and Performance)	g	0	0	20-25	60-65	286	0	0	0	20-25
Richard Milner (Deputy Chief Executive)		2.5-5	2.5-5	20-25	50-55	313	267	46	0	20-25

Notes

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

b) Non-Executive members do not receive pensionable remuneration. There are no payments in respect of pensions for Non-Executive members (2015/16: £nil).

c) During 2016/17 the Trust paid no employer's contribution into Directors' personal pension plans (2015/16: £nil).

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

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

f) The 2015/16 and 2014/15 Pension, Lump Sum and CETV for Dr Joanne Medhurst exclude Practitioner (i.e. GP) pension benefits.

g) Mr Mike Fox'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 2016/17 and his 2015/16 data was not available. Mr James Riley left the Trust during 2015/16 and did not contribute to the NHS Pensions scheme in 2016/17.

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. This will continue to be the case moving into 2017/18 with Sexual Health Inner, Dental services and several Inner School Nursing units leaving us at the 1st April but several services due to join us including Brent Health Visiting, South West London sexual Health services and Wandsworth Community Adult Health Services.

Staff sickness absences rates are within targeted tolerances closing at a 12 month rolling position of 3.29%.

Expenditure relating to consultancy is disclosed in note 7 of the financial statements. Exit package payments are disclosed in note 9.3 of the financial statements.

The head count split of individuals paid through CLCH payroll at 31 March 2017 was (13%) male to (87%) female (31 March 2016: 403 (15%) male to 2,351 (85%) female). Our Board Management gender breakdown as at 31 March 2017 was as follows: 4 Male, 6 Female (31 March 2016 was as follows: 5 Male, 6 Female).

Staff numbers (Whole Time Equivalents - WTE)

	2016/17			2015/16		
	Total	**Permanently Employed**	**Others**	Total	Permanently Employed	Others
	Number	**Number**	**Number**	Number	Number	Number
Medical and dental	**87**	**74**	**13**	114	76	38
Administration and estates	**656**	**602**	**54**	722	598	124
Healthcare assistants and other support staff	**32**	**31**	**1**	64	64	0
Nursing, midwifery and health visiting staff	**1,694**	**1,349**	**345**	1,426	1,145	281
Nursing, midwifery and health visiting learners	**0**	**0**	**0**	45	0	45
Scientific, therapeutic and technical staff	**612**	**483**	**129**	565	431	134
Social Care Staff	**3**	**3**	**0**	3	3	0
Total staff numbers	**3,084**	**2,542**	**542**	2,939	2,317	622

Staff (WTE) engaged in capital projects in 2016//17: 8 (2015/16: nil).

Exit packages agreed for staff

2016/17

Exit package cost band (including any special payment element)	Number of compulsory redundancies, Number	Cost of compulsory redundancies, £'000	Number of other departures agreed, Number	Cost of other departures agreed, £'000	Total number of exit packages by cost band, Number	Total cost of exit packages by cost band, £'000
Less than £10,000	6	35	0	0	**6**	**35**
£10,001 - £25,000	2	22	0	0	**2**	**22**
£25,001 - £50,000	0	0	0	0	**0**	**0**
£50,001 - £100,000	1	100	0	0	**1**	**100**
Total	**9**	**157**	**0**	**0**	**9**	**157**
Total number of special payments (and total cost of special payment element)					**0**	**0**

2015/16

Exit package cost band (including any special payment element)	Number of compulsory redundancies, Number	Cost of compulsory redundancies, £'000	Number of other departures agreed, Number	Cost of other departures agreed, £'000	Total number of exit packages by cost band, Number	Total cost of exit packages by cost band, £'000
£10,001 - £25,000	5	74	0	0	5	74
£25,001 - £50,000	5	171	0	0	5	171
£50,001 - £100,000	1	70	0	0	1	70
Total	**11**	**315**	**0**	**0**	**11**	**315**
Total number of special payments (and total cost of special payment element)					**0**	**0**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme as the employee's role is made redundant through service redesign or reconfiguration.
Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pension Scheme. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the table.
This disclosure reports the number and value of exit packages taken by staff leaving in the year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Sickness absences

During the 2016/17 financial year the Trust's staff took a total of 19,328 days (2015/16: 21,063 days) of sickness absence. This is an average of 7.6 days (2015/16: 8.7) per staff member. These amounts are for the calendar year 2016.

Retirements due to ill-health

During 2016/17 two persons retired early on ill-health grounds during the financial period (2015/16: two). The associated additional accrued pension liabilities total £19K (2015/16: £94K).

Andrew Ridley, Chief Executive
(on behalf of the Board)
Date: 31 May 2017

Financial overview

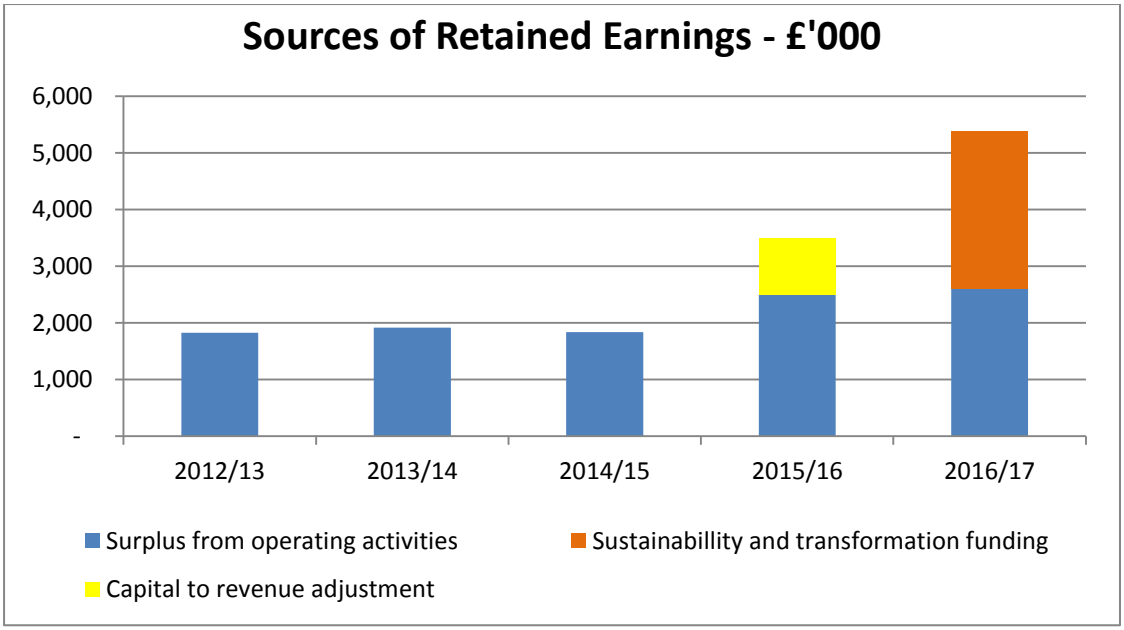
In 2016/17 the Trust achieved all key financial targets agreed with the Department of Health and NHS Improvement at the start of the financial year. These achievements include

- Achieving a surplus of £5,380k against plan of £4,820k;
- Investing £7,839k of Capital in IT, Estates and Medical Equipment (£100k lower than our Capital Resource Limit);
- Cash on hand was £11,346k at the end of March 2017 (£5,051k higher than plan);
- Reducing reliance on high cost temporary staffing resulting in agency spend being £5,831k lower than 2015/16 (£497k below the NHSI agency cap for CLCH); 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 2017 were £11,714k which equates to a 5.5% gross margin (2015/16: £9,122k, 4.6% gross margin). The increase of £2,592k 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 (£2,778k) which CLCH was not permitted to spend as well as improved operational efficiency in the Trust.

The Trust had capital and reserves totaling £53,627k at 31 March 2017 (2015/16: £48,824k). Our capital and reserves have risen by £4,803k during the year; the increase is attributable to net surplus retained for the year of £5,380k offset by a £577k net loss on revaluation of property plant and equipment.

The Trust delivered a full year surplus of £5,380k (2015/16: £3,506k), £560k (11.6%) more than plan due to £558k of STF above plan (£2,778k in total) received from NHS Improvement for meeting key performance indicators. The Trust surplus consisted of £2,602k generated from operating activities and £2,778k of STF. The Sustainability and Transformation Fund (STF) is non-recurrent central funding provided to assist Trust with various transformation schemes geared at improving efficiency within the Trust. The surplus generated by our operating activities was mainly driven by increased efficiency in services and reductions in spend on high cost agency staffing.



In 2015/16, the Trust agreed to a central technical accounting adjustment that required the Trust to defer £1,000k in capital for which the Trust received same amount (£1,000k) in revenue funding.

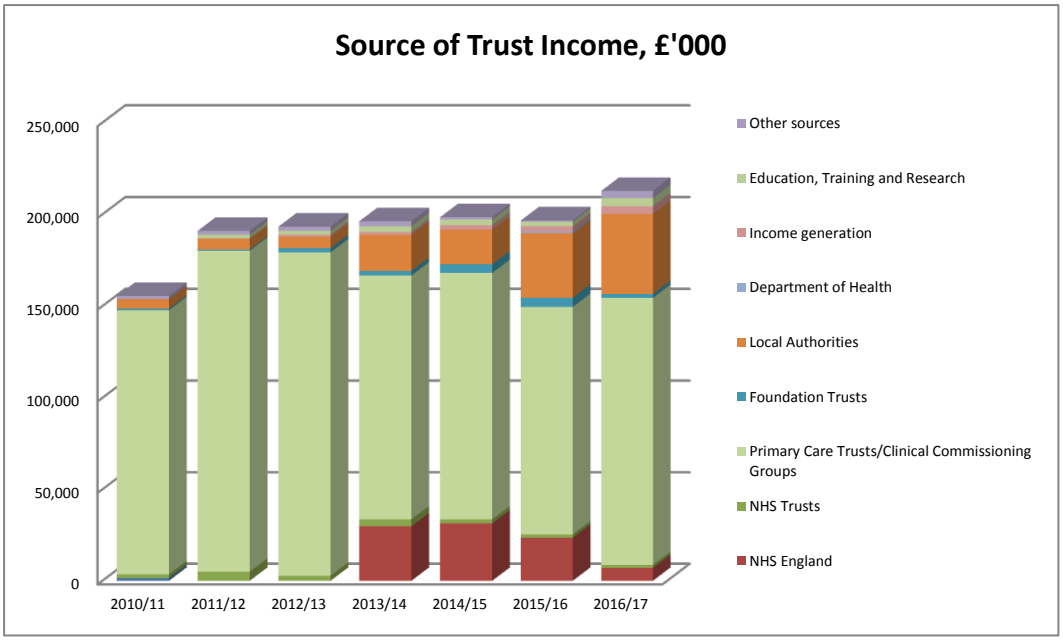
In 2015/16, the Trust completed a key milestone of the corporate transformation programme by selecting Capita as our strategic partnership to deliver some of its corporate services functions including parts of the Trust's Human Resources, Finance, Estates, Information Management and Technology and Business Intelligence. During 2016/17, the Trust negotiated the transfer of Strategic Procurement to Capita and this service will commence in April 2017. CLCH retains the strategic leadership and control across all these Departments.

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 with 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 2017 the Trust had cash balances of £11,346k (2015/16: £14,862k), sufficient to pay for 20 days of the Trust's operating expenditure. During the year the Trust continued to carefully manage its working capital, outstanding receivables and payables. This management enabled the Trust to invest £7,839k during 2016/17 (2015/16: £6,461k) in information technology infrastructure, estates maintenance and medical equipment used by our clinical and support staff.

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

Income

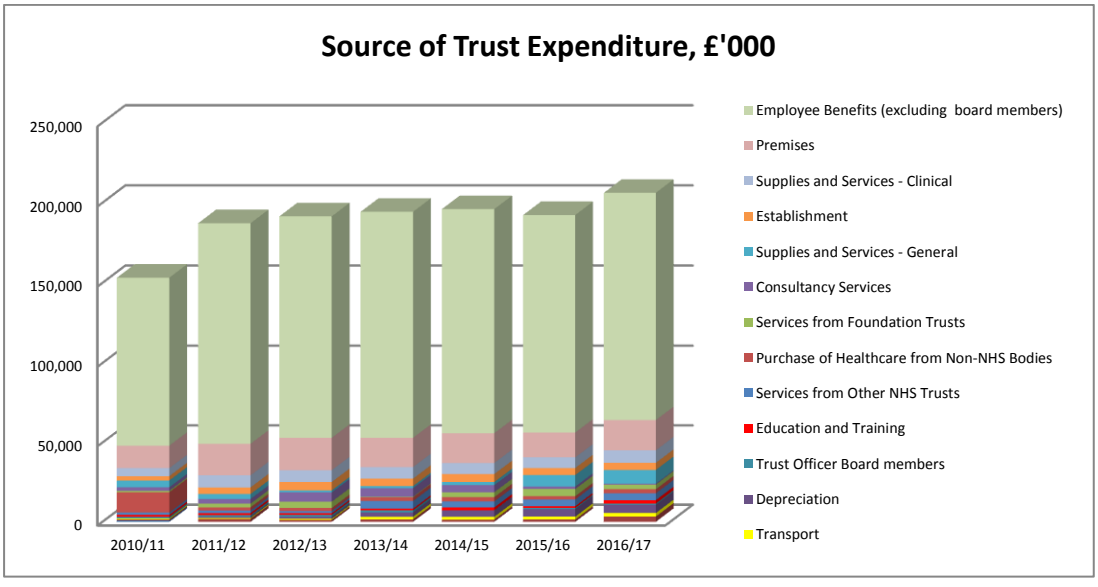
Our operating income (which excludes interest earned) for the year to 31 March 2017 was £212,749k (2015/16: £196,671k) which came from the following sources:

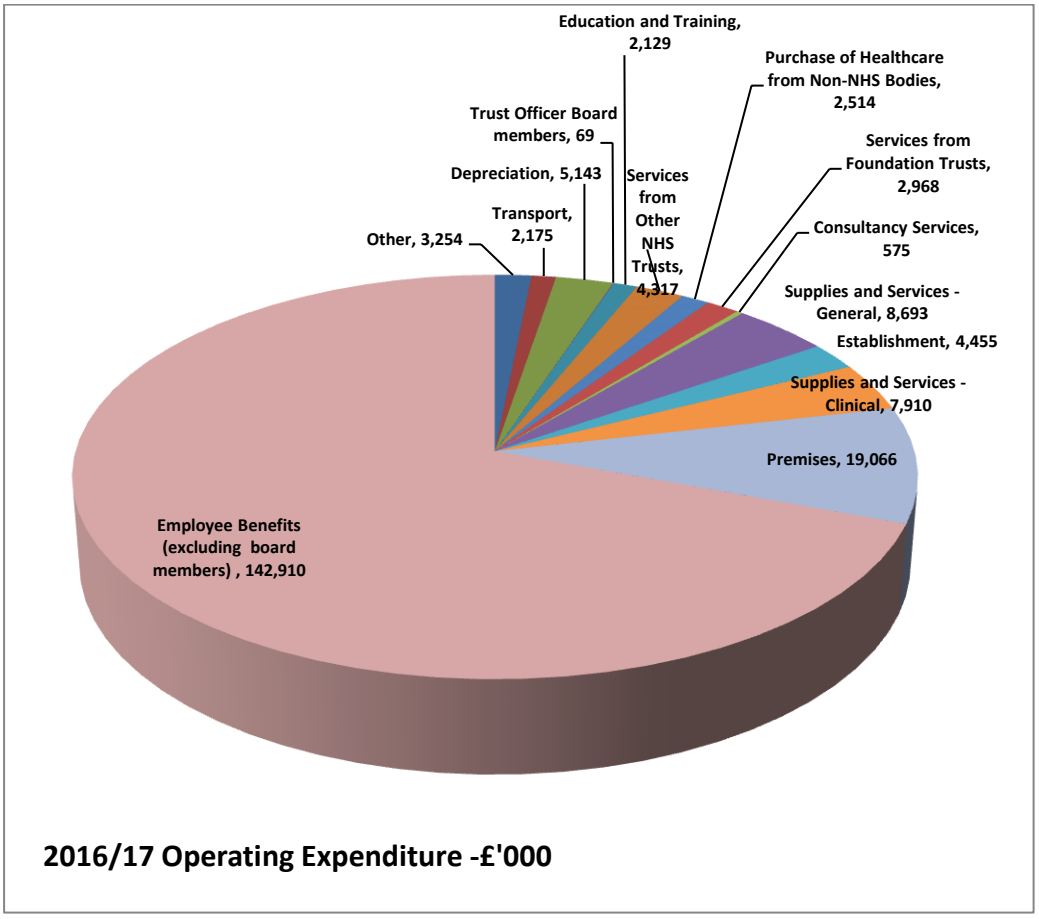


Income increased by 8% or £16.0m due to net gain in business, the most significant gain being Harrow and Merton Community Health Services. We have no income due from private patients ordinarily resident in the UK but we generate income from overseas patients without reciprocal agreements. The reduction in income from NHS England (NHSE) and growth in income from Local Authorities is due to the transfer of commissioning of some children's services from NHSE to Local Authorities.

Expenditure

Expenditure increased by 7% or £14.0m primarily due to increased activities. Our operating expenditure (which does not include financing costs) for the year to 31 March 2016 was £206,178k (2015/16: £192,300k) and was spent in the following areas:





Treasury policies and objectives and liquidity of the Trust

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

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

Our BPPC performance against target:

Our performance in paying our liabilities as they fall due was strong at the end of 2016/17. 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 in the beginning of the current financial year leading to under performance against the targets set by the Better Payment Practice Policy, which is detailed below in our Financial Statements. However, performance improved during the second half of the financial year and the Trust is confident it will improve its delivery against this target in the future.

	Q1	Q2	Q3	Q4	YTD	Target
2016/17	74%	88%	91%	93%	88%	95%
2015/16	98%	96%	96%	91%	95%	95%

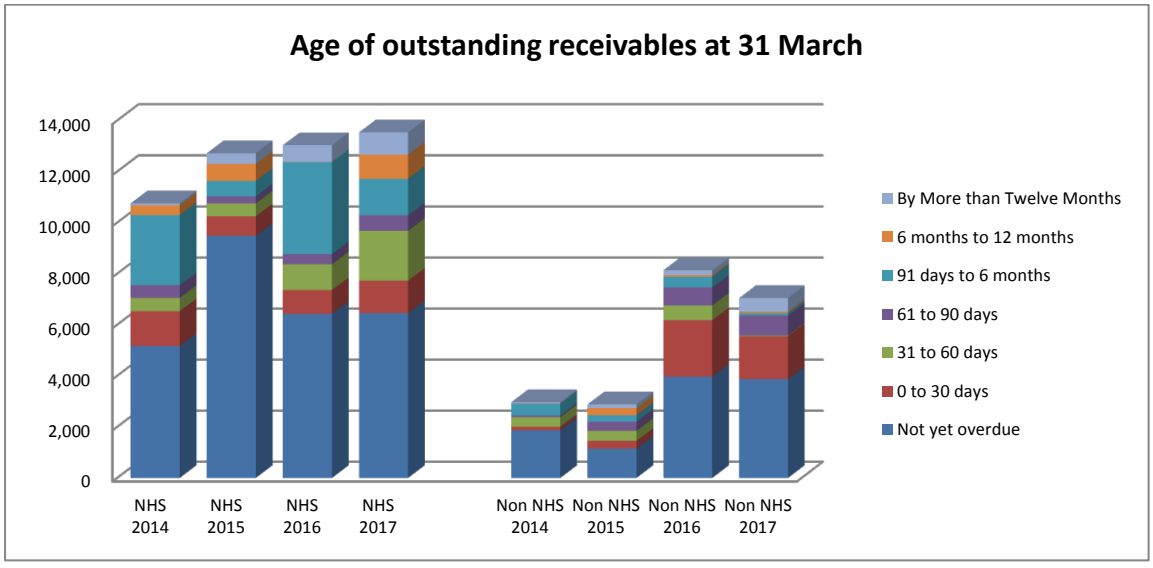
Our working capital management performance against target:

	31 March 2017	31 March 2016	Target
Receivables uncollected over 90 days past due	13%	23%	5%
Payables unpaid over 90 days past due	23%	42%	5%

We acknowledge that while performance has improved from prior year, 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 2017/18. The underperformance on Payables unpaid over 90 days past due is as a result of unpaid invoices due to four organisations at year end, most of which have been resolved subsequent to yearend.

CLCH has a track record of recovering amounts owed. During 2016/17 and 2015/16 the Trust did not write-off any debt of amounts due and has a provision against unrecoverable debts of £1,332k (2014/15: £355k). The Trust had a healthy cash position throughout the year relative to plan which enabled it to mobilise new services at Harrow and Merton without recourse to external sources of finance. Much of the cash balance carried forward to 2017/18 is allocated to meet existing financial commitments and fund future service developments.

The Trust has £19,929k receivable from NHS and non-NHS bodies at 31 March 2017 (31 March 2016: £21,170k). 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 are £24k higher than prior year whilst old NHS debts have broadly remained the same level. Non-overdue non NHS debts are £97k less than

prior year. Overall, debt recovery in 2016/17 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 2017/18.

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 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;

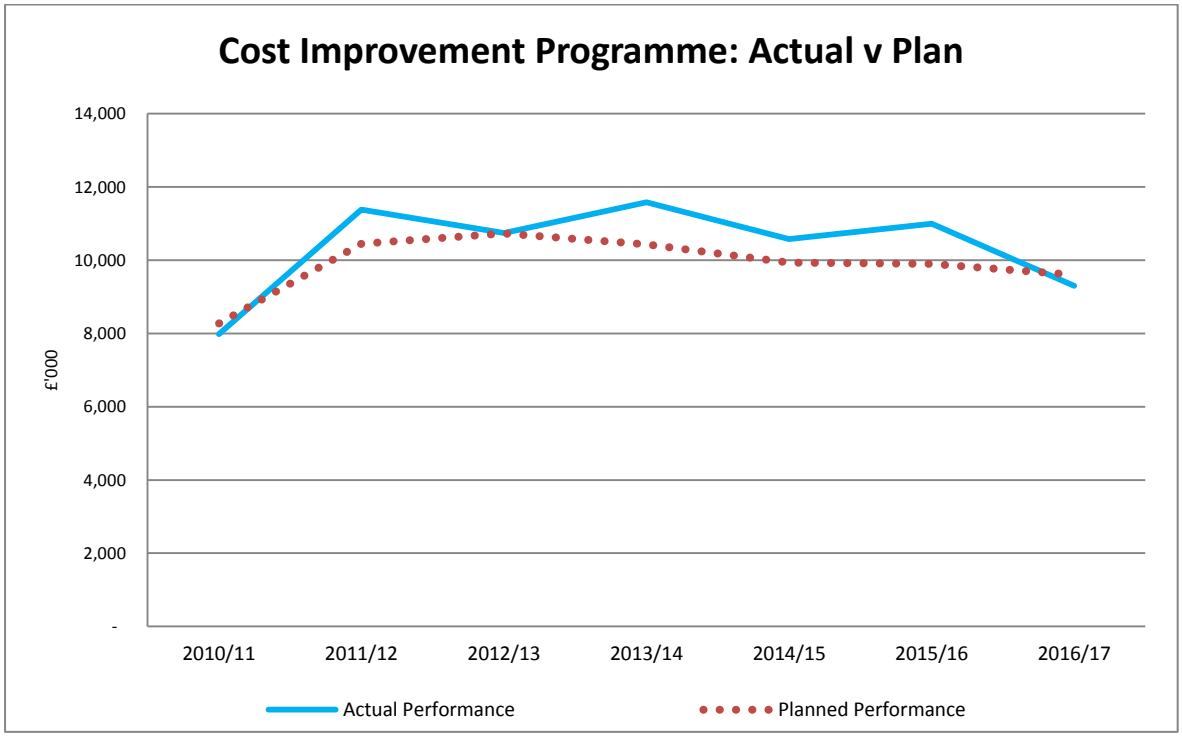
- **Distance from Financial Plan in Relation to I&E Margin:** variance between the trust's planned I&E margin in its annual forward plan and its actual I&E margin within the year. The Trust achieved a score of 1 out of 4 in this category, as the Trust achieved its planned surplus in addition to receiving bonus STF funding 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 £0.5m 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.

QIPP (Quality, Innovation, Productivity and Prevention)

The QIPP requirement for 2016/17 was £10.7m (£9.6m net of contingency).

£9.3m of the target has been achieved for 2016/17; the shortfall net of contingency was therefore £0.3m. The recurrent value of 16/17 QIPP is £10.7m meaning there is no residual gap that needs bridging in 2017/18.



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.

The QIPP target for 2017/18 is £9.7m. The programme is finalised and comprises 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 2017/18 QIPP plan relate to the efficient use of resources 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 Chief Nurse & Director of Quality Governance.

Financing and investment

During 2016/17 we made significant investments in various capital projects. Some of these investments were to complete projects that began during 2015/16 such as mobile working infrastructure, deployment of Voice-Over-Internet-Protocol (VOIP) telephones and e-rostering while investments in new projects include EMIS Patient Administration System (PAS) 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. They will demonstrably improve our productivity and free both clinical time and financial resources to focus on improving patient care. Our 2016/17 capital investments totaled £7,839k (2015/16: £6,461k). The most significant investments were:

- £2,676k invested in various estates related projects including at Parsons Green Health Centre (property owned by the Trust) to improve facilities for clinical staff and to enable the Trust to vacate expensive rented space at Westminster City Hall and refurbishment of clinical and administrative sites across Hertfordshire, Watford, Merton and Westminster ensuring that these sites are compliant with requirements to deliver our services to safe standards and comply with the requirements of the Care Quality Commission (CQC);
- £891k to implement EMIS Patient Administration System across Harrow locality and £398k in creating a scalable interoperable solution across core CLCH PAS and PAS of major partners across the boroughs we currently serve;
- £622k investment in VOIP infrastructure across clinical and corporate services;
- £1,191k expenditure on mobile working infrastructure to ensure clinical and support staff can easily access fast wireless internet connection via various devices while working in a mobile or remote manner and enable optimal utilisation of our estates; and
- £70k spend on modern medical devices including endodontic devices, defibrillators, calibration & support units and dynafoam mercury advance mattresses.

We have identified a number of areas where future investment will help us achieve our objectives and meet the aspirations of all of our stakeholders. These include investments in assistive technologies, clinical systems development allowing the Trust to utilise available technologies in both clinical services and administrative activities and investments in estates which is broadly aimed at rationalising existing sites to reduce the Trust's estate footprint while ensuring that all CLCH site remain compliant with CQC and HSE requirements.

Political and charitable donations

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

Pension liabilities

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

The Trust does not reflect in its financial statements any NHS Pension scheme assets or liabilities attributable to scheme members who are employed by the Trust. There is £1,767k in respect of outstanding NHS Pension contributions at 31 March 2017 (31 March 2016: £1,477k).

Disclosure of information to Auditors

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

Our annual accounts

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

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

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

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

Andrew Ridley Date: 31 May 2017
Chief Executive

Mike Fox Date: 31 May 2017
Director of Finance, Contracting and Performance

Financial statements for the 12 months ended 31 March 2017

Foreword to the accounts

These accounts for the 12 months ended 31 March 2017 have been prepared by the Central London Community Healthcare NHS Trust under the National Health Service Act 2006 in the form which the Secretary of State has, with the approval of the Treasury, directed.

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

The Chief Executive of the NHS Improvement has designated that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers' Memorandum issued by the Chief Executive of the NHS Improvement. These include ensuring that:

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

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

Andrew Ridley, Chief Executive Date: 31 May 2017

Statement of directors' responsibilities in respect of the accounts

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

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

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

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

Andrew Ridley, Chief Executive: Date: 31 May 2017

Mike Fox, Director of Finance,
Contracting and Performance Date: 31 May 2017

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

We have audited the financial statements of Central London Community Healthcare NHS Trust for the year ended 31 March 2017 on pages 54 to 98 under the Local Audit and Accountability Act 2014. These financial statements have been prepared under applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England. We have also audited the information in the Remuneration and Staff Report that is subject to audit.

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

Respective responsibilities of Directors, the Accountable Officer and auditor

As explained more fully in the Statement of Directors' Responsibilities set out on page 54, the Directors are responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources. 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. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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

Scope of the audit of the financial statements

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

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2016, 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. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2017 and of the Trust's expenditure and income for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England.

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England; and
- the other information published together with the audited financial statements in the Annual Report and Accounts is consistent with the financial statements.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the Department of Health Group Accounting Manual 2016/17; or
- 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; or
- we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

We have nothing to report in respect of the above responsibilities.

Certificate

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

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

31 May 2017

Statement of comprehensive income for the year ended 31 March 2017

	Notes	2016/17 £'000	2015/16 £'000
Revenue			
Revenue from patient care activities	5	**200,841**	191,252
Other operating revenue	6	**11,908**	5,419
Employee benefits	7/9	**(142,910)**	(136,762)
Other operating expenses	7	**(63,268)**	(55,538)
Operating surplus/(deficit)		**6,571**	4,371
Investment revenue	12	**16**	56
Other gains and losses		(11)	0
Surplus/(deficit) for the financial year		**6,576**	4,427
Public dividend capital dividends payable		**(1,196)**	(921)
Retained surplus/(deficit) for the year		**5,380**	3,506
Other comprehensive income			
Net gain/(loss) on revaluation of property, plant, equipment	13	**(577)**	3,135
Total comprehensive income for the year		**4,803**	6,641

The notes on pages 62 to 98 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 2017

	Notes	31-Mar-17 £'000	31-Mar-16 £'000
Non-current assets:			
Property, plant, and equipment	13	**40,538**	39,980
Intangible assets	14	**9,088**	7,566
Total non-current assets		**49,626**	47,546
Current assets:			
Trade and other receivables	15	**25,308**	26,804
Cash and cash equivalents	17	**11,346**	14,862
Total current assets		**36,654**	41,666
Total assets		**86,280**	89,212
Current liabilities:			
Trade and other payables	18	**(29,981)**	(37,237)
Provisions	20	**(1,822)**	(2,922)
Total current liabilities		**(31,803)**	(40,159)
Net current assets		**4,851**	1,507
Total assets less current liabilities		**54,477**	49,053
Non-current liabilities:			
Provisions	20	**(850)**	(229)
Total non-current liabilities		**(850)**	(229)
Total assets employed:		**53,627**	48,824
Financed by:			
Taxpayers' equity			
Public Dividend Capital		**202**	202
Retained surplus		**42,422**	37,042
Revaluation reserve		**11,003**	11,580
Total taxpayers' equity		**53,627**	48,824

The notes on pages 62 to 98 form part of these accounts.

The financial statements on pages 58 to 61 and accompanying notes were approved by the Audit committee on behalf of the Board on the 30 May 2017 and signed on its behalf by:

Andrew Ridley, Chief Executive  Date: 31 May 2017

Mike Fox, Director of Finance, Contracting and Performance  Date: 31 May 2017

Statement of changes in taxpayers' equity for the year ended 31 March 2017

	PDC	Retained Surplus	Revaluation Reserve	Total Reserves
	£'000	£'000	£'000	£'000
Balance at 1 April 2015	**202**	**33,536**	**8,445**	**42,183**
Retained surplus/(deficit) for the year	0	3,506	0	3,506
Net gain/ (loss) on revaluation of property, plant and equipment	0	0	3,135	3,135
Balance at 31 March 2016	**202**	**37,042**	**11,580**	**48,824**
Retained surplus/(deficit) for the year	0	5,380	0	5,380
Net gain/ (loss) on revaluation of property, plant and equipment	0	0	(577)	(577)
Balance at 31 March 2017	**202**	**42,422**	**11,003**	**53,627**

The notes on pages 62 to 98 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

	2016/17	2015/16
	£'000	£'000
Cash flows from operating activities		
Operating surplus/(deficit)	**6,571**	4,371
Depreciation and Amortisation	**5,143**	4,751
(Increase)/decrease in trade and other receivables	**1,496**	(8,513)
Increase/(decrease) in trade and other payables	**(6,077)**	189
Provisions Utilised	**(1,347)**	(2,457)
Increase/(Decrease) in Provisions	**868**	0
Net cash inflow/(outflow) from operating activities	**6,654**	(1,659)
Cash flows from investing activities		
Interest received	**16**	56
Payments for Property, Plant and Equipment	**(5,189)**	(4,169)
Payments for Intangible Assets	**(3,718)**	(2,761)
Proceeds of disposal of assets held for sale (PPE)	**28**	69
Rental Revenue	**0**	0
Net cash inflow/(outflow) from investing activities	**(8,863)**	(6,805)
Net cash inflow/(outflow) before financing	**(2,209)**	(8,464)
Net cash inflow/(outflow) from financing		
Dividend (Paid)/Refunded	**(1,307)**	(708)
Net Cash Inflow/(Outflow) from Financing Activities	**(1,307)**	(708)
Net increase / (decrease) in cash and cash equivalents	**(3,516)**	(9,172)
Period opening cash and cash equivalents	**14,862**	24,034
Period closing cash and cash equivalents	**11,346**	14,862

The notes on pages 62 to 98 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 2016/17, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the Department of Health Group Accounting Manual 2016/17 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Department of Health Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1 Movement of assets within the DH group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury Financial Reporting Manual 2016/17 (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.

2 Accounting convention

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

3 Accruals

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

4 Revenue

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

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

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

5 Critical accounting judgments and key sources of estimation uncertainty

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

5a Critical judgments in applying accounting policies

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

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

Leases
The Trust recognises leases when in the judgment of the Board the transaction either meets the definition of a lease as set down by IAS 17 or where the transaction has the substance of a lease as required by IFRIC 4. The Trust will decide on whether to recognise leases as finance or operating leases using the criteria laid down by IAS 17. Within IAS 17 there is a rebuttable presumption that, where the net present value of future lease payments exceeds 90% of the asset's fair value at the inception of the lease, the lease will be capitalised as a finance lease. However, where other factors suggest a finance lease category better reflects the substance of the transaction and the transfer of risks and rewards of the leased asset the Trust will capitalise the lease even if the 90% target is not met.

5b Key sources of estimation uncertainty

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

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

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

6 Inventories

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

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

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

7 Cash and cash equivalents

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

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

8 Losses and special payments

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

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

9 Clinical negligence costs

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

10 Employee benefits

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

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

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

11 Other operating expenses

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

12 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised if:

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

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

Valuation
All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.
Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.
Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

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

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 an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment

charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

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

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

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

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

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

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

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

13 Intangible assets

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

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

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

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

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

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

Intangible assets including application software are amortised over 3-10 years.

14 Leases

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

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

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

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

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

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

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

15 Contingencies

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

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

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

16 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.7% in real terms.
When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

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

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

17 Financial instruments

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

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

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

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

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

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

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly or through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the Statement of Comprehensive Income to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

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

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

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

18 Value Added Tax

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

19 Foreign currencies

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

20 Third party assets

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

21 Public dividend capital (PDC) and PDC dividend

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

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

22 Research and development

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

23 Non-clinical risk pooling

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

24 Subsidiaries (IAS 27 *consolidated and separate financial statements*)

Material entities over which the Trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust or where the subsidiary's accounting date is not co-terminous.

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

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

25 Accounting standards and amendments issued but not yet adopted in the FReM

The following table presents a list of recently issued accounting standards and amendments which have not yet been adopted within the FReM, and are therefore not applicable to DH group accounts in 2016/17. The application of the Standards as revised would not have a material impact on the accounts for 2016/17, were they applied in that year:

- 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 14 Regulatory Deferral Accounts - Not yet EU-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DH group bodies.
- 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.

Note 2 Authorisation of the financial statements

These financial statements were authorised for issue on 30 May 2017 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 and Hertfordshire. Community healthcare covers a wide range of services, including:

- Adult community nursing services, including 24 hour district nursing, community matrons and case management;
- Child and family services, including health visiting, school nursing, children's community nursing teams, speech and language therapy, haemaglobinopathy nursing and children's occupational therapy;
- Rehabilitation and therapies, including physiotherapy, occupational therapy, podiatry, speech and language therapy and osteopathy;
- Palliative care services;
- 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 £5,380k which was the final position disclosed below.

	Revenue from customers	Retained surplus for the period	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 31/3/2017	212,749	5,380	16	0	5,143	(577)
12 months to 31/3/2016	196,671	3,506	56	0	4,751	3,135

All 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 and Hertfordshire.

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

The Trust has three customers (2015/16: five) who individually account for over 10% of the Trust's turnover. These customers account for 39% (2015/16: 68%) 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:

Income from Commissioners	**2016/17**	2015/16
	£'000	£'000
Barnet CCG	**35,077**	31,910
Central London (Westminster) CCG	**0**	24,177
Hammersmith And Fulham CCG	**0**	21,638
Merton CCG	**21,341**	0
NHS England	**0**	23,492
West London (K&C & QPP) CCG	**27,416**	31,642
	83,834	132,859
Income from other organisations	**128,915**	63,812
Total revenue	**212,749**	196,671

Income from NHS England at £9,734k, Hammersmith and Fulham CCG at £16,840k and Central London (Westminster) CCG £20,154k is less than 10% of Trust's aggregate turnover in 2016/17.

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

	2016/17	2015/16
	£'000	£'000
NHS England	**6,984**	23,492
NHS Trusts	**1,637**	1,828
Clinical Commissioning Groups	**145,788**	124,209
Foundation Trusts	**2,169**	4,999
Local Authorities	**43,545**	35,236
Department of Health	**0**	1,000
Non-NHS:		
Injury cost recovery	**271**	272
Overseas patients (non-reciprocal)	**447**	216
	200,841	191,252

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.

5.1 Overseas patients

	2016/17
	£'000
Income from overseas visitors (where the patient is charged directly) / cash payments received in year (relating to invoices raised in the current and prior years)	**144**
amounts added to the provision for impairment of receivables (relating to invoices raised in the current and prior years)	**0**
amounts written off in-year (relating to invoices raised in the current and prior years)	**0**

Note 6 Other operating revenue

	2016/17	2015/16
	£'000	£'000
Education, training and research	**4,419**	2,496
Charitable and other contributions to expenditure	**277**	112
Sustainability & Transformation Fund (STF) income	**2,778**	0
Income generation	**4,233**	2,656
Rental revenue from operating leases	**60**	50
Other income	**141**	105
	11,908	5,419

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. In 2015/16 the Trust received non- recurrent funding of £1.0m for provision of healthcare from Department of Health, this income is disclosed in Note 5 above. Other income relates to income earned through the recharging of costs associated with prescription charge income, and other miscellaneous income.

Note 7 Operating Expenses

7.1 Analysis of other operating expenses

	2016/17	2015/16
	£'000	£'000
Services from other NHS Trusts	**4,317**	4,296
Services from Foundation Trusts	**2,968**	4,529
Purchase of healthcare from non NHS bodies	**2,514**	2,032
Trust chair and non-executive directors	**69**	54
Employee benefits - non board member	**142,022**	135,972
Employee benefits - board member	**888**	790
Supplies and services - clinical	**7,910**	6,686
Supplies and services - general	**8,693**	7,259
Consultancy services	**575**	1,549
Establishment	**4,455**	4,473
Transport	**2,176**	1,800
Premises	**19,066**	15,696
Hospitality	**5**	74
Insurance	**1**	152
Legal Fees	**479**	428
Provision for impairment of receivables	**977**	(83)
Depreciation	**2,947**	2,714
Amortisation	**2,196**	2,037
Internal audit fees	**78**	48
Audit fees	**62**	62
Other auditors' remuneration	**65**	67
Clinical negligence	**293**	313
Education and training	**2,129**	1,028
Other	**1,294**	324
	206,178	192,300

Other auditors' remuneration includes £59k (2015/16: £50k) paid to our internal auditors for local counter-fraud services. 'Other' costs incurred during 2016/17 relate to cost of overseas recruitment and dilapidation provisions.

7.2 Auditor remuneration

	2016/17 £000	2015/16 £000
Remuneration paid to the external auditor:		
Financial Statements Audit	52	50
Whole of Government Accounts	2	2
Audit related assurance services	12	12
All taxation advisory services not falling within item 3 above	0	0
Internal audit services	0	0
All other assurance services	0	0
Corporate finance transaction services not falling within items 1 to 6 above	0	0
Other non-audit services	0	0
Total	**66**	**64**

7.3 Limitation on auditor's liability

There is no limit on the liability of the auditor. Whilst the liability is unlimited, the auditors do have indemnity from Public Sector Audit Appointments Limited (PSAA) to support them should any action be taken in relation to the exercise (or not) of the auditors' statutory powers.

Note 8 Operating leases

CLCH leases some of the properties it occupies for both the provision of healthcare and the administration of the Trust's activities. These properties are leased to CLCH by the following organisations:

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

The lease between CLCH and Westminster City Council is a 10 year lease, running until 2019/20, with one rent review during its term. From March 2013 either party can exit the lease with six months' notice. As part of the Trust's estates rationalisation, part of the head office was vacated and handed back to the Council during the financial year 2016/17. The Trust intends to fully vacate this premise by 31 May 2017.

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

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

8.1 Trust as lessee

	2016/17	2015/16
Payments recognised as an expense:	**£'000**	**£'000**
Minimum lease payments	17,105	12,965
Total	**17,105**	**12,965**
Payable:		
No later than one year	16,526	15,795
Between one and five years	0	3,298
After five years	0	0
Total	**16,526**	**19,093**

CLCH owns the freehold and leaseholds on eleven properties. CLCH is the landlord for other tenants in these properties. The tenancy agreements with the tenants on these properties are now being formalised. 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.

8.2 Trust as lessor

	2016/17	2015/16
	£'000	**£'000**
Recognised as revenue		
Rental revenue	60	50
Total	**60**	**50**
Receivable:		
No later than one year	58	50
Between one and five years	211	176
After five years	0	0
Total	**269**	**226**

Note 9 Employee benefits and staff numbers

9.1 Employee benefits

9.1 Employee benefits

	2016/17	2015/16
	£'000	£'000
Salaries and wages	**96,372**	86,300
Social security costs	**9,720**	7,056
Employer contributions to NHS Pensions scheme	**12,052**	10,931
Termination benefits	**0**	0
Other (bank and agency)	**25,000**	52,475
TOTAL - including capitalised costs	**143,144**	136,762
Costs capitalised as part of assets	**(234)**	0
Total employee benefits (excluding capitalised staff costs)	**142,910**	136,762

Permanently employed includes £1,321k (2015-16: £1,211k) 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.

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

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 are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19,

relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. 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 their 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 appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016. 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

	2016/17		2015/16	
	Number	£'000	Number	£'000
Non-NHS payables				
Invoices paid in the year	36,175	97,712	52,769	116,216
Invoices paid within target	32,118	84,579	51,916	114,588
Invoices paid within target - %	**88.8**	**86.6**	**98.4**	**98.6**
NHS payables				
Invoices paid in the year	411	5,943	486	8,674
Invoices paid within target	176	1,531	484	8,670
Invoices paid within target - %	**42.8**	**25.8**	**99.6**	**100.0**

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

Note 12 Investment revenue

	2016/17 £'000	2015/16 £'000
Interest earned from monies held on deposit at the National Loans Fund.	16	56

Note 13a Property plant and equipment

	Land	Buildings excluding Dwellings	Plant & Machinery	Information Technology	Furniture & Fittings	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Opening Valuation at 1 April 2016	**13,969**	**22,245**	**2,441**	**10,709**	**67**	**49,431**
Additions purchased	0	2,628	221	1,225	48	4,122
Disposals other than for sale	0	0	(99)	0	0	(99)
Reclassifications	0	0	0	0	0	0
Revaluation	(49)	(1,116)	0	0	0	(1,165)
Impairments/negative indexation charged to reserves	0	0	0	0	0	**0**
Valuation at 31 March 2017	**13,920**	**23,757**	**2,563**	**11,934**	**115**	**52,289**
Opening depreciation at 1 April 2016	0	(1,337)	(1,688)	(6,390)	(36)	(9,451)
Disposals other than for sale	0	0	59	0	0	59
Revaluation	0	588	0	0	0	588
Charged during the year	0	(983)	(295)	(1,655)	(14)	(2,947)
Depreciation at 31 March 2017	**0**	**(1,732)**	**(1,924)**	**(8,045)**	**(50)**	**(11,751)**
Net Book Value at 1 April 2016	13,969	20,908	753	4,319	31	39,980
Net Book Value at 31 March 2017	**13,920**	**22,025**	**639**	**3,889**	**65**	**40,538**
Source of asset:						
Purchased at 31 March 2016	13,969	20,908	753	4,319	31	39,980
Purchased at 31 March 2017	**13,920**	**22,025**	**639**	**3,889**	**65**	**40,538**
Asset Financing:						
Owned at 31 March 2016	13,969	20,908	753	4,319	31	39,980
Owned 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**

	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 £6,044K (2015/16: £5,734K) 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 2017. 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
Opening Valuation at 1 April 2015	**13,812**	**18,245**	**2,343**	**8,747**	**36**	**43,183**
Additions purchased	0	1,511	196	1,962	31	3,700
Disposals other than for sale			(98)			(98)
Reclassifications	111	(111)	0	0	0	0
Revaluation	46	2,600	0	0	0	2,646
Valuation at 31 March 2016	**13,969**	**22,245**	**2,441**	**10,709**	**67**	**49,431**
Opening depreciation at 1 April 2015	0	(1,176)	(1,444)	(4,608)	(27)	(7,255)
Disposals other than for sale	0	0	29	0	0	29
Revaluation	0	489				489
Charged during the year	0	(650)	(273)	(1,782)	(9)	(2,714)
Depreciation at 31 March 2016	**0**	**(1,337)**	**(1,688)**	**(6,390)**	**(36)**	**(9,451)**
Net Book Value at 1 April 2015	13,812	17,069	899	4,139	9	35,928
Net Book Value at 31 March 2016	**13,969**	**20,908**	**753**	**4,319**	**31**	**39,980**
Source of asset:						
Purchased at 31 March 2015	13,812	17,069	899	4,139	9	35,928
Purchased at 31 March 2016	**13,969**	**20,908**	**753**	**4,319**	**31**	**39,980**
Asset Financing:						
Owned at 31 March 2015	13,812	17,069	899	4,139	9	35,928
Owned at 31 March 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
Attributable revaluation reserve:						
Revaluation Reserve Balance for Property, Plant & Equipment:						
As at 1 April 2015	**5,555**	**2,890**	**0**	**0**	**0**	**8,445**
Revaluations in the year	46	3,089	0	0	0	3,135
As at 31 March 2016	**5,601**	**5,979**	**0**	**0**	**0**	**11,580**

Note 14a Intangible non-current assets

	Computer Software- Purchased £'000	Total £'000
Cost at 1 April 2016	**12,193**	**12,193**
Additions purchased	**3,718**	**3,718**
Disposals other than for sale	**0**	**0**
Cost at 31 March 2017	15,911	15,911
Amortisation at 1 April 2016	**(4,627)**	**(4,627)**
Disposals other than for sale	0	0
Charged during the year	(2,196)	(2,196)
Amortisation at 31 March 2017	**(6,823)**	**(6,823)**
Net Book Value at 31 March 2016	7,566	7,566
Net Book Value at 31 March 2017	**9,088**	**9,088**
Source of asset:		
Purchased at 31 March 2016	7,566	7,566
Purchased at 31 March 2017	**9,088**	**9,088**
Asset Financing:		
Purchased at 31 March 2016	7,566	7,566
Purchased at 31 March 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 £3,347K (2015/16: £2,444K) that have no net book value. There are no temporarily idle assets.

Note 14b Intangible non-current assets prior year

	Computer Software- Purchased £'000	Total £'000
Cost at 1 April 2015	**9,432**	**9,432**
Additions purchased	**2,761**	**2,761**
Disposals other than for sale	**0**	**0**
Cost at 31 March 2016	**12,193**	**12,193**
Amortisation at 1 April 2015	**(2,590)**	**(2,590)**
Disposals other than for sale	0	0
Charged during the year	(2,037)	(2,037)
Amortisation at 31 March 2016	**(4,627)**	**(4,627)**
Net Book Value at 31 March 2015	6,842	6,842
Net Book Value at 31 March 2016	**7,566**	**7,566**
Source of asset:		
Purchased at 31 March 2015	6,842	6,842
Purchased at 31 March 2016	**7,566**	**7,566**
Asset Financing:		
Purchased at 31 March 2015	6,842	6,842
Purchased at 31 March 2016	**7,566**	**7,566**
Useful economic life:		
Minimum life (years)	3	
Maximum life (years)	10	

Note 15 Trade and other receivables

	Current	Non-current	Current	Non-current
	2016/17	**2016/17**	2015/16	2015/16
	£'000	**£'000**	£'000	£'000
NHS receivables - revenue	**13,546**	**0**	13,032	0
NHS prepayments and accrued income	**2,740**	**0**	2,282	0
Non-NHS receivables - revenue	**6,383**	**0**	8,138	0
Non - NHS prepayments & other accrued income	**2,895**	**0**	2,576	0
Provision for the impairment of receivables	**(1,332)**	**0**	(355)	0
VAT	**361**	**0**	542	0
Other Receivables	**715**	**0**	589	0
Total	**25,308**	**0**	26,804	0

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

	2016/17	2015/16
	£'000	£'000
By up to three months	**2,409**	5,833
By three to six months	**1,521**	4,021
By more than six months	**2,410**	920
Total	**6,340**	10,774

15.2 Provision for impairment of receivables

	2016/17	2015/16
	£'000	£'000
Balance as at 1April	**(355)**	(438)
Amount written off during the year	**0**	0
Amount recovered during the year	**0**	186
(Increase)/decrease in receivables impaired	**(977)**	(103)
Balance at 31 March	**(1332)**	(355)

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 increase in bad debts provision in 2016/17 is as a result of perceived risks of non-recoverable non NHS debts outstanding for more than sixty days particularly premises related debts due from non-NHS providers.

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

	At Fair Value Through Profit and Loss	**Loans and Receivables**	**Available for Sale**	**Total**
	£'000	**£'000**	**£'000**	**£'000**
Embedded Derivatives	**0**	**0**	**0**	**0**
Receivables - NHS	**0**	**13,546**	**0**	**13,546**
Receivables - non NHS	**0**	**7,098**	**0**	**7,098**
Cash at Bank and in Hand	**0**	**11,346**	**0**	**11,346**
Other Financial Assets	**0**	**0**	**0**	**0**
Total at 31 March 2017	**0**	**31,990**	**0**	**31,990**

	At Fair Value Through Profit and Loss	Loans and Receivables	Available for Sale	Total
	£'000	£'000	£'000	£'000
Embedded Derivatives	0	0	0	0
Receivables - NHS	0	13,032	0	13,032
Receivables - non NHS	0	8,727	0	8,727
Cash at Bank and in Hand	0	14,862	0	14,862
Other Financial Assets	0	0	0	0
Total at 31 March 2016	0	36,621	0	36,621

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 £361k (2015/16: £542k) 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 £5,635K (2015/16: £4,858k) and the bad debt provision £1,332k (2015/16: £355k) are also excluded from this note.

16.2 Financial Liabilities

	At Fair Value Through Profit and Loss £'000	**Other £'000**	**Total £'000**
Payables - NHS	0	15,659	**15,659**
Payables - non NHS	0	9,765	**9,765**
Total at 31 March 2017	**0**	**25,424**	**25,424**

	At Fair Value Through Profit and Loss £'000	Other £'000	Total £'000
Payables - NHS	0	16,588	16,588
Payables - non NHS	0	16,823	16,823
Total at 31 March 2016	0	33,411	33,411

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 £4,557K (2015/16: £3,826K), are not contractual and so are excluded from the disclosure.

16.3 Maturity of financial liabilities

	2016/17 £'000	2015/16 £'000
In one year or less	25,424	33,411
Total	**25,424**	33,411

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

	2016/17	2015/16
	£'000	£'000
Opening balance at 31 March	**14,862**	24,034
Net change in year	(3,516)	(9,172)
Closing balance at 31 March	**11,346**	14,862
Comprising:		
Cash with Government Banking Service	11,327	14,843
Liquid deposit with National Loan Fund	0	0
Cash in hand	19	19
	11,346	14,862

Note 18 Trade and other payables

	Current	**Non-current**	Current	Non-current
	2016/17	**2016/17**	2015/16	2015/16
	£'000	**£'000**	£'000	£'000
NHS payables - revenue	7,139	0	9,392	0
NHS - accruals and deferred income	8,520	0	7,196	0
Non-NHS trade payables - revenue	474	0	3,160	0
Non NHS – accruals and deferred income	8,364	0	11,667	0
Non NHS – capital creditors	927	0	1,996	0
Tax	1,113	0	1,018	0
Social Security Costs	1,528	0	1,055	0
Other Payables	1,916	0	1,753	0
Total	**29,981**	**0**	37,237	0

Other payables include £1,767K in respect of outstanding pension contributions at 31 March 2017 (31 March 2016: £1,477K).

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

	Injury and Sickness Benefits	Legal Claims	Other	Redundancy	Total
	£'000	£'000	£'000	£'000	£'000
Balance as at 31 March 2015	261	477	2,606	2,264	5,608
Arising during the year	0	0	0	0	0
Utilised during the year	(16)	0	(1,034)	(291)	(1,341)
Reversed unused	0	(102)	(380)	(634)	(1,116)
Balance as at 31 March 2016	**245**	**375**	**1,192**	**1,339**	**3,151**
Arising during the year	0	27	346	495	**868**
Utilised during the year	(8)	0	0	(1,339)	**(1,347)**
Reversed unused	0	0	0	0	**0**
Balance as at 31 March 2017	**237**	**402**	**1,538**	**495**	**2,672**
Expected timing of cash flows as at 31 March 2017					
No later than one year	16	402	909	495	**1,822**
Later than one year and not later than five years	16	0	0	0	**16**
Later than five years	205	0	629	0	**834**
	237	**402**	**1,538**	**495**	**2,672**
Expected timing of cash flows as at 31 March 2016					
No later than one year	16	375	1,192	1,339	2,922
Later than one year and not later than five years	64	0	0	0	64
Later than five years	165	0	0	0	165
	245	375	1,192	1,339	3,151

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 £420k (2015/16: £643k) and non-clinical provisions with a value of £241k (2015/16: £173k) 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 £49K (2015/16: £53K). This excess is fully provided for within

the provisions for 'Other' above. The NHSLA has estimated a probability that the Trust will have to pay this excess.

Other provisions of £1,538k (2015/16: £1,192k) is in respect of dilapidations provisions, disputed invoices with two suppliers and disputed VAT reclaimed from HMRC.

The restructuring provisions of £495k (2015/16:£1,339K) in place at the reporting date relates to those at risk in 2017/18 restructure.

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 (2015/16: six) for which the Trust will have to pay a set excess. This excess is estimated by the NHSLA as £49K (2015/16: £53K).

The NHSLA believes that it is unlikely the Trust will have to pay £13K (2015/16: £20K) excess and recommends that this amount is therefore disclosed as a contingent liability.

Note 22 Related party transactions

In financial years 2016/17 and 2015/16 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 2016/17 the Charity paid the Trust £277K for goods and services provided by CLCH (2015/16: £112K). As at 31 March 2017 the Trust had a total of £nil (2015/16: £80K) 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:

	Payables £'000	Receivables £'000	Revenue £'000	Expenditure £'000
Barnet CCG	0	3,177	35,077	0
West London (K&C & QPP) CCG	109	2,125	27,416	109
Merton CCG	22	35	21,341	22
Central London (Westminster) CCG	12	655	20,154	12
Hammersmith And Fulham CCG	0	495	16,840	0
Harrow CCG	0	729	10,907	0
NHS England - London Region	0	1,179	9,734	0
Royal Free London NHS Foundation Trust	2,905	1,953	2,364	1,462
Imperial College Healthcare NHS Trust	1,798	870	1,378	1,257
Herts Valleys CCG	0	869	3,333	0
Brent CCG	167	803	2,857	44
Chelsea and Westminster Hospital NHS Foundation Trust	636	389	914	846
Hounslow CCG	0	202	2,559	0
West Hertfordshire Hospitals NHS Trust	603	19	125	1,108
Camden CCG	0	220	878	0
Hounslow and Richmond Community Healthcare NHS Trust	101	15	34	911
Central and North West London NHS Foundation Trust	317	102	77	495
Ealing CCG	0	151	700	0
London North West Healthcare NHS Trust	273	2	1	575
Wandsworth CCG	0	264	391	0
Barnet, Enfield and Haringey Mental Health NHS Trust	240	79	195	1
Haringey CCG	0	83	426	0
Enfield CCG	0	36	460	0
Islington CCG	0	197	251	0
Lambeth CCG	0	59	297	0
West London Mental Health NHS Trust	45	39	30	235
City And Hackney CCG	0	154	175	0
NHS Litigation Authority	241	0	0	293
South East CSU	259	0	0	1
Tower Hamlets CCG	0	84	164	0
Guys and St Thomas NHS Foundation Trust	125	3	7	111
Southwark CCG	0	45	196	0
Hertfordshire Community NHS Trust	0	0	2	228
Health Education England	37	0	2,774	0

Note 23 Third party assets: patients' monies

The Trust held £128K cash at bank and in hand at 31 March 2017 on behalf of patients (31 March 2016: £258K).

Note 24 Losses and special payments

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

	2016/17	**2016/17**	2015/16	2015/16
	£	**Number**	£	Number
Fruitless payments	**0**	**0**	0	0
Bad debts and abandoned claims	**0**	**0**	0	0
Other Negligence and Injury	**0**	**0**	0	0
Other Payments	**16,680**	**7**	415	3

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

	2016/17	2015/16
	£'000	£'000
External Financing Limit	**5,697**	13,042
Cash flow financing	**3,516**	9,172
Unwinding of discount adjustment	**0**	0
Other capital receipts	**0**	0
External financing requirement	**3,516**	9,172
Under/(Over) spend against EFL	**2,181**	3,870

Note 27 Breakeven performance

	2016/17	**2015/16**	**2014/15**	**2013/14**	**2012/13**	**2011/12**
Turnover, £'000	212,749	196,671	198,409	196,191	193,270	190,946
Retained surplus/(deficit) for the year, £'000	5,380	3,506	1,836	1,915	1,826	3,835
Break-even in-year position, £'000	5,380	3,506	1,836	1,915	1,826	3,835
Break-even cumulative position, £'000	20,494	15,114	11,608	9,832	7,917	6,031
Break-even in-year position as a percentage of turnover	2.53%	1.78%	0.93%	0.98%	0.94%	2.01%
Break-even cumulative position as a percentage of turnover	9.63%	7.68%	5.85%	5.01%	4.10%	3.16%

Note 28 Capital resource limit

	2016/17	2015/16
	£'000	£'000
Gross capital expenditure	7,839	6,461
Less: book value of assets disposed of	(39)	(69)
Less: capital grants	0	0
Less: donations towards the acquisition of non-current assets	0	0
Charge against the capital resource limit	**7,800**	6,392
Capital resource limit	**7,920**	7,688
(Over)/underspend against the capital resource limit	**120**	1,296

All capital investments in 2016/17 and 2015/16 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 2017 but not yet delivered) at the statement of financial reporting date (2015/16: £0).

Note 30 Annual capital cost absorption rate

	2016/17	2015/16
	£'000	£'000
Dividends on Public Dividend Capital	1,196	921
Opening Capital and Reserves (Total Assets Employed)	48,824	42,183
Opening Relevant Net Assets	**48,824**	**42,183**
Closing Capital and Reserves (Total Assets Employed)	53,627	48,824
Adjustment to closing balances re Q4 Sustainability Transformation Fund	(558)	0
Closing Relevant Net Assets	**53,069**	**48,824**
Sum of Opening/Closing Relevant Net Assets	101,893	91,007
Initial Average Relevant Net Assets	50,947	45,504
Average Daily Cleared Balances in GBS/NLF	(16,765)	(19,170)
Final Average Relevant Net Assets	**34,182**	**26,334**
Full Year Effect for Part Year Trusts	**1,196**	**921**
Capital Cost Absorption Rate (%)	**3.5**	**3.5**