Cambridgeshire Community Services NHS
NHS Trust

Annual Report
2014/15

Annual Report 2014-15

Our vision

As a provider of services which focus on health promotion and prevention of ill health, our vision is to:

> ***Deliver high quality care to the diverse communities we serve to make their lives better.***

Our values

- Honesty
- Empathy
- Ambition
- Respect.

Our 2014/16 objectives

1. **Quality:** To be recognised as a provider of safe and effective services that people want to use
2. **Quality:** To collaborate with organisations to improve the care given to people who use our services
3. **People:** To ensure that the Trust attracts and retains a quality workforce
4. **Finance:** To be a financially sound organisation
5. **Finance:** To achieve a contract model that links activity to payment
6. **Sustainability:** To be recognised as a provider of safe and innovative services that help commissioners achieve their outcomes.

Our Services

Our portfolio of services in 2014/15 were provided in people's own homes, from GP surgeries and health centres, community settings such as schools, as well as from the following main sites:

- **Cambridgeshire:** Brookfields Hospital, Cambridge; Doddington Hospital, Doddington; Princess of Wales Hospital, Ely; North Cambs Hospital, Wisbech; Oaktree Centre, Huntingdon; Hinchingbrooke Hospital, Huntingdon
- **Luton:** Luton Treatment Centre and the Redgrave children and young people's centre
- **Norfolk:** James Paget Hospital in Great Yarmouth, Oak Street Clinic in Norwich, Queen Elizabeth Hospital in Kings Lynn
- **Peterborough:** City Care Centre, City Health Clinic, the Healthy Living Centre and Kings Chambers
- **Suffolk Sexual Health Services:** Orwell Clinic in Ipswich, Lowestoft, Bury and a range of community based facilities.

	Cambridgeshire	Luton	Norfolk	Peterborough	Suffolk
Adult services					
District nursing	■	■		■	
Specialist nurses/long term conditions	■	■		■	
Community matrons	■	■		■	
Intensive case management	■			■	
Intermediate care	■	■		■	
Radiography services	■				
Minor injury units	■				
Therapies and rehabilitation incl. neuro-rehabilitation	■			■	
Outpatient clinics	■				
Dermatology	■			■	
Inpatient rehabilitation services	■			■	
Specialist palliative care	■	■		■	
Podiatry	■			■	
Dietetics	■			■	
GP out of hours service				■	
Specialist services					
Community dental services and/or oral surgery	■			■	■
Musculoskeletal services	■			■	
Sexual health services	■	■	■ *(from 01/03/15)*	■	■
Drug services		■			
Children's services			*(from 01/10/15)*		
Inpatient, outpatient, special care baby unit	■				
Health visiting	■	■	■		
School nursing	■	■	■		
Therapies	■				
Community nursing	■	■			
Audiology	■	■			
Community paediatricians	■	■			
Family Nursing Partnership	■		■		
National Child Measurement Programme	■		■		
Healthy schools team			■		
School immunisation programme (from 01 Sept 2015)	■		■	■	■


Check In 5 (Dental)

Contents

Chairman and Chief Executive's Welcome

Welcome to the 2014/15 annual report for Cambridgeshire Community Services NHS Trust

We are delighted to report that the Trust has achieved the vast majority of its quality, financial and performance ambitions and targets in the last 12 months.

We are proud to provide high quality innovative services that enable people to receive care closer to home and live healthier lives. We hope the examples in this report demonstrate just some of the innovative ways we are supporting people across the east of England and improving their quality of life.

Highlights in 2014/15 have included:

- the Care Quality Commission rating our services 'Good' following an extensive inspection
- 90% of the 9000 patients we surveyed expressing satisfaction with our services
- winning three multi-million pound contracts across the region during 2014/15 and a further contract to provide the Norfolk Healthy Child Programme in April 2015; each for periods of up to five years, bringing additional resources and security in to the Trust
- playing a vital role in enabling significant numbers of patients with increasingly complex needs, to avoid hospital admissions or leave hospital earlier; particularly over the winter period when local hospitals experienced unprecedented pressures
- achieving a modest and planned operating surplus of £754,000 despite on-going financial constraints and ever-growing demands for our services, all of which will be ploughed back into improving services in the coming year
- staff rating the Trust best in the country in the national staff survey compared to our peer community trusts in 11 of the 29 key finding areas and fifth best in the country (irrespective of type of service provided) in relation to staff engagement.

These achievements result from the outstanding commitment of staff and we acknowledge and thank them for their amazing dedication. Our particular thanks go to colleagues within adults and older people's services across Cambridgeshire and Peterborough, and Luton based intermediate care who transferred to new employers in April 2015. Our sincere thanks also go to staff within our Luton based children's and adults' services who were due to transfer to a new employer in June 2015 but who, we are pleased to confirm, will now remain with CCS NHS Trust following the commissioner's cancellation of this procurement process. Despite the challenges presented, staff continued to put patients first and provided high quality care right throughout these periods of significant change.

We would also like to thank Heather Peck, former Chairman and Peter Sulston, Non Executive Director, both of whom were valued members of our Trust Board through to December 2014. Their passion and commitment to local health services were key factors in the Trust's success to date. We welcomed two new Non Executive Directors to the Board in January 2015, Gill Thomas and Anne McConville, strengthening the Board's skills in areas such as commercial law and public health.

We continued to receive invaluable support from hundreds of dedicated volunteers, as well as charities such as the Dreamdrops children's charity, the Arthur Rank Hospice charity, and the Friends of Hospital at Home in Peterborough, all of whom provided a vital role in helping us improve the quality of services we provide. Without their dedication and support, our task would be even harder.

Our focus for 2015/16 is on achieving our ambitious plans for the future, aligned to the system-wide priorities identified by our commissioners and which are responsive to the specific needs of the local populations we serve. Central to this is working collaboratively with our staff, GPs, social care practitioners and hospital clinicians, to develop seamless care irrespective of organisational boundaries.

In line with our five year plan, we will continue to submit bids to expand the geographic area across which we provide the specialist, high quality services that now makes up our portfolio. This will enable other commissioners and populations to benefit from our expertise in providing these specialist services, which focus on health promotion and prevention of ill health.

The Government policy prior to the May 2015 General Election was that NHS Trusts, as an organisational form, could not continue long term. As a smaller organisation providing specialist services, we will determine during 2015 our future organisational form in the context of what is in the best interests of patients and our staff. Whilst we await policy guidance from the new Government on options available in relation to organisational form, we will take forward development work to evidence our viability as a stand-alone organisation, whatever form that takes. We anticipate that this process will take approximately two years to come to fruition, during which time we will continue to operate as an NHS Trust. We will of course involve staff, commissioners and the Trust Development Authority in these deliberations.

Please enjoy reading our annual review and we look forward to a successful year in 2015/16.

Nicola Scrivings
Chairman

June 2015

Matthew Winn
Chief Executive

Strategic Report

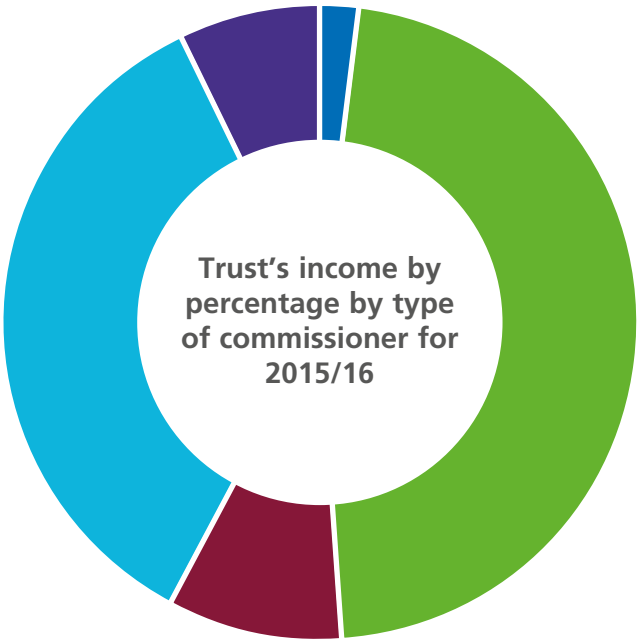
We became a community NHS Trust in England on 1 April 2010, having previously operated as an arms length trading organisation of the then Cambridgeshire Primary Care Trust. This move to become a separate NHS Trust was as a result of the Department of Health's 'Transforming Community Services' policy to separate the commissioning and provider functions of organisations. The Trust was established under sections 25(1) and 272(7) of, and paragraph 5 of Schedule 4 to, the National Health Service Act 2006 (Establishment Order 2010 no. 727). We report under the Accounts Direction determined by the Department of Health (Secretary of State) and approved by the Treasury. The Accounts Direction is made under the following legislation: National Health Service Act 2006 c. 41 Schedule 15: Preparation of annual accounts.

The Trust Board is accountable to the NHS Trust Development Authority (TDA), which has responsibility for all NHS Trusts which are not foundation trusts. The TDA views CCS NHS Trust as a viable 'going concern' providing good care; operating in a financially sustainable way.

As a result of the procurements the Trust has successfully won and those which transferred out of the Trust (see page 43), our portfolio will consist predominantly, from June 2015, of a range of high quality specialist services. The Trust's annual budget for 2014/15 was £160 million. Our annual budget for 2015/16 started at £76 million increasing to circa £116 million by October 2015 (full year effect) as a result of winning the procurements outlined earlier.

Many of our services are provided at a regional level and are predominantly focused on preventative care, funded by public health commissioners. Our strategy is to focus on expansion within these specialist services across a wider geography and not to expand our service portfolio into other service markets. The following diagram shows the Trust's income by percentage (including all procurements won) by type of commissioner for 2015/16 (full year effect).

Our staff and services have a range of unique skills, historical knowledge and a justified



positive reputation for developing innovative and integrated services. This sets them apart from other organisations and ensures we can continue to submit strong bids, to run the specialist services we will focus on throughout the region in the future.

In the context of national policy prior to the May 2015 Election, the Trust Board considered an outline business case in April 2015 focussing on our future viability as a smaller, specialist organisation. The key issues the Board considered were what is in the best interests of patients and staff and whether a stand-alone organisation would be viable in terms of quality and financial matters. The Board also considered the views of all of our commissioners, as well as staff feedback. On the basis of the outline case,

the Board concluded that a stand-alone organisation is the best option going forward, continuing to deliver ambulatory and children's services on a region-wide basis.

We will work with the Trust Development Authority to align this intent with their accountability framework. Initially this will involve developing a full business plan and long term financial model. The Trust Board will reach a conclusion towards the end of 2015 about which type of organisational form is its preference. We anticipate that the process to introduce any new organisational form would take approximately two years to come to fruition, during which time we will continue to operate as an NHS Trust.

The work we undertake will become more important as the NHS seeks to prevent ill health in the context of an ever increasing population, increasing level of obesity and the complexity of need being managed within the community setting.

Central to the on-going viability of all community providers is achieving a sustainable contract model with commissioners, which links activity to payment, ensuring a level playing field across providers and recognising the vital importance of community services in achieving system-wide priorities.

This report sets out our many achievements over the last 12 months, focusing on how we have successfully improved existing services and introduced innovative new ones, in line with our aim to deliver services that:

- are locally accessible - provided close to or in people's own homes
- are provided to the highest standard by skilled and compassionate staff
- promote good health and the prevention of ill health
- reduce inequalities and ensure equity of access, including through working with partner organisations
- are integrated across health and social care 'boundaries'
- are focussed on maximising an individual's potential and independence.

Like all public sector organisations in the current economic climate we have faced significant challenges during 2014/15, which we expect to continue in 2015/16 and beyond.

These challenges are replicated nationally and for the Trust, this equates to us needing to make a 4.6% efficiency saving in 2015/16 - the equivalent of £3.7 million. To meet this challenge we will continue to work with our partners and staff to develop cost improvement schemes and collaborative initiatives, to support achievement of commissioners' plans. From a Trust perspective, these plans will ensure that, where it is clinically appropriate, services will move from the acute hospital setting to the community, making them more accessible for patients and more cost effective for the system as a whole, whilst maintaining the quality of care provided.

Risk management

The Trust can be affected by a variety of financial, clinical, operational and regulatory risks and uncertainties. This is reflected in the organisation's risk management strategy, which clarifies responsibility for the identification, assessment and management of risk throughout the Trust.

The Board retains ultimate responsibility for the Trust's risk management framework and a formal risk management system is in place to identify and evaluate both internal and external risks. The Board and Audit Committee regularly review strategic risks. Component risks of the corporate risk register are reviewed by appropriate Board sub-committees.

Further information on risk management procedures is provided within the annual governance statement (page 62).

STRATEGIC OBJECTIVE 1

Quality: To be recognised as a provider of safe and effective services that people want to use

In May 2014, 25 inspectors from the Care Quality Commission (CQC) undertook a comprehensive inspection of the Trust's services. We were delighted that the CQC assessed our services as 'Good'.

Highlights from the CQC's report included:

- service users were consistently treated with compassion, dignity and respect
- a clear picture of safety was evidenced across most services
- care and treatment were effectively meeting the needs of patients, families and carers
- very good patient focussed multi-disciplinary working was demonstrated
- an effective governance system was in place
- good clinical leadership was present with visible, strong leadership at Board level.

The two historic CQC compliance issues (assessing and monitoring the quality of services at HQ and staffing levels on Holly children's ward) were both assessed as compliant.

There were three areas where the CQC identified improvements were required:

- continue to develop effective recruitment, caseload management and staff support strategies to ensure satisfactory staffing in community nursing teams
- ensure adequate systems are in place to monitor and prevent medicines omissions in the Trust's four inpatient rehabilitation wards
- regularly assess and monitor the quality of all services, including care after death, to protect those who may be at risk.

An immediate action plan was implemented to address these issues. In March 2015, the Trust reported compliance had been achieved over the lifetime of the action plan. However, our district nursing services continued to experience high demand as a result of multiple issues, including a historic under-funding equivalent to 17% compared to peer services across the country. These staffing levels will require on-going monitoring by their new employer, having transferred in April 2015.

On 24 February 2015, the CQC undertook an unannounced visit to our Cambridge sexual health services at the Laurels. The Trust was aware of issues with the quality of this premises and an improvement plan was underway. The CQC required that we take action to ensure that all health and safety risks were rectified (e.g. corridors and walkways used as storage areas, dampness, heaters left unguarded and hygiene practices). All compliance actions were completed by 13 April 2015 and, following a further inspection in June 2015, the CQC found that the Trust was meeting the relevant regulation.

The following pages set out the Trust's achievements in the three spheres of quality: patient safety, clinical effectiveness and patient experience. A full review of actions undertaken to improve care is included in our Quality Account for 2014/15, which can be found at **www.cambscommunityservices.nhs.uk**.

Patient safety

Harm free care

This national programme aims to help organisations to understand the prevalence of four harm areas that affect patients: pressure ulcers, falls, catheter infections and venous thromboembolus.

In line with national guidance, patients visited by community nurses or being cared for on our inpatient wards on a nationally specified day each month were included in data collection.

2014/15 performance	%
2014/15 target for provision of harm free care	95%
Harm free care provided solely by CCS NHS Trust services	96%
Harm free care achieved, including patients experiencing 'harm' prior to entry in to CCS NHS Trust service (e.g. on discharge from hospital)	91%

Incidents

During the previous 12 calendar months, approximately 6800 incidents and near miss incidents were reported using our web-based (Datix) incident reporting system:

- 82% of these incident and near miss incident reports affected patient safety
- 41% of all incidents originated outside of our Trust but were reported by CCS NHS Trust staff on referral in to our services
- the remaining 59% of total reported incidents originated within the Trust's services, with 89% of these resulting in assessments of no harm or low harm.

Serious incidents (SI's)

Pressure ulcers were the most prevalent type of serious incident investigated by the Trust.

Type of Serious Incident	2011/12**	2012/13**	2013/14	2014/15
Grade 3 and 4 pressure ulcers	392	266	236	256
Pressure ulcers deemed avoidable	Not available	6	11	8
Other Serious Incidents##	42	16	21	33

*** Data prior to July 2012 includes all pressure ulcers identified by Trust staff, including in settings/services not provided by the Trust. Figures from July 2012 include only those acquired whilst under the Trust's care due to revised commissioning requirements.*

"Other SI's" included breaches of confidentiality, safeguarding, delayed diagnosis, falls, lost diaries, theft of documents and equipment, needle stick injuries and IT issues.

The Trust implemented the following good practice and learning from pressure ulcer incidents during 2014/15:

- extended membership of our Pressure Ulcer Ambition Group to seek consistency of care across the health economy
- implemented an awareness campaign and an increase in medical equipment choice to promote patient concordance in pressure sore development to the heel area
- maintained a network of pressure ulcer champions across the Trust and provided regular updates and research based learning on a bespoke section of the Trust's staff intranet.

Infection Prevention and Control

The Trust continued to roll out an extensive infection prevention and control work programme. The table below summarises our 2014/15 targets and performance.

	MRSA bacteraemia		Clostridium difficile	
	Target	Performance	Target	Performance
Cambridgeshire & Peterborough	0	0	2	3**
Luton	0	0	0	0
Total	0	0	2	3**

*** All three patients had previously received antimicrobial therapy before being transferred to CCS NHS Trust from an acute hospital, which would have contributed to the diagnosis of C. difficile on transfer to the Trust. One of the patients had been confirmed as having C. difficile prior to transfer to the Trust.*

Safeguarding children

During 2014/15 the Trust undertook a range of actions to support staff to safeguard children including:

- embedding learning from system-wide serious case reviews
- embedding the 'Safer Sleeping Campaign' within our universal children's services
- developing and delivering training to support staff to recognise and manage neglect cases
- implementing, with Luton Clinical Commissioning Group and other providers, recommendations from the July 2014 CQC system-wide Safeguarding Looked After Children Inspection.

Children's safeguarding key actions for 2015/16:

- ensure that the voice of the child and siblings, and the 'think family' agenda remain at the forefront of all we do
- update the Trust's supervision policy in line with national guidance and audit results
- support local or national campaigns e.g. 'Share Aware' (the NSPCC's internet safety campaign)
- continue to ensure that child sexual exploitation and female genital mutilation issues remain a priority
- continue to champion the needs of children who become looked after
- implement action plans and recommendations from serious case reviews.

Safeguarding adults

During 2014/15, we:

- continued our membership of the multi-agency safeguarding adult boards and sub groups in Cambridgeshire, Peterborough and Luton
- re-modelled the Trust's incident reporting database to provide data and trends on adult safeguarding concerns
- updated the Trust's safeguarding adult policy and promoted this to staff
- continued to implement recommendations from Robert Francis QC's inquiry in to the standard of care provided at the Mid Staffordshire NHS Foundation Trust
- continued to roll out a clinically prioritised programme of PREVENT staff awareness training (part of the Government's anti-terrorism strategy) for children and adult services
- developed and implemented training for Mental Capacity and Deprivation of Liberty Safeguards to reflect changes from The Care Bill and recent legislative changes
- implemented all recommendations from the Cambridgeshire & Peterborough Clinical Commissioning Group deep dive review of adult safeguarding
- received 'substantial assurance' from an internal audit of the Trust's adult safeguarding policy and process.

Adult safeguarding - key actions for 2015/16:

- develop action plans in response to Kate Lampard's 'Lessons Learnt' report detailing the investigations in to the abuse by Jimmy Saville on NHS premises (published February 2015) and Sir Robert Francis' review in to whistleblowing and creating an open culture within the NHS (Freedom to Speak Up, published February 2015)
- continue to implement plans to achieve 85% PREVENT training compliance across our workforce within a three year timescale
- increase staff awareness of emerging trends within domestic abuse, sexual exploitation and modern slavery widen the network of safeguarding champions within clinical teams.

Safeguarding training (children and adults)

Children's safeguarding training	% achieved 2013/14	% achieved 2014/15
Level 1 mandatory for all staff	95%	91%
Level 2 mandatory for all clinical and non-clinical staff in regular contact with parents, children and young people	94%	96%
Level 3 mandatory for all staff predominantly working with children, young people and parents	95%	91%
Adult safeguarding training	92%	93%

The tables above demonstrate that we achieved our contractual target of 90% of staff attending the appropriate level of children's and adults safeguarding training (although we did not achieve our internal aspirational target of 95%).

Information Governance

The Trust achieved a score of 78% in the information governance toolkit self-assessment for 2014/15; an improvement from a score of 66% in 2013/14. For the 38 standards involved, there were four ratings possible (0, 1, 2, or 3, with 3 being the most positive outcome). The Trust achieved level 2 for 24 standards and level 3 for 14 standards. An internal audit report confirmed the Trust's self-assessment score.

This assessment provides assurance to the Board that the Trust is meeting its obligations in relation to information governance. Action plans for improvement were monitored by the Trust's internal Information Governance Steering Group with progress reports presented to the Quality Improvement and Safety Committee quarterly. These processes will continue to further improve our score in 2015/16.

During 2014/15 there were 24 confirmed information governance serious incidents; all were subject to full root cause analysis, reported to the appropriate commissioning organisation and closed. None of these incidents resulted in harm to any patient. Seven incidents were reported to the Information Commissioner's Office (ICO). The ICO acknowledged the actions taken by the Trust to prevent reoccurrence and requested no further action; although four remain under review.

Emergency Planning, Resilience and Response

The Trust continued to support two Local Health Resilience Partnerships (LHRPs) and meet its statutory duties and obligations, for delivering an effective response to disruptions and emergencies. On peer review, the Trust was assessed as compliant across all the national NHS England Core Standards for Emergency Planning Resilience and Response. The Trust is also compliant with the NHS Commissioning Board Emergency Preparedness Framework 2013 and associated guidance.

"I came to this job on a six month secondment and now ten years later I still love my job.

Every day brings new learning, new patients and families to meet and varying challenges that we overcome (housing problems, funding issues etc.) Once a patient has been discharged to their chosen destination and all the work that has been planned falls into place, it is very rewarding. Families will call us to say that we really made a difference.

Not many jobs offer you that opportunity."

Ann Hobbs

Liaison Sister - Integrated Discharge Team

Clinical effectiveness

Clinical audit

During 2014/15 the Trust participated in all six of the national clinical audits:

- Sentinel Stroke National Audit Programme (SSNAP)
- Epilepsy 12 Audit (Childhood Epilepsy)
- Neonatal Intensive and Special Care
- National Paediatric Diabetes Audit
- Paediatric Asthma
- National Intermediate Care Audit.

We undertook an extensive programme of clinical audits with outcomes reported through the Trust's governance structures, to offer assurance to the Board and via the Trust's staff intranet to allow shared learning and improved practice. Some examples include:

- dental services, sexual health services, medicines management and pharmacy services continued to provide a high level of assurance
- Holly children's inpatient services undertook a major project to redesign and update nursing documentation with weekly audits consistently demonstrating >90% compliance
- the heart failure service in Luton demonstrated 100% compliance with NICE chronic heart failure guidance recommendations
- the health visiting service in Cambridgeshire made improvements to the IT system to allow health visitors access to safeguarding reports
- the health visiting service in Luton achieved full compliance with responding to urgent referrals before the end of the next working day
- the musculoskeletal service introduced training for staff following identified inconsistencies with referrals marked as urgent or routine.

National Confidential Inquiries

There were three National Confidential Inquiries in 2014/15, which the Trust did not participate in as they were not relevant to services provided by the Trust.

Clinical research

In 2014/15, the Trust recruited 233 patients to participate in the National Institute of Health Research (NIHR) portfolio studies. Six new NIHR studies opened and NIHR portfolio studies ran in 14 services. The Trust hosts the public involvement in research group, INsPIRE, with members commenting on 11 NIHR grant applications.

Research carried out within the Trust in 2014/15 was published in 12 publications, helping to improve patient outcomes and experience across the NHS principally related to: feeding and nutrition of babies, perinatal mental health, outcome measures related to neuro-rehabilitation and end of life care.

Impact of NIHR research

Research study	Benefits of participating
The ATTILA Trial: Assistive Technology and Telecare (AT&T) to maintain independent living at home for people with dementia	Understanding whether AT&T can safely extend the time that people with dementia can live independently in their own homes, reduce stress and increase quality of life
An Epidemiological Autism Spectrum Disorder (ASD) study and establishing a research database	Participating families receive newsletters with the results of ASD research studies and are contacted about research projects
Can text messages increase safer sex behaviours in young people? pilot trial	Demonstrated young people's knowledge and safer sex behaviours increased. CCS NHS Trust now involved in the university-led main trial
Predictors of patient uptake of telehealth and subsequent abandonment	The development of a valid and reliable tool that can be used to assess patients' telehealth user compliance
Baby Milk Study	Anecdotally, mums have reported satisfaction with the advice received on the study, particularly the additional advice on top of their usual care around bottle feeding
Understanding Hospital Admissions Close to the End of Life (ACE Study)	It is anticipated as a result of the study more will be known about end of life admissions to hospital to help improve patient care and clinician practice
Identifying the prevalence and nature of Hyperacusis in Traumatic Brain Injury (TBI)	The study has informed a change in the procedure used to assess clients for hyperacusis at the Oliver Zangwill Centre
Community Care Pathways at the end of life (CAPE)	A study reviewing care provision in the last year of life of 400 patients in 20 general practices.

In 2014/15, two members of staff completed Cambridgeshire and Peterborough Collaboration for Leadership in Applied Health Research and Care Fellowships, one focussing on end of life choices and the other designing a fatigue toolkit for clients who had acquired brain injury.

A further two members of staff completed Health Education East of England Quality Improvement Fellowships, including assessing the impact of a patient reported outcome measure (EQ5D) for patients who had treatment following traumatic brain injury.

The Trust recognises the importance of research, development and innovation and as a result is contributing to evidence based practice and improving the effectiveness of care. Year on year our patient recruitment to studies has increased and more staff are being involved in the research process.

Patient Experience

Engaging the public and service users in developing and providing feedback on our services helps us monitor the quality of and make improvements to these services. The following summarises some of the initiatives and actions undertaken during 2014/15.

Complaints, Concerns and Patient Advice and Liaison Service (PALS) contacts

The table below summarises the total number of complaints, concerns and PALS enquiries received in 2014/15.

	2012/ 2013	2013/ 2014	2014/ 2015
Formal Complaints	192	187	153
Concerns (for investigation)	107	52	155
PALS	629	818	631

Formal complaints: The reduction in formal complaints and PALS contacts received during 2014/15 is aligned to our policy of encouraging staff to actively seek to satisfactorily resolve concerns as they arise (and hence the rise in concerns recorded for the same period).

Compliments: Over 7000 positive comments and compliments were received by services during the year – these are recorded separately to the above data.

Parliamentary and Health Services Ombudsman (PHSO): We have incorporated the main themes from the Parliamentary and Health Service Ombudsman (PHSO) document 'principles of remedy' into our complaints policy, to ensure we meet complainants' expectations as quickly as possible. The PHSO reviewed four complaints cases relating to the Trust in 2014/15. Two of these were sent direct to the PHSO without the Trust having an opportunity to respond. The PHSO therefore referred these back to the Trust for investigation, whilst keeping an oversight of the outcome. Two of the four cases were resolved satisfactorily and two are on-going.

Patient Stories

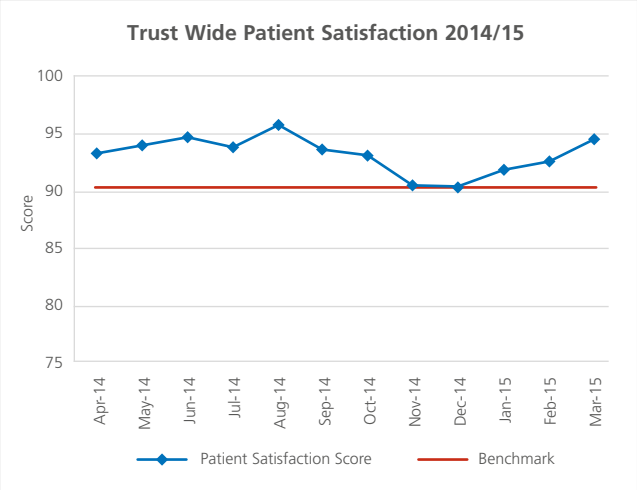
Additional 17 community beds open at Lord Byron ward, Brookfields Hospital

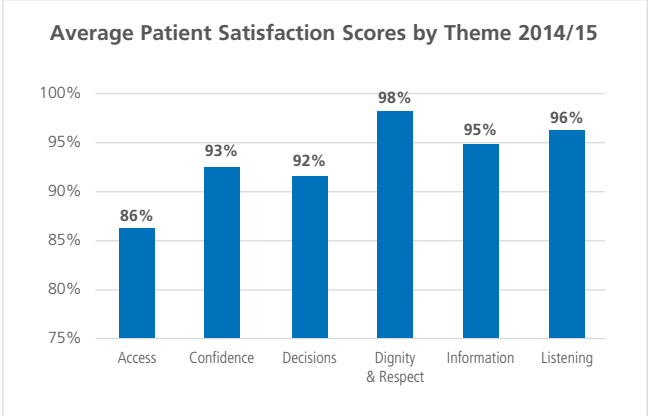
A rehabilitation ward at Brookfields Hospital, Cambridge added 17 community beds after a refurbishment of a previously disused ward. The 20-bed Lord Byron ward run by Cambridgeshire Community Services NHS Trust was expanded after an adjacent ward underwent a major overhaul. The existing 20-bed unit is known as Lord Byron A and the additonal 17-bed unit is Lord Byron B. Lord Byron A provides rehabilitation and long term condition treatment/management for patients with complex needs. Lord Byron B will operate as a step down facility, so that patients who need less complex care, but are not well enough to return home, continue to get the care they need. Annette Hawkins, ward manager, Cambridgeshire Community Services NHS Trust, explained: "Lord Byron A will continue to support patients with more complex needs. The aim of Lord Byron B is to enable us to smoothly transfer patients who are medically fit and stable, but may need further treatment, assessment or a home care package arranging, before they can be discharged.

"The additional capacity will enable us to help more patients and support quicker referrals from acute hospitals like Addenbrooke's."

Surveys

Nine thousand service users responded to our surveys online, via hard copy, and via smart phone QR (quick read) codes. As shown below, overall satisfaction rates throughout 2014-2015 and in relation to specific issues were in excess of 90%.

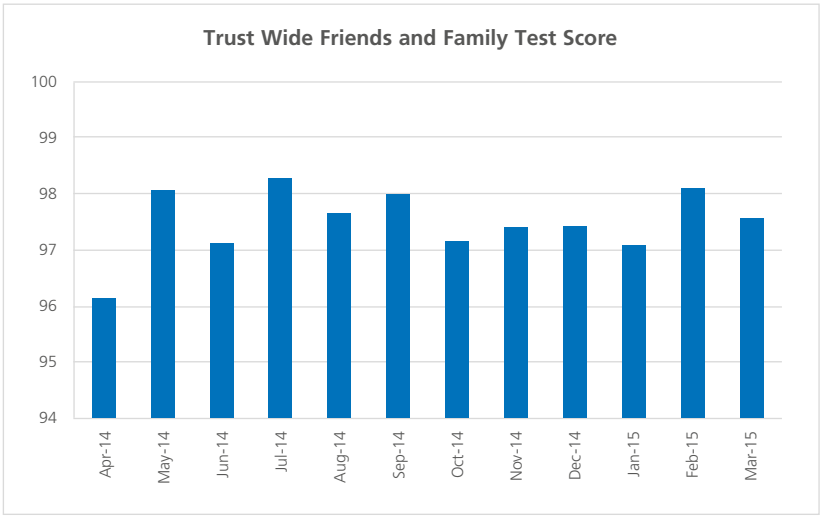




Key messages:

- for the third year running "staff treating patients with privacy, dignity and respect" scored the highest satisfaction rate
- satisfaction rates with being treated with dignity and respect and being listened to exceeded the Trust target of 90% every month throughout 2014/15
- access to services is the single theme that consistently did not meet the Trust 90% target (read more about how we are addressing this in the Equality and Diversity section of this report).

The Trust used the national Friends and Families test in all surveys during 2014/15, asking patients "How likely is it that you would recommend this service to friends and family if they needed similar care or treatment?" Our target of 90% of patients responding positively to this question was achieved, as well as scores higher than the national figures for A&E and acute hospital inpatients (data for community trusts will be available from March 2015).



Patient Advice and Liaison Service (PALS)

The Patient Advice and Liaison Service received and satisfactorily resolved 631 contacts during the year as summarised below:

Advice (from 1 September 2014 'advice' contacts were included in the 'enquiry/signposting category)	101
Enquiry/signposting	397
Comments and suggestions	17
Patient and public engagement	18
Concerns	98

Improving services using patient feedback: You Said, We Did

Services across the Trust used feedback to improve the services we provide. Just a few examples are set out below:

- developing a risk management tool in one of our children's services for staff working in settings owned by other organisations
- improving access through developing service leaflets including easy read versions and introducing single points of access to steamline referrals and aid communications
- our musculoskeletal service improved signage to the department, installed a privacy barrier at receptions, purchased a departmental wheelchair for patients with walking difficulties and reworded certain patient leaflets to make them more user friendly and explanatory
- our patient experience team developed and made available a list of agencies and services that can provide support to newly diagnosed patients.

Service Visits

Patient representatives participated in visits to inpatient wards and outpatient departments to assess the patient environment, as part of the Fifteen Steps and Patient Led Assessment of the Care Environment (PLACE) programmes. Remedial work undertaken as a result included:

- improving signage
- cleaning plans for toys and deep cleaning of carpets
- improving storage of equipment, replacing broken lights, replacing guttering/ceiling tiles
- ensuring wheelchairs and commodes were clearly labelled with clean equipment signs.

Patient Stories

Patients presented their stories at Trust Board meetings during 2014/15 either in person, in writing or via filmed recordings. Each story provided powerful feedback about the patient's experience of using our services. This feedback included inspirational stories of how our staff had improved the quality of people's lives, as well as how improvements could be made. Where improvements were identified, action plans were implemented and monitored by the Trust's Clinical Operational Boards.

Patient Report Outcome Measures

The Trust used EQ5D – a patient reported outcome tool that provides an indication of health related quality of life - in two services. More than 7000 patients from our community rehabilitation and MSK physiotherapy services participated, with positive outcomes identified by patients in relation to improvements to their quality of life, as measured on referral to and having accessed these services.

King's Fund experience based co-design patient stories project

This project involved gathering experiences from patients and staff using observations, discussions and in-depth interviews; the latter of which were filmed and enabled patients and staff to identify improvements for the service. Changes made as a result included:

- musculoskeletal services introduced rapid access to the most senior clinician, ensuring patients see the right clinician first time, improved self management through earlier reassurance, and improved communications for appointments
- community rehabilitation services involved patients, their informal carers and staff in the design of more integrated services (Cambridge), improved access to information and help for carers, increased sharing of information on SystmOne, improved patient pathways for physiotherapy patients discharged from hospital, provided a named care co-ordinator on patient correspondence and launched integrated notes and care plans.

Patient and Public Engagement

Services self assessed their level of engagement with patients and the wider community using a Trust-wide tool enabling them to develop plans to empower individual patients and to further engage with community groups to develop their services to meet future needs.

A staff guide for engagement is being finalised and will be available during 2015.

Trust representatives regularly attended community group meetings e.g. Healthwatch, health strategy group (learning needs), golden age, involvement groups.

Equality and Diversity

We are committed to providing personal, fair and diverse services to our communities in line with the Equality Act 2010 and our duty to promote equality and eliminate discrimination.

Progress against four objectives (developed with patients/public representatives and built in to our quality and workforce strategies) is outlined below.

Patient focussed objectives	Progress during 2014/15
Achieve an improvement in the percentage of service users who report that they are able to access the Trust services that they require	Responses from patient surveys identified a 4% decrease in services users who reported they were able to access Trust services: 2013 response: 89% 2014 response: 85% Issues identified by service users in relation to 'accessibility' of specific services including car parking, signposting, patient information, length of time taken to answer phones and length of waiting time for appointments. Examples of work undertaken to improve access are outlined earlier. This issue will remain a key priority for our equality and diversity work programme in 2015/16.
Improving the depth and breadth of the Trust's understanding of the experience of hard to reach, seldom heard, varied community groups	The Trust's complaints policy was reviewed to include stronger collection methods for protected characteristics. Complaints feedback is now stratified against these characteristics. A new complaints leaflet was developed and easy read versions of this and our Friends and Family Test survey support the capture of feedback from, for example, people with learning disabilities. Action plans are developed to respond to any equality and diversity concerns that arise.
Staff focussed objectives	
Achieve an improvement in the percentage of staff who report that they are able to access training and education opportunities.	An 8% increase in the % of staff saying their manager supported them to receive training, learning or development was demonstrated via the annual staff survey: 2013 response: 86% 2014 response: 94% Community Trust average: 89%
Embedding the appraisal policy and processes including discussion at appraisal between managers and staff to access knowledge and competence in equality and diversity and cultural awareness	Equality and diversity training is embedded within the Trust's induction processes and is mandatory for all staff. An equality and diversity briefing sheet to support mandatory training was introduced. Additional equality and diversity cultural awareness training was offered, tailored to local demographics and challenges in the geographic areas covered by the Trust.

The Trust has expanded how it engages with stakeholders ensuring patients and staff have been involved in assessing our progress against objectives. Positive results from the stakeholder RAG-rating panels held in March and May 2015 are outlined below.

Grading rating	E	A	D	U
Meaning	Excelling	Achieving	Developing	Undeveloped

Objective	Narrative	Outcome	Grading Panel rating Results 2013-14	Grading Panel rating Results 2014-15
1. Better health outcomes for all	The NHS should achieve improvements in patient health, public health and patient safety for all, based on comprehensive evidence of needs and results	1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities	A	A
		1.2 Individual people's health needs are assessed and met in appropriate and effective ways	A	A
		1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well informed	D	D
		1.4 When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse	A	A
		1.5 Screening, vaccination and other health promotion services reach and benefit all local communities	A	A
2. Improved patient access and experience	The NHS should improve accessibility and information, and deliver the right services that are targeted, useful, useable and used in order to improve patient experience	2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied in unreasonable grounds	A	A
		2.2 People are informed and supported to be as involved as they wish to be in decisions about their care	A	A
		2.3 People report positive experiences of the NHS	A	A
		2.4 People's complaints about services are handled respectfully and efficiently	E	E

Objective	Narrative	Outcome	Grading Panel rating Results 2013-14	Grading Panel rating Results 2014-15
3. Empowered, engaged and well supported staff	The NHS should increase the diversity and quality of the working lives of the paid and non-paid workforce, supporting all staff to better respond to patients' and communities' needs becomes as diverse as it can be within all occupations and grades	3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	E	E
		3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	E	E
		3.3 Training and development opportunities are taken up and positively evaluated by all staff	D	A
		3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source	A	D
		3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	A	A
		3.6 Staff report positive experiences of their membership of the workforce	A	A
4. Inclusive leadership at all levels	NHS organisations should ensure that equality is everyone's business, and everyone is expected to take an active part, supported by the work of specialist equality leaders and champions	4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	A	A
		4.2 Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed.	D	A
		4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	A	A

Providing services that are highly rated for their quality: Looking Forward 2015/16

We will:

- join the Sign up to Safety campaign and implement our safety plan across the Trust
- maintain the standards of care that were rated as 'good' by the Care Quality Commission and aim to achieve an 'outstanding' rating at our next inspection anticipated in 2017
- improve how we process and handle information measured against the information governance toolkit
- assess ourselves against the new NHS Well Led Framework and implement any improvements identified
- agree and implement with our commissioners a full seven day service in our children's inpatient ward
- fully implement the national Health Visitor Call to Action and Healthy Child Programme in Cambridgeshire
- implement three collaborative working initiatives with other providers of children's services in Cambridgeshire and Peterborough.

Patient Stories

Life after brain injury

The Evelyn Community Head Injury Service (ECHIS) provides specialist holistic neuro-rehabilitation for adults in Cambridgeshire who have had a traumatic brain injury.

The service provides bespoke assessments, individual and group sessions for people with head injury and their families. Rehabilitation programmes are tailored to identify individual goals and needs.

ECHIS works closely with the neuro-rehabiltation specialists in the Trust's community teams, external agencies such as Headway and social care to form virtual teams around each client.

Having been seen by the neuro-rehab consultant at the Addenbrookes Neurotrauma clinic, clients are discussed at the ECHIS team meeting and then invited to an initial assessment if appropriate, together with a family member or close friend. Realistic goals are identified, such as participating in an activity in the community, returning to work or study.

Outpatient appointments and group sessions are offered across the county, most frequently at Brookfields Hospital, Cambridge or the Princess of Wales Hospital, Ely. Clients can attend specific rehabilitation groups focusing on areas such as fatigue management, cognitive strategies and communication, depending on their needs.

Daniel has attended many of the rehab groups over the last year. He said: "I find this group and the people very important. If it wasn't for these people, understanding brain injury wouldn't be possible and I wouldn't be able to cope with this. A lot of people who have a brain injury do not understand what they are going to go through."

Judith Allanson, Evelyn consultant in neurological rehabilitation said: "We would like to build on the work already done by creating a head injury registry, to better understand the scale of the issue and by developing a specialised county wide neuro rehabilitation service to use existing expertise and facilitate working with relevant agencies."

"This will ensure that people with complex problems resulting from brain injury have access to the specialist advice and interventions that they need."

STRATEGIC OBJECTIVE 2

Quality: To collaborate with organisations to improve the care given to people who use our services

Working in partnership with other agencies is fundamental to our shared success and ambition to ensure the best outcomes for local residents.

Examples of new partnership initiatives this year included:

- membership of the Cambridgeshire and Peterborough health system transformation team to lead work to address the significant challenges faced by this health economy
- introduction of an electronic trauma and orthopaedic clinical triage and consultant physiotherapist led clinical assessment and treatment service in Huntingdonshire, in partnership with local commissioning groups in February 2014 and Ely in October 2014
- working with the Terence Higgins Trust to successfully win the procurement to provide sexual health services in Norfolk from March 2015 and Suffolk from May 2015
- opening 17 additional beds on the Brookfields Hospital site to enable appropriate patients to leave acute hospital earlier or avoid a hospital admission; funded by the Cambridgeshire and Peterborough Clinical Commissioning Group
- working in partnership with Amazing Interactives Ltd, our Dreamdrops children's charity and staff from our children's services to develop and introduce a world first mini, mobile 3D interactive pain and anxiety unit to distract young patients during clinical treatments
- extending the opening hours – in partnership with the Isle of Ely Local Commissioning Group – of our Minor Injuries Unit at the Princess of Wales Hospital Ely, to alleviate unprecedented winter pressures on A&E at Addenbrooke's Hospital.

The following existing partnership initiatives continued during 2014/15:

- a collaboration between the Trust, Luton Clinical Commissioning Group, Luton and Dunstable University Hospital and Keech Hospice Care to improve joined up working for patients at the end of their lives
- the Better Together Board in Luton, hosted by Luton Borough Council and Luton Clinical Commissioning Group bringing together health, social care and voluntary organisations to improve the health and wellbeing of people in Luton
- the establishment of multi-disciplinary teams to support the frail elderly and people with a long term condition and those at the end of life
- provision of seamless and co-ordinated pathways for people with long term conditions through
- working with Peterborough and Stamford Hospitals NHS Foundation Trust working in partnership with the Arthur Rank Hospice Charity to deliver the hospice at home service, enabling hundreds more people to die with dignity in their own homes
- successful partnership working with the East of England Ambulance Services NHS Trust to support people who have suffered falls to remain at home with appropriate care and avoid a hospital admission
- our Cambridgeshire Children's Continuing Care Team is providing short break/respite care in partnership with Action for Children.

"You are encouraged to thrive in an environment that embraces change, and continues to strive towards excellence.

We have a large and dynamic team, with a wide range of expertise and clinical interests."

Colleen Kiley

Senior Musculoskeletal Physiotherapist
Physiotherapy Department
Hinchingbrooke Hospital

STRATEGIC OBJECTIVE 3

People: To ensure that the Trust attracts and retains a quality workforce

The Trust cannot achieve its objectives without its dedicated workforce and we thank all of our staff for their continued commitment.

We continued to recognise our staff's strengths and to build on best practice to develop a workforce with a shared vision and values aligned to our strategic objectives. The following sections set out how we have achieved this during 2014/15.

Workforce review programme

A process of continuous review and improvement of staffing levels continued in 2014/15.

All services undertook local workforce reviews, which were presented to the Trust Board twice a year (in line with the Government response to the Francis Report). Subsequent actions were implemented and monitored.

Staff survey

The results from the 2014 staff survey, which involved a random sample of 850 staff were published nationally in February 2015.

For the second year running, staff rated working for the Trust incredibly positively, reflecting the fantastic culture and behaviours our staff helped to create. Out of 29 key findings, staff rated the Trust the most positive in the country compared to peer community trusts in eleven key finding areas, including recommending the Trust as a good place to work or receive treatment.

Our Trust was also rated the best in the country for staff engagement in comparison to peer community trusts and fifth best in the country in relation to all trusts, irrespective of the type of services provided.

Staff rated working at the Trust better than average in 24 out of the 29 key finding areas; average in three areas and below average in two areas.

These excellent ratings are good news for patients and staff. Evidence shows that staff satisfaction plays a vital part in assuring quality of patient care and safety ,so that a good organisation to work for is also a good organisation in which to be cared for.

In response to the previous year's results, the Trust developed an improvement plan that focused on the three lowest scores, which were rated 'average' when compared to peer community trusts. A summary of progress with these findings is shown below.

Our improvement plan will now be reviewed and updated in response to the 2014 results and the regular real-time surveys undertaken by the Trust, which enable immediate improvements to be put in place wherever possible.

Key Finding	2013 score	2014 score	
Percentage of staff saying hand washing materials are always available	52%	Question not asked in 2014 survey	
KF6. Percentage of staff receiving job-relevant training, learning or development in last 12 months	83%	85% (national average 83% - the higher the score the better)	▲
Percentage of staff working extra hours	68%	72% (national average 71% - the lower the score the better)	▼

Supporting staff and staff engagement

During 2014/15, the Trust:

- introduced innovative recruitment initiatives in hard to recruit areas and services resulting in vacancy rates in adult services reducing from 19.6% at December 2013 to 9.6%
- successfully transferred staff into the Trust as a result of procurements won including introducing bespoke inductions, training and cultural awareness sessions
- simplified appraisal paperwork following staff feedback and enhancing the link between appraisals and performance/pay progression
- promoted the benefits of effective appraisals achieving 89% compliance for 2014/15 compared to 90.5% in 2013/14 and against a contractual target of 90% and an internal aspirational target of 95%. Results from the 2014 national staff survey reported a 91% achievement rate
- embedded our leadership behaviours (created by the Trust's senior leadership forum and expanded to relate to all staff) within the Trust's appraisals processes
- offered flexible working and family friendly arrangements, a carers and special leave policy, a zero tolerance approach to violence in the workplace and encouraged staff to raise concerns through an 'open' approach and a formal whistle blowing policy continued to receive accreditation to use the Two Ticks Disability Symbol for employers who meet a range of commitments towards disabled people and as a Mindful Employer, which increases awareness of mental health in the workplace
- continued to host the bi-monthly Joint Consultative Negotiating Partnership to engage with trade union representatives to exchange information, revise HR policies and processes, as well as consult and negotiate on employment matters
- was identified by NHS Employers in partnership with the Health Service Journal as one of their Top 100 NHS employers in 2014.

Mandatory training

During 2014/15, we:

- built on the significant progress made in 2013/14 to increase the quality and provision of mandatory training including via the four day corporate induction programme
- developed plans to implement the electronic Oracle Learning Management System (OLM) from April 2015 to support achieving compliance, provide accurate records and identify future training needs
- purchased and made available high quality, user focused e-learning packages for the Mental Capacity Act (MCA), Deprivation of Liberty (DOL) and dementia care.

Supporting a skilled workforce

In the last 12 months:

- the bands 1-4 Best Practice Programme and Manager's Skills Programme continued to be offered, including support for staff during periods when personal resilience and the ability to lead teams through change was a priority
- the Trust appointed a Widening Participation Officer role, to commence in April 2015, to continue to develop staff in band 1-4 posts and attract new staff into apprenticeships and other training roles we introduced a Trust-wide Health Coaching Programme training five train the trainers and over 130 health coaches, supporting clinical staff to empower service users to improve outcomes and the quality of their lives ran our highly successful Chrysalis Leadership Development programme for the sixth year, with staff gaining the skills to create an environment where change and innovation can flourish
- sponsored two of our clinical leaders to become train the trainers in quality service improvement and redesign tools and techniques, provided by NHS Improving Quality; we will roll out this programme to a further 60 individuals during 2015/16, introduced a Preceptorship Academy to support newly qualified staff and mentors implemented a robust evaluation process to ensure that all funded continuous professional development was aligned to our objectives and was fit for purpose (sharing feedback with higher education institutions to ensure improvement)
- continued to promote access to the Virtual Ashridge Leadership and Management resource library and the Springboard Women's Development Programme.

Our award winning staff

During 2014/15: our annual excellence and innovation awards celebrated the outstanding achievements of our staff who made a real difference to people's lives

- Liz Webb, the Trust's Head of Palliative Care won the Health Education East Leadership Recognition Award for Outstanding Collaborative Leadership
- Dr Ashmeet Gupta and Dr Prakash Srivastava, community consultant paediatricians won the Health Education East research poster of the year award
- the Trust was a finalist in the Health Education East Board of the Year award category and the prestigious Health Service Journal 'Provider Trust of the Year' award category
- the Trust was named as a finalist in the 2014 Health Enterprise East Innovation Awards in the software/ICT/assistive technology category
- Clinical neuropsychologist Professor Barbara Wilson OBE (founder of the Trust's Oliver Zangwill Centre) was awarded three national/international accolades during 2014, including the distinguished National Academy of Neuroscience award
- Anne-Marie Perrin, Tissue Viability Specialist won the Health Worker of the Year award as part of the Cambridge News Pride of Cambridge Community Awards 2014
- Sue Patterson won the CPHVA/Unite Nursery Nurse of the Year award
- health visitors from the Trust's Sawston and Melbourn team and Luton Practice Teachers were two of the joint winners of the Team Award and Kevin O'Regan from our Luton health visiting team won the Programme Lead Special Recognition Award at the Health Education East of England Health Visiting Awards.

Health and wellbeing and sickness absence reduction

The Trust continued to implement a Live Life Well staff health and wellbeing programme during 2014/15 including:

- availability of personal resilience training and coaching conversation training
- roving health check kiosks enabling staff to gauge health measurements such as body mass index, blood pressure and body fat
- introduction of a rapid access to musculoskeletal service for staff who are off sick (or at risk of going off sick) as a result of a condition for which they are awaiting investigation, treatment or surgery; pilates classes for staff were also introduced
- inducting all new staff in the Trust's culture and explaining their rights and responsibilities
- promoting Live Life Well activities through a range of communication channels.

The following table provides information on the Trust's sickness absence rates.

Data category	2011/12	2012/13	2013/14	2014/15
Average WTE	2879	2964	2924	2854
Average monthly sickness rate	4.48%	4.79%	4.90%	4.73%
FTE days lost	47,228	52,158	52,321	49,993
FTE days available	1,054,381	1,085,981	1,068,674	1,042,141
Cumulative sickness rate	4.48%	4.80%	4.85%	4.8%

Note: the above table reflects data from our internal monitoring process for based on a full calendar year e.g. 365 days. As such, the sickness rates included within the Trust's annual accounts, which are based on Department of Health estimated figures over 225 days per year (i.e. excluding weekends and bank holidays) will not correlate with the above.

Patient Stories

Trust's community nursing services recognised at 10 Downing Street reception

Two innovative community services - both winners of the national Chief Nurse's 6Cs award - were celebrated at a reception with Prime Minister, David Cameron and Jeremy Hunt, Secretary of State for Health at 10 Downing Street.

Mags Hirst, Jenni Sherman and Vicky Amiss-Smith from the Trust's children's community nursing team (CCNT), together with Lucy Stewart and Ben Bowers from the Ely and Fenland community rapid response team got to walk through the doors at 10 Downing Street.

Mandy Renton, chief nurse, Cambridgeshire Community Services NHS Trust said: "I am really proud of both of these teams. To be recognised for not one, but two 6Cs awards in one year is a tremendous achievement and highlights the fantastic work that the Trust is doing to improve the quality of life of those we care for."

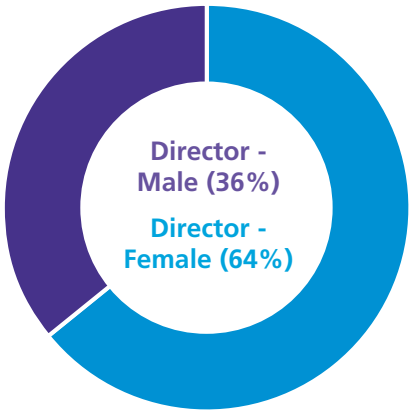
Lucy Stewart, community matron for the community rapid response team said:

"I met other Queen's nurses and it was a really useful way to network and talk to health professionals from across the country. Mr Cameron spoke with passion about the current state of the NHS and thanked us all for our continued dedication and commitment to providing quality care for all."

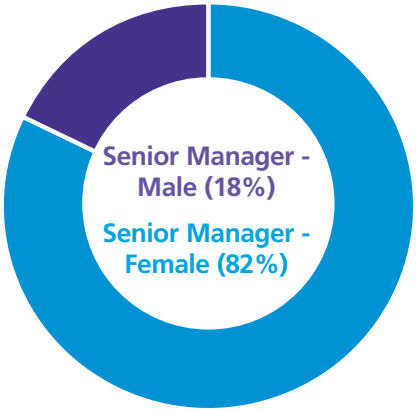
Analysis of gender distribution within our workforce

The following charts set out the gender distribution across the Trust.

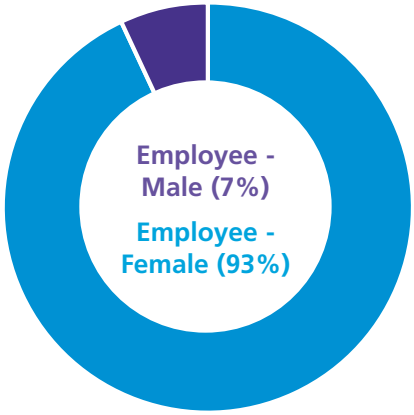
Gender distribution - Directors
(including Executive & Non-executive Directors)



Gender distribution - Senior Managers



Gender distribution - Employees



Attracting and retaining a quality workforce: Looking forward to 2015/16

We will:

- continue to embed a coaching culture across the Trust investing in further health coaching training for our clinical workforce
- expand opportunities for apprenticeships and focus on the development of our Bands 1-4 workforce, linking with the Health Education East of England 'grow your own' initiative
- develop the skills of our clinical staff in quality, service improvement and redesign tools and techniques
- refresh our workforce, organisational development and service redesign strategy to support the delivery of our 2015/16 Annual Plan.
- continue to focus on the following four programmes of work:

  People and Productivity: building on our existing programmes of staff involvement, engagement and continuous improvement

  Quality and Safety: including the health and wellbeing of our workforce and the delivery of the new race equality standard

  Organisational Development and Service Redesign

  Systems and Infrastructure: including development of our electronic staff record capability and roll out of the self-service function

Patient Stories

Huge thank you sign surprises physiotherapist

A Southoe man with osteoarthritic knees was so pleased with treatment that has left him pain free for the first time in two years, that he decided to publicly thank his physiotherapist.

Geoffrey Bowman, 71, built a 8ft x 4ft 'thank you' sign in his front garden and gave a bottle of wine to Alison Taylor, a musculoskeletal physiotherapist with Cambridgeshire Community Services NHS Trust. Alison prescribed steroid injections, which have proved so successful that Geoffrey was recently well enough to go on a trekking holiday in Cuba, where he walked an average of 10 miles each day.

He said: "Since the pain in my knees started five years ago I've seen a number of consultants and have undergone several treatments, including two arthroscopies, which hadn't been entirely successful. I was referred to Alison, who said that she thought steroid injections might be the solution. The relief was immediate. Alison mentioned that she cycles past my house every Saturday morning, so I built a sign and left her a bottle of wine to show my appreciation."

Alison added: "I was really surprised when I cycled past his house and saw the sign and a bottle of wine waiting for me – it's a good job I could fit the bottle in my water holder on my bike! The treatment for osteoarthritic knees can vary, so I talked through the options with Geoffrey and we decided that steroid injections might be the answer."

"I'm delighted the treatment has worked so well in this case. It's very rewarding to help someone to improve the quality of their life."

STRATEGIC OBJECTIVE 4

Finance: To be a financially sound organisation

2014/15 has been another challenging year financially for the Trust but we successfully exceeded our planned surplus target of £754,000.

Key messages for the year are set out below:

- The Trust has maintained its high level of financial governance, recognised by the Internal Auditors giving an opinion of 'substantial assurance' over the Trust's financial systems, budget control and financial improvement.
- The Trust has responsibility to pay its suppliers in line with the payment terms agreed at the time of purchase. Failure to do this harms the reputation of the Trust and the wider NHS, as well as damaging supply sources and straining relationships with suppliers.

The Trust has adopted the national NHS Better Payment Practice Code. The target set is that at least 95% of all trade payables should be paid within 30 days of a valid invoice being received or the goods being delivered, whichever is later – unless other terms have been agreed previously. The Trust's detailed performance against this target for NHS and non-NHS trade payables is set out in note 9.1 in the annual accounts and is also shown in the table below. Its overall performance in relation to the code improved during 2014/15. It is anticipated that this improvement will be sustained going into the new financial year.

Better Payment Practice Code (30 day target)	2014-15	
	Number	£'000
Non-NHS Payables		
Total Non-NHS Trade Invoices Paid in the Year	27,891	41,074
Total Non-NHS Trade Invoices Paid Within Target	23,296	35,751
Percentage of Non-NHS Trade Invoices Paid Within Target	83.5%	87%
NHS Payables		
Total NHS Trade Invoices Paid in the Year	1,960	13,665
Total NHS Trade Invoices Paid Within Target	1,584	11,928
Percentage of NHS Trade Invoices Paid Within Target	80.8%	87.3%

- The Trust's 2014/15 accounts have been externally audited by PricewaterhouseCoopers LLP. External audit fees for 2014/15 were agreed as £88,617 excluding VAT (2013/14 £88,617 excluding VAT), which is in line with the framework agreement set out by the Audit Commission. There will be a variation to the fee of £5,000 to reflect additional procedures performed to investigate the Trust's future organisational structure and its financial standing following the transfer of services from the Trust; see note 24 of the annual accounts.
- The Trust is a member of the NHS Pension Scheme. The scheme is unfunded with defined benefits. Full details of the treatment of the Trust's Pension Policy can be found in note 8 of the annual accounts. The Trust is also a contributing member of the Cambridgeshire County Council Local Government Pension Scheme. Details of the Trust's accounting policy are also given in note 1.5.2 and 1.7 of the annual accounts. The Remuneration Report on page 54 shows the salary and pension entitlements of the senior managers of the Trust.
- The Trust made one exit package as set out in note 7.4 of the annual accounts.
- The Trust had five off payroll engagements during 2014/15, the details of which can be found in the Remuneration Report (page 54).
- There have been no accounting policy changes during 2014/15. Critical accounting judgements and key sources of estimation of uncertainty are shown in note 1.5.2 of the accounts.
- The Trust has spent £7.55 million in 2014/15 (2013/14 £7.5 million) on items that come within the NHS management costs definition. This represents only 4.7% (2013/14 4.8%) of total turnover for the financial year.
- The Freedom of Information Act (FOIA) gives individuals the right to ask any public sector organisation for the recorded information they have on any subject. Most requests are free but in some cases individuals may be asked to pay a small amount for photocopies or postage. The Trust has complied with Treasury's guidance on setting charges for information.
- So far as the directors are aware, there is no relevant audit information of which the auditors are unaware. Directors have taken all of the steps that they ought to have taken in order to make themselves aware of any relevant audit information, and to establish that the auditors are aware of that information.
- The directors have a reasonable expectation that the NHS Trust has adequate resources to continue in operational existence for the foreseeable future. Although 2015/16 will be financially challenging with a savings target in excess of £3.7 million, cash flow forecasts support the conclusion that the Trust is a 'going concern'. For this reason, directors continue to adopt the 'going concern' basis in preparing the accounts. To obtain further detail of our financial performance, please write to:

  Director of Finance and Resources
  Cambridgeshire Community Services NHS Trust
  Unit 3, Meadow Lane, St Ives, PE27 4LG

Our full audited accounts will be available on our website at www.cambscommunityservices.nhs.uk

Performance against contractual targets in 2014/15

Throughout the year, the Trust's Board has scrutinised performance against targets and remedial action plans through: monthly reporting at Board meetings against all quality, risk, financial, performance and contracted targets and indicators comprehensive governance arrangements including weekly wider executive team meetings and monthly clinical operational boards across all locality divisions; all of which monitor performance and standards in their areas of expertise monthly divisional performance meetings between members of the executive team and key front line management and clinical staff on a locality basis.

During 2014/15 the Trust was monitored against a range of key performance indicators and targets. A number of these targets are nationally measured; other targets are locally contracted by each commissioner. A series of tables overleaf summarise our performance against these key performance targets by commissioner.

A glossary setting out further information on the definition, calculation and source of information included in the following tables, is available at the end of this annual report.

Commissioner - Cambridgeshire & Peterborough Clinical Commissioning Group (CCG)

Key performance targets	2013/14 Actual	2014/15 Target	2014/15 Actual
C. difficile: reduce infection rates	2	<3	**3**
MRSA: reduce infection rates	0	0	**0**
18 week referral to treatment - % non-admitted patients completing pathways within 18 weeks	99.6%	95.0%	**99.0%**
18 week referral to treatment - % non-admitted patients incomplete pathways <18 weeks	99.3%	92.0%	**98.5%**
Total time in minor treatment centres: patients seen within four hours or less	100.0%	95.0%	**99.9%**
Inpatients: Mixed sex sleeping accommodation breach	0	0	**0**
Risk assessments for VTE for all admissions to community hospital inpatient beds	100.0%	95.0%	**98.7%**

Key: Red = target not achieved, Green = target achieved

The Trust met 88% of all contracted targets for services commissioned by Cambridgeshire and Peterborough CCG in 2014/15

Other performance targets not met	2014/15 Target	2014/15 Actual	Variance
Non consultant led 18 week referral to treatment adult specialist Chronic Fatigue Syndrome/ME Service	95%	86.4%	**Significant**
Community Hospital bed utilisation - Brookfields, Cambridge	90%	83%	**Significant**
Community Hospital bed utilisation - Princess of Wales, Ely	90%	86%	**Marginal**
Community Hospital bed percent length of stay within 33 days - Brookfields, Cambridge	75%	72%	**Marginal**
Community Hospital bed percent length of stay within 33 days - Princess of Wales, Ely	75%	66%	**Significant**
Community Hospital bed percent length of stay within 33 days - North Cambs, Wisbech	85%	65%	**Significant**

Remedial action plans continue to be maintained for the above to deliver improved performance to meet targets in future months:

- The Trust's Clostridium Difficile policy has been updated and staff awareness will be improved through mandatory training, monitored by the Trust's Infection Prevention and Control Committee
- The CFS/ME service has experienced unprecedented demand and is working to ensure referral processes are understood and inappropriate referrals are minimised
- Community hospital inpatient beds will not be provided by CCS NHS Trust from April 2015

Commissioner - Cambridgeshire County Council

Key performance targets	2013/14 Actual	2014/15 Target	2014/15 Actual
Percentage of people offered appointment or walk in, within 48 hours of contacting a provider	n/a	98%	**75%**
Percentage of first time service users (clinical based services) offered a HIV test	n/a	100%	**100%**
Percentage of all under 25 year olds (new attendances) screened for Chlamydia	n/a	75%	**88%**
Percentage of positive patients who received treatment within six weeks of test dates	n/a	95%	**99%**
Percentage of users experiencing waiting times in clinics of < 2 hours	n/a	100%	**100%**
Percentage of specialist reproductive health referrals from GP seen within 18 weeks of referral	n/a	100%	**100%**
Percentage of women with access to urgent contraceptive advice services within 24 hours of first contact	n/a	90%	**99%**

Key: Red = target not achieved, Green = target achieved

The Trust met 87% of all contracted targets for services commissioned by Cambridgeshire County Council in 2014/15

Other performance targets not met	2014/15 Target	2014/15 Actual	Variance
Percentage of first time service users (of clinical based services) offered and accepting a HIV test	97%	86%	**Significant**
Percentage of routine STI laboratory reports of results (or preliminary reports), which are received by clinicians within seven working days of a specimen being taken	100%	98%	**Marginal**
95% of MSM (men who have sex with men) living with a diagnosed HIV infection to have a suppressed viral load	97%	52%	**Significant**

- Remedial action plans continue to be maintained for the above to deliver improved performance to meet targets in future months
- Significant progress has been made in 2014/15 against the numbers of service users offered appointment or walk in within 48 hours, with the quarter 3 achievement of 58% increasing to 86% in quarter 4
- HIV testing is offered as normal practice to all patients attending the service. Work is being undertaken to improve the quality of recording. Data quality reports have been written and distributed to ensure data compliance
- The 2% of routine STI results not received by clinicians within seven working days was due to factors outside the Trust's control
- The result for MSM with a suppressed viral load reflects individual non-compliance (full support provided), resistant strain HIV, MSM transferring to the service with high viral loads, and patient choice

Commissioner - NHS England

Key performance targets	2013/14 Actual	2014/15 Target	2014/15 Actual
18 week dental referral to treatment - % non-admitted patients completing pathways within 18 weeks	100.0%	95.0%	**100.0%**
18 week dental referral to treatment - % non-admitted patients waiting <18 weeks	100.0%	92.0%	**100.0%**
Uptake of human papilloma virus (HPV) vaccination for year 8 children (Cambs/Peterborough localities)	95%	90%	**93%**
Uptake of human papilloma virus (HPV) vaccination for year 8 children (Luton locality)	87%	85%	**86%**

Key: Red = target not achieved, Green = target achieved

The Trust met 100% of all contracted targets for services commissioned by NHS England in 2014/15.

Patient Stories

Mini 3D Pain Distraction unit is a "World First"

A very special piece of equipment was delivered to the Trust's Children's Unit based at Hinchingbrooke Hospital.

The mini, mobile 3D Interactive Pain and Anxiety unit, a world first, was designed to fit into a suitcase by Amazing Interactives Ltd, a company that specialises in the development of interactive 3D content and hardware solutions. The unit is designed to distract young patients during clinical treatments.

Anne-Marie Hamilton, Chairman of the 'dreamdrops' fundraising committee said: "I approached Amazing Interactives to see if it was possible for them to design a mobile unit for use in the local community.

"This project took 18 months to come to fruition, with a lot of time and effort going into the whole project not only by the NHS and Amazing Interactives, but also with help and guidance from Tony Moss, a computer expert from the Rotary Club of Kimbolton Castle, as well as other members of the club.

"We would like to say a huge thank you to the Rotary Club who kindly offered to purchase the system for us. The machine is incredible and will revolutionise children's treatment. It is causing a real interest in other areas of the NHS, with one London hospital already interested in purchasing a unit."

Mags Hirst, play specialist, Cambridgeshire Community Services NHS Trust, who piloted various prototypes of the machine out in the community before the final design was agreed, said: "We requested a truly mobile unit which could be taken out in a car to a patient's home."

"Feedback is very positive and the unit will benefit children and young people who are having home based treatment such as wound dressings, as it provides a distraction to the child without getting in the way of the nurse. It's a really innovative piece of equipment and it will make a huge difference to the care we offer our patients."

Commissioner - Luton Clinical Commissioning Group

Key performance targets	2013/14 Actual	2014/15 Target	2014/15 Actual
C difficile: reduce infection rates	0	0	**0**
MRSA: reduce infection rates	0	0	**0**
18 week referral to treatment - % non-admitted patients completing pathways within 18 weeks	100%	95%	**100%**
18 week referral to treatment - % non-admitted patients waiting <18 weeks	100%	92%	**100%**
Percentage of patients waiting six weeks or more for diagnostic tests	0%	0%	**0%**

Key: Red = target not achieved, Green = target achieved

The Trust met 88% of all contracted targets for services commissioned by Luton Clinical Commissioning Group in 2014/15

Other performance targets not met	2014/15 Target	2014/15 Actual	Variance
Percent of 13-18 year olds receiving tetanus, diphtheria and polio (DTP) boosters (13/14 academic year)	90%	87%	**Marginal**
Number of smokers referred to Luton Wellness service in six month period	100#	39#	**Significant**
Percent of flu vaccinations delivered to frontline staff	45%	33%	**Significant**

aggregate target (not %)

- Remedial action plans continue to be maintained for the above to deliver improved performance to meet targets in future months.
- The additional requirement for Meningitis C vaccines in 2014 meant the school nursing service was unable to allocate resource resulting in the marginal DTP shortfall. The service is on course to deliver this target in the 2014/15 academic year, which ends in August 2015.
- Public health and health promotion awareness initiatives locally are expected to have a positive impact on volumes of smoking referrals and flu vaccinations.

Commissioner - Suffolk County Council

Key performance targets	2013/14 Actual	2014/15 Target	2014/15 Actual
% of people with STI needs offered appointment or walk in within two working days of first contact	n/a	98.0%	**98.2%**
Proportion of newly diagnosed in primary care seen in an HIV specialist department < 2 weeks of diagnosis	n/a	100%	**100%**
Percentage of patients accessing psychosexual counselling within 18 weeks	n/a	100%	**100%**
% of people with needs relating to STIs recorded as having HIV test at 1st attend (excl already diagnosed)	n/a	80% Q4	**73%**
% chlamydia positive patients	n/a	>= 5%	**Green**

Key: Red = target not achieved, Green = target achieved

The Trust met 94% of all contracted targets for services commissioned by Suffolk County Council in 2014/15.

All other performance targets were met in 2014/15

- Remedial action plans continue to be maintained for the above to deliver improved performance to meet targets in future months.
- HIV testing is offered as normal practice to all patients attending the service. Work is being undertaken to improve the quality of recording. Data quality reports have been written and distributed to ensure data compliance.

Commissioner - Peterborough City Council

Key performance targets	2013/14 Actual	2014/15 Target	2014/15 Actual
% of people with STI needs offered appointment or walk in within two working days of first contact	n/a	98%	**98.0%**
% of people with STI needs offered HIV test at first attendance (excl. those already diagnosed with HIV)	n/a	97%	**92.0%**
% of women with emergency/urgent contraceptive needs offered access on the same working day	n/a	95%	**100.0%**
% of people experiencing waiting times of less than two hours in walk in services	n/a	75%	**100.0%**
% chlamydia positive patients receiving treatment within six weeks of test date	n/a	95%	**96.0%**

Key: Red = target not achieved, Green = target achieved

The Trust met 84% of all contracted targets for services commissioned by Peterborough County Council in 2014/15.

Other performance targets not met	2014/15 Target	2014/15 Actual	Variance
% of people with contraceptive needs offered appointment to be seen within two working days of first contact	95%	69.0%	**Significant**
% of women offered access to Long Acting Reversible Contraceptives (LARC) method of choice within 10 working days/ two calendar weeks of first contact (where medically appropriate)	90%	81.0%	**Significant**

- Remedial action plans continue to be maintained for the above to deliver improved performance to meet targets in future months
- Work is being undertaken to improve the quality of recording. HIV tests are routinely offered to patients with sexual health needs within the service. Data quality reports have been written and distributed to ensure data compliance
- Staffing issues have significantly contributed to reduced access to both general appointments within 48 hours and Long Acting Reversible Contraceptives (LARC) appointments within two weeks. Additional clinics are being added as the current staffing allows, and a new clinic timetable and staff schedule model is being progressed to ensure sufficient capacity in future.

STRATEGIC OBJECTIVE 5

Finance: To achieve a contract model that links activity to payment in 2015/16

The Trust has historically been paid on a block contract. This means the income is fixed, irrespective of demand for patient care and the costs incurred. During 2014/15, the Trust had to invest in many older people's services to fund extra staffing to ensure the demand for care and nationally set safer staffing requirements were met.

Over the past year, the Trust has ensured that any new contracts won through a tender process i.e. drug and sexual health services, had explicit activity thresholds linked to the price of the contracts.

In 2015/16 the Trust has committed to establish a shadow tariff for outpatients activity with the Cambridgeshire and Peterborough Clinical Commissioning Group.

A move away from the block contract model will ensure that the Trust is funded for the activities it carries out, rather than the current contract model, which results in under-funding in services where activity is higher than the financial ceiling of the contract.

STRATEGIC OBJECTIVE 6

Sustainability: To be recognised as a provider of safe and innovative services that help commissioners achieve their outcomes

In addition to the contracts won during 2013/14 for sexual health services across Cambridgeshire and Peterborough, and drug services in Luton, our portfolio of specialist services continued to expand this year.

As a result of submitting strong and compelling cases, reflecting our specialist knowledge, expertise and history, we were delighted to win contracts during 2014/15 to provide:

- integrated contraception and sexual health services across Norfolk from March 2015
- integrated contraception and sexual health services in Suffolk from May 2015 (an expansion of an existing contract)
- provide the school immunisation programme across Cambridgeshire, Peterborough, Norfolk and Suffolk from September 2015.

In April 2015, we were also successfully awarded the contract to provide the 0-19 Healthy Child Programme across Norfolk from October 2015.

These multi-million pound contracts were each for periods of between three and five year periods (with opportunities to extend), bringing additional resources and longer term security into the Trust. This was welcome news for both staff and patients and creates additional opportunities for longer term planning and sustainability.

The Trust was not awarded the contracts to provide adult and older people's services across Cambridgeshire and Peterborough and intermediate care services in Luton, which transferred out of the Trust on 1 April 2015.

Luton based children's and adults' services were due to transfer to a new employer in June 2015 but we are pleased to confirm will now remain with CCS NHS Trust following the relevant commissioner's cancellation of this procurement process.

The Trust's annual budget for 2014/15 was £160 million. Our annual budget for 2015/16 started at £76 million increasing to circa £116 million by October 2015 (full year effect) as a result of winning the procurements outlined earlier.

In line with our five year plan, during 2015/16 we will continue to submit bids to expand the geographic area across which we provide the small set of high quality, specialist services that make up the majority of our portfolio from June 2015. This will enable other commissioners and populations to benefit from our expertise in providing these services, which focus on health promotion and prevention of ill health.

Strategic Report

The narrative outlined above meets all the requirements and disclosures of Strategic Reports as required by the Companies Act 2006.

Sustainability Report

(not subject to audit)

The Trust recognises that its actions as an organisation have an impact on the local, regional and global environment. We are committed to continuous improvement in environmental performance and the prevention of any actions that may cause damage to, or do not support attempts to improve the sustainability of the environment.

We operate an Environmental Management System that meets the requirements of the Government's Sustainable Development Strategy ('Securing the Future') which commits the public sector to lead by example in delivering the following objectives:

- effective protection of the environment
- prudent use of natural resources
- social progress which recognises the needs of everyone
- maintenance of high and stable levels of economic growth and employment.

The Trust complies with environmental regulations, legislation, directives and codes of practice.

Looking forward, during 2015/16 we aim to:

- review and implement the Trust's sustainable development management plan
- introduce sustainability champion roles across the organisation
- maintain a range of policies and an annual action plan to monitor sustainability and environmental impact targets and standards including staff and client travel, waste management, and energy consumption
- utilise the Good Corporate Citizenship model to assess the sustainability of the organisation and identify areas of strength and those in need of improvement
- incentivise the use of low-emission vehicles via our local expenses policy, seek to operate a staff travel card loan and bike purchase schemes and encourage employees to access them
- utilise mobile working technology and intelligent route planning to minimise business travel, together with video and audio conferencing
- operate local recycling schemes at the majority of our offices
- purchase fairly traded produce where possible.

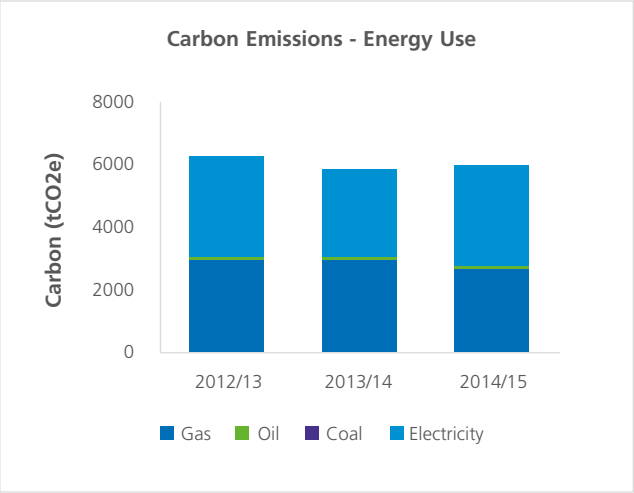
The detail of the Trust's carbon footprint is set out in the table below.

CCS NHS TRUST Category	GHG Protocol Scope	Measure	2007/ 2008	2008/ 2009	2009/ 2010	2010/ 2011	2011/ 2012	2012/ 2013	2013/ 2014	2015 Target	2014/ 2015 Actual
Gas	1	Tonnes CO_2e	3,423	3,828	3,524	3,653	2,380	2,967	2935	3,081	2727
Oil	1	Tonnes CO_2e	37	37	37	38	27	27	38	33	34
Electricity	2	Tonnes CO_2e	2,762	3,078	3,274	3,120	2,466	3,263	3159	2,486	3242
Water	3	Tonnes CO_2e	8	9	9	11	8	8	10	7	9
Sewage	3	Tonnes CO_2e	17	19	19	24	17	17	22	15	20
Waste	3	Tonnes CO_2e	204	204	204	279	186	188	178	184	38
Business travel	1	Tonnes CO_2e	1,407	1,439	1,561	1,646	1,339	1,409	1,351	1,266	1213
Employee commute	3	Tonnes CO_2e	628	524	590	597	759	689	666	565	666
Total		**Tonnes CO_2e**	**11,437**	**9,661**	**10,031**	**9,528**	**7,035**	**8,439**	**8,211**	**10,294**	**7950**
Estate CO_2e		CO_2e	9,402	7,697	7,880	7,285	4,937	6,342	6,194	0	6,070
Size of estate		m^2	51,636	52,497	53,177	54,241	59,323	71,057	60,679	0	60,679
Carbon efficiency		$kgCO_2e/m2$	182	147	148	134	83	89	102	0	100

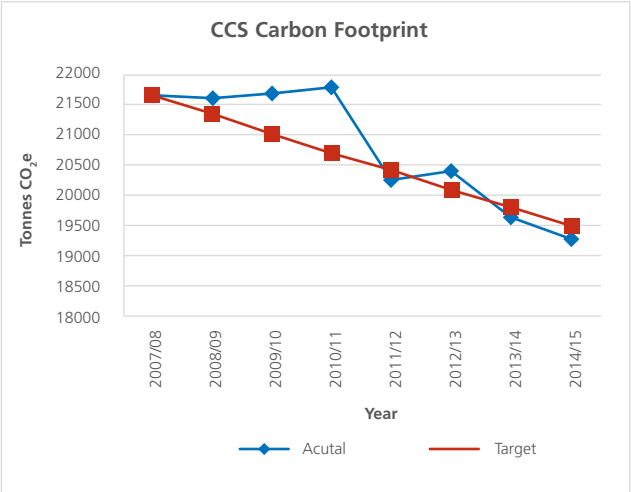
More detailed sustainability reporting, inline with the Sustainability Development Unit's template for 2014/15 follows.

Energy Usage and Expenditure

There was a slight increase on energy usage in 2014/15 when compared to 2013/14 as shown in figure one below:



Energy carbon emissions versus 2015 target are illustrated in the table below:



Spend on energy was slightly higher in 2014/15 than in 2013/14 as shown in the table below.

Resource		2012/13	2013/14	2014/15
Gas	Use (kWh)	14843638	13990618.5	12998876
	tCO_2e	3033.29743	2967.9698	2727.20322
Oil	Use (kWh)	144446	118896.298	125989
	tCO_2e	46.0566071	37.9695328	40.3189247
Coal	Use (kWh)	0	0	0
	tCO_2e	0	0	0
Electricity	Use (kWh)	5598581	5100268.47	5234166
	tCO_2e	3195.72602	2855.69132	3241.67603
Total Energy CO_2e		**6275.08005**	**5861.63065**	**6009.19817**
Total Energy Spend		**£ 867,749**	**£ 877,584**	**£ 880,435**

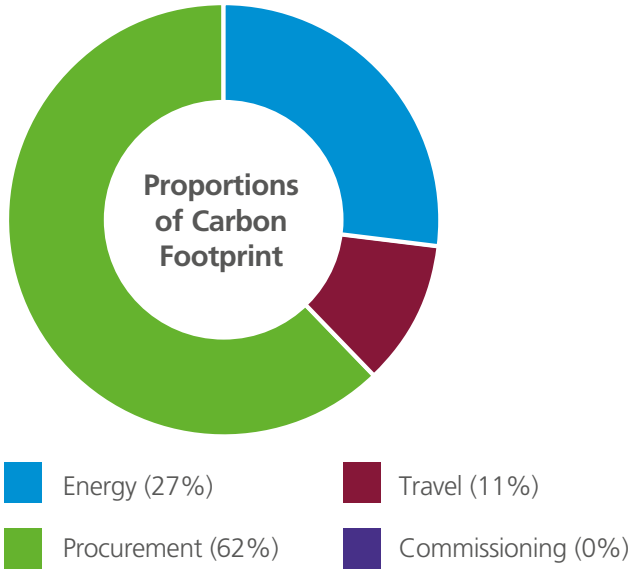
Recycling and Waste

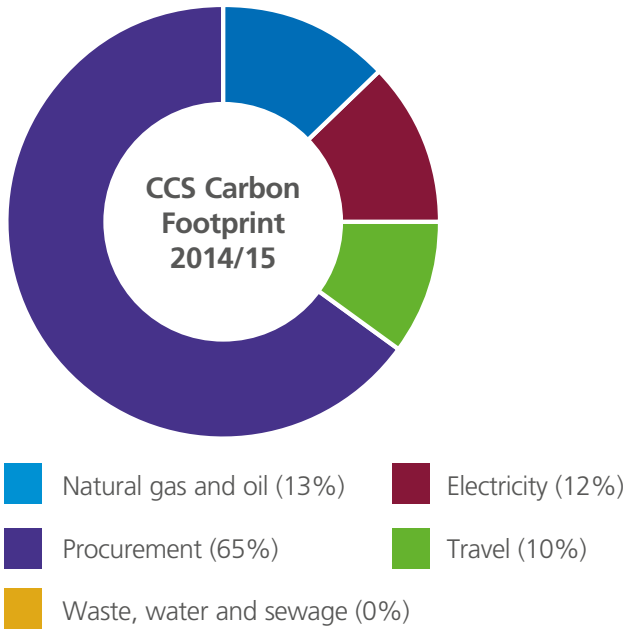
The table below shows that the volume of waste generated in 2014/15 slightly increased when compared with 2013/14.

Waste		2012/13	2013/14	2014/15
Recycling	(tonnes)	202.00	188.00	180.00
	tCO_2e	4.24	3.95	3.78
Re-use	(tonnes)	0.00	0.00	0.00
	tCO_2e	0.00	0.00	0.00
Compost	(tonnes)	0.00	0.00	0.00
	tCO_2e	0.00	0.00	0.00
WEEE	(tonnes)	2.00	2.00	2.00
	tCO_2e	0.04	0.04	0.04
High Temp recovery	(tonnes)	0.00	0.00	0.00
	tCO_2e	0.00	0.00	0.00
High Temp disposal	(tonnes)	103.00	93.00	98.00
	tCO_2e	22.66	20.46	21.56
Non-burn disposal	(tonnes)	0.00	0.00	0.00
	tCO_2e	0.00	0.00	0.00
Landfill	(tonnes)	192.00	152.00	150.00
	tCO_2e	46.93	37.15	36.66
Total Waste (tonnes)		**499.00**	**435.00**	**430.00**
% Recycled or Re-used		**40%**	**43%**	**42%**
Total Waste tCO_2e		**73.87**	**61.60**	**62.04**

Modelled Carbon Footprint

The information provided in the previous sections of this sustainability report uses the ERIC returns as its data source. However, we are aware that this does not reflect our entire carbon footprint; in particular the carbon footprint associated with procurement is outside the scope of the Trust's 2015 target. Therefore, the following information uses a scaled model based on work performed by the NHS Sustainable Development Unit (SDU) in 2009/10 to illustrate the entirety of the Trust's carbon footprint. The proportions are consistent with national modelling expectations.





Patient Stories

One sport, 9 days and one excited physio

Rugby teams competing in the Commonwealth Games were in the caring hands of one of the Trust's Luton based physiotherapists.

Louise Armstrong, from the Community Assessment and Rehabilitation Team (CART) was accepted to be one of the first contact physios at the games in Glasgow in August 2014. This involved general sport physiotherapy, which was mainly strapping of joints, injury assessment on the field and referral to the Commonwealth Village Polyclinic for further input where required.

Louise worked with six teams from around the world - England, Wales, Canada, Trinidad & Tobago, Papua New Guinea and Barbados. She said: "I had a brilliant time, so much so I'm hoping to head off to Rio 2016 to work for the Olympics!

"One of my best bits would have to be having some fun and laughs with the Barbados rugby team, who would bring me stashes of Iron Bru from the Commonwealth Village because they found out I was partial to it."

Although she didn't get to see any of the competition games, Louise watched training games from the best seat in the house, standing at the touch line.

The advert asking for volunteers appeared in the Chartered Society of Physiotherapists magazine last year and Louise applied for the opportunity on a whim. She said: "It was just like applying for a job; I filled in the forms and had an interview. I feel immensely proud and honoured to have been picked. There were so many people that applied and just to be part of that small amount chosen I feel very grateful."

"I get to say that I was part of the Commonwealth Games."

Looking to the future

Our objectives for 2015/16 are as follows and have formed the basis of the longer term plan we submitted to the Trust Development Authority in June 2014:

- **Quality:** To be recognised as a provider of safe and effective services that people want to use
- **Quality:** To collaborate with organisations to improve the care given to people who use our services
- **People:** To ensure that the Trust attracts and retains a quality workforce
- **Finance:** To be a financially sound organisation
- **Finance:** To achieve a contract model that links activity to payment (e.g. we receive payment for what we provide)
- **Sustainability:** To be recognised as a provider of safe and innovative services that help commissioners achieve their outcomes.

These objectives will be governed through three broad work streams:

1. Sustaining and Developing Quality Care comprising:

- **Quality:** developing our safety culture (including joining the 'Sign up to Safety' campaign from April 15), improving our CQC rating from 'Good' to 'Outstanding' (our next inspection is anticipated in 2017)
- **Children's Services:** implementing at last three initiatives in collaboration with other providers, extending mobile working, establishing a single point of access
- **Musculoskeletal Services:** establishing novel integrated pathways in partnership with Peterborough and Stamford Hospitals NHS Foundation Trust
- **Integrated Contraception and Sexual Health Services:** implementing a new service model and service-wide infrastructure across the Trust.

2. Future Form comprising:

- pursuing and implementing the Trust's decision on its proposed future form
- right-sizing the Trust and infrastructure to reflect our smaller size
- development and implementation of an organisational development plan.

3. Business Development:

- pursuing business development opportunities
- tailored development of specific services where we have a proven track record
- growing our revenue and operating increasingly on a regional and pan-regional basis.

Underpinning strategies

The following work programmes will underpin the successful delivery of our objectives:

- quality (see page 25)
- workforce, organisational development and transformation (see page 32)
- information and technology, which focusses on the following four work programmes:

  - implementing the Trust Information Systems Delivery Model e.g. rolling out Trust-wide mobile working and specific network upgrades

  - supporting 'business as usual' including asset reconciliation, desktop refresh and centralised IT procurement

  - creating an IM&T capability within the Trust.
- communication which focusses on the following six work programmes:

  - promoting the quality of services to build brand strength and reputation

  - enhancing the Trust's reputation through promoting successful collaboration

  - implementing vibrant staff communication and engagement mechanisms

  - ensuring key programmes of work are clinically led and informed by robust stakeholder engagement

  - providing specialist communication support as required to achieve a contract model that links activity to payment

  - producing communication plans for all bid submissions.

Contract services for 2015/16

Our contracts for services with commissioners covering Cambridgeshire, Luton, Norfolk, Peterborough and Suffolk set out ambitious objectives and targets for the coming year. We have every expectation of achieving these, ensuring that local people are able to access services that promote healthier lives closer to home.

Financial outlook

Since establishment in 2010, the Trust has each year operated to create a financial surplus for re-investment in our services.

The changing commissioning landscape is providing opportunities for the Trust to pursue new service development opportunities, particularly in our specialist areas of expertise of health promotion and prevention.

The financial plan for 2015/16 assumes:

- the transfer out of adult and older peoples services in Cambridgeshire and Peterborough and all community health services in Luton*
- the transfer in of sexual health services in Norfolk, expanded sexual health services in Suffolk and the 0-19 Healthy Child Programme services in Norfolk
- other services are retained.

The Cost Improvement Plan target will be circa £3.7 million for the year. Savings initiatives will be focussed on enabling our workforce to work efficiently, increased productivity, securing additional income for existing and future contract service activities, increasing estates utilisation and targeting procurement price and volume opportunities. Cost Improvement Plans are subject to quality impact assessment and internal approval mechanisms.

**The financial plan for 2015/16 has subsequently been updated to reflect that Luton community health services remain with the Trust.*

Directors' Report 2014/15

Board of directors

How is Cambridgeshire Community Services NHS Trust governed?

The Trust's Board of executive and non-executive directors is responsible for overseeing the development of strategic direction and compliance with all governance, probity and assurance requirements. Membership of some of the Board subcommittees changed during the year as reflected in the table below.

The Trust's Charitable Funds Committee existed under the delegated authority of the Trust Board up until December 2014, when direct registration with the Charity Commission meant all Board members became Trustees of the charitable fund. In addition, the Public Involvement and Patient Experience Committee met only once in the year (April 2014) before it was disbanded. The Ambulatory Clinical Operational Board was constituted in October 2014 and the Adults and Older People Clinical Operational Board met until March 2015 when it was disbanded in line with the transfer of these services out of the Trust.

Names	Title	Sub Committee Membership (* Denotes Chair of that Committee)
Heather Peck	Chairman (until 31.12.2014)	Quality Improvement & Safety, Remuneration, Strategic Change Board*, Public Involvement and Patient Experience (PIPE), Charitable Funds, Adults & Older People Clinical Operational Board, Luton Clinical Operational Board, Children's Clinical Operational Board.
Nicola Scrivings	Non Executive Director (until 31.12.2014) Chairman (from 01.01.2015)	Strategic Change Board (*member until 12.14, Chair from 01.15), Estates, Remuneration, Ambulatory Clinical Operational Board, Luton Clinical Operational Board, Adults & Older People Clinical Operational Board (until 10.14).
Mike Hindmarch	Non Executive Director	Audit *, Remuneration, PIPE, Adults & Older People's Clinical Operational Board, Charitable Funds.
Peter Sulston	Non Executive Director (until 31.12.2014)	Estates *, Remuneration*, Luton Clinical Operational Board*, Strategic Change Board.
Trish Davies	Non Executive Director	Quality Improvement & Safety (* Chair until 03.15, member from 04.15), Audit, Children's Clinical Operational Board*.
Julie Goldsmith	Non Executive Director	Strategic Change Board (from 01.15), Audit, Quality Improvement & Safety, PIPE, Ambulatory Clinical Operational Board, Adults and Older People's Clinical Operational Board (member from 10.14, Chair between 01.15 and 03.15).
Gill Thomas	Non Executive Director (from 01.01.2015)	Strategic Change Board, Estates*, Remuneration (* from 01.15).

Names	Title	Sub Committee Membership (* Denotes Chair of that Committee)
Anne McConville	Non Executive Director (from 01.01.2015)	Quality Improvement & Safety (member from 01.15, Chair from 04.15), Ambulatory Clinical Operational Board.
Scott Haldane	Director of Finance and Resources (until 31.12.2014)	Estates, Audit (in attendance only), Strategic Change Board, A&O Clinical Operational Board, Children's Clinical Operational Board, Charitable Funds.
Kevin Orford	Interim Director of Finance and Resources (from 12.01.2015)	Strategic Change Board, Audit (in attendance only), Estates, Children's Clinical Operational Board.
Anita Pisani	Deputy Chief Executive and Director of Workforce & Service Redesign	Quality Improvement & Safety, Strategic Change Board, PIPE, Luton Clinical Operational Board, Ambulatory Clinical Operational Board, Remuneration (in attendance for relevant discussions only), Children's Clinical Operational Board (until 10.14).
Mandy Renton	Chief Nurse	Quality Improvement & Safety, Estates, Strategic Change Board, PIPE, Adults & Older People's Clinical Operational Board, Children's Clinical Operational Board, Charitable Funds.
David Vickers	Medical Director	Quality Improvement & Safety, Charitable Funds, Strategic Change Board, Luton Clinical Operational Board, Estates (until 12.14).
Matthew Winn	Chief Executive	Strategic Change Board, Remuneration (in attendance for relevant discussions only), Audit (in attendance only), Adults & Older People's Clinical Operational Board, Ambulatory Clinical Operational Board.

Record of attendance

The following table sets out the number of meetings attended by each Board member during 2014/15. It should be noted that non executive director membership of the Board changed during the year as terms of office concluded.

Membership of Board sub-committees also changed to reflect the Trust's new portfolio of services. These changes are reflected in the attendance levels shown below indicating that individuals may not have been members of sub committees for the full year.

Name and Position	Board **	Audit Committee	Quality Improvement & Safety Committee	Remuneration Committee	Charitable Funds Committee	Patient & Public Involvement Committee	Estates Committee	Strategic Change Board	Ambulatory Clinical Operational Board	Children's Clinical Operational Board	Adults & Older People Clinical Operational Board	Luton Clinical Operational Board
Heather Peck, Chairman (until 31.12.14)	8(9)		5		3		1	6		8	5	1
Mike Hindmarch (NED)	11(12)	4			2						8	
Peter Sulston (NED) (until 31.12.14)	7(9)	1			3		2	5				7
Trish Davies (NED)	11(12)	2	5						1	10		1
Julie Goldsmith (NED)	10(12)		5		2	1	1	3	3	6	2	1
Nicola Scrivings (NED until 31.12.14, Chairman from 01.01.15)	12(12)	3	2					6	5	2	4	4
Anne McConville (NED from 01.01.15)	2(3)		1						1			
Gill Thomas (NED from 01.01.15)	3(3)		1					2	1		1	
Scott Haldane (Finance Director until 31.12.14)	9 (9)	4			3		2	5	1	1	4	
Kevin Orford (Interim Director of Finance from 12.01.15)	3(3)	1	1					2	1	2	1	
Anita Pisani (Deputy Chief Executive)	11(12)		2					6	4	2		7
Mandy Renton (Chief Nurse)	11(12)	1	4		2	1	2	7		8	2	
David Vickers (Medical Director)	9(12)		4				2	4		3		7
Matthew Winn (Chief Executive)	11(12)	1			2			3	4	2	4	

*** Figures in brackets show total number of Board meetings members could have attended in year.*

Compliance statement

A register of directors' interests for the Trust is maintained and is available on the Trust's website or available on request by contacting our Chief Executive's office on 01480 308223. No Trust Board members hold a company directorship with companies who are likely to do business or are seeking (or may seek) to do business with the NHS.

The Trust has undertaken the necessary action to evidence that each director has stated, that as far as he/she is aware, there is no relevant audit information of which the NHS body's auditors are unaware and he/she has taken all the steps that he/she ought to have taken as a director, in order to make themselves aware of any relevant audit information, and to establish that the NHS body's auditors are aware of that information.

Patient Stories

Trust delighted with Care Quality Commission seal of approval for treating people with compassion, dignity and respect

Our community health services were assessed as good by the Care Quality Commission (CQC) following a comprehensive inspection in May 2014.

Inspectors found patients of the Trust were consistently treated with compassion, dignity and respect. Patients were also positive about the experience of receiving care from our services.

Matthew Winn, chief executive of the Trust said: "The Trust Board is delighted with the findings of the Care Quality Commission's recent comprehensive inspection. Overall, the CQC assessed our services as good and found a wide range of evidence that showed how our dedicated staff consistently provided high quality care to patients.

"Inspectors also found many examples of very good patient focussed multi-disciplinary working, alongside initiatives to support people at home and avoid patients being admitted to hospital."

The inspection grouped the services provided by the Trust into five areas and these were reviewed against five key questions; whether they were safe, effective, caring, responsive and well-led.

Commenting on the findings of the inspection, Mandy Renton, chief nurse at the Trust added: "A clear picture of safety was evidenced across most services and care and treatment provided was found to be effectively meeting the needs of patients, families and carers. Two pre-existing CQC compliance issues (assessing and monitoring the quality of services at HQ and staffing levels on our children's inpatient ward on the Hinchingbrooke Hospital site) were both assessed as compliant."

"This is fantastic validation for staff and reflects the CQC's findings of good clinical leadership throughout the Trust."

Remuneration Report 2014/15

Membership of the Remuneration, Terms of Service and Nominations Committee (not subject to audit)

Name	Position
Peter Sulston	Non Executive Director (Chair of the Committee)
Michael Hindmarch	Non Executive Director
Heather Peck	Chairman of the Board
Matthew Winn	Chief Executive (in attendance for relevant discussions only).
Anita Pisani	Deputy Chief Executive (in attendance for relevant discussions only).

Policy on the remuneration of senior managers

For the purposes of the remuneration report the Chief Executive considers the executive and non-executive directors of the Trust to be 'senior managers'.

Remuneration payments made to the non-executive directors are set nationally by the Secretary of State. The remuneration of executive directors is set by the remuneration committee. The committee considers comparative salary data, benchmarking information for similar organisations and labour market conditions in arriving at its final decision. All executive directors are employed on permanent contracts with the Trust.

No remuneration was waived by members and no compensation was paid for loss of office during the financial year ended 31 March 2015. No payments were made to co-opted members and no payments were made for golden hellos. The Trust does not have any staff members on performance related pay systems.

Where national review bodies govern salaries, then the national rates of increase have been applied. Where national review bodies do not cover staff, then increases have been in line with the percentage notified by the NHS chief executive and approved by the remuneration committee.

The remuneration committee takes the financial circumstances of the organisation into consideration in making pay awards, as well as advance letters of advice from the Department of Health. All uplifts were discussed with and decided by the remuneration committee, which is supported by a human resource (HR) professional.

Policy on performance conditions

The Trust's annual objectives are set through the annual business planning cycle. The Trust's chairman then agrees these objectives with the Chief Executive whose performance is monitored via monthly one-to-one meetings. The Chief Executive agrees his objectives with the Trust's executive directors and holds similar monthly one-to-ones to manage their performance. The Chairman also holds bi-monthly performance meetings with each of the executive directors.

Policy on duration of contracts, notice periods and termination payments

Executive directors' contracts are subject to three months' contractual notice. Termination payments are made in accordance with NHS policy.

Service Contracts (not subject to audit)

Details of remuneration payable to the senior managers of Cambridgeshire Community Services NHS Trust in respect of their services for the year ended 31 March 2015 are given in the tables on the following four pages.

Name	Position	Date of contract	Unexpired term (if applicable)	Early termination terms	Notice Period
Matthew Winn	Chief Executive	01/04/2010	N/A	N/A	3 months
David Vickers	Medical Director	01/04/2010	N/A	N/A	3 months
Scott Haldane	Director of Finance & Resources	01/12/2012	Left 31/12/2014	N/A	3 months
Anita Pisani	Director of Workforce and Transformation & Deputy CEO	01/06/2012	N/A	N/A	3 months
Mandy Renton	Chief Nurse	23/01/2012	N/A	N/A	3 months
Kevin Orford	Interim Director of Finance & Resources	Jan 2015	April 2015	N/A	1 month

Patient Stories

CCS team named finalists in innovation awards

One of our teams celebrated being named finalists in the 2014 Innovation Competition orgainised by Health Enterprise East, a leading NHS innovation hub. Dr Stephen Barclay and his team were recognised in the software/ICT/assistive technology category for data sharing in end of life care.

Jane Crawford-White, clinical systems programme lead said: "We were delighted to be recognised as finalists in Health Enterprise East's Innovation Awards. The electronic record system we have introduced is designed to provide better care for patients approaching the end of their lives, transforming the way information is shared (with patient consent) and ensuring that care needs and preferences are known by all the professionals involved, enabling informed decisions in line with the patient's wishes."

As of July 2014, more than 800 patients had data shared through the project, from more than 70 GP practices, most district nursing teams, all local hospices and all community palliative care teams. Also, more than 320 health professionals, primarily district nurses, GPs and out of hours clinicians, have been trained in the use of the data sharing template and associated aspects of end of life care.

The NHS Innovation Awards Ceremony was hosted by BBC Look East presenter Susie Fowler-Watt on 24 September at Girton College, Cambridge.

Remuneration 2014/15 (subject to audit)

Name	Position	2014/15				
		Salary (bands of £5,000)	Expense Payments (taxable) total to nearest £100	Bonus Payments (bands of £5,000)	All pension related benefits (bands of £2,500)	Total (bands of £5,000)
Heather Peck	Chair (to 31st December 2014)	15 - 20	0	0	0	15 - 20
Peter Sulston	Non Executive Director (to 31st December 2014)	0 - 5	0	0	0	0 - 5
Nicola Scrivings	Non Executive Director (to 31st December 2014, Chair from 1st January 2015	10 - 15	0	0	0	10 - 15
Julie Goldsmith	Non Executive Director	5 - 10	0	0	0	5 - 10
Mike Hindmarch	Non Executive Director	5 - 10	0	0	0	5 - 10
Trish Davies	Non Executive Director	5 - 10	0	0	0	5 - 10
Dr Gillian Thomsa	Non Executive Director (from 1st January 2015)	0 - 5	0	0	0	0 - 5
Anne McConville	Non Executive Director (from 1st January 2015)	0 - 5	0	0	0	0 - 5
Matthew Winn	Chief Executive	130 - 135	0	0	2.5 - 5	135 - 140
David Vickers	Medical Director *	125 - 130	0	35 - 40	0	160 - 165
Scott Haldane	Director of Finance and Resources (to 31st December 2014)	75 - 80	0	0	7.5 - 10	80 - 85
Kevin Orford	Interim Director of Finance and Resources (from 12th January 2015)	40 - 45	0	0	0	40 - 45
Anita Pisani	Deputy Chief Executive & Director of Workforce and Transformation	95 - 100	0	0	0	95 - 100
Mandy Renton	Chief Nurse	95 - 100	0	0	20 - 22.5	115 - 120
		2013/14				
Heather Peck	Chair	20 - 25	0	0	0	20 - 25
Peter Sulston	Non Executive Director	5 - 10	0	0	0	5 - 10
Gary Norgate	Non Executive Director (to 30th September 2013)	0 - 5	0	0	0	0 - 5
Nicola Scrivings	Non Executive Director	5 - 10	0	0	0	5 - 10
Julie Goldsmith	Non Executive Director	5 - 10	0	0	0	5 - 10
Mike Hindmarch	Non Executive Director	5 - 10	0	0	0	5 - 10
Trish Davies	Non Executive Director	5 - 10	0	0	0	5 - 10
Matthew Winn	Chief Executive	125 - 130	0	0	7.5 - 10	135 - 140
David Vickers	Medical Director *	125 - 130	0	35 - 40	52.5 - 55	215 - 220
Scott Haldane	Director of Finance and Resources	95 - 100	0	0	20 - 22.5	120 - 125
Anita Pisani	Deputy Chief Executive & Director of Workforce and Transformation	90 - 95	0	0	20 - 22.5	115 - 120
Alison Gilbert	Director of Clinical Delivery (to 31st October 2013, on secondment March to October 2013)	50 - 55	0	0	0	50 - 55
Mandy Renton	Chief Nurse	90 - 95	0	0	0	90 - 95

** David Vickers is employed as both a paediatric consultant and medical director at the Trust. His "salary" includes his role as a paediatric consultant (£95,000 - £100,000). His "bonus payments" reflect his clinical excellence award payments.*

The Trust does not make any payments to directors based on the financial performance of the Trust.

Salary and other remuneration exclude the employer's pension contributions and is gross of pay charges to other NHS Trusts.

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director and the median remuneration of the organisation's workforce.

The mid-point of the banded remuneration of the highest paid director in 2014/15 was £166,351 (2013/14 comparator £165,336). This was 6.45 times the median remuneration of the workforce (subject to audit), which was £25,783 (2013/14 comparator was 6.67 times the median remuneration of the workforce which was £24,779). Remuneration ranged from £12,692 to £130,000. See the salaries and allowances table on the previous page for details of the highest paid director.

The calculation was based on staff employed in substantive and bank contracts as at 31 March 2015, sorted by full time equivalent salary value, and then taking the middle employee from this list.

In 2014/15, 0 employees (2013/14 comparator 0 employees) received remuneration in excess of the highest paid director.

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

No payments were made in respect of 'golden hellos' or compensation for loss of office.

No compensation payments were made to a third party for the services of an executive director or non-executive director.

Review of Tax Arrangements of Public Sector Appointees (not subject to audit)

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

	Number
Number of existing engagements as of 31 March 2015	2
Of which, the number that have existed:	
for less than one year at the time of reporting	4
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	1*
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

**This engagement ceased in October 2014.*

The Trust has undertaken a risk-based assessment as to whether assurance is required that the individual is paying the correct amount of tax and NI. The Trust has concluded that the risk of significant exposure in relation to these individuals is minimal.

For all new off-payroll engagements between 1 April 2014 and 31 March 2015, for more than £220 per day and that last longer than six months:

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

Four engagements were entered into without contractual clauses allowing us to seek assurance as to their tax obligations. Three of the engagements are through a third party recruitment agency and one through their own private limited company. Therefore, assurance has not been requested and received in this regard.

Signed: 

Matthew Winn, Chief Executive

2 June 2015

Pension Benefits - 2014/15 (subject to audit)

Name	Position	2014/15							
		Real Increase in pension at age 60 (bands of £2,500) £'000	Real Increase in lump sum at age 60 (bands of £2,500) £'000	Total accrued pension at age 60 at 31 March 2015 (bands of £5,000) £'000	Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 31 March 2015 £'000	Cash Equivalent Transfer Value at 1 April 2014 £'000	Real Increase in Cash Equivalent Transfer Value £'000	Employer's contribution to stakeholder pension £'000
Matthew Winn	Chief Executive	0 - 2.5	2.5 - 5	20 - 25	70 - 75	366	332	25	N/A
David Vickers	Medical Director	0 - 2.5	0 - 2.5	50 - 55	160 - 165	1,163	1,095	38	N/A
Anita Pisani	Director of Workforce and Transformation	0 - 2.5	0 - 2.5	25 - 30	75 - 80	411	381	19	N/A
Mandy Renton	Chief Nurse	0 - 2.5	2.5 - 5	30 - 35	95 - 100	631	574	42	N/A
Scott Haldane	Director of Finance (to 31st Dec 2014)	0 - 2.5	0 - 2.5	0 - 5	0 - 5	40	30	10	N/A

Prior Year - Pension Benefits - 2013/14

Name	Position	2013/14							
		Real Increase in pension at age 60 (bands of £2,500) £'000	Real Increase in lump sum at age 60 (bands of £2,500) £'000	Total accrued pension at age 60 at 31 March 2015 (bands of £5,000) £'000	Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 31 March 2015 £'000	Cash Equivalent Transfer Value at 1 April 2014 £'000	Real Increase in Cash Equivalent Transfer Value £'000	Employer's contribution to stakeholder pension £'000
Matthew Winn	Chief Executive	0 - 2.5	2.5 - 5	20 - 25	65 - 70	332	269	58	N/A
David Vickers	Medical Director	2.5 - 5	7.5 - 10	50 - 55	155 - 160	1,095	980	94	N/A
Alison Gilbert	Director of Clinical Delivery (to 31st October 2013, on secondment March to October 2013)	0 - 2.5	0 - 2.5	25 - 30	75 - 80	437	411	16	N/A
Anita Pisani	Director of Workforce and Transformation	0 - 2.5	2.5 - 5	20 - 25	70 - 75	381	315	59	N/A
Mandy Renton	Chief Nurse	0 - 2.5	0 - 2.5	30 - 35	90 - 95	574	537	25	N/A
Scott Haldane	Director of Finance (from 1st Dec 2012)	0 - 2.5	0 - 2.5	0 - 5	0 - 5	30	7	22	N/A

“I enjoy working in the local community and helping a wide variety of people.

We have a great team spirit and a good support network, so you are never alone.”

Rosie McAvoy

Senior Health and Social Care Assistant
Intermediate Care

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

The Chief Executive of the NHS 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 Department of Health. These include ensuring that:

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

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

Signed: 

Matthew Winn, Chief Executive

2 June 2015

Patient Stories

New one stop clinics buck the trend in Norfolk

New clinics broke from tradition to offer contraception and sexual health services in one place for the first time in Norfolk, starting with Norwich on 1 April 2015. The new premises in Oak Street, brings together existing contraception, genitourinary medicine (GUM) and HIV services, currently based at Grove Road Clinic and Norfolk and Norwich University Hospitals. Two further hubs in King's Lynn and Great Yarmouth will be opening over the next year, however until then services will continue to be delivered from existing location.

iCaSH (integrated Contraception & Sexual Health) Norfolk is the new contraception and sexual health service for Norfolk - provided by Cambridgeshire Community Services NHS Trust on behalf of Norfolk County Council Public Health. It provides all aspects of sexual health, including contraception, sexually transmitted infection (STI) testing & treatment and HIV care and treatment which will be available from easily accessible single locations across Norfolk.

Mike Passfield, head of sexual health services, Cambridgeshire Community Services NHS Trust said: "Traditionally, sexual health services have been split into contraceptive or genitourinary medicine (GUM) services. This means that someone needing contraception who also has STI symptoms must go to separate appointments at different locations, which may stop some people getting all the advice and support they need, because they cannot or don't want two appointments.

"We're delighted that we can bring together community and hospital sexual health services across Norfolk for the first time, where someone can have all their sexual health and contraceptive needs met in one place by one clinician wherever possible."

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;
- 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.

By order of the Board

Chief Executive

2 June 2015

Finance Director

2 June 2015

Annual Governance Statement

Scope of responsibility

The Board of Directors (the Board) is accountable for risk management and internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of risk management and internal control that supports the achievement of the organisation's policies, aims and objectives. This includes counter-fraud and bribery, external audit, internal audit, and internal financial control.

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.

As the Accountable Officer, I ensure the organisation works effectively, in collaboration with the Trust Development Authority, local authorities, local primary care, NHS and Foundation Trusts. I and the Trust, actively participate in relevant Chief Executive and partner fora, to deliver the expectations as stated in the NHS Constitution.

I acknowledge the Accountable Officer's responsibilities as set out in the Accountable Officer Memorandum and my responsibilities contained therein for the propriety and regularity of public finances in the Trust, for the keeping of proper accounts, for prudent and economical administration, for the avoidance of waste and extravagance, and for the efficient and effective use of all the resources in my charge.

The governance framework of the organisation

The Trust commissioned Deloitte to undertake an external review of the Trust's governance arrangements in January/February 2014. The recommendations from this review have been implemented and reviewed during the course of 2014/15.

The Board is compliant with the main principles of HM Treasury/Cabinet Office Corporate Governance Code:

- **Leadership** - the Board operates as a unitary Board, with clear division of responsibilities between the Chairman of the Board and Chief Executive of the Trust, and appropriate challenge on strategic development
- **Effectiveness** - with re-election and replacement of directors to provide a balance of continuity and fresh challenge, induction, development and review.
- **Accountability** - openly assessing Trust performance and risk in public meetings.
- **Remuneration** - with a formal and transparent procedure for developing Trust policy on executive remuneration.
- **Relations with stakeholders** - maintaining a positive dialogue.

Arrangements are in place for the discharge of statutory functions and these have been checked for any irregularities, and are legally compliant.

The Board's committee structure includes the following sub-committees:

Audit Committee

The Audit Committee has responsibility for providing assurance to the Board that risk is being managed appropriately, maintaining direct oversight of all high level risks, including clinical, generic risks, specific risks arising from the integrated business plan and risks to financial processes and control. It is also responsible for reviewing the effectiveness of risk management arrangements through the internal audit programme and the review of resulting reports. The Board Assurance Framework (BAF) incorporating the Trust's highest risks, is regularly reviewed by the Committee.

The Committee is constituted in accordance with the provisions of the NHS Audit Committee Handbook 2014 and has overseen the audit of 2014/15 accounts, the development of internal and external audit plans and the risk management and internal control processes, including control processes around counter fraud.

During 2014/15, the Committee met four times and in addition to the above, the Committee reviewed all reports from completed internal audit assignments for the 2014/15 work plan, which had been agreed by the Committee at the start of the year. The following table summarises the outcomes from those assignments:

Review Title	IA Assurance Opinion
Estates Management	Insufficient Assurance
Safeguarding	Substantial Assurance
Portable IT Assets	Insufficient Assurance
Backlog Maintenance	Insufficient Assurance
Data Quality	Requires Improvement
IGT – Critical friend style review	No assurance opinion given
IGT – Review of evidence supporting scores	Requires Improvement
Financial Reporting and Budgetary Control	Substantial Assurance
Cost Improvement Plans (CIP's)	Substantial Assurance
Key Financial Systems	Substantial Assurance
Board Governance Assurance Arrangements	Substantial Assurance
Service/Unit Reviews of Personal Files	Substantial Assurance
Locality Reviews – Petty Cash handling	Substantial Assurance

Estates Committee

The Estates Committee has been refreshed in March 2015 with a new Chair and membership to support the Board by ensuring that an Estates Strategy is developed and implemented. It also ensures that there are effective structures and systems in place to support the continuous improvement of the Trust's estate, that our estate is statutorily compliant and that it supports quality services and safeguards high standards of patient care. The Committee will also advise the Board on Trust compliance with health and safety and sustainability requirements and provides an effective reporting, escalation and engagement route for key groups with estates services to the Trust and commissioners and the corresponding return of information. The corporate risk register (estates risks) is reviewed within this Committee including risks identified on the BAF.

Clinical Operational Boards

The Clinical Operational Boards meet monthly to support the Board by undertaking detailed, integrated analysis of the following and highlight areas of concern requiring the Board's attention and/or action: quality standards (patient safety, patient experience and clinical effectiveness), financial strategy, budget setting, workforce issues, investment proposals and activity information to support the income of the Trust, achievement of Trust performance objectives, key performance indicators (KPIs), efficiency and economy, effectiveness and efficacy, progress on the tendering, negotiation and finalisation of contracts with commissioners and suppliers. The Committees highlight, as required, emerging areas of financial and operational risk, gaps in control, gaps in assurance and actions being undertaken to address these issues. Service level risks are identified by the leads in each area and reviewed and discussed by the Clinical Operational Boards. In 2014/15 the Trust had four Clinical Operational Boards (Adults and Older People's services, Children and Young People's services, Ambulatory Care and Luton).

Public Involvement and Patient Engagement Committee

The Public Involvement and Patient Engagement Committee supports the Board to ensure that services users and representatives are involved and consulted on: the planning of the provision of the Trust's services, the development and consideration of proposals for changes in the way those services are provided, and decisions to be made by the Trust affecting the operation of those services. This Committee met in April 2014 and was then disbanded and its responsibilities shared between the Clinical Operational Boards and the Quality Improvement and Safety Committee. The aim of this was to integrated patient experience and public involvement discussions with service level and quality discussions.

Quality Improvement and Safety Committee

The Quality Improvement and Safety Committee supports the Board to foster a culture of continuous improvement with regard to the following:

- to ensure patient safety is at the heart of the delivery of services within the Trust and to provide assurance that the Trust meets all its duties and responsibilities to its patients, users and staff;
- to ensure that there are effective structures and systems in place to support the continuous improvement of quality services and safeguard high standards of patient care and to advise the Board on quality standards, research governance and associated clinical risk management; and
- to advise the Board on Trust compliance with quality regulatory requirements and accreditation (e.g. Care Quality Commission (CQC), National Health Service Litigation Authority (NHSLA), NHS England, National Institute for Health and Clinical Excellence (NICE), National Service Frameworks (NSFs)).

The Committee has responsibility for reviewing clinical effectiveness, analysing trends in Darzi indicators, as required, emerging areas of clinical and quality risk, gaps in control, gaps in assurance and actions being undertaken to address these issues. The corporate risk register (clinical risks) is reviewed within this Committee including risks identified on the BAF.

The Committee met five times during 2014/15 and considered a range of key issues including safeguarding, end of life care, information governance, patient reported outcomes, research, complaints and various workforce matters.

Remuneration Committee

The Remuneration Committee supports the Board to ensure fairness, equity and consistency in remuneration practices on behalf of the Trust Board. The Committee met once during the year to determine clinical excellence awards and executive level remuneration.

Strategic Change Board

The Strategic Change Board oversees the Trust's key strategic change programmes on behalf of the Board.

Executive directors and their managers are responsible for maintaining effective systems of control on a day-to-day basis.

A full governance rationale has been developed providing terms of reference and escalation policies for all sub-committees and the Board, together with standing items, which are in turn encapsulated into programmes of business for each Committee and for the Board.

The Board met nine times during the year to review the delivery of strategic programmes and transitions.

Charitable Funds Board of Trustees

In its previous form, the Charitable Funds Committee existed under the delegated authority of the Trust Board. However, during 2014/15 direct registration with the Charity Commission means that a Board of Trustees was established, which is now directly answerable to the Charity Commission. The trustees are responsible for the effective overall management of charitable funds.

Risk assessment

The internal control and risk management system is designed to manage risk to a reasonable level, rather than to eliminate all risk of failure to achieve policies, aims and objectives of Cambridgeshire Community Services NHS Trust; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of Cambridgeshire Community Services NHS Trust's policies, aims and objectives, evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in Cambridgeshire Community Services NHS Trust for the year ended 31 March 2015 and up to the date of approval of the annual report and accounts. At 31 March 2015 the Trust's major strategic risks and corresponding mitigations are:

Identification reference and summary		Rating	Mitigation
1312	The Trust is left with stranded costs as a result of the outcome of on-going procurements.	12	Discussions take place with commissioners and successful bidders to ensure all appropriate costs related to "in scope" services are covered by additional income.
1320	Services fail to remain compliant with the CQC Outcomes Framework, leading to patient safety incidents, regulatory enforcement action and reduction in confidence from the public and commissioners in specific services.	12	A comprehensive review of unit compliance took place in preparation for the CQC visit. CQC self-assessments take place at team level using the new key lines of enquiry approach. The Quality Early Warning Trigger Tool captures relevant information for analysis on a monthly basis. Quality information is captured in reports to the Clinical Operational Boards and to the Board. Back to the floor and peer review visits take place on a regular basis and a review of complaints was undertaken with a new policy being introduced. Actions to deliver the releasing time to care programme have being reviewed and strengthened based on CQC feedback and preparation.
1674	There is a risk that Cambridgeshire and Peterborough commissioners cannot agree on what needs to change/develop for children's' services and turn to a tender process as fall back approach.	12	There is clinical and managerial engagement in any workstreams organised by commissioners and written clarifications are submitted via the contractual process. Requests for further development of commissioner thinking has been made by CEO to the commissioner's accountable officer.
1288	The Trust may see a significant increase in turnover and recruitment and retention difficulties, and/or sickness levels, which may mean it is unable to meet its contract and quality standards.	9	Monthly workforce KPI reports are discussed at unit meetings, Clinical Operational Boards and by the Workforce Review Steering Group. The Quality Early Warning Trigger Tool and quality dashboard also capture this information. There is an Internal recruitment and retention team in place and a recruitment plan for hot spots is being delivered. Sickness absence is being managed within units and weekly updates on transition and procurements are included in the organisation's Communications Cascade. Frequently asked questions have been developed and additional resources to manage transition are in place.

Note: the Trust has risk registers that track and monitor clinical risks that are escalated to the Board, via Clinical Operational Boards, in line with the Trust's risk management and escalation process.
** Likelihood x Consequence of risk occurring*

Outcomes will be assessed against appropriate action plans and projects, managed through the designated leads and overseen by the Board, and relevant sub-committees.

The Trust has identified and risk-assessed cost improvement plans across the organisation and will be monitoring their achievement on a monthly basis.

The Trust achieved a score of 78% in the information governance toolkit self-assessment for 2014/15; an improvement from a score of 66% in 2013/14. For the 38 standards involved, there are four ratings possible (0, 1, 2, or 3, with 3 being the most positive outcome). The Trust achieved level 2 for 24 standards and level 3 for 14 standards. An internal audit report confirmed the Trust's self-assessment score.

This assessment provides assurance to the Board that the Trust is meeting its obligations in relation to information governance. Continuous action plans for improvement are monitored by the Trust's internal information governance steering group, with progress reports presented to the Quality Improvement and Safety Committee quarterly.

During 2014/15 there were 24 confirmed information governance serious incidents; all were subject to full root cause analysis, reported to the appropriate commissioning organisation and closed. None of these incidents resulted in harm to any patient. Seven incidents were reported to the Information Commissioner's Office (ICO). The ICO acknowledged the actions taken by the Trust to prevent reoccurrence and requested no further action by the Trust; although four remain under review.

The Board Assurance Framework is shared with key stakeholders (including Healthwatch through their attendance at Board meetings held in public) and risks relating to the contracts with the commissioners are identified and discussed during the contract negotiation stage.

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

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

The Trust's preparation for climate change, and the necessary adaptations, form part of its emergency preparedness and civil contingency

requirements, as based on the UK Climate Projections 2009 (UKCP09), to ensure that this organisation's obligations under the Climate Change Act are met. The Trust has a major incident plan that is fully compliant with the requirements of the NHS Emergency Planning Guidance 2005 and all associated guidance.

Areas identified for improvement by the CQC have been fully scrutinised and action plans have been submitted to the CQC covering the areas of non-compliance. We are confident that at the next CQC inspection (anticipated in 2017) all standards will be met.

The risk and control framework

The Trust has a risk management strategy, which makes it clear that managing risk is a key responsibility for the Trust and all staff employed by it. The Board receives regular reports that detail risk, financial, quality and performance issues and, where required, the action being taken to reduce identified high-level risks.

The quality team coordinates and supports risk activity across the Trust. Full details of this work are contained in the Trust's risk management strategy. The principles of risk management are included as part of the mandatory corporate induction programme and cover both clinical and non-clinical risk, an explanation of the Trust's approach to managing risk and how individual staff can assist in minimising risk.

Guidance and training are also provided to staff through specific risk management training, wider management training, policies and procedures, information on the Trust's intranet and feedback from audits, inspections and incidents. Included within all of this is sharing of good practice and learning from incidents. Information from a variety of sources is considered in a holistic manner to provide learning and inform changes to practice that would improve patient safety and overall experience of using the Trust's services.

The risk management strategy sets out the key responsibilities for managing risk within the organisation, including the ways in which risk is identified, evaluated and controlled. It identifies strategic and operational risk and how both should be identified, recorded and escalated and highlights the open and honest approach the Board expects with regard to risk. The Trust's risk assessment policy describes the process for standardised assessment of risk including assessment of likelihood and consequence.

The Board has identified the risks to the achievement of the Trust's objectives. The nominated lead for each risk has identified existing controls and sources of assurance that these controls operate effectively. Any gaps in controls have been identified and action plans put in place to strengthen controls where appropriate. The outcome of this process is articulated in the Board Assurance Framework (BAF) and this is presented to the Board for endorsement. In line with the Trust's risk management strategy, risks rated 15 or above are escalated to the Board. All corporate risks are reviewed regularly by identified Board sub-committees and an escalation process is in place, as outlined in the risk management strategy.

Risk is assessed at all levels in the organisation from individual members of staff within business units to the Board. This ensures that both strategic and operational risks are identified and addressed. Risk assessment information is held in an organisation-wide risk register.

The Trust has in place a BAF, which sets out the principal risks to delivery of the Trust's strategic corporate objectives. Executive directors review the risk register and enter strategic risks onto the corporate risk register. In addition, other corporate risks scoring 15 or above, that have been reviewed by the relevant subcommittee, appear on the BAF. The executive director with delegated responsibility for managing and monitoring each risk is clearly identified. The BAF identifies the key controls in place to manage each of the principal risks and explains how the Board is assured that those controls are in place and operating effectively. These include the monthly integrated performance report, minutes of the audit, quality, finance and performance, and quality improvement and safety, assurances provided through the work of internal and external audit, the CQC and the NHS Litigation Authority.

Specific areas of risk such as fraud, corruption and bribery are addressed through specific policies and procedures and regular reports made to the Board via the Audit Committee.

Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the risk management processes. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. The Head of Internal Audit's Opinion is of 'significant assurance'. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by clinical audits, the Trust's External Auditors, CQC and the NHS Litigation Authority.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the audit, quality, finance and performance, and quality improvement and safety committees. A plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board's role is to determine the overall strategic direction and to provide active leadership of the Trust within a framework of prudent and effective controls, which enables risk to be assessed and managed. Corporate objectives are derived from the priorities determined in the medium-term strategy and are defined as:

1. **Quality:** To be recognised as a provider of safe and effective services that people want to use
2. **Quality:** To collaborate with organisations to improve the care given to people who use our services
3. **People:** To ensure that the Trust attracts and retains a quality workforce
4. **Finance:** To be a financially sound organisation
5. **Finance:** To achieve a contract model that links activity to payment (e.g. we receive payment for what we provide)
6. **Sustainability:** To be recognised as a provider of safe and innovative services that helps commissioners achieve their outcomes

All objectives have identified outcomes, measures and timescales. The objectives integrate external (e.g. national targets), local (e.g. commissioners' contract targets) and internal (e.g. effective patient care) drivers of the organisation. Indicators relating to the Quality Account and the Commissioning for Quality & Innovation (CQUIN) framework have been incorporated where appropriate, along with other measures agreed with executive directors.

Conclusion

There has been no evidence presented to myself or the Board to suggest that at any time during 2014/15, the Trust has operated outside of its statutory authorities and duties. In relation to our reporting of the Trust's corporate governance arrangements, we have drawn from the best practice including those elements of the UK Corporate Governance code, which are applicable to the Trust.

With the exception of the internal control issues that I have outlined in this statement, my review confirms that Cambridgeshire Community Services NHS Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

Signed: 

Matthew Winn, Chief Executive

2 June 2015

Patient Stories

For they are jolly good fellows

Four of the Trust's health visitors have been awarded the prestigious title of Fellow of the Institute of Health Visiting.

Elaine McInnes, a health visiting practice teacher based at the Nuffield Road practice in Cambridge, has been recognised as a senior leader in the profession. Elaine said: "I'm delighted to be named as one of the first Fellows of the Institute of Health Visiting (iHV). The aim of this prestigious award is to develop professional accountability through raising the HV profile nationally. I'm passionate about education for health visitors and research and my ambition is to be able to undertake a PhD." Fleur Seekins, professional lead for health visiting felt honoured and privileged to be awarded the fellowship. She said: "Having attended the first of four leadership development days I felt energised to meet some of health visiting's most inspirational leaders. These included Cheryl Adams, founding director of the Institute of Health Visiting, Dame Sarah Cowley, published widely for her research within health visiting and public health needs assessment and Kate Billingham, CBE, nurse advisor who led the introduction of Family Nurse Partnership in the Department of Health and Chair of Queens Nursing Institute."

Julia Mclean, who is based in Cambridge, manages the Trust's north city and Ely health visiting teams. Julia also played a large part in the Governments Call to Action Initiative through the recruitment of health visitors and health visitor students. Julia said: "I am honoured and excited by this prestigious opportunity. This is a pivotal time for the profession, now that we have grown the service we are looking to deliver high quality care in line with the new NHS Health Visitor Service Specification. The iHV will support the profession through the changes to come and I hope to be a good conduit between the iHV and my colleagues." Bridget Halnan is based in Sawston and is the Trust's infant feeding lead/ prescribing lead and clinical practice teacher. Bridget said:

> ***"I was delighted to hear that I had been awarded this Fellowship from the iHV. Alongside my other Fellows within the Trust, this award will allow us to strengthen health visiting for CCS, as well as enabling health visiting nationally to gain a higher profile for the benefit for all families with young children."***

Independent auditors' report to the Directors of the Board of Cambridgeshire Community Services NHS Trust

Report on the financial statements

Our Opinion

In our opinion the financial statements, defined below:

- give a true and fair view, of the state of the Trust's affairs as at 31March 2014 and of its income and expenditure and cash flows 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 HM Treasury as being relevant to the National Health Service in England.

This opinion is to be read in the context of what we say in the remainder of this report.

What we have audited

The financial statements, which are prepared by Cambridgeshire Community Services NHS Trust, comprise:

- the Statement of Financial Position as at 31 March 2015;
- the Statement of Comprehensive Income for the year then ended;
- the Statement of Changes in Taxpayers' Equity for the year then ended;
- the Statement of Cash Flows for the year then ended; and
- the notes to the financial statements, which include a summary of significant accounting policies and other explanatory information.

The financial reporting framework that has been applied in their preparation is the accounting policies directed by the Secretary of State for Health with the consent of HM Treasury as being relevant to the National Health Service in England.

In applying the financial reporting framework, the directors have made a number of subjective judgements, for example in respect of significant accounting estimates. In making such estimates, they have made assumptions and considered future events.

We have also audited the information in the Remuneration Report, published within the Annual Report, that is subject to audit, being:

- the table of salaries and allowances and senior managers and related narrative notes;
- the pay multiple narrative note; and
- the table of pension benefits of senior managers.

What an audit of financial statements involves

We conducted our audit in accordance with International Standards on Auditing (UK and Ireland) ("ISAs (UK & Ireland)"). An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed the reasonableness of significant accounting estimates made by the directors; and
- the overall presentation of the financial statements.

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

Opinions on other matters prescribed by the Code of Audit Practice

In our opinion:

- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements; and
- the part of the Remuneration Report to be audited has been properly prepared in accordance with the requirements directed by the Secretary of State with the consent of HM Treasury as being relevant to the National Health Service in England.

Other matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Code of Audit Practice issued by the Audit Commission requires us to report to you if:

- in our opinion, the Governance Statement does not comply with the Trust Development Authority's Guidance or is misleading or inconsistent with information of which we are aware from our audit;
- we refer a matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

Responsibilities for the financial statements and the audit

Our responsibilities and those of the Directors

As explained more fully in the Statement of Directors' Responsibilities the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view in accordance with the accounting policies directed by the Secretary of State, with the consent of HM Treasury, as being relevant to the National Health Service in England.

Our responsibility is to audit and express an opinion on the financial statements in accordance with Part II of the Audit Commission Act 1998, the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission and ISAs (UK & Ireland).Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the Board of Cambridgeshire Community Services NHS Trust in accordance with Part II of the Audit Commission Act 1998 as set out in paragraph 44 of the Statement of Responsibilities of Auditors and of Audited Bodies (Local NHS bodies) published by the Audit Commission in April 2014, and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

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

Conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission on 13 October 2014, we are satisfied that, in all significant respects, Cambridgeshire Community Services NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2015.

What a review of the arrangements for securing economy, efficiency and effectiveness in the use of resources involves

We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by

the Audit Commission on 13 October 2014, as to whether the Trust has proper arrangements for:

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

The Audit Commission has determined these two criteria as those necessary for us to consider under the Code of Audit Practice 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 31March 2015.

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.

Our responsibilities and those of the Trust

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

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission on 13 October 2014.

We report if significant matters have come to our attention which prevent us from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Certificate

We certify that we have completed the audit of the financial statements of Cambridgeshire Community Services NHS Trust in accordance with the requirements of Part II of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Harriet Aldridge (Senior Statutory Auditor)
for and on behalf of PricewnterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Southampton

4 June 2015

(a) The maintenance and integrity of the Cambridgeshire Community Services NHS Trust website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.

(b) Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

"I like working for the team because we all work towards the same goals and know exactly how we each contribute. You also get a lot of support and guidance.

We're all committed to providing high quality, cost effective physiotherapy."

Sathish Govindarajalu

Senior Physiotherapist
Musculoskeletal Team
Chesterton Medical Centre

Annual Accounts 2014/15

Statement of Comprehensive Income for year ended 31 March 2015

	NOTE	2014-15 £000s	2013-14 £000s
Gross employee benefits	7	**(113,558)**	(111,283)
Other operating costs	5	**(45,173)**	(45,506)
Revenue from patient care activities	3	**158,022**	155,416
Other operating revenue	4	**2,479**	2,173
Operating surplus		**1,770**	800
Finance costs	10	**(68)**	(23)
Surplus for the financial year		**1,702**	777
Public dividend capital dividends payable		**(936)**	0
Retained surplus for the year		**766**	777

Other Comprehensive Income		**2014-15 £000s**	2013-14 £000s
Impairments and reversals taken to the Revaluation Reserve	11	**(17)**	(653)
Gain on revaluation of property, plant & equipment	11	**2,155**	4,084
Net actuarial loss on pension schemes	8	**(1,184)**	(1,343)
Other pension remeasurements	8	**0**	962
Total comprehensive income for the year		**1,720**	3,827

Financial performance for the year		
Retained surplus for the year	**766**	777
Adjusted retained surplus	**766**	777

The notes on pages 78 to 110 form part of this account.

Statement of Financial Position as at 31 March 2015

	NOTE	31 March 2015 £000s	31 March 2014 £000s
Non-current assets:			
Property, plant and equipment	11	**47,385**	44,124
Intangible assets	12	**207**	198
Total non-current assets		**47,592**	44,322
Current assets:			
Inventories		**41**	41
Trade and other receivables	15	**12,975**	10,303
Cash and cash equivalents	16	**15,744**	16,590
Total current assets		**28,760**	26,934
Total assets		**76,352**	71,256
Current liabilities			
Trade and other payables	17	**(23,122)**	(21,738)
Provisions	19	**(662)**	(370)
Total current liabilities		**(23,784)**	(22,108)
Net current assets		**4,976**	4,826
Total assets less current liablilities		**52,568**	49,148
Non-current liabilities			
Trade and other payables	17	**(3,176)**	(1,848)
Provisions	19	**(1,051)**	(679)
Total non-current liabilities		**(4,227)**	**(2,527)**
Total assets employed:		**48,341**	**46,621**
FINANCED BY:			
Public Dividend Capital		**2,107**	2,107
Retained earnings		**30,604**	31,022
Revaluation reserve		**17,283**	15,145
Other reserves		**(1,653)**	(1,653)
Total Taxpayers' Equity:		**48,341**	**46,621**

The notes on pages 78 to 110 form part of this account.

The financial statements on pages 74 to 110 were approved by the Board on 2nd June 2015 and signed on its behalf by

Chief Executive: 

Date: 2 June 2015

Statement of Changes in Taxpayers' Equity for the year ending 31 March 2015

	NOTE	Public Dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Other reserves £000s	Total reserves £000s
Balance at 1 April 2014		**2,107**	**31,022**	**15,145**	**(1,653)**	**46,621**
Changes in taxpayers' equity for the year ended 31 March 2015						
Retained surplus for the year		0	766	0	0	766
Gain on revaluation of property, plant, equipment	11	0	0	2,155	0	2,155
Impairments and reversals	11	0	0	(17)	0	(17)
Reclassification Adjustments						
Net actuarial (loss) on pension	8	0	(1,184)	0	0	(1,184)
Net recognised revenue/(expense) for the year		**0**	**(418)**	**2,138**	**0**	**1,720**
Balance at 31 March 2015		**2,107**	**30,604**	**17,283**	**(1,653)**	**48,341**
Balance at 1 April 2013		**1,653**	**3,558**	**0**	**(1,653)**	**3,558**
Retained surplus for the year		0	777	0	0	777
Gain on revaluation of property, plant, equipment	11	0	0	4,084	0	4,084
Impairments and reversals	11	0	0	(653)	0	(653)
Transfers under Modified Absorption Accounting - PCTs & SHAs		0	38,782	0	0	38,782
Reclassification Adjustments						
New PDC received - PCTs and SHAs legacy items paid for by DH		454	0	0	0	454
Net actuarial (loss) on pension		0	(1,343)	0	0	(1,343)
Other pension remeasurement		0	962	0	0	962
Net recognised revenue for the year		**454**	**39,178**	**3,431**	**0**	**43,063**
Transfers between reserves in respect of modified absorption - PCTs & SHAs		0	(11,714)	11,714	0	0
Balance at 31 March 2014		**2,107**	**31,022**	**15,145**	**(1,653)**	**46,621**

Public Dividend Capital

Public dividend capital represents the Department of Health's equity interest in the Trust.

Retained earnings

The Trust's retained earnings reserve represents the Trust's cumulative earnings to date.

Revaluation reserve

The revaluation reserve is used to record revaluation gains/losses and impairments impairment reversals on property, plant and equipment (PPE) recognised in Other Comprehensive Income.

Merger reserve

In line with Department of Health accounting instructions in the 2010-11 Manual for Accounts the net assets (£1,653,000) of the Trust's predecessor Autonomous Provider Organisation (APO) were acquired by the Trust upon establishment. The transaction resulted in the Trust making a payment to NHS Cambridgeshire, returning the reserves associated with these assets to them. This created a merger reserve in the CCS NHS Trust's 2010/11 accounts.

Statement of Cash Flows for the Year ended 31 March 2015

	NOTE	2014-15 £000s	2013-14 £000s
Cash Flows from Operating Activities			
Operating surplus		**1,770**	800
Depreciation and amortisation	11, 12	**1,739**	1,534
Dividend paid		**(1,088)**	0
(Increase)/Decrease in Trade and Other Receivables	15	**(2,520)**	4,136
Increase in Trade and Other Payables	17	**1,070**	4,727
Provisions utilised	19	**(283)**	(697)
Increase in movement in non cash provisions	19	**947**	197
Net Cash Inflow from Operating Activities		**1,635**	10,697
Cash Flows from Investing Activities			
Payments for Property, Plant and Equipment		**(2,424)**	(1,884)
Payments for Intangible Assets	12	**(57)**	(105)
Net Cash Outflow from Investing Activities		**(2,481)**	(1,989)
Net Cash (Outflow) / Inflow before Financing		**(846)**	8,708
Cash Flows from Financing Activities			
Gross Temporary and Permanent PDC Received		**0**	536
Gross Temporary and Permanent PDC Repaid		**0**	(82)
Net Cash Inflow from Financing Activities		**0**	454
NET (DECREASE) / INCREASE IN CASH AND CASH EQUIVALENTS		**(846)**	**9,162**
Cash and Cash Equivalents at Beginning of the Period	16	**16,590**	**7,428**
Cash and Cash Equivalents at Year End	16	**15,744**	**16,590**

Notes to the Accounts

1. 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 Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2014-15 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 Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 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.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

On the 1st April 2015 there was a transfer of activities between the Trust and another NHS body, see note 24 for further details.

1.3 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 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 SOCNE/SOCNI, and is disclosed separately from operating costs.

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

For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, Treasury agreed that a modified absorption approach should be applied. For these transactions and only in the prior-period, gains and losses are recognised in reserves rather than the SOCNE/SOCNI.

1.4 Charitable Funds

Under the provisions of IFRS 10 Consolidated financial statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact.

As the Trust does not have any material Charitable Funds, no consolidation has taken place (see note 22)

1.5 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, 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 and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.5.1 Critical judgements in applying accounting policies

The need for the application of management judgement within the Trust's accounts is limited by the nature of its transactions. 71% of the Trust's expenditure is in relation to staff costs that are paid in the month the costs are incurred.

1.5.2 Key sources of estimation uncertainty

There are a number of areas in which management have exercised judgement in order to estimate Trust liabilities. Management do not consider that any of these constitute a material risk to the financial statements of the Trust, however more information on these risks is detailed below.

The Trust's provision for the impairment of receivables

There are a number of long standing debts owed to the Trust from non NHS bodies. Management have reviewed all debts past their due date and formed a judgement on each one's recoverability. This provision represents the sum of all those debts that management consider to be at significant risk. Resolution on these outstanding debts is expected within the next financial year.

Accruals and provisions

In line with the framework set out by International Financial Reporting Standards, the Trust has made expenditure accruals and provisions for transactions (and other events) that relate to 2013/14 irrespective of whether cash or its equivalent has been paid.

In some cases, this has resulted in estimates being made by management for transactions or events that have already occurred but whose costs are not known exactly. In such cases management have exercised judgement in calculating an estimate for the costs and do not expect that to differ significantly to those finally incurred on payment. The liabilities will be settled during the normal course of the Trust's business.

Asset lives, impairment & depreciation methodology

In line with IAS 16, Property, Plant and Equipment (PPE), the Trust depreciates its Non Current PPE in line with the assets' useful economic lives. The Trust's management team believe that the economic benefits associated with such assets are broadly consumed on a straight line basis in line with the useful economic lives contained within note 1.9.

Local Government Pension Liability

The Trust employs staff who transferred from Cambridgeshire PCT and Peterborough PCT as members of the Local Government Pension Scheme (LGPS). The LGPS is a defined benefit statutory scheme administered in accordance with Local Government Pension Scheme Regulations. IAS 19, Employee Benefits, aims to ensure that the financial statements of an employer reflects a liability when employees have provided a service in exchange for benefits to be paid in the future. This makes accounting for defined benefit pension schemes complex because actuarial assumptions and valuation methods are required to measure the current value of the future obligation on the employer's SOFP. The Trust has relied on an actuary to provide these figures for inclusion in its financial statements (see note 8).

1.6 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 from commissioners for healthcare services.

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 Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.7 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, except for bonuses earned but not yet taken which, like leave earned but not yet taken is not accrued for at the year end, on the grounds of immateriality.

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.

Some employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the Trust's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within investment revenue. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. Actuarial gains and losses during the year are recognised in the Income and Expenditure reserve and reported as an item of other comprehensive income (see note 8).

1.8 Other expenses

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

1.9 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 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. The Trust does not currently have any such buildings.

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.

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-out and charged to operating expenses.

1.10 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 £5000.

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
- 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.

1.11 Depreciation, amortisation and impairments

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

Otherwise, depreciation and amortisation are 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.

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.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.

AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.12 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 does not have any finance leases.

The Trust as lessee

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

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

1.13 Inventories

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

1.14 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 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.15 Provisions

Provisions are recognised when the NHS Trust has a present legal or constructive obligation as a result of a past event, it is probable that the NHS 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.

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

1.16 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 NHS Trust'. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at note 19.

1.17 Non-clinical risk pooling

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

1.18 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 initally recognised at fair value.

All of the Trust's financial assets fall into the loans and receivables category, as defined by IAS 39. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial 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.

At the end of the reporting period, 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 expenditure and the carrying amount of the asset is reduced 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 expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.19 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 de-recognised when the liability has been discharged, that is, the liability has been paid or has expired. All of the Trust's financial liabilities fall into the category of Other financial liabilities as defined by IAS 39.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value. The Trust does not currently have any loans from the Department of Health.

Other financial liabilities

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

1.20 Value Added Tax

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

1.21 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the 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 donated assets and 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.

1.22 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 that individual cases are 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 the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.23 Segmental Reporting

Operating Segments are reported in a manner consistent with the internal reporting provided to the Chief Operating Decision Maker. The Chief Operating Decision Maker, who is responsible for allocating resources and assessing performance of the operating segments, has been identified as the Board of Directors.

1.24 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 SOCNE/SOCI 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.

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

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

IFRS 9 Financial Instruments - subject to consultation - subject to consultation

IFRS 13 Fair Value Measurement - subject to consultation

IFRS 15 Revenue from Contracts with Customers

2. Operating segments

IFRS 8 requires income and expenditure to be broken down into the operating segments reported to the Chief Operating Decision Maker. The Trust considers the Board to be the Chief Operating Decision Maker because it is responsible for approving its budget and hence responsible for allocating resources to operating segments and assessing their performance. The Trust has five Divisions, Cambridgeshire and Peterborough Adults and Older Peoples Services, providing a range of community nursing, therapy and hospital based services throughout Cambridgeshire, Ambulatory Care Services, providing a diverse range of primary care services including sexual health, musculoskeletal services and outpatients, Luton Community Unit, providing a range of community nursing, therapy and hospital based services for both Adults and Children throughout Luton, Children's and Young Peoples Services (including Health Visiting, School Nursing and Speech Therapies services within Cambridgeshire) and Other Services which includes Corporate Costs, Contracted income and other indirect costs. The Trust's operating segments reflect the services that it provides across Cambridgeshire, Suffolk and Luton. Expenditure is reported to the Board on a regular basis by Division.

The Statement of Financial Position is reported to the Board on a Trust wide basis only.

2014/15	Income £'000	Pay £'000	Non-Pay £'000	Net Total £'000
Division Level				
Cambridgeshire & Peterborough Adults & Older Peoples Services	4,096	(50,237)	(11,217)	(57,358)
Ambulatory Care Services	2,001	(16,131)	(7,487)	(21,617)
Luton Community Unit	1,566	(18,925)	(3,761)	(21,120)
Childrens & Young People's Services	3,580	(20,226)	(2,599)	(19,245)
Other Services	149,258	(8,039)	(21,113)	120,106
CCS Total 2014/15	**160,501**	**(113,558)**	**(46,177)**	**766**

2013/14	Income £'000	Pay £'000	Non-Pay £'000	Net Total £'000
Division Level				
Cambridgeshire & Peterborough Adults & Older Peoples Services	10,597	(58,851)	(15,462)	(63,716)
Luton Community Unit	633	(10,329)	(3,272)	(12,968)
Childrens & Young People's Services	5,160	(26,115)	(3,928)	(24,883)
Other Services (incl. Corporate, Dental, Sexual Health, and Contract Income)	141,199	(15,988)	(22,844)	102,367
CCS Total 2013/14	**157,589**	**(111,283)**	**(45,506)**	**800**

	2014-15 £000	2013-14 £000
Revenue from patient care activities	158,022	155,416
Other operating revenue	2,479	2,173
Operating expenses	(158,731)	(156,789)
Operating surplus	**1,770**	**800**
Net finance (cost)/income	(68)	(23)
Surplus for the financial year	**1,702**	**777**
Public dividend capital dividends payable	(936)	0
Retained Surplus for the financial year	**766**	**777**

3. Revenue from patient care activities

	2014-15 £000s	2013-14 £000s
NHS Trusts	**2,091**	1,942
NHS England	**14,834**	13,532
Clinical Commissioning Groups	**101,007**	99,481
Foundation Trusts	**4,647**	5,158
Department of Health	**34**	70
NHS Other (including Public Health England and Prop Co)	**3,431**	3,397
Non-NHS:		
Local Authorities	**25,135**	26,191
Private patients	**307**	165
Injury costs recovery	**174**	136
Other	**6,362**	5,344
Total Revenue from patient care activities	**158,022**	155,416

4. Other operating revenue

	2014-15 £000s	2013-14 £000s
Recoveries in respect of employee benefits	**185**	131
Education, training and research	**290**	58
Charitable and other contributions to revenue expenditure -non- NHS	**1,475**	1,427
Other revenue	**529**	557
Total Other Operating Revenue	**2,479**	2,173
Total Operating revenue	**160,501**	157,589

5. Operating expenses

	2014-15 £000s	2013-14 £000s
Services from other NHS Trusts	**3,686**	3,913
Services from CCGs/NHS England	**76**	216
Services from NHS Foundation Trusts	**3,463**	2,664
Total Services from NHS bodies	**7,225**	6,793
Purchase of healthcare from non-NHS bodies	**94**	141
Trust Chair and Non-executive Directors	**54**	57
Supplies and services - clinical	**9,930**	8,850
Supplies and services - general	**7,550**	6,879
Consultancy services	**527**	590
Establishment	**2,455**	2,780
Transport	**3,883**	4,361
Business rates paid to local authorities	**1,222**	1,265
Premises	**7,834**	8,838
Hospitality	**13**	15
Insurance	**18**	14
Legal Fees	**232**	162
Impairments and Reversals of Receivables	**(23)**	198
Depreciation	**1,691**	1,524
Amortisation	**48**	10
Audit fees	**220**	254
Clinical negligence	**311**	318
Research and development (excluding staff costs)	**122**	55
Education and Training	**629**	962
Other	**1,138**	1,440
Total Operating Expenses (excluding employee benefits)	**45,173**	45,506
Employee Benefits		
Employee benefits excluding Board members	**112,937**	110,639
Board members	**621**	644
Total Employee Benefits	**113,558**	111,283
Total Operating Expenses	**158,731**	156,789

External audit fees for 2014/15 were agreed as £88,617 excluding VAT (2013/14 £88,617 excluding VAT). There will be a variation to the fee of £5,000 to reflect additional procedures performed to investigate the Trust's future organisational structure and its financial standing following the transfer of services from the Trust, see note 24.

6. Operating Leases

The Trust operates from the following main properties:

Chesterton Medical Centre, Cambridge
Dumbleton Medical Centre, St Neots
New Horsefair Clinic, Wisbech
The Oaktree Centre, Huntingdon
Healthy Living Centre, Peterborough
Clody House, Luton
Marsh Farm Health Centre, Luton
Orwell Clinic, Ipswich
Oak Street, Norwich
Kings Chambers, Peterborough

6.1 Trust as lessee

	Buildings £000s	2014-15 Total £000s	2013-14 £000s
Payments recognised as an expense			
Minimum lease payments		**2,312**	2,146
Total		**2,312**	2,146
Payable:			
No later than one year	2,297	**2,297**	2,019
Between one and five years	8,545	**8,545**	7,849
After five years	10,414	**10,414**	9,717
Total	**21,256**	**21,256**	19,585

7. Employee benefits and staff numbers

7.1 Employee benefits

	2014-15		
	Total £000s	Permanently employed £000s	Other £000s
Employee Benefits - Gross Expenditure			
Salaries and wages	96,290	87,803	8,487
Social security costs	6,186	6,186	0
Employer Contributions to NHS BSA - Pensions Division	10,579	10,579	0
Other pension costs	476	476	0
Termination benefits	27	27	0
Total employee benefits	**113,558**	**105,071**	**8,487**

	2013-14		
	Total £000s	Permanently employed £000s	Other £000s
Employee Benefits - Gross Expenditure 2013-14			
Salaries and wages	93,499	87,309	6,190
Social security costs	6,331	6,265	66
Employer Contributions to NHS BSA - Pensions Division	10,497	10,388	109
Other pension costs	465	465	0
Termination benefits	491	491	0
TOTAL - including capitalised costs	111,283	104,918	6,365

7.2 Staff Numbers

	2014-15			2013-14
	Total Number	Permanently employed Number	Other Number	Total Number
Average Staff Numbers				
Medical and dental	**92**	64	28	87
Administration and estates	**617**	571	46	620
Healthcare assistants and other support staff	**754**	734	20	575
Nursing, midwifery and health visiting staff	**954**	914	40	951
Nursing, midwifery and health visiting learners	**63**	11	52	47
Scientific, therapeutic and technical staff	**396**	375	21	444
Social Care Staff	**0**	0	0	157
Other	**0**	0	0	7
TOTAL	**2,876**	**2,669**	**207**	2,888

Agency staff numbers have not been included in the note above.

7.3 Ill health retirements

	2014-15 Number	2013-14 Number
Number of persons retired early on ill health grounds	**0**	5
	£000s	£000s
Total additional pensions liabilities accrued in the year	**0**	357

7.4 Exit Packages agreed in 2014-15

Exit package cost band (including any special payment element)	2014-15 Number of compulsory redundancies Number	2014-15 Number of other departures agreed Number	2014-15 Total number of exit packages by cost band Number	2013-14 Number of compulsory redundancies Number	2013-14 Number of other departures agreed Number	2013-14 Total number of exit packages by cost band Number
Less than £10,000	0	0	0	0	4	4
£10,000-£25,000	0	0	0	0	3	3
£25,001-£50,000	1	0	1	0	3	3
£50,001-£100,000	0	0	0	0	5	5
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type (total cost)	**1**	**0**	**1**	0	15	15
Total resource cost (£s)	**26,822**	**0**	**26,822**	0	491,128	491,128

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Agenda for Change scheme. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous year.

	2014-15 Agreements Number	2014-15 Total value of agreements Number	2013-14 Agreements Number	2013-14 Total value of agreements Number
Voluntary redundancies including early retirement contractual costs	0	0	5	223
Mutually agreed resignations (MARS) contractual costs	0	0	10	268
Total	0	0	15	491

8. Pension costs

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

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

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

c) Scheme provisions

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

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

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

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

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

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

The Trust also employs a number of staff that transferred from Cambridgeshire PCT on 1 April 2010 as members of the Local Government Pension Scheme (LGPS). These staff formerly worked for Cambridgeshire County Council but transferred into the NHS in April 2004 as part of the Cambridgeshire wide section 75 agreement for the provision of Health and Social Care for Older People. During 2013/14 some of these services transferred to new providers, namely Extra Care on 1st April 2013, Day Care on 1st July 2014 and Planned Social Care on 1st October 2013. Please see further details below.

The LGPS is a defined benefit statutory scheme administered in accordance with the Local Government Pension Scheme Regulations. The Trust became an admitted body to the scheme effective on 1 April 2010.

Financial transactions arising from contributions to and the costs of the scheme, along with the changing valuation of the assets of the scheme affect the Statement of Comprehensive Income, the Statement of Changes in Taxpayers Equity, and both Reserves and Non Current Trade Payables within the Statement of Financial Position.

Contribution rates are determined by the scheme's actuary based on triennial actuarial valuations. The last full valuation was at 31 March 2013.

The liabilities of the Cambridgeshire County Council pension scheme attributable to the Trust are included in the Statement of Financial Position on an actuarial basis using the projected unit method i.e. an assessment of the future payments that will be made in relation to retirement benefits earned to date by employees, based on assumptions about mortality rates, employee turnover rates etc, and projections of earnings for current employees.

The post-retirement mortality assumptions are in line with Club Vita analysis carried out by the Actuaries as part of the formal funding valuation as at 31 March 2013. These are a bespoke set of VitaCurves specifically tailored to the membership profile of the Fund and based on the data provided for the purposes of the last formal valuation. These are in line with the CMI 2010 model assumng the rate of longevity improvements has reached a peak and will converge to a long term rate of 1.25% p.a.

The major assumptions used by the actuary were:

	At 31/03/15	At 31/03/14
Rate of increase in salaries	4.30%	4.60%
Rate of increase in pensions in payment	2.40%	2.80%
Discount rate	3.20%	4.30%

The assets in the scheme and the expected rate of return were:

	Long-term rate of return expected at 31/03/15	Long-term rate of return expected at 31/03/14
Equities	3.20%	4.30%
Bonds	3.20%	4.30%
Property	3.20%	4.30%
Cash	3.20%	4.30%

The expected return on assets is based on the long term future expected investment return for each asset class as at the beginning of the period (i.e. as at 1 April 2014 for the year to 31 March 2015).

The average future life expectancies at age 65 are summarised below:

	31/03/15	
	Male	Female
Current Pensioners	22.5 years	24.5 years
Future Pensioners	24.4 years	26.9 years

	31/03/14	
	Male	Female
Current Pensioners	22.5 years	24.5 years
Future Pensioners	24.4 years	26.9 years

The scheme assets and liabilities attributable to those employees can be identified and are recognised in the Trust's accounts. The assets are measured at fair value and the liabilities at present value of the future obligation.

Present value of defined benefit obligation	2014/15 £000s	2013/14 £000s
Opening defined benefit obligation as at 1 April	13,724	19,586
Current Service Cost	403	532
Past Service Cost	0	1
Effect of settlements *	0	(5,247)
Interest Cost	588	739
Actuarial losses	2,171	377
Other experience	(71)	(1,982)
Contributions by employee	80	123
Benefits paid	(544)	(405)
Closing Defined Benefit Obligation at 31 March	16,351	13,724

** Effect of settlements - see following page*

Reconciliation of opening and closing fair value of plan assets:

Fair value of plan assets	2014/15 £000s	2013/14 £000s
Opening fair value of plan assets as at 1 April	12,192	18,551
Effect of settlements *	0	(4,285)
Net interest	520	716
Actuarial gains / (losses)	0	0
Contributions by employer	293	440
Contributions by employee	80	123
Benefits paid	(544)	(405)
Return on assets excluding amounts included in net interest	916	(2,948)
Closing value of plan assets at 31 March	13,457	12,192

** Effect of settlements - see below*

Effect of settlements (2013/14)

This relates to the transfer of services to other providers as explained on page 93, with the following transferring:

Date of transfer	Assets £000s	Members Transferred (No)
1st April 2013 - Extra Care services	314	3
1st July 2013 - Day Care services	1,778	31
1st October 2013 - Planned Social Care services	2,193	17

Movement in net pension liability during the year:

	2014/15 £000s	2014/15 £000s	2013/14 £000s	2013/14 £000s
Deficit in the scheme at beginning of the year		(1,532)		(1,035)
Movement in year:				
Current and past service cost	(403)		(533)	
Contributions	293		440	
Expected (loss) on plan assets net of interest	(68)		(23)	
Net amount charged to the year's Statement of Comprehensive Income		(178)		(116)
Actuarial loss on scheme assets (charged to Retained Earnings)		(1,184)		(381)
Scheme deficit at the end of the year		(2,894)		(1,532)

Fair value of plan assets comprises:

	2014/15 %	2014/15 £000s	31/03/2014 %	31/03/2014 £000s
Equity Securities	36.42%	4,901	39.83%	4,856
Private Equity	7.09%	954	5.95%	725
Investment funds and unit trusts	53.50%	7,199	52.89%	6,448
Cash and cash equivalents	2.99%	403	1.34%	163
Total		13,457		12,192

The current service cost of £403,000 (2013/14 £532,000) has been recognised within the Trust's operating expenses (note 5) under 'Employee benefits'.

The net interest was a cost of £68,000 (2013/14 cost of £23,000) has been recognised as a finance cost (note 10) on the face of the Statement of Comprehensive Income.

The 2014/15 in year net actuarial loss of £1,184,000 has been included in the Statement of Taxpayers' Equity and in the Statement of Comprehensive Income as an other comprehensive income item.

The difference between the current service cost and the employer contributions to the scheme has been included in the Trust's cash flow statement as an operating cost which does not result in an in year cash transaction.

The Trust expects to make Employer's contributions of approximately £129,000 (2013/14 £365,000) during the year ended 31 March 2016.

IAS19 requires a five year history to be shown disclosing the present value of the scheme liabilities, the fair value of the scheme assets and the surplus or deficit in the scheme (plus any experience adjustments). The Trust joined the LGPS scheme with effect from 1 April 2010. A four year history of the Trust's LGPS pension asset/liability is shown below:

	31/03/2015 £000s	31/03/2014 £000s	31/03/2013 £000s	31/03/2012 £000s	31/03/2011 £000s
Fair Value of Employer Assets	13,457	12,192	18,551	15,352	12,053
Present Value of Defined Benefit Obligation	(16,351)	(13,724)	(19,586)	(16,289)	(12,658)
Deficit	(2,894)	(1,532)	(1,035)	(937)	(605)

9. Better Payment Practice Code

9.1 Measure of compliance

	2014-15 Number	2014-15 £000s	2013-14 Number	2013-14 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**27,891**	**41,074**	25,013	32,264
Total Non-NHS Trade Invoices Paid Within Target	**23,296**	**35,751**	20,360	27,924
Percentage of NHS Trade Invoices Paid Within Target	**83.53%**	**87.04%**	81.40%	86.55%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**1,960**	**13,665**	1,809	18,931
Total NHS Trade Invoices Paid Within Target	**1,584**	**11,928**	1,392	15,289
Percentage of NHS Trade Invoices Paid Within Target	**80.82%**	**87.29%**	76.95%	80.76%

The Better Payment Practice Code requires the NHS body to aim to pay at least 95% of all trade payables within 30 days of a valid invoice being received or the goods being delivered, whichever is the later, unless other terms have been agreed previously.

9.2 The Late Payment of Commercial Debts (Interest) Act 1998

During 2014/15, there was no costs incurred by the Trust as a result of Late Payment of Commercial Debts (2013/14, nil).

10. Finance Costs

	2014-15 £000s	2013-14 £000s
Pension interest cost	**68**	23
Total	**68**	23

11.

11.1 Property, plant and equipment

2014-15	Land £000's	Buildings excluding dwellings £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
Cost or valuation:							
At 1 April 2014	**11,623**	**32,234**	**5,526**	**10**	**872**	**1,040**	**51,305**
Additions Purchased	0	2,146	288	0	274	106	**2,814**
Disposals other than for sale	0	0	(4,322)	(9)	(348)	(814)	**(5,493)**
Upward revaluation/positive indexation	86	2,069	0	0	0	0	**2,155**
Impairments/negative indexation	0	(17)	0	0	0	0	**(17)**
At 31 March 2015	**11,709**	**36,432**	**1,492**	**1**	**798**	**332**	**50,764**
Accumulated Depreciation							
At 1 April 2014	**0**	**1,208**	**4,730**	**9**	**388**	**846**	**7,181**
Disposals other than for sale	0	0	(4,322)	(9)	(348)	(814)	**(5,493)**
Charged During the Year	0	1,324	204	0	135	28	**1,691**
At 31 March 2015	**0**	**2,532**	**612**	**0**	**175**	**60**	**3,379**
Net Book Value at 31 March 2015	**11,709**	**33,900**	**880**	**1**	**623**	**272**	**47,385**
Asset financing:							
Owned - Purchased	11,709	33,900	880	1	623	272	**47,385**
Total at 31 March 2015	**11,709**	**33,900**	**880**	**1**	**623**	**272**	**47,385**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £000's	Buildings excluding dwellings £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
At 1 April 2014	4,923	10,222	0	0	0	0	**15,145**
Revaluations	86	2,052	0	0	0	0	**2,138**
At 31 March 2015	**5,009**	**12,274**	**0**	**0**	**0**	**0**	**17,283**

In accordance with the requirements of the Manual for Accounts, the Trust's freehold land and buildings were valued in 2014/15 by external valuers Boshiers and Company, Chartered Surveyors, in accordance with the requirements of the RICS Valuation Standards and the International Accounting Standards. The valuation represents the Trust's Quinquennial valuation, and reflects values at 31st March 2015.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the Statement fo Financial Position date. In practice the Trust will ensure there is a full quinquennial valuation and an interim caluation in the third year of each quinquennial cycle. In any intervening year the Trust will carry out a review of movements in appropriate land and building

indicies and where material fluctuations occur, will engage the services of a professional valuer to determine appropriate adjustments to the valuations of assets to ensure that book values reflect fair values. Fair values are determined as follows:

- Land and non specialised buildings - market value for exisitng use/modern
- Specialised building - Depreciated Replacement Cost

The valuation of each property was on the basis of fair value, subject to the assumption that all property would be sold as part of the continuing enterprise in occupation.

The Valuer's opinion of market value was primarily derived using comparable recent market transactions on arm's length terms.

The depreciated replacement cost method of valuation as the specialised nature of the asset means that there is no market transactions of this type of asset except as part of the enterprise in occupation and is subject to the prospect and viability of the continued occupation and use.

All movements on revalutation in 2014/15 have been recognised in the revaluation reserve as there was sufficent value in the reserve for each asset.

The disposals other than for sale in the above note relate to assets that the Trust still held within its accounts, but no longer used and therefore these have been included as disposals in year. All assets were of nil Net Book Value and therefore this had no impact on the Statement of Financial Position.

11.2 Property, plant and equipment prior year

2013-14	Land £000's	Buildings excluding dwellings £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
Cost or valuation:							
At 1 April 2013	0	0	5,194	10	348	973	**6,525**
Transfers under Modified Absorption Accounting - PCTs & SHAs	10,571	28,751	129	0	3	29	**39,483**
Additions Purchased	0	1,104	203	0	521	38	**1,866**
Revaluation	1,548	2,536	0	0	0	0	**4,084**
Impairments/negative indexation charged to reserves	(496)	(157)	0	0	0	0	**(653)**
	11,623	**32,234**	**5,526**	**10**	**872**	**1,040**	**51,305**
Accumulated Depreciation							
At 1 April 2013	0	0	4,479	9	348	821	**5,657**
Charged During the Year	0	1,208	251	0	40	25	**1,524**
At 31 March 2014	**0**	**1,208**	**4,730**	**9**	**388**	**846**	**7,181**
Net Book Value at 31 March 2014	11,623	31,026	796	1	484	194	**44,124**
Asset financing:							
Owned - Purchased	11,623	31,026	796	1	484	194	**44,124**
Total at 31 March 2014	**11,623**	**31,026**	**796**	**1**	**484**	**194**	**44,124**

11.3 Economic life of Property, plant and equipment

	Min life Years	Max life Years
Land	-	-
Buildings	25	25
Plant & machinery	3	10
Transport equipment	3	10
Information technology	3	5
Furniture & fittings	5	10

12.

12.1 Intangible Assets

2014-15	Computer Licenses £000's	Development Expenditure - Internally Generated £000's	Total £000's
At 1 April 2014	**29**	**188**	**217**
Additions Purchased	0	57	57
At 31 March 2015	**29**	**245**	**274**
Accumulated Amortisation			
	19	**0**	**19**
Charged during the year	10	38	48
At 31 March 2015	**29**	**38**	**67**
Net Book Value at 31 March 2015	**0**	**207**	**207**
Asset Financing: Net book value at 31 March 2015 comprises:			
Purchased	0	207	207
Total at 31 March 2015	**0**	**207**	**207**

12.2 Intangible Assets

2013-14	Computer Licenses £000's	Development Expenditure - Internally Generated £000's	Total £000's
At 1 April 2013	29	83	112
Additions - purchased	0	105	105
At 31 March 2014	29	188	217
Accumulated Amortisation			
At 1 April 2013	9	0	9
Charged during the year	10	0	10
At 31 March 2014	19	0	19
Net book value at 31 March 2014	10	188	198

13. Commitments

The Trust did not have any material contracted capital or other financial commitments at 31 March 2015 (2014, nil), other than those recognised in the Trust's Statement of Financial position.

14. Intra-Government and other balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with Other Central Government Bodies	0	0	1,826	0
Balances with Local Authorities	191	0	109	0
Balances with NHS bodies inside the Departmental Group	5,395	0	5,151	0
Balances with Bodies External to Government	7,389	0	16,036	3,176
At 31 March 2015	**12,975**	**0**	**23,122**	**3,176**
Balances with Other Central Government Bodies	3,658	0	4,786	0
Balances with Local Authorities	2,044	0	269	0
Balances with NHS Trusts and FTs	1,120	0	3,031	0
Balances with Bodies External to Government	3,481	0	13,652	1,848
At 31 March 2014	**10,303**	**0**	**21,738**	**1,848**

15.

15.1 Trade and other receivables

	Current	
	31 March 2015 £000s	31 March 2014 £000s
NHS receivables - revenue	**5,243**	4,778
Non-NHS receivables - revenue	**3,852**	2,336
Non-NHS prepayments and accrued income	**3,882**	3,256
PDC Dividend prepaid to DH	**152**	0
Provision for the impairment of receivables	**(433)**	(446)
VAT	**279**	379
Total current	**12,975**	10,303

The great majority of trade is with NHS bodies and Local Authorities. As these are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

15.2 Receivables past their due date but not impaired

	31 March 2015 £000s	31 March 2014 £000s
By up to three months	**1,738**	589
By three to six months	**230**	518
By more than six months	**253**	685
Total	**2,221**	1,792

15.3 Provision for impairment of receivables

	2014-15 £000s	2013-14 £000s
Balance at 1 April 2014	**(446)**	(362)
Amount written off during the year	**0**	114
Amount recovered during the year	**304**	0
Increase in receivables impaired	**(281)**	(198)
Transfers (to) Other Public Sector Bodies under Absorption Accounting	**(10)**	0
Balance at 31 March 2015	**(433)**	(446)

There are a number of long standing debts owed to the Trust from non NHS bodies. Management have reviewed all debts past their due date and formed a judgement on each one's recoverability. This provision represents the sum of all the debts that management consider to be at significant risk. Resolution of these outstanding debts is expected within the next financial year. No collateral or equity is held as security by the Trust in respect of these debts.

16. Cash and Cash Equivalents

	31 March 2015 £000s	31 March 2014 £000s
Opening balance	**16,590**	7,428
Net change in year	**(846)**	9,162
Closing balance	**15,744**	16,590
Made up of		
Cash with Government Banking Service	**15,734**	16,584
Cash in hand	**10**	6
Cash and cash equivalents as in statement of financial position	**15,744**	16,590
Cash and cash equivalents as in statement of cash flows	**15,744**	16,590

17. Trade and other payables

	Current		Non-current	
	31 March 2015 £000s	31 March 2014 £000s	31 March 2015 £000s	31 March 2014 £000s
NHS payables - revenue	**4,327**	4,423	**0**	0
NHS payables - capital	**0**	48	**0**	0
NHS accruals and deferred income	**824**	0	**0**	0
Non-NHS payables - revenue	**4,749**	3,931	**0**	0
Non-NHS payables - capital	**577**	139	**0**	0
Non-NHS accruals and deferred income	**10,819**	11,360	**282**	316
Tax and social security costs	**1,826**	1,837	**0**	0
Other	**0**	0	**2,894**	1,532
Total	**23,122**	21,738	**3,176**	1,848
Total payables (current and non-current)	**26,298**	**23,586**		

18. Deferred revenue

	Current		Non-current	
	31 March 2015 £000s	31 March 2014 £000s	31 March 2015 £000s	31 March 2014 £000s
Opening balance at 1 April 2014	783	1,316	316	0
Deferred revenue addition	555	38	0	316
Transfer of deferred revenue	(777)	(571)	(34)	0
Current deferred income at 31 March 2015	561	783	282	316
Total deferred income (current and non-current)	843	1,099		

19. Provisions

	Total £000s	Legal Claims £000s	Restructuring £000s	Other £000s
Balance at 1 April 2014	**1,049**	75	231	743
Arising during the year	**947**	120	0	827
Utilised during the year	**(283)**	(58)	(211)	(14)
Balance at 31 March 2015	**1,713**	**137**	**20**	**1,556**
Expected Timing of Cash Flows:				
No Later than One Year	**662**	137	20	505
Later than One Year and not later than Five Years	**373**	0	0	373
Later than Five Years	**678**	0	0	678

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2015	0
As at 31 March 2014	0

Dilapidations

The Trust occupies a number of properties on short term leasehold agreements. There are a number of lease covenants requiring that during and on expiry of the leases, the properties need to be maintained in good condition and state of repair, which usually requires a level of reinstatement, repair and decoration. As such, it is deemed appropriate to create a provision to ensure that leased properties can be maintained and vacated in the correct condition. Sweett UK Limited were appointed by the Trust to advise on this.

Legal Claims

The Trust is involved in a number of tribunal cases, the outcome of which is uncertain or unknown but based on advice the Trust has calculated it's best estimate of amounts required to settle these cases.

Restructuring Provision

During December 2013, staff were given the opportunity to apply for a Mutually Agreed Resignation Scheme (MARS). The Trust agreed in March 2014 to allow 7 members of staff to leave the Trust under the MARS which resulted in a cost of £228k.

NHSLA

The Trust received a statement from the Litigation Authority which advised the Trust to provide against 7 cases being assessed under the Liability to Third Parties Scheme.

Onerous Leases

As a result of the transfer of services from the Trust to other providers in 2015/16 (see note 24 for further details) the Trust now has two service contracts which are deemed as onerous as costs have not decreased commenserate with the services transferred.

20. Financial Instruments

20.1 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 those 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. Trust 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.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2015 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with CCG's and Local Authorities, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

20.2 Financial Assets

	Loans and receivables £000s	Total £000s
Receivables - NHS	5,243	**5,243**
Receivables - non-NHS	3,852	**3,852**
Cash at bank and in hand	15,744	**15,744**
Total at 31 March 2015	**24,839**	**24,839**
Receivables - NHS	4,778	4,778
Receivables - non-NHS	2,336	2,336
Cash at bank and in hand	16,590	16,590
Total at 31 March 2014	23,704	23,704

20.3 Financial Liabilities

	Other £000s	Total £000s
NHS payables	4,184	**4,184**
Non-NHS payables	4,749	**4,749**
Total at 31 March 2015	**8,933**	**8,933**
NHS payables	4,423	4,423
Non-NHS payables	3,931	3,931
Total at 31 March 2014	8,354	8,354

21. Losses and special payments

The total number of losses cases in 2014-15 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	0	0
Special payments	0	0
Total losses and special payments	0	0

The total number of losses cases in 2013-14 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	3,236	14
Special payments	0	0
Total losses and special payments	3,236	14

22. Related party transactions

The Department of Health is regarded as a related party. During the year, Cambridgeshire Community Services NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. The Trust also had transactions with other government bodies which are regarded as related parties.
These entities are:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Local Area Teams - East Anglia	0	10,699	0	(54)
Local Area Teams - Hertfordshire and the South Midlands	0	4,135	0	968
Bedfordshire CCG	0	1,389	0	27
Cambridgeshire and Peterborough CCG	76	80,906	552	2,446
Luton CCG	0	16,589	0	185
Cambridgeshire and Peterborough NHS Foundation Trust	287	363	72	91
Hinchingbrooke Health Care NHS Trust	3,644	1,952	674	0
Ipswich Hospital NHS Trust	521	0	360	0
Cambridge University Hospitals NHS Foundation Trust	1,691	802	1,035	337
Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust	737	2,339	296	184
South Lincolnshire CCG	0	595	0	77
West Norfolk CCG	0	662	0	54
Peterborough and Stamford NHS Foundation Trust	1,316	690	988	82
Luton Borough Council	214	3,608	0	0
Suffolk County Council	19	4,699	0	10
Peterborough City Council	54	1,413	0	522
Cambridgeshire County Council	592	14,324	82	191
Huntingdonshire District Council	1,419	0	0	0
Health Education England	0	3,683	0	349
NHS Property Services	2,572	0	688	0
HM Revenue and Customs	6,186	0	1,826	0
NHS Pension Scheme	10,579	0	0	0

Pension Schemes

The NHS Pension Scheme and the Cambridgeshire County Council Local Government Pension scheme are also related parties to the Trust.

Transactions with the NHS Pension Scheme comprise the employer contribution disclosed in note 8. No contributions were owed at the start or end of the financial year. The Scheme is administered by the NHS Business Services Authority.

Transactions with the Cambridgeshire County Council Local Government Pension scheme comprise the employer contributions disclosed in note 8. No contributions were owed at the beginning or end of the financial year.

There have been transactions in the ordinary course of the Trust's business with an organisation with which Directors of the Trust are connected.

The Chief Executive is a Board member of the local Education and Training board and Chair of the Cambridgeshire and Peterborough workforce partnership, both hosted by Health Education England. The Chairman is a board member of Cambridge Housing Association. The Medical Director is Trustee for East Anglia's Childrens Hospices.

Details of directors' and senior managers remuneration are given in the Remuneration Report included in the Trust's Annual Report.

The Trust is corporate Trustee for the children's charity Dreamdrops and the Community Services. This has not been consolidated within the Trust's accounts on the grounds on materiality, with the unaudited results for 2014/15 being £181k of income generation and a closing fund balance of £1,380k.

Prior year 2013/14

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Local Area Teams - East Anglia	0	10,438	0	125
Local Area Teams - Hertfordshire and the South Midlands	0	3,094	0	504
Bedfordshire CCG	0	1,411	0	47
Cambridgeshire and Peterborough CCG	218	79,503	612	1,338
Luton CCG	0	16,464	0	332
Cambridgeshire and Peterborough NHS Foundation Trust	260	420	150	185
Hinchingbrooke Health Care NHS Trust	4,111	1,933	689	2
Cambridge University Hospitals NHS Foundation Trust	1,822	1,047	1,238	384
Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust	1,063	2,453	378	0
South Lincolnshire CCG	0	551	0	66
West Norfolk CCG	0	705	0	88
Peterborough and Stamford NHS Foundation Trust	566	1,105	91	454
Luton Borough Council	128	4,025	15	43
Suffolk County Council	0	4,225	0	54
Cambridgeshire County Council	109	16,629	70	1,763

23. Financial performance targets

The Trust was established as an independent NHS Trust on 1st April 2010 and can therefore only provide 5 years of histroic performance.

23.1 Breakeven performance

	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s
Turnover	102,793	158,331	161,921	157,589	**160,501**
Retained surplus/(deficit) for the year	513	681	1,632	777	**766**
Adjustment for:					
Adjustments for impairments	531	0	0	0	**0**
Other agreed adjustments	(531)	0	0	0	**0**
Break-even in-year position	**513**	**681**	**1,632**	**777**	**766**
Break-even cumulative position	**513**	**1,194**	**2,826**	**3,603**	**4,369**

Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, the Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %
Materiality test (i.e. is it equal to or less than 0.5%):					
Break-even in-year position as a percentage of turnover	0.50	0.43	1.01	0.49	**0.48**
Break-even cumulative position as a percentage of turnover	0.50	0.75	1.75	2.29	**2.72**

23.2 Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

23.3 External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2014-15 £000s	2013-14 £000s
External financing limit (EFL)	**846**	(4,410)
Cash flow financing	**846**	(8,708)
External financing requirement	**846**	(8,708)
Under/(over) spend against EFL	**0**	4,298

23.4 Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2014-15 £000s	2013-14 £000s
Gross capital expenditure	**2,871**	1,971
Charge against the capital resource limit	**2,871**	1,971
Capital resource limit	**3,000**	2,050
Underspend against the capital resource limit	**129**	79

24. Events after the reporting period

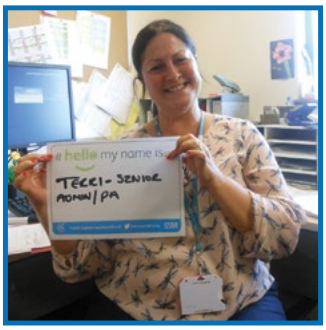
After this accounting date of 31 March 2015, the Trust ceased responsibility for the provision of a range of services for Adults and Older People within the Cambridgeshire and Peterborough localities. This was as the result of the decision of Cambridgeshire and Peterborough Clinical Commissioning Group to change its commissioning arrangements for the following services, putting them out to open market tender:

- Mental Health Services for people aged over 65
- Adult (all people over 18) community health services for example, district nursing, rehabilitation and therapy after injury or illness, speech and language therapy, care for patients with complex wounds, support for people with respiratory disease or diabetes
- Other health services which support the care of people aged over 65.

The successful bidder was a Limited Liability Partnership, UnitingCare, which then awarded the sub-contract for the provision of the community health services to Cambridge and Peterborough NHS Foundation Trust, effective 1st April 2015. This has resulted in the loss of income to the Trust of approximately £50million, and has seen approximately 1,350 staff transfer between the two organisations. Assets and Liabilities relating to the services prior to this date have remained with CCS with the exception of an immaterial transfer of working balances relating to the future operation of the services.

#hello my name is...

Inspired by Dr Kate Granger, a doctor and terminally ill cancer patient, CCS has signed up to the #hello my name is campaign introduced by Kate after a hospital stay where many staff looking after her did not introduce themselves. As Kate says "it is not just about knowing someone's name, but it runs much deeper. It is about making a human connection… "



Glossary
(key performance indicators)

Target	Definition	Calculation method	Purpose of target	Source of underlying data (including assumptions made)	Quantification or commentary on future targets
C difficile: reduce infection rates	Minimise the number of C. difficile infections identified in community hospitals managed by the provider	No. of C. difficile infections in community hospitals managed by the provider	To reduce serious infection rates	Infection control team specialists	Current threshold maintained
MRSA: reduce infection rates	Maintain the number of MRSA infections identified in community hospitals managed by the provider at zero	No. of MRSA infections in community hospitals managed by the provider	To reduce serious infection rates.	Infection control team specialists	Current threshold maintained
18 week referral to treatment completed [and incomplete] pathways (non-admitted patients)	Minimise waiting times for consultant led services, to within national thresholds	No. of patients waiting longer than 18 weeks/ No. patients	To ensure patients are seen in a timely manner	PAS / SystmOne	National threshold maintained
Total time in minor treatment centres: patients seen within 4 hours or less	% patients are seen within 4 hour national targets in minor treatment centres	No. patients seen within 4 hours/ No. patients seen	To ensure patients are seen in a timely manner	SystmOne	National threshold maintained
Sleeping Accommodation Breach	Any breaches of national elimination of NHS mixed-sex accommodation	Total occupied bed days breaching mixed-sex rules	To enhance privacy and dignity of service users	PAS	National threshold maintained
Risk assessments for VTE for all admissions to community hospital inpatient beds	% patients risk assessed for venous thromboembolism upon admission	No. admitted patients VTE risk assessed / No. patients admitted	To ensure appropriate levels of patient safety	PAS	National threshold maintained

Target	Definition	Calculation method	Purpose of target	Source of underlying data (including assumptions made)	Quantification or commentary on future targets
iCaSH - % of people offered an appointment or walk in, within 48 hours of contacting the service	Maximising swift access to sexual health services	No. of patients offered an appt within 48 hours / No. of requests for appt	To ensure sexual health service patients are seen swiftly	LILIE	National threshold maintained
iCaSH - % of first time service users offered an HIV test	Maximising those seeking sexual health services that are screened for HIV	No. of HIV tests offered / No. of new service users	To screen new sexual health service users for HIV	LILIE	Local threshold maintained
iCaSH - % of all under 25 year olds (new attendances) screened for Chlamydia	Maximising those screened for Chlamydia amongst at risk age group	No. of Chlamydia screens achieved from / No. of under 25 years attending service for first time	To screen new sexual health service users for Chlamydia	Specialist Database	Local threshold maintained
iCaSH - % of patients with positive Chlamydia result who received treatment within six weeks of test date	Maximising swift treatment for those with Chlamydia	No. of treatments started in 6 weeks / No. of newly positive for Chlamydia patients	To ensure those newly diagnosed with Chlamydia receive swift treatment	Specialist Database	Local threshold maintained
iCaSH - % of service users experiencing waiting times in clinics of < 2 hours	Ensuring swift access to clinics for service users	Waiting time between arrival and clinic appointment	To minimise un-necessary waiting for service users	LILIE	Local threshold maintained
iCaSH - % of specialist reproductive health referrals from GP seen within 18 weeks of referral	Minimise waiting times for specialist sexual health clinics	Waiting time between referral and appointment date	To ensure users are seen swiftly	LILIE	Local threshold maintained

“I enjoy the area and find that Luton is a fun, vibrant and diverse area to work. No day is the same.”

Wendy Flynn

Team Leader
Central Health Visiting Team

Target	Definition	Calculation method	Purpose of target	Source of underlying data (including assumptions made)	Quantification or commentary on future targets
iCaSH - % of women with access to urgent contraceptive advice services within 24 hours of first contact	Maximise access to contraceptive advice for urgent cases	Waiting time between contact and appointment start	To ensure specific urgent cases are seen swiftly	LILIE	Local threshold maintained
iCaSH – Prevalence of Chlamydia: positive screens recorded	Volume of positive Chlamydia screens in year	Volume of positive Chlamydia screens in year	To maximise coverage and detection of Chlamydia	Specialist Database	Local threshold maintained
Uptake of human papilloma virus vaccination results for school year 8 cohort	Year 8 agreed % of school year cohort immunisation coverage	No. immunised/ No. in school year cohort	To ensure high vaccination rates.	SystmOne	Current thresholds maintained
Percentage of patients waiting 6 weeks or more for diagnostic tests	Any breaches of the 6 week target for a diagnostic test	No. patients waiting more than 6 weeks for diagnostic tests / No. patients	To ensure diagnostic tests are carried out in a timely manner	Specialist databases	National threshold maintained

If you require this information in a different format such as in large print or on audio tape, or in a different language, please contact the Trust's communications team on 01480 308216 or email ccscommunications@ccs.nhs.uk

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