Performance analysis

Clinical Services

In line with the Next Steps on the NHS Five Year Forward View, which promotes better integration of primary and community services, such as general practice, community nursing and social care, we reviewed our clinical services management structures in 2018-19.

Now in 2019, with the publication of the NHS Long Term Plan, HRCH is well on its way to boosting out-of-hospital care and delivering urgent community response and recovery support in primary care networks. In the same week that the long-term plan was published in January 2019, the Chief Executive Officer (CEO) of NHS England, Simon Stevens, visited some of our urgent community response and recovery services in Richmond.

We aim to continue to prepare the trust for the journey towards an integrated care system, focusing on the health and care of people in Hounslow, Richmond and further afield across north and south-west London.

Children's services

Health visiting services play a vital role in public health and prevention and, similarly to workforce challenges in community nursing, the service has experienced problems with recruitment, which meant our nurses in post were carrying heavy caseloads.[1]

The health visiting service took a transformational approach to these challenges, which won the team a prestigious national HSJ workforce award for "challenging the world view on health visiting".[2] Previously, we were not able to offer all expectant mothers an appointment with a health visitor before they gave birth, but we can now. Seven out of ten children are reviewed individually at the age of one and two, compared with four out of ten previously. In addition, 95% of new babies have their reviews completed within 14 days.

Paediatric audiology continues to achieve the Improving Quality in Physiological Diagnostic Services (IQIPS) standard, a professionally-led assessment and accreditation scheme designed to help healthcare organisations ensure that patients receive consistently high-quality services, tests, examinations and procedures delivered by competent staff working in safe environments.[3]

In line with a wider national challenge, we experienced long waiting times for children to get an autism spectrum disorder diagnosis.

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[1] Nursing Times; Health visitors fear staff shortages mean another child tragedy is 'waiting to happen'; https://www.nursingtimes.net/news/news-topics/public-health/health-visitors-warn-staff-shortages-mean-tragedy-waiting-to-happen/7026984.article/

[2] http://www.hrch.nhs.uk/news/press-releases/hrch-wins-national-award/

[3] Physiology Services accreditation (IQIPS); https://www.ukas.com/services/accreditation-services/physiological-services-accreditation-iqips/

Therefore, in 2018 we took an innovative, multidisciplinary approach in the community to reduce waiting times. This reduced average waiting times for an initial discussion from 10.5 months in 2017 to two months in 2018.

Our paediatric team presented this work at an International Paediatric Neurology Conference in January 2019. We continue to work with commissioners to invest in and redesign the service to maintain the improvements we have made.

The childhood immunisations team have undertaken more than 100,000 childhood immunisations across eight London boroughs. The service is leading the way on using technology to reduce costs, increase capacity and make better use of staff time. We were the first London trust to use e-consent forms for parents to sign electronically.

We also vaccinated 1,266 pupils against the human papillomavirus in 12 schools. We had a 73% response rate via e-consent forms, making us the most successful trust for these immunisations in London.

Adult services

Community nursing review

Our district nursing workforce continues to need "to expand at scale and pace in order to meet high quality care, meet rising demand and reduce unacceptable pressures on existing staff."[1] Over the last 18 months we have worked with frontline clinical teams to transform our way of working to mitigate these challenges. Because of this innovative approach to a national challenge, we won a 2018 Nursing Times Award for the best place to work for employee satisfaction.

Our tissue viability service also won the Journal of Community Nursing (JCN) international award for outstanding practice in wound care for our successful implementation of the Wound Care Buddy app for district nurses.[2]

The Care Quality Commission (CQC) inspection this year highlighted the outstanding work of Intravenous therapy nurses who have used technology to develop a new cellulitis pathway; an innovative approach that allows more patients to be treated at home.

Urgent care

Clinical and non-clinical teams at the Teddington Urgent Treatment Centre (UTC) have worked well together to transition smoothly from a walk-in centre to a more comprehensive urgent treatment service, incorporating nurses, therapists, GPs and a new children's acute nursing service. The UTC opened in July 2018. Last year, we saw 50,832 patients in the walk-in centre/UTC with a variety of complaints, including minor illnesses in adults and children, limb fractures and other minor injuries.

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[1] House of Commons Health Committee; The nursing workforce, Second Report of Session 2017-19; page 10: https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/353/353.pdf/

[2] Entechealth: http://blog.entechealth.com/blog/hounslow-and-richmond-community-trust-jcn-award-wound-care-buddy-app/

The service consistently sees patients in under four hours, with most patients being treated within two hours. Between its opening on 9 July 2018 and the end of the year, the centre received 4,724 written compliments. This is just under a half of compliments for all our services whose patients complete a Friends and Family Test survey to say they would recommend them to other people who might need them.

The Urgent Care Centre (UCC) at West Middlesex Hospital saw 102,574patients this year and more than 98% were seen within four hours. This has provided significant support to Chelsea and Westminster Hospital NHS Foundation Trust's emergency access performance. Our latest CQC inspection highlighted the outstanding work of our patient champions, especially their work to help homeless patients access services.

Falls

We worked with the NHSI Falls Collaborative in 2018 because we were concerned about an increasing trend in falls in our inpatient rehabilitation unit at Teddington Memorial Hospital. In the last three months of 2017-18 we reported an average of 7.8 falls per 1,000 occupied bed days. Our analysis showed we needed to focus on initial assessments of patients, but also to look at postural blood pressure recording and visual acuity. Using a plan-do-study-act (PDSA) quality improvement methodology, we achieved a steady reduction and our year-to-date average shows a reduction to 5.95 falls per 1,000 occupied bed days.

Richmond Rapid Response and Rehabilitation Team and Hounslow Integrated Community Response Services

These services work with patients who are sent to them by local hospitals and other community services. They aim to help people avoid the need for hospital care and can respond rapidly (within two hours) to get to patients quickly.

This year, both services trialled Raizer beds in partnership with the London Ambulance Service and our local GPs. The beds allow people to raise patients safely up from the floor after a fall and into a chair or a bed, so we do not need to call an ambulance to attend to them.

Musculoskeletal services

The Hounslow musculoskeletal service has been working closely with GPs to pilot a first-contact practitioner service. Our physiotherapists have been working in GP practices to identify patients they can treat, rather than a GP. This has reduced waiting times for patients to have physiotherapy and freed GPs to see other patients.

End-of-life care

We saw an increase in the number of patients who died where they chose to 92.5%. In addition, 96% (target 85%) of clinical employees completed introductory training in end-of-life care and 80% (target 70%) of registered nurses completed an intermediate level of end-of-life-care training.

They also attended training in advanced care planning and Coordinate My Care, a shared urgent care record for people who are at the end of their lives. We reviewed our annual audit programme against the five priorities of care from One Chance to Get it Right and NICE quality standards and guidelines.

We continue to develop our Always Event in end-of-life care, which helps people living with long-term conditions talk to clinicians about their preferences for safe and effective care at every stage. NHS England are supporting us in gaining accreditation for this work.

Working with partners

In support of the Five Year Forward View and now the NHS Long-Term Plan, we have been developing integrated multi-disciplinary teams to improve the way primary care, community health and social care professionals work in partnership with acute hospitals to deliver care. We are also members of the North West London and the South West London Health and Care Partnerships, which are refreshing their plans, with renewed emphasis on the themes of 'Start well, Live well, Age well'.

At borough level, we are taking a lead on community health services, as part of the Hounslow and Richmond Health and Care provider alliances and are working in partnership with the Hounslow GP Federation and the Richmond GP Alliance to redesign services focused on co-ordinated care and improved patient outcomes.

We have been working with Hounslow GPs on several services. This includes our Primary Care Patient Coordination Service, assisting Hounslow GP practices to deliver joined-up, proactive and planned patient care.

In addition, we continue to work closely with primary care in Richmond via Richmond Community Healthcare in Partnership (RCHiP) with the Richmond GP Alliance. Together we set up care pathways for diabetes, respiratory and cardiology patients. We also worked with commissioners on co-designing urgent care services in the borough.

The trust is working with health and care partners in the boroughs of Hounslow and Richmond to deliver more coordinated, person-centred care across multidisciplinary teams, based on networks. These networks cover population sizes of 30,000 to 50,000 people.

Health and care organisations in Hounslow are coming together to form a partnership. We will work more closely together to join up and improve services offered by the NHS, Hounslow Council, hospitals, mental health trusts and voluntary organisations locally.

We aim to:

- improve health and social care for local people and use our budgets jointly in efficient ways
- join up and coordinate health and care services in better ways
- break down barriers between our different services
- change the things that are not working well in health and care

We continue to work closely with colleagues in the borough of Richmond to improve care for local people and move towards joined-up services. We are also active contributors to the local health and care plan as part of wider initiatives in south-west London.

Services gained and lost

We retained all our services during the last year and acquired the Hounslow school nursing and diabetes services.

Measuring and monitoring performance

Measuring performance

Measurements of performance may be set nationally, agreed locally with commissioners, or devised by the trust itself to monitor improvements in care, safety and service delivery.

In addition to producing regular, scheduled performance reports, the trust's performance and information team produce performance reports on request for managers. The trust also has a business intelligence portal on the intranet, which allows managers to access useful performance information.

Monitoring performance

The trust's performance management framework acknowledges the national context as well as addressing local quality and service priorities. HRCH has a culture of continuous improvement using the cycle of performance management and uses a system of performance reporting against agreed measures and quality priorities.

The monthly performance scorecard allows continuous monitoring of specific datasets such as quality and finance, service specific information and deviation from commissioned targets. This information is used to monitor compliance with service standards and contract review and is used to populate national external data sets, as set out below

The scorecard is reported to the performance executive committee, finance and performance board sub-committee, and the trust board itself. All reports are monitored and discussed at these meetings to identify reasons for any deviation from expected performance, as well as review of progress with action plans to remedy underperformance.

In addition, sub-committee chairs submit a report to the board to highlight areas of assurance or where further actions are needed. The trust continues to develop its performance scorecard report to ensure we are monitoring the things that matter to the delivery of high-quality care and has been commended by NHSI for use of Statistical Process Control (SPC) charts and benchmarking to provide greater assurance.

Board sub-committees receive specific reports on subject areas within their terms of reference e.g. quarterly performance reports covering outcomes against the trust's quality priorities, patient experience, infection prevention and control, safeguarding together with annual reports in these areas.

Contractual performance reports are also reviewed internally each month by the performance executive committee and finance and performance board sub-committee and externally, in partnership with commissioners. The trust also discusses its quality performance with our local commissioners.

During 2018-19, the trust reported monthly to NHS Improvement (NHSI), which supports and holds NHS provider organisations to account for the delivery of consistently safe, high quality, compassionate care for patients within local health systems that are financially sustainable. NHSI assessed HRCH on its financial outturn performance, including agency staffing expenditure.

Since the introduction of the national single oversight framework (SOF) on 1 October 2016, NHSI has also assessed the trust's performance and support needs across five areas: quality of care; finance and use of resources; operational performance; strategic change and leadership and improvement capability.

The framework segments NHS trusts into one of four categories, where 4 indicates a high level of support and intervention and 1 denotes the lowest level of regulator support and intervention. As at 31 March 2018, HRCH was rated as a segment 1 organisation for its use of resources and this has been maintained throughout 2018-19. This means that oversight from NHSI has moved to a 'light touch' approach.

Finally, the trust also publishes its annual outcomes in respect of its performance on workforce race equality and against the NHS Equality Delivery System framework. Please see more detail further on in this report in the 'Embracing equality, diversity and inclusion' section.

Performance 2018-19

The trust reports performance against the five CQC quality domains to ensure a continued focus on quality. The year-end position against a suite of indicators used to measure performance is outlined in the following tables. Unless indicated otherwise, the 'actual' figure quoted is the average for the year or the total number in 18-19. Further detail is provided under the headings of:

• Clinical Services • Quality • Workforce • Finance • Information Governance • Sustainability

SAFE

People are protected from abuse and avoidable harm.

KPI DESCRIPTION	TARGET	ACTUAL	
Incidence of Clostridium difficile	1	1	
Incidence of MRSA	0	0	
Never events occurring in month	0	0	
Medication errors causing serious harm	0	0	
Inpatient falls per 1,000 occupied bed days	8.6	5.95	
Percentage of harm free care (Safety Thermometer)	95%	94.3%	

EFFECTIVE

People's care, treatment and support achieve good outcomes, promote a good quality of life and are based on the best available evidence.

KPI DESCRIPTION	TARGET	ACTUAL	
Percentage of staff appraised	93%	92.3%	
Percentage of staff – statutory & mandatory training	85%	94.7%	
Clinical supervision – % of staff)	90%	95.7%	

CARING

Involving people in their care and treating them with compassion, kindness, dignity and respect.

KPI DESCRIPTION	TARGET	ACTUAL	
Trust composite FFT – % recommend	90%	95.6%	● (green)
Trust composite FFT – % not recommend	10%	1.5%	● (green)
Staff FFT – % recommend the trust as a place to receive care and treatment (year end)	67%	90	● (green)
Staff FFT – % not recommend the trust as a place to receive care and treatment (year end)	33%	3.7%	● (green)
Patient Survey – % patients who felt their privacy and dignity were respected	95%	98.3%	● (green)
Patient Survey – % of patients who felt they received their care in a way that was right for them	95%	98.4%	● (green)

RESPONSIVE

Organising services so that they are tailored to people's needs.

KPI DESCRIPTION	TARGET	ACTUAL	
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge	95%	99.1%	● (green)
RTT waiting times for non-admitted pathways: percentage within 18 weeks	92%	100%	● (green)
RTT waiting times incomplete pathways: percentage within 18 weeks	92%	100%	● (green)
Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	1%	0%	● (green)
Percentage of Delayed Transfers of care	7.5%	7.8%	● (red)
Percentage of services meeting contractual waiting times targets	85%	89.5%	● (green)

WELL LED

Leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, support learning and innovation, and promote an open and fair culture.

KPI DESCRIPTION	TARGET	ACTUAL	
Inpatient Friends & Family Test (FFT) response rate	30%	84.5%	●
A&E FFT (urgent treatment centre and urgent care centre response rate	5%	8.5%	●
Staff FFT – % recommend the trust as a place to work (year end)	61%	71%	●
Staff sickness	3.2%	3.26%	●
Staff turnover	16%	17.2%	●
Vacancy rate	10%	9.4%	●
Temporary costs and overtime as a percentage of total pay bill (reported a month in arrears)	20%	13.8%	●

Quality

Our Journey to Outstanding (J2O) quality improvement programme is our framework for continuous improvement and assurance of compliance with CQC standards. The accountable officer for quality and the CQC is Donna Lamb, director of nursing and non-medical professionals.

Registration with the Care Quality Commission 2018-19

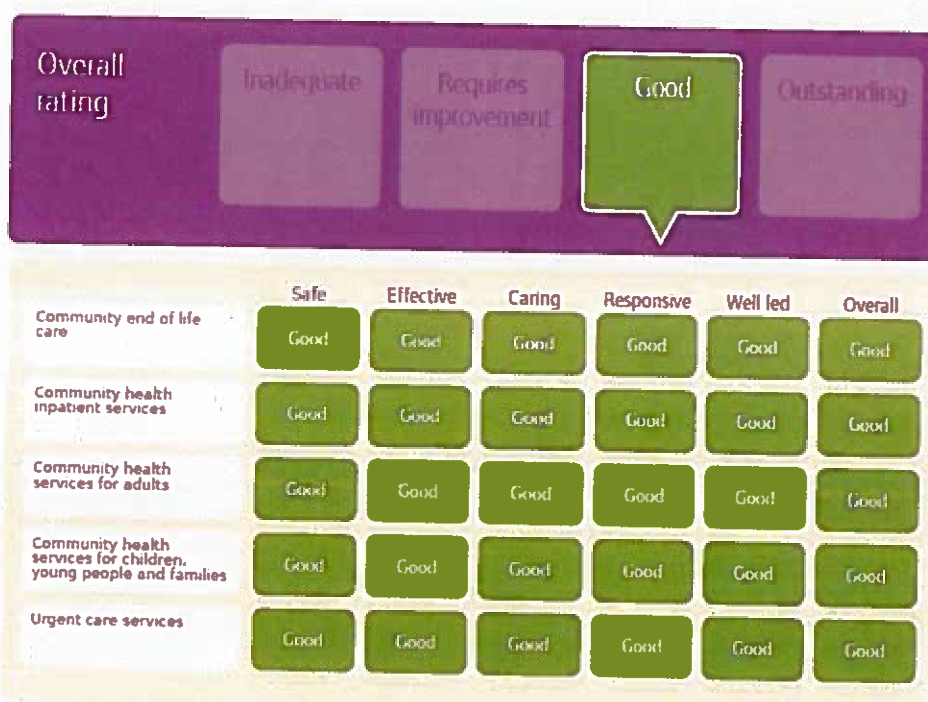
We are registered with the Care Quality Commission (CQC) without any conditions and were not required to participate in any special reviews or investigations between 1 April 2018 and 31 March 2019.

The CQC inspected Hounslow and Richmond Community NHS Trust from 26 June to 24 July 2018. They inspected adult community services, end of life care and urgent care services. The trust was rated as 'Good' in all services and domains of quality, safe, effective, caring, responsive and well led. This is a significant improvement from the inspection in 2016 when the trust was rated 'Requires Improvement' and had three regulatory breaches.

The trust now has no regulatory breaches, but the CQC suggested areas for improvement for which an action plan is being monitored by the Executive Committee. The trust is aspirational and focuses on delivering consistent high-quality care while moving to become an outstanding trust.

Last rated
19 October 2018

Hounslow and Richmond Community Healthcare NHS Trust



Overall rating	Inadequate	Requires improvement	Good	Outstanding

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

Overarching Journey to Outstanding focus for 2018-19

Delivery of our Journey to Outstanding action plan was one of the goals in our 2018-19 strategic quality objectives, with two strands:

CQC compliance

- continued self-assessment through gap analysis to demonstrate Good in all domains
- a programme of peer review
- clear identification of domains that should be the focus for Outstanding
- a programme to support readiness for CQC inspection

Quality Improvement (QI)

- Identifying a clear process and methodology for QI
- Scoping and identifying QI training at a range of levels across the trust
- Support in identifying and initiating QI projects

Quality priorities

We identify three quality priorities each year in the domains of patient safety, patient experience and clinical effectiveness. We also set several other priorities to improve quality of care. However, the three below are the priorities against which we report progress in our annual Quality Account.

Improving patient safety

Priority 1: Improve the management of the deteriorating patient through effective sharing of information

We introduced the SBAR tool (situation, background, assessment, recommendation) to facilitate prompt and effective communication, which is key to safe care.

Our aim

To introduce SBAR in relevant services as a framework for sharing information which leads to safe, timely and effective transfer of care.

Improving clinical effectiveness

Priority 2: Strengthen the application of evidence-based guidance and research

As an organisation that aims to deliver outstanding care in all services, we focus on national best practice and evidence-based guidance, for instance, National Institute for Health and Care Excellence (NICE), to ensure standardised best practice for our patients.

Our aim

To be able to measure actions resulting from our review of NICE guidance relevant to our services. Consideration of guidance must be part of normal record keeping as relevant to the care of the patient. Whenever possible, we will audit electronically, sharing findings with services and clinicians.

Improving patient experience

Priority 3: Promote patient-centred care through better understanding of what matters to our patients

Hearing the voices of patients through stories is key to understanding what matters to them and this is an integral part of co-designing an Always Event. This is a way of defining what patients and families expect from their care, from individual NHS workers and from the NHS generally so that they get the best possible outcomes and experiences.

Our aim

To continue the work started on the Always Events programme in 2017-18 so that we can demonstrate the positive impact of this on patient care and experience. Focus on the Always Events programme in end of life care, inpatient services and dementia care.

Outcomes are reported in our Quality Account, available on our website.

The figures below outline the important achievements made by the year end for 2018-19

0 medication errors causing serious harm
0 never events

94.3% of patients received harm-free care

Number of patients who fell in our inpatient unit
5.95 falls per 1,000 bed days averaged across the year

94.7% of staff completed their statutory and mandatory training by end of year
95.7% of patients on average reported they would recommend our services to their friends and family

98.3% of patients, on average reported their privacy and dignity were respected

Monitoring quality performance

As reported previously in this report, we review all the information available to us about the quality of care in the services we provide. We produce a wide range of reports for internal and external monitoring and performance management each month, as well as action plans for rectifying any issues.

For further details of improvements in 2018-2019, see the trust's quality account – available online at: www.hrch.nhs.uk/quality

Patient feedback

We have an online system which we use to collect patient feedback, clinical audits and other surveys. Feedback from patients is collected using various methods such as iPads, kiosks, comment cards, electronic links and our website.

We also use paper surveys when electronic means are not appropriate and upload results to the system. Last year, 21,965 people told us about their care and treatment as compared to 14,363 in 2017-18.

As part of this year's patient feedback:

98.3% **of patients said they were treated with respect and in dignified ways**

97% **of patients said they felt they had been listened to**

Friends and Family Test (FFT)

Our patients are positive about our services and even more of them than last year would recommend our services to their friends and family if they needed similar care or treatment.

In 2018-19, 19 out of 20 patients said they would recommend our services to their friends and family. We increased our satisfaction rate to 96% this year, compared with 95% for the previous three years.

We also have a children's comment card, designed with their input to ensure we are hearing their voice. In 2018-19, 95% of respondents recommended the children's services they used.

Listening to what patients tell us

Compliments

The vast majority of patients appreciate the kindness, care and expertise of our colleagues and share their appreciation with us. We record and report all compliments and are pleased to report we received 393 **formal** compliments compared to 408 in 2017-18.

These numbers do not capture the many lovely expressions of thanks that patients regularly share with our teams. We are always grateful when patients and families take the time to tell us how much they appreciate our care, as we want to provide the kind of care we would want our families to receive.

The word clouds below capture what people say about our services and our colleagues in feedback that we captured on our electronic patient feedback system in 2018-19.

Service

Staff

Complaints

In 2018-19, we had 67 formal complaints that required detailed investigation and 158 enhanced PALS enquiries that were resolved at a local level, which is a total of 225. In 2017-18 we had 43 formal complaints and 148 enhanced PALS enquiries, which is a total of 191

This suggests complainants want their complaints to be handled as quickly as possible but still investigated properly. We respond in the way that is right for each complainant, which means more complaints receive an immediate response from the service manager or lead clinician to resolve the issue.

The top three complaint areas in 2018-19 are the same as reported in 2017-18. These are 'staff attitude' at 24% of our total complaints for the year, 'treatment/ability' at 18% and diagnosis at 18%. Last year 100% of all formal complaints were responded to within 25 working days. This is an improvement from 91% in the previous year.

However, we are concerned about the number of complaints related to staff attitude. To improve on this our organisational development team devised a new customer service training package which has been piloted with the district nursing teams.

Patient survey

We undertake an annual postal survey of 1,000 patients, focusing on a specific service to provide a snap shot of patient satisfaction. The 2018-19 survey was of Children's Health Visiting services in Hounslow and we will report the learning from the feedback once the survey responses have been analysed.

Embracing equality, diversity and inclusion

Hounslow and Richmond Community Healthcare NHS Trust presents its equality report every year, in line with specific duties for publicly-funded bodies in the Equality Act (2010). We are strongly committed to providing personal, fair and diverse services to the people we serve and employ for three key reasons.

First, this aligns with our core equality aims to be the local community healthcare provider and employer of choice. Secondly, we believe fundamentally in the business case for valuing diversity and inclusion, supported by underpinning evidence, that demonstrates that more diverse organisations provide higher quality care. Thirdly, this is the right thing to do from a moral and ethical perspective to advance fairness for our patients and staff and to eliminate discrimination.

Our ambition remains to improve the health outcomes, access and experience of all our patients, carers, visitors, volunteers and employees.

During the past year, we focused on:

Working with patients

- implementing three NHS England Always Events through co-design methodology, working with a social enterprise company
- developing patient pathways through outcomes-based commissioning in diabetes and respiratory care
- holding 'Hear to Inform' groups to develop audiology materials for children and families
- designing a leavers' pack for the cardiac rehabilitation service

Working with the local community

- medicine training for foster carers in Hounslow
- gaining feedback to determine demand for weekend rehabilitation appointments in the community rehabilitation service
- participating in Hounslow Parent Forum meetings with the designated clinical officer and head of special educational needs and disability
- delivering dementia training at Homelink (day respite centre)
- wide public consultation using a range of methods, including social media, on our 2018-19 quality priorities
- continuing representation from Healthwatch on the trust board and quality governance committee
- the interview process for the Learning Disability Service, which was redesigned to include service users in interviewing for new members of staff
- selecting a new name and logo for the integrated Wheelchair Hub service, following engagement with service users
- working with AccessAble, who were commissioned to review access to our sites and provide access guides
- working with local schools and colleges to promote careers and work experience in the NHS, including a careers bootcamp and visiting secondary schools

Valuing our people

- training for community nurses from an expert carer as a result of a patient story
- focus groups with staff, following NHS staff survey findings on bullying and harassment from patients and staff, with divisional local actions to address this
- celebrating diversity events for employees, which received 100% positive feedback
- setting up unconscious bias training for up to 200 staff – this is embedded as a core part of our Management Essentials training programme
- board accountability, which is well established, with the director of workforce as lead executive for workforce, and director of nursing as lead executive for patients and the public, along with a named non-executive director (NED) for equality and diversity
- supporting the NExT NED programme, which develops future potential NEDs from diverse backgrounds,
- continuing to have one of the more diverse NHS boards in London and England as a whole
- improving employees' health and wellbeing with a range of physical activities and mindfulness sessions
- launching a diversity communications toolkit for managers

However, we know we can do more to build diversity into high-quality services and meet the health needs of our diverse population. We will, therefore, use our move to working in Networks to better understand the needs of local people and plan how we can work with our partners in primary care and the local authority to have a real impact on the health of black and minority ethnic communities and people from diverse backgrounds more generally.

Our latest public sector equality duty annual report shows we have a diverse and representative workforce – more information is available on our website, including patient access information:
http://www.hrch.nhs.uk/about-us/equality-and-diversity/

Mortality data

NHS Improvement's national guidance on learning from deaths, published in March 2017, states 'community trusts should ensure their governance arrangements and processes include, facilitate and give due focus to the review, investigation and reporting of deaths, including those deaths that are determined more likely than not to have resulted from problems in care. Trusts should also ensure that they share and act upon any learning derived from these processes.

The trust reports separately if any adults die in the Teddington Memorial Hospital inpatient unit or the community and records deaths of any adults with learning disabilities through the Learning Disability Mortality Review Programme (LeDeR) process, managed by Hounslow CCG and Richmond CCG.

Adult Services

- All deaths of patients in our inpatient care or who have been recently discharged within 30 days are to be screened once the service becomes aware of the death
- All deaths occurring while services were being provided in the carrying on of a regulated activity or have, or may have, resulted from the carrying on of a regulated activity (eg, wrong dose of medication) are to be screened once the service becomes aware of the death (reportable to the CQC)
- In addition to the mandatory list above, the trust takes a measured approach to identifying other groups for review; frontline clinicians and managers identify any case that might warrant review and from which learning would be beneficial

Cases on the adult caseload are reviewed if:

- there is a concern that the management of care fell short of expected clinical practice
- the GP, pharmacist or any other relevant health professional requests a review
- patients' families or friends raise issues or concerns
- individual members of a clinical team wish for a review to take place
- the trust decides it will record the total number of deaths on a service caseload, once we are informed of the death – these deaths may be entirely unrelated to our services, for example, if someone dies in a road traffic accident, or one of our patients with a leg ulcer then has an unrelated stroke

While a number of patients died in the community or in the Teddington Memorial Hospital inpatient unit, only one was reviewed in line with the criteria.

More information is available on our website: http://www.hrch.nhs.uk/about-us/publications-declarations/

Our people

Our people are fundamental to our success in delivering high-quality patient care. We are proud of our around 1,100 colleagues who recognise the important role they play in maintaining the health and wellbeing of the people we serve.

The people we employ reflect the diverse backgrounds of the communities we serve. In 2018-2019, the Trust Board had 15 members, of whom eight were female and seven were male. We are proud to have diverse staff and board members to serve and engage with our diverse population.

Percentage of employees, leaders and board members with BME backgrounds:

38.9% **of employees – up 1.4% since 2017-18**
31.4% **of leaders up to Band 8C – up 3.3%**
42.9% **of executive directors – up 12.1%**
35.7% **of board members – up 2.4%**

Gender

85.1% **of employees are female – up 0.2%**
14.9% **are male – down 0.2%**

Disability

13.2% **of staff survey responders have declared a disability – up 1.2%**

Our approach to developing our workforce is set out in our Workforce Strategy, which was co-developed with staff. During 2018-19, we continued to deliver on the ambitions set out in the strategy and are pleased that several performance indicators show how successful our plans have been. Work started in 2018-19 on developing a new Workforce Strategy to align with the NHS Long Term Plan, Trust Strategy and the development of an updated Clinical and Quality Strategy.

The NHS is facing another period of change, with an even greater focus on improving the way we run our services to be as efficient as possible. Our colleagues have been rising to the challenge by working in collaboration with health and social care partners on service redesign to meet the changing needs of patients.

An example is our work with local GPs in Hounslow and Richmond to design more seamless services, utilising the skills of the whole primary and community workforce. We are also working closely with health and social care partners to deliver the priorities outlined in the north west and south west London partnerships.

Every single member of our staff is fundamental to our mission to provide care and services that we and our families would want to use. We are committed to constantly improving HRCH as a great place to work. We have also taken steps to ensure we have an inclusive workforce that feels listened to and is engaged.

Workforce performance

Over the course of 2018-19, HRCH met or was within 10% of meeting its workforce targets. The trust made significant improvements as a result of senior-level focus on this key priority area.

Statutory & mandatory training 94.7%

Vacancy rate 9.4%

Staff turnover 17.2%

Staff sickness rates 3.26%

Staff appraisals 92.3%

Some of this year's highlights include:

- **Trust and staff awards:** we won three workforce national awards and continued to invest in our much-valued staff annual and champion awards
- **Equality, diversity and inclusion**: we launched our Celebrating Diversity events to celebrate and raise awareness of the range of backgrounds and experience of our staff and the positive impact this can have on the way we care for patients - due to 100% positive feedback, we held three events during 2018/19
- **Apprenticeships**: we continued to promote apprenticeships as a gateway to careers in the NHS, including more non-clinical apprentices, as well as promoting new Nursing Associate apprentice roles
- **e-Rostering** – we were one of the few trusts nationally to implement this for all staff groups and spent the year supporting staff in using it properly – this helped us reduce unfilled shifts and use our bank more for temporary cover, cutting down on agency costs
- **Paper lite/e-HR processes** – we moved seamlessly to online payslips and absence recording, in addition to electronic recruitment and personnel files
- **Agile working** – we reviewed all our estate to ensure it is fit for purpose and have facilitated more agile working for staff by creating hot desks at all of the sites and ensuring that all relevant staff have access to technology that aids remote working

Wellbeing matters

In 2018-19, 96% of employees said our trust takes positive action on health and wellbeing and we continue to work on making our trust a great place to work. We always look for opportunities to improve employees' wellbeing and time at work.

This year our staff health and wellbeing group became wellbeing champions for employee groups or activities and helped lead on improving wellbeing in their areas. Highlights from this year include the employee wellbeing group hosting a programme of wellbeing events across the trust, including health checks, tai chi taster sessions, team mindfulness sessions, nutrition and weight management advice, art sessions and free stop-smoking support. These sessions were held throughout October and November as part of our employee wellbeing months.

We are aware of pressures on our employees and are always looking for new ways to reduce workplace stress. This year we reviewed and expanded the range of our emotional wellbeing support, including a new stress support guide with links to resources. We also set up more mindfulness groups at different sites by training several new facilitators.

One of our principle wellbeing priorities this year was to create an environment in which mental health can be openly discussed. This began with teams participating in activities for Time to Talk Day and continued in April and May with mental health awareness training in partnership with Richmond Mind.

These sessions provided useful tools to be able to discuss mental health with colleagues and to create suitable action plans for future support. We will continue to prioritise a positive culture where mental health and work pressures can be openly discussed and supported.

Flu vaccinations for patient-facing employees

By using electronic forms for employees to give their consent to having the flu vaccine this year, we were delighted to see a 15% increase in the percentage of patient-facing staff being vaccinated – up from 71% last year to 86% in 2018-19.

Valuing and recognising our colleagues

Employees from across the trust gathered at Twickenham Stoop in November 2018 for our annual staff awards ceremony. They shared in the successes of colleagues who received awards for their dedication, professionalism and compassion.

We are incredibly proud of our outstanding colleagues and the ceremony honoured their many achievements. We received more than 160 nominations for colleagues who demonstrate our trust values in their work each day. The judges said selecting winners was extremely difficult with such strong competition in every category.

To celebrate the 70th year of the NHS we added a special award for Spirit of the NHS, won by the Urgent Treatment Centre team at Teddington Memorial Hospital. This award was for a standard of service that consistently exceeds expectations and dedication to quality improvements and efficiency in their service. We were delighted that Ruth Cadbury, MP for Brentford and Isleworth, joined us to present this award.

Eight other awards were presented to: Nicholas Newman (clinician of the year); Matan Czaczkes & Peer Salahudeen (non-clinicians of the year); Adele Takeda (unsung hero of the year); Veronica Bowles (leader of the year); Dr Vanessa Impey (quality improvement award); Emily Edmondson (employee of the year); The Wheelchair Hub (clinical team of the year); and programme management office (non-clinical team of the year).

We also regularly recognise and reward the hard work and accomplishments of people who go the extra mile for local patients through our quarterly HRCH Champion Awards programme, with individual awards for caring, respect and rising star, plus a team award for communication and innovation. This year more than 30 champion awards have been presented to deserving employees demonstrating outstanding care for patients in our community.

NHS Staff Survey 2018

Each year we take part in the annual national NHS Staff Survey to receive feedback from staff on their experience of working here, to monitor trends and measure the impact of changes we have made in response to feedback.

Out of 90 questions in the survey, we achieved the best score for community trusts in 18. Our results improved in 62 questions overall and 13 of those improved by more than 5%. Five areas remained the same as 2017 and we had a small decline in 22 questions. We will continue to use the survey to focus on working with employees to improve their working lives.

- We had the highest percentage of community trust employees agreeing their role makes a difference to patients/service users at 93%
- 87% of employees are satisfied with the quality of care they give to patients – the national average is 79.9%
- 80% would be happy with the standard of care provided by the trust if a friend or relative needed treatment, compared with a national average of 74.8% – an improvement of 1.2% since last year
- 70.3% of employees would recommend the trust as a place to work – an improvement of 2.1% since last year – the national average is 59.4%
- 68% of our workforce completed the survey – the national average for community trusts is 53%
- We were pleased that the percentage of colleagues who felt unwell due to work-related stress dropped to 32.5% from 34.7% the previous year, equal to the best score for community trusts – the national average is 41.2%

Since last year's survey we have been working to improve the following areas:

- employees agreeing the trust provides equal opportunities for career progression or promotion – this has improved from 82.8% to 85.5%
- percentage of employees working unpaid extra hours – this dropped to 63.7% from 65.2% the previous year
- percentage of colleagues reporting their most recent experience of harassment, bullying, abuse or discrimination at work – reporting improved from 50.9% to 64.5%

We have continued to improve in key areas, including:

- 'I know who the senior managers are here' has improved from 81.3% to 86.9%
- 'I receive regular updates on patient/service user experience feedback in my directorate/department' has improved from 60.5% to 70.4%
- 'I am satisfied with the recognition I get for good work' improved from 54.6% to 59.6%
- 'Communication between senior management and staff is effective' has improved from 43.6% to 54.6%
- 'I am satisfied with the extent to which my organisation values my work' has increased from 47.2% to 53.7%
- 'Senior managers act on staff feedback' has improved from 37.2% to 43.6%

Areas of focus for improvement during 2019-20 following the staff survey:

- Teamwork, support and respect – our results highlight a need to improve the support we offer to teams and the respect we give our colleagues
- Recognition of employee achievements – employees feeling recognised and valued has improved significantly in the last year, but we are below the average for community trusts and want everyone to feel valued and recognised for their work

We will also maintain our continual focus on providing equal opportunities for career progression and promotion.

Best community trust nationally

93% agree their role makes a difference to patients/service users

87% of employees are satisfied with the quality of their work and care

71.2% are satisfied with resources and support

68% of our workforce completed the survey – national average is 53%

Equal best community trust nationally

81.6% of employees feel motivated at work

66% of employees were satisfied with the quality of their appraisals

46% of employees said communication between senior management and staff was good

Top two for community trusts nationally

80.4% of employees would recommend the trust as a place to work or receive treatment

79.6% of our people felt engaged with the trust

79.6% of our people were satisfied with their level of responsibility and involvement

78.2% had confidence and security in reporting unsafe clinical practice

77.4% thought the trust made effective use of patient and service user feedback

64% were satisfied with opportunities for flexible working

Continued to improve scores in most key areas

Our results improved in 62 questions out of 90 and 13 improved by more than 5%

Staff Friends and Family Test

In addition to the annual NHS Staff Survey, our people feed back their views via a quarterly Staff Friends and Family Test survey. In 2018-19, 90% of colleagues told us they would recommend HRCH to friends and family as a place to receive care or treatment. Furthermore, 71% of our employees would recommend HRCH as a place to work

People development

We developed a learning and development strategy in early 2018, to ensure our people get the right support to develop their knowledge, skills and talent. We are committed to training, learning and development for all our people and offer a wide range of opportunities.

In 2018-19, we:

- promoted apprenticeships while collaborating with our STP partners, including National Apprenticeship Week, career fairs and our own community fairs
- ensured enough statutory and mandatory training was available to reach our targets and maintained compliance through the year
- increased knowledge and understanding of organisational development within the workforce team to support design and development programmes across the Trust
- ran our in-house Management Essentials programme, with three cohorts and 50 managers completing it
- embedded unconscious bias training as a module in Management Essentials, in line with our equality and diversity agenda
- continued to improve clinical skills development, through supporting staff at University with funding from Health Education England – this was supplemented by directly-funded development sessions for people applying through the training panel
- procured training to develop a cohort of 24 accredited coaches to build a coaching culture at the Trust

Statutory and mandatory training

By the end of 2018-19, 94.7% of colleagues had done their statutory and mandatory training – significantly exceeding our target of 85% (the previous year we reached 93%). Our training programme promotes the safety and wellbeing of all our people and patients. It includes national core skills which have a direct impact on patient safety, such as information governance, safeguarding adults and children, and resuscitation. In addition, 96.4% of colleagues completed their information governance training.

e-Rostering

In 2018-19, e-Rostering focused on giving managers the skills to make it a useful tool for planning their workforce, reduce unfilled shifts and fill vacant shifts with bank staff before turning to more expensive agency staff. We are one of only a few trusts that have implemented e-rostering across all staff groups and departments and we continue to embed and use this to safely plan cover for all our services.

Finance and information

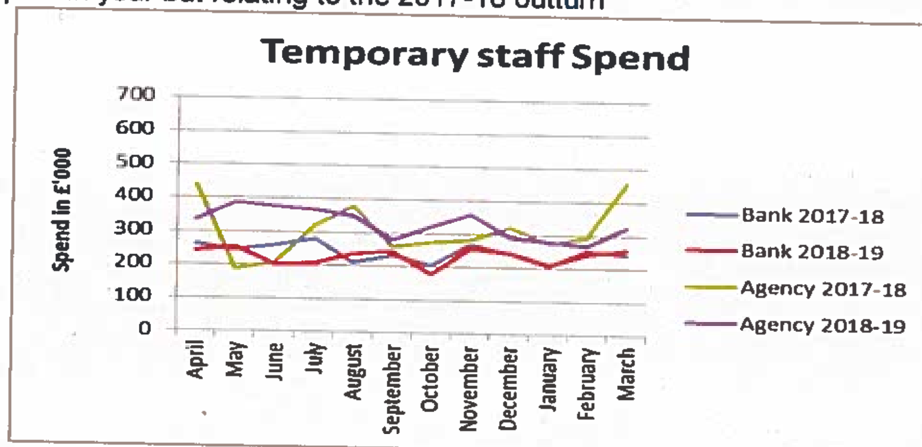
In 2018-19 the trust:

- received £73.9 million in income
- exceeded our planned surplus of £0.697million with an actual surplus of £0.734 million, which enabled the Trust to receive an additional £2.99 million of sustainability and transformation funding (STF) given as a reward to Trusts who meet their NHS budget targets. We also received £0.534 million of donated income to purchase fixed assets. Our total surplus for the year, including this reward funding and donated income was, therefore, £4.258 million
- incurred £2.55 million of capital expenditure, £2.015m on purchased assets, just below our plan of £2.033 million and £534k on donated assets
- contained our spending on agency staff within the cap set by NHS Improvement – despite the need to cover for staff vacancies, we spent £3.9 million on agency staff (8% of our overall spending on pay and lower than the cap of £4.134 million). We maintained our low spending on agency staff through a number of measures, including increasing the number of staff who work for us through bank arrangements, a positive in terms of quality of care and lower costs
- achieved the highest rating under NHS Improvement's 'use of resources' framework, which rates NHS Trusts against a range of financial management tests

Accounts payable – position as at 31 March 2019

Better Payment Policy Compliance (BPPC) – cumulative	Non-NHS	NHS
By number	95.1%	98.7%
By Value	97.9%	99.62%

- Debtors due more than 90 days are £1,539k
- Despite significant pressure on staffing, we maintained low spending on agency staff and remained within pay rate caps, except for small numbers of specialist staff. The agency spend cap in 2018-19 was £4,134,000. We spent £3,929,257, which was 95% of the cap on agency spending and 8% of our overall pay bill
- Cash at 31 March was £21,872,000 against a target of £17,303,000 – cash balances were above plan, mainly as a consequence of a reduction in overall debt and additional STF monies paid in year but relating to the 2017-18 outturn



Information governance

Information governance supports our statutory duty to safeguard patients' information and keep it confidential but available. It assures us and patients that personal information is dealt with legally, securely, efficiently and effectively.

NHS Digital's new data security and protection toolkit helps us assess ourselves against the NHS information governance assurance framework, giving either a pass or fail mark.

We submitted a fully compliant assessment on 27 March 2019. This was achieved through a variety of measures and actions, including:

- implementation of all aspects of the General Data Protection Regulations (GDPR)
- appointment of a data protection officer (statutory role)
- review and revision of privacy notices
- extensive data flow mapping which reviewed flows of information in and out of the organisation, to ensure accountability
- an audit of our compliance against the standards set out in the toolkit by our internal auditors
- business continuity table top exercise
- complete review of policies and staff guidance
- helping colleagues to complete information governance and security e-learning training – 96.4% of staff completed by March 2019

Cyber security

In November 2017 we obtained Cyber Essentials self-assessment certification. This is a government-backed scheme to provide assurance of an organisation's cyber security readiness and security level. We are currently working with the support of NHS Digital to attain Cyber Essentials Plus accreditation.

Environmental sustainability

We operate within the guidelines of the sustainable development strategy for the health and social care system 2014-2020. The trust has invested heavily in efficient technologies, replacing Teddington Memorial Hospital's heating and boiler systems with energy-efficient alternatives. In addition, we replaced heating at many of our sites, standardising equipment and removing inefficient old systems. We also carried out energy surveys and now have a robust five-year plan for efficiency projects.

Staff engagement

Wherever possible, colleagues are consulted and asked for their involvement in new and innovative ideas. People were concerned about the rise in the use of plastic and the effect on the environment. With their support we removed single-use plastic cups and accessories from our canteens and hot drink stations. Our NHS Sustainability Day events in March each year are well attended. This year we invited a representative from Veolia to promote the reduced use of plastics and processes to reduce waste.

Actions to encourage environmental sustainability

- We have a zero waste-to-landfill policy
- We hold monthly waste management training sessions to ensure colleagues follow correct protocols; more than 1,000 people have done this training
- All domestic waste is burned to generate energy, enabling zero landfill; this energy is distributed to the National Grid
- Public transport usage and agile working is encouraged, with agile working locations added to the trust's property portfolio
- Continuous auditing and the introduction of ISO9001 processes, ensuring legal compliance and capturing any missed carbon and/or financial saving opportunities
- Up-to-date reporting identifies trends in utility consumption and waste production and enables the estates team to take action to resolve issues

Utilities

Electricity is hourly metered, so we can see daily peaks and troughs, enabling closer usage management. We have efficient gas boilers and anticipate that we will realise the benefits in the first quarter of 2019, with no increase in gas consumption.

Water consumption has been tightly controlled, reducing stored water on site, while creating a more reliable water system of reducing leaks and water waste.

Waste

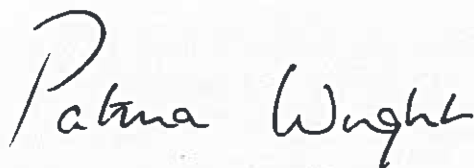
We recycle just over 61% of non-clinical waste, which is almost double the UK national average of 35%.

Transport

We have rationalised our estate, using the space more efficiently, creating a large number of agile working spaces and reducing the need for colleagues to travel around Hounslow and Richmond boroughs. Walking and public transport are encouraged whenever possible. We have also partnered with AccessAble, which provides online information to help colleagues and patients plan their travel, particularly by public transport.

Modern Slavery Act (2015)

In accordance with the Modern Slavery Act 2015, the trust has made a statement on its website regarding the steps taken to ensure that slavery and human trafficking are not taking place in any part of its own business or any of its supply chains: http://www.hrch.nhs.uk/about-us/publications-declarations/(Policies for public domain).



Chief Executive 28 May 2019

SECTION 2 – ACCOUNTABILITY REPORT

2.1 Members of HRCH's Trust Board

Non-Executive Directors:
Stephen Swords, Chairman
Phil Hall
Joanne Hay
Ajay Mehta, Senior Independent Director
Judith Rutherford, Vice Chair
Bindesh Shah

Board Advisor:
Ginny Colwell

Executive Directors:
Patricia Wright, Chief Executive
Monique Carayol, Director of Transformation*
David Hawkins, Director of Finance & Corporate Services
Stephen Hall, Director of Clinical Services^, Richmond and South West London (SWL)
Alison Heeralall, Director of Workforce*
Donna Lamb, Director of Nursing & Non-Medical Professionals
Dr Tony Snell, Interim Medical Director (to 30 April 2018)
Dr John Omany, Medical Director (from 1 May 2018)
Anne Stratton, Director of Clinical Services, Hounslow and North West London (NWL)^
*Non-voting Directors, ^ Voting Directors who share a single vote

Observers (non-voting):
The following are also able to attend board meetings in a non-voting capacity, to represent the community's views:
Sue Charteris - Healthwatch Hounslow representative (to July 2018)
John Marshall – Healthwatch Hounslow (from July 2018)
Paul Pegden Smith - Healthwatch Richmond
Ella Jaczynska – NHS NExT Director
Fiona McKenzie – NHS NExT Director

Membership of Board Committees
The following committees reported to The Board (* denotes committee chair): Patricia Wright, Chief Executive attends each committee a minimum of once a year with the exception of Charitable Funds' Committee and Nominations and Renumeration Committee where attendance is by invitation, as required.

Audit and Risk Committee
Phil Hall*
Bindesh Shah
Judith Rutherford

Charitable Funds' Committee
Ajay Mehta
Stephen Swords*
Anne Stratton

Finance and Performance Committee
Bindesh Shah*
Phil Hall
Joanne Hay
David Hawkins
Stephen Hall

Quality Governance Committee
Ajay Mehta*
Ginny Colwell
Stephen Swords
Donna Lamb
Ann Stratton
Dr Tony Snell (to 30 April 2018)
Dr John Omany (from May 2018)

Nominations and Remuneration Committee
Stephen Swords*
Ajay Mehta
Judith Rutherford
Bindesh Shah
Phil Hall
Joanne Hay

Workforce and Education Committee
Stephen Swords
Joanne Hay*
Ginny Colwell
Alison Heeralall
Donna Lamb
Stephen Hall

Richmond Community Healthcare in Partnership Committee (RCHIP)**
Judith Rutherford*
Monique Carayol
David Hawkins
Donna Lamb
Dr Kieran O'Flynn (Richmond GP Alliance (RGPA) Medical Director) (to Oct 2018)
Dr Michelle Nunes (Richmond GP Alliance (RGPA) Medical Director) (from Oct 2018)
Penny Taylor, RGPA Business Director
Dr Darren Tymens, RGPA Chairman (to Oct 2018)
Dr Karina Knights, RGPA Chair (from Oct 2018)
Dr Alexandra Strahan, RGPA Vice Chair (from Oct 2018)
Patricia Wright, Chief Executive
** RCHiP is a joint committee set up with the RGPA to oversee progress with delivery of the Outcome-Based Commissioning contract. RCHiP is a committee of both the Trust's and RGPA's Boards.

Non-Executive appraisal process
Each year, the Chairman and Non-Executive Directors evaluate their performance through a formal appraisal process and identify any areas for development. The chairman's appraisal review is led by the trust's senior independent director, Ajay Mehta, and in addition, the chairman is subject to an annual appraisal by NHSi

Hounslow and Richmond Community Healthcare
NHS Trust's Board of Directors' declarations of interests

In line with the Nolan principles of public life, Hounslow and Richmond Community Healthcare NHS Trust is committed to openness and transparency in its work and decision making. As part of that commitment, we maintain and publish an annual register of interests on our website which draws together declarations of interests made by members of the Board of Directors. In addition, at the commencement of each Board meeting, members of the Board are required to declare any interests in respect of specific items on the agenda.

Name and position	Job title	Interests declared
Monique Carayol	Director of Transformation	• None
Ginny Colwell	Board Advisor	• Non-Executive Director, Queen Victoria Hospital NHS Foundation Trust
Phil Hall	Non-Executive director	• Managing Director, PHJ Management Consulting Ltd • Finance lead, Surrey County Council
Stephen Hall	Director of Clinical Services (Richmond and South West London)	• Business Development Consultant, Acumentice
David Hawkins	Director of Finance and Corporate Services	• None
Joanne Hay	Non-Executive director	• Chief Executive, Education and Health Charity for young people based in London and Manchester
Alison Heeralall	Director of Workforce	• None
Donna Lamb	Director of Nursing and Non-Medical Professionals	• None
Ajay Mehta	Non-Executive Director	• Non-Executive Director, The Hounslow Arts Trust Ltd • Managing Director, Ki-rin consultancy • Head of Foundation, The Chalker Foundation for Africa • Director, Em4 Ltd

Name and position	Job title	Interests declared
John Omany	Medical Director	• Palliative Medicine Consultant, West Middlesex University Hospital • Director, Omany Medical Ltd • NICE End of Life Care clinical reviewer
Judith Rutherford	Non-Executive Director	• Lead consultant, Anderford Consulting • Lay member of Audit & Risk Committee, Royal College of Veterinary Surgeons • Enterprise Investment Scheme in Time for Medicine Ltd, subsequently acquired by Signum Health • Spouse receives a pension from KPMG
Bindesh Shah	Non-Executive Director	• Chief Executive Officer, Amiri Capital LLP – ended 2018 • Chief Executive Officer, Primrose Hill Capital LLP
Anne Stratton	Direct of Clinical Services	• Spouse is a trustee of NPL Sports Club
Stephen Swords	Chairman	• None
Patricia Wright	Chief Executive	• Member, Royal Pharmaceutical Society of Great Britain • Member, General Pharmaceutical Council • Board Member, Health Innovation Network

Patricia Wright

Chief Executive Date: 28 May 2019

2.2 Financial report from the Director of Finance

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:

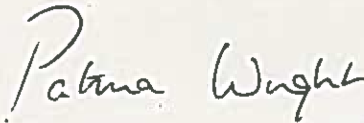
- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and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

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy.

By order of the Board

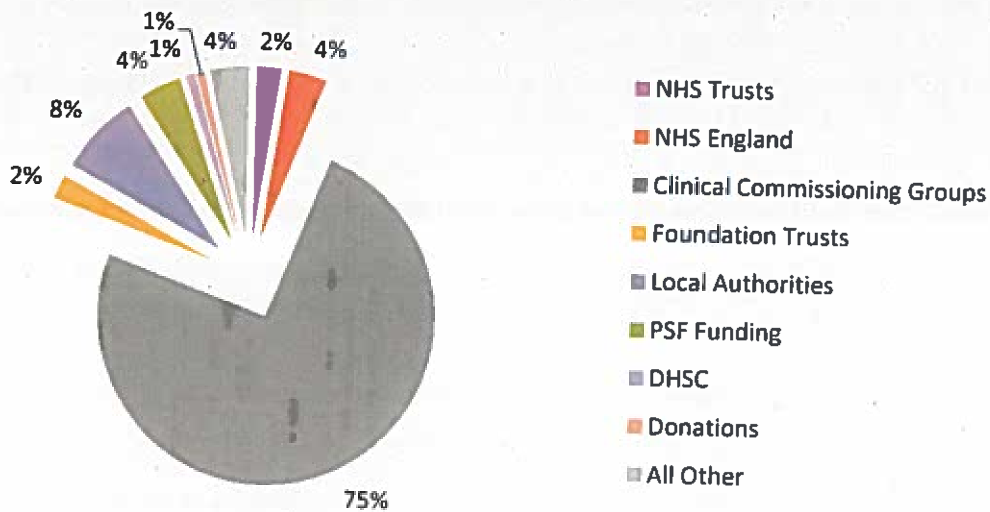
28 May 2019....Date  ..Chief Executive

28 May 2019 Date ..Finance Director

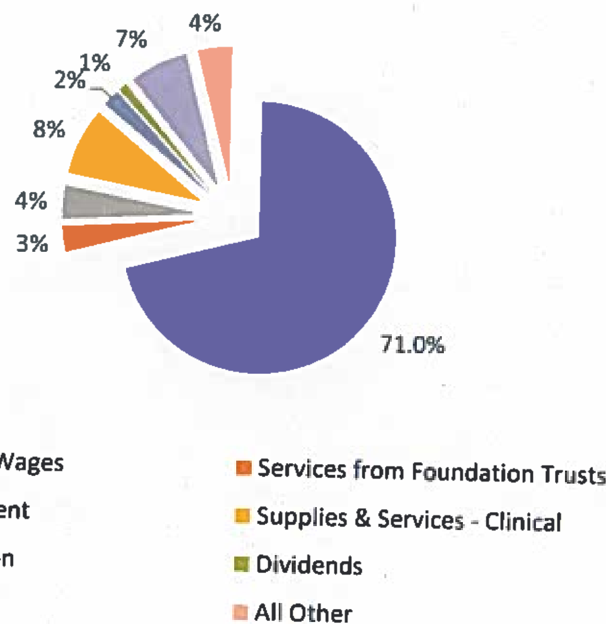
Financial Balance

Hounslow and Richmond Community Healthcare NHS Trust planned for a control total of £1,965k (which included a £1,268k contribution from the Provider Sustainability Fund (PSF)) and delivered a £4,259k surplus. This was achieved through sound financial planning and control by budget managers despite being faced with a number of in-year financial pressures. In addition to the original planned STF funding, the Trust received £255k PSF financial incentive funding and £1467k STF bonus funding which contributed a further £1,722k to the surplus. In addition to this, income of £535k, donated to purchase fixed assets was also accounted for through the Statement of Comprehensive Income (SOCI), adding £535k to the operating surplus.

Total Income for 2018-19 was £73.9m with 75% of this coming from Clinical Commissioning Groups. Hounslow and Richmond CCGs were the trust's two main commissioners.



Total Expenditure for 2017-18 was £69.6m and 71% of this was spent on staff salaries and wages.



Statement of Financial Position

Hounslow and Richmond Community Healthcare NHS Trust ended the year in a strong financial position. Total assets employed increased by £3.7m to £43.3m due to new investment of £2.6m, mainly into buildings, and IT. Trust creditors and accruals have increased by £2.1m. The trust continues to have no borrowing.

Cash-flow

Cash increased by £5.9m in the year due to the high level of surplus delivered, a decrease in overall debtors and an increase in creditors. The cash balance may contribute positively towards future plans including spending on capital projects to improve the patient experience and enhance our technology and systems.

Better Payment Practice Code

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

Hounslow and Richmond Community Healthcare NHS Trust recognises the need in the current economic climate to pay suppliers promptly and has continued to maintain good performance against this code, consistently achieving above the target of 95%.

	2018-19	2017-18
	Number	Number
Non-NHS Creditors		
Total bills paid in the year	18,336	16,671
Total bills paid within target	17,434	15,909
Percentage of bills paid within target	**95.1%**	**95.4%**
NHS Creditors		
Total bills paid in the year	699	826
Total bills paid within target	690	811
Percentage of bills paid within target	**98.7%**	**98.2%**
Overall		
Total bills paid in the year	19035	17,497
Total bills paid within target	18124	16,720
Percentage of bills paid within target	**95.2%**	**95.6%**

The trust has signed up to the Prompt Payments Code.

Auditors

The trust's external auditors for 2018-19 were KPMG. The cost of external audit for work undertaken in 2018-19 was £37,600 excluding VAT. (2017-18 £33,600 excluding VAT).

As far as the directors are aware there is no relevant audit information of which the NHS body's auditors are unaware and that the directors have taken all the required steps as directors in order to ensure they are aware of any relevant audit information and to establish that the auditors are aware of that information.

Looking forward

While the NHS is in a period of transition, HRCH continues to plan on a longer term basis for both revenue and capital spends, which in turn will allow it to provide high quality services for the local population.

2.3 Annual governance statement

2.3.1 Scope of responsibility

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

2.3.2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies and strategic objectives of Hounslow and Richmond Community Healthcare NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Hounslow and Richmond Community Healthcare NHS Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

2.3.3 Capacity to handle risk

The Trust has a robust approach to risk management with:

- the Board holding an annual risk seminar to review risk management systems and processes and to agree the organisational risk appetite statement
- the Audit and Risk Committee assuming delegated authority from the Board for oversight and assurance on the management of strategic risks to the delivery of the Trust's objectives. The Audit and Risk Committee is supported in its oversight of strategic risks by the Finance and Performance, Executive, Quality Governance and Workforce and Education Committees which lead on specific strategic risks
- the Chief Executive has overall accountability for the development of risk management systems and delegates responsibility for the management of specific areas of risk to named Directors
- all staff being provided with risk management training as part of their induction to the Trust
- face-to-face training for those staff regularly involved in risk management being provided as appropriate
- specific training delivered face to face by the Head of Quality and Safety being available, upon request
- an open culture to empower staff to report and resolve incidents and risks through the Datix recording system and to share learning with teams

2.3.4 Managing workforce risks

HRCH has a five-year workforce strategy in place (2014-2019), which was co-developed with clinical and corporate staff and agreed by the Board

- the strategy and its associated action plans and workforce risks are monitored and assured through the Board's Workforce and Education Committee (WEC), which is a sub-committee of the Board. The WEC receives the workforce performance report that uses local and national metrics and triangulates with benchmark data and quality and financial data

- the workforce planning methodology entails firstly understanding the Trust strategy and how to best serve our vision that people will live healthier lives through high-quality, effective and co-ordinated care. Then follows a review of where the trust is and what gaps in skills and training are required to deliver that vision (such as digital and mobile technology and multi-agency transformation and engagement skills), followed by planning of the workforce required to meet the future strategy and activity assumptions in the most efficient way. The planning phase includes consideration of the needs of the local population in terms of workforce diversity, workforce supply (greater use of apprenticeships, 'retire and return' options and the development of new roles) and service transformation in line with the NHS Long Term Plan (greater use of on-line consultations etc)

2.3.5 Managing quality risk

The clinical governance agenda is led by the Director of Nursing and Non-Medical Professionals and the Medical Director. Monitoring arrangements are delivered through a structure of committees, supporting clear responsibilities and accountabilities from board to front line delivery. The Quality Governance Committee (QGC) is a committee of the Board, which affords scrutiny and monitoring of the quality agenda.

- the Quality and Safety Committee (QSC) reports to the QGC. The Director of Nursing and Non-Medical Professionals chairs this committee; membership of the QSC's committees and working groups ensures senior leadership as well as frontline engagement with the governance agenda.
- the trust's clinical governance structure ensures there are robust systems in place for key governance and performance issues to be escalated from frontline services to Board and gives assurance of clinical quality. It gives a strong focus on service improvement and ensures high standards of delivery are maintained
- the Board and the relevant committees use a performance scorecard which has been developed to include a suite of quality indicators at trust and service level aligned to each of the Care Quality Commission's five domains of quality. Services are expected to provide exception reports for any indicators which are not performing as agreed and managers are held to account against action plans to ensure trajectories are maintained. This approach enables centralised reporting of performance and quality data and improved triangulation of information
- the trust's quality improvement strategy is encapsulated in the Journey to Outstanding (J2O) programme. The J2O programme is a structured quality improvement plan with quality improvement plans in all services to monitor and demonstrate compliance with the CQC's fundamental standards and against each of the CQC's domains and Key Lines of Enquiry (KLOE)

2.3.6 The risk and control framework

It is recognised risk management must be forward thinking, the responsibility of all, must be comprehensive and coordinated and that proactive and continuous identification and management of risk is essential to the delivery of high quality healthcare. The trust is committed to a unified approach to risk management and has integrated safety and incident reporting systems. It has developed a governance system of internal control ensuring all strands of governance, financial, clinical and operations are brought together in a coherent way. The aim of the trust's risk management strategy is to support the delivery of organisational aims and objectives through the effective management of risks across all the Trust's functions and activities through effective risk management processes, analysis and organisational learning.

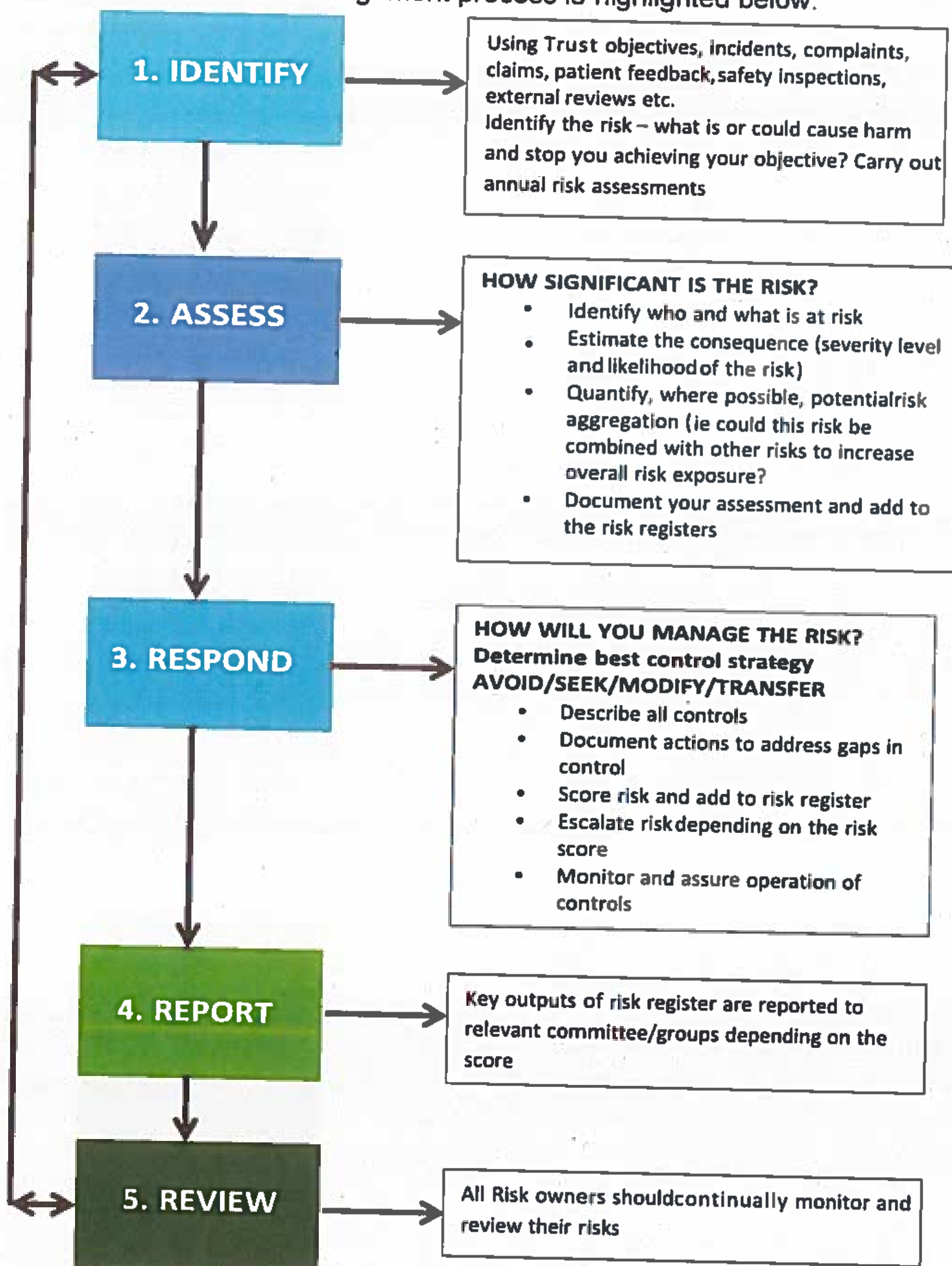
The Trust's approach to risk management aims to:

- embed the effective management of risk as part of everyday practice
- support a culture which encourages continuous improvement and development
- focus on proactive, forward looking, innovative and comprehensive (rather than reactive) risk management
- support well thought through decision making

The Trust Board reviews its risk appetite at least annually when its tolerance for respective risks relating to quality, financial, workforce and system-wide objectives are discussed and set. It achieves this through a framework of committees and documents that ensure systematic identification and mitigation of risks at a strategic and operational level as described in more detail below

2.3.6.1 Risk management process

A snapshot of the trust's risk management process is highlighted below:



2.3.6.2 Trust Risk Registers (TRR) (inc Board Assurance Framework (BAF))
Comprises the local risk registers, the trust risk register as well as the board assurance framework (BAF), which seek to present an overview of the main risks facing the organisation. The local risk registers are reviewed, updated and monitored regularly by the relevant directorate and, if necessary, a risk can be escalated onto the trust risk register, which is monitored each quarter by the Quality and Safety and Quality Governance Committees.

The BAF is monitored by each Executive Director who assesses the status of their risk entry by having oversight of the Trust Risk Register. The BAF is monitored each month by the Executive Committee and quarterly by the Audit and Risk Committee and Trust Board.

The BAF provides a framework for reporting the principal strategic risks to the delivery of the trust's business. It identifies the controls and assurances in place to mitigate these risks, the gaps or weaknesses in controls and assurances, and actions required to further strengthen these mechanisms. The Audit and Risk Committee leads on oversight of the mitigation of risks to delivery of the trust's strategic objectives and is supported by other relevant Board Committees and the Executive Committee.

An annual advisory review on the BAF and Risk Management was carried out by RSM Risk Assurance Services LLP (who also provide our internal audit advice) and concluded the trust controls are robust and effectively designed. RSM confirmed the BAF is discussed at relevant committee meetings to ensure that risks included are up to date with regards to controls and assurances; and any progress against actions is also included.

2.3.6.3 Incident reporting
The trust follows the National Patient Safety Agency viewpoint that *"Trusts that report incidents regularly suggest a stronger organisational culture of safety. They take all incidents seriously and link reporting with learning."* All services and staff are trained to use the Datix system which facilitates linking of information across incident reporting, complaints and risk management.

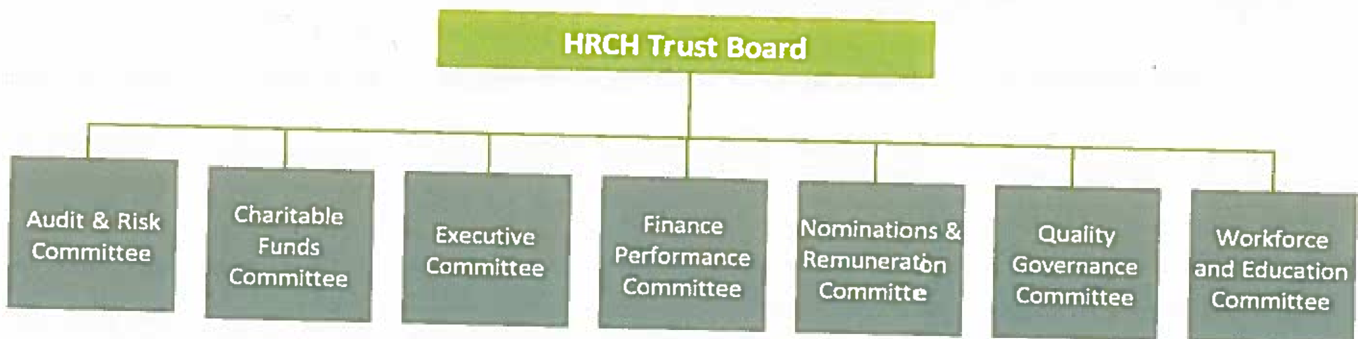
A monthly report of incidents and serious incidents is reported to the Quality and Safety Committee where it is discussed and analysed for themes and trends and assurance is sought that risk is being managed.

The trust is a learning organisation and uses all opportunities to learn from when things go wrong and to share that learning. It has embraced a 'being open' approach and the duty of candour. Organisational and service level learning is identified through incidents, audit and patient feedback and it reports lessons learned and monitor that any required changes in practice are implemented.

The trust promotes a culture of 'shared learning' that is embedded throughout the services and has a number of processes to enable this which includes a monthly 'Learn and Share' newsletter and reflective learning panels to ensure that staff are involved in the discussion and agreement of actions. This promotes clinical ownership, mitigates the risk of a Serious Incident reoccurring and promotes shared learning.

2.3.6.4 Board and Committee oversight and assurance

The Board of Directors leads on integrated governance and delegates key duties and functions to its sub-committees. In addition, the Board reserves certain decision making powers including decisions on strategy and budgets. The diagram below gives an overview of the trust's integrated governance structure



There are five key committees with responsibility for receiving information on risk management within the structure that provide assurance to the Board of Directors. These are: Audit and Risk; Quality Governance; Finance and Performance; Workforce and Education; and, the Executive Committee reporting directly to the Board although not a Board sub-committee.

There are a range of mechanisms available to these committees to gain assurance that systems are robust and effective. These include utilising internal and external audit, peer review, management reporting and clinical audit.

Committee structures

Each Committee Chair works within a framework which ensures a consistent approach across all committees, including terms of reference, upward reporting and review of effectiveness.

The Board of Directors

Membership of the Board of Directors is currently made up of the trust chairman, five independent, Non-Executive Directors, a Board Advisor on clinical matters, and eight Executive Directors of which six are voting members of the Board, two with a share of one vote. The key roles and responsibilities of the Board are as follows:

- to set and oversee the strategic direction of the trust
- review and appraisal of financial and operational performance
- to review areas of assurance and concerns as detailed in the chair's assurance reports from its board committees
- to discharge its duties of regulation and control and meet statutory obligations
- to ensure the trust continues to deliver high quality patient care, with quality and safety as its primary focus, receiving and reviewing quality and patient safety reports and also a chair's report from the key board committee which deals with patient quality and safety – the Quality Governance Committee
- to receive reports from the Audit and Risk Committee, the annual internal auditor's report and external auditor's report and to take decisions, as appropriate
- to agree the trust's annual budget and plan and submissions to NHS Improvement
- to approve the annual report and annual accounts
- to certify against the requirements of NHS provider licence conditions

The Board of Directors meets in public bi-monthly and a breakdown of attendance for the Board's 2018-19 part I meetings is shown below:

Job Title and Name	Attendance
Chairman, Stephen Swords	6 of 6
Board Advisor, Virginia Colwell (non-voting)	6 of 6
Non-Executive Director, Phil Hall	5 of 6
Non-Executive Director, Joanne Hay	5 of 6
Non-Executive Director, Ajay Mehta	5 of 6
Non-Executive Director, Judith Rutherford	5 of 6
Non-Executive Director, Bindesh Shah	5 of 6
Chief Executive, Patricia Wright	6 of 6
Director of Clinical Services, Stephen Hall (shared vote)	6 of 6
Director of Clinical Services, Anne Stratton (shared vote)	6 of 6
Director of Finance and Corporate Services, David Hawkins	6 of 6
Director and Nursing and Non-Medical Professionals, Donna Lamb	6 of 6
Director of Transformation, Monique Carayol (non-voting)	6 of 6
Director of Workforce, Alison Heeralall (non-voting)	5 of 6
Medical Director, John Omany	6 of 6

Audit and Risk Committee

The Audit and Risk Committee is a formal committee of the Board and is accountable to the Board for reviewing the establishment and maintenance of an effective system of internal control. The Committee holds five meetings per annum at appropriate times in the reporting and audit cycle.

Since December 2017, the Audit and Risk Committee leads on providing assurance to the Board on the mitigation of risks to the delivery of the Trust's strategic objectives. It is supported in this oversight and assurance role by the Finance and Performance, Quality Governance and Workforce and Education Board sub committees which lead on reviewing and updating key risks pertinent to their terms of reference. In addition, it receives support from the Executive Committee's monthly oversight and review of progress with the effective mitigation of strategic BAF risks.

This committee also approves the annual audit plans for internal and external audit activities and ensures that recommendations to improve weaknesses in control arising from audits are actioned by executive management.

The Audit and Risk Committee ensures the robustness of the underlying process used in developing the BAF and provides assurance to the Board. The Board monitors the BAF and progress against the delivery of strategic objectives each quarter, ensuring actions to address gaps in control and gaps in assurance are progressed.

Quality Governance Committee

The Quality Governance Committee (QGC) is a formal committee of the Board and is accountable to the Board for reviewing the effectiveness of quality systems, including the management of risks to the trust's quality and patient engagement strategic priorities as well as operational risks to the quality of services.

The committee meets at least six times per year. It also monitors performance against quarterly quality indicators, the quality accounts and all aspects of the three domains of quality namely - patient safety, clinical effectiveness and patient experience.

Finance and Performance Committee

The Finance and Performance Committee reviews financial and non-financial performance across the trust, reporting to the Board. It also has lead oversight for risks to the delivery of trust's sustainability strategic priority, along with delivery of the trust's strategies for estates and information management and technology. The committee holds seven meetings each year.

Workforce and Education Committee

The Workforce and Education Committee meets four times each year and leads on oversight of BAF risks which relate to the trust's staff engagement and recruitment and retention strategic priorities. It reviews performance against the delivery of key workforce plans which also cover staff engagement actions taken following the outcome of the annual NHS staff survey.

Executive Committee

The Executive Committee meets monthly and has delegated responsibility for the management of the trust. In particular, it reviews:

- the development and implementation of business plans, policies, procedures and budgets
- operating and financial performance
- the prioritisation and allocation of investment and resources within limits set down by standing financial instructions
- the effective mitigation of risks to the delivery of the trust's strategic priorities

Nominations and Remuneration Committee

The Nominations and Remuneration Committee is responsible for determining the pay and contractual arrangements for Executive Directors and for monitoring and evaluating their performance and ensuring appropriate succession plans are in place for board members. It is also responsible for ensuring that Directors meet the Fit and Proper Person Test as required by the Health and Social Care Act 2008, (Regulated Activities), Regulations 2014.

Charitable Funds' Committee

Hounslow and Richmond Community NHS Trust, as an NHS body, holds the charitable funds in the capacity of a corporate trustee. The Board has delegated the powers and functions of the corporate trustee to the Charitable Funds' Committee, to act on behalf of the corporate trustee and oversee money deemed to be used for charitable purposes within the organisation. The committee ensures that appropriate policies and procedures are in place to support the objects of the charity and ensures that donated funds and assets are properly spent, managed, invested and accounted for in line with guidance from the Charity Commission and in compliance with the Charities Act 2011, the Audit Commission, and the terms of the fund's governing documents.

Annual committee effectiveness reviews

In line with good governance practice and, as an integral part of being a well-led organisation, each Board Committee annually reviews its performance against its specific terms of reference and objectives. Each committee also comments on its oversight of performance against the delivery of the key work plans for the year. This information is then presented to the trust Board with any revisions to the terms of reference and the forthcoming year's work plan. The Trust Board also considers the whole of its committee structure annually to ensure that it is delivering its requirements.

2.3.7 Provider licence conditions

In terms of the NHS provider license condition four, the Board confirmed that the trust applies principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of healthcare services. In particular, the Board is satisfied that the trust has established and implements:

- an effective Board and Committee structure
- clear responsibilities for the Board and Committees reporting to the Board and for staff reporting to either the Board or its Committees
- clear reporting lines and accountabilities throughout the organisation

2.3.8 Equality analysis

Equality analyses (formerly known as equality impact assessments) are integrated into core business as a requirement for all trust decisions contained in its strategies, policies, procedures and protocols. The trust also has systems in place to ensure that it collects, analyses and acts on information relating to the legislation relating to equality and diversity of its workforce and the population it serves. Control measures are in place to ensure that all the organisation's obligations under quality, diversity and human rights legislation are complied with.

2.3.9 Care Quality Commission registration

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

2.3.10 NHS Pension Scheme

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

2.3.11 Miscellaneous

The trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The trust is fully compliant with emergency preparedness and civil contingency requirements.

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

The trust has in place a range of processes which help to ensure that resources are used economically, efficiently and effectively. These include:

- monthly reporting of financial and non-financial performance to the Board of Directors and the Finance and Performance Committee of the Board
- monthly Executive Performance review meetings where directorates are held to account for financial and non-financial performance
- the production of annual reference costs, including comparisons with national reference costs
- continuous benchmarking of costs and key performance indicators (KPIs) against community trusts and other providers
- standing financial instructions, standing orders and treasury management policy

- a budget holder's manual which sets out managers' responsibilities in relation to managing budgets
- policies covering the declaration of conflicts of interest, anti-fraud and anti-bribery measures, and also standards of business conduct
- reports by RSM Risk Assurance Services LLP as part of the annual internal audit work plan on control mechanisms which may need reviewing
- the Head of Internal Audit's draft and final opinions being presented to the Audit and Risk Committee
- external audit of our accounts by KPMG LLP who also provide an independent view of the trust's effective and efficient use of resources, particularly against value for money considerations
- good performance under NHS Improvement's Single Oversight Framework for NHS providers

2.3.13 Information governance

The NHS Information Governance Framework for health and social care is formed by those elements of law and policy from which applicable information governance standards are derived, and the activities and roles which individually and collectively ensure that these standards are clearly defined and met.

Whilst a key focus of information governance is the use of information about HRCH service users, it applies to information and information processing in its broadest sense and underpins both clinical and corporate governance. Accordingly this has been afforded appropriate priority.

The NHS Operating Framework requires NHS organisations to achieve compliance against all key requirements identified in the Data Security and Protection (DSP) Toolkit. This replaces the previous Information Governance Toolkit. The revised reporting toolkit reflects the new reporting requirements of the General Data Protection Regulation (GDPR), and for relevant organisations the Networks and Information System (NIS) Regulations.

The trust manages its risks to data security through a number of different approaches.

The trust has a Board level Senior Information Risk Owner (SIRO) – the Director of Finance and Corporate Services - who works closely with the Caldicott Guardian (Medical Director). The Information Governance Committee is responsible for setting the framework for information security standards in the trust and ensuring delivery of action plans to improve compliance. A key part of the group's work is to review compliance against the Information Security requirements of the DSP Toolkit and to ensure the evidence is externally assured through audit. It is a sub-committee of the Quality Governance Committee (QGC) and provides assurance to the QGC and the HRCH Board that the Trust is meeting the requirements of the DSP Toolkit and monitors any information incidents/issues.

The key strands of the trust's management of risk to data security are:

- ensuring that the trust has an Information Governance Policy that provides a framework for managing information risk that is in line with national guidance and the trust strategy, information security and overall Risk Management Policy
- developing a range of information governance training packages and literature, suitable to the needs of different staff groups and mandating this annually
- ensuring the trust's IT systems are physically secure and have sufficient password protection and firewalls to prevent harm from malware or external hacking. This also includes provision of encrypted portable devices and provision of email encryption facilities

The trust reports information governance "serious incidents" onto the national serious incident reporting system, STEIS, and to the Information Commissioners' Office (ICO).
In 2018-19, one IG incident was reported as an SI and so was reported to the ICO.

The ICO have advised that they are taking no further action because the incident was due to a human error, the risk of detriment to the data subjects as a result of the incident was regarded as low and we had taken appropriate actions to mitigate any further incidents occurring.

From 25 May 2018, the trust has been following General Data Protection Regulation guidance and reporting all incidents which have deemed to affect the rights and freedoms of an individual to the ICO within 72 hours.

2.3.12 Annual Quality Account

In line with the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) the trust prepares an annual Quality Account which is signed off by the Trust Board prior to it being shared with commissioners, Healthwatch and the local authority scrutiny committees.

The Quality Account is a summary of performance in the last year in relation to quality priorities and national requirements. The Account is not required to be audited however an internal process of scrutinising the data to ensure it is consistent with the trust performance scorecard is used. The template used for the quality account meets statutory requirements and the trust reviews new guidance annually - for instance the inclusion of mortality data in the 2017-18 quality account.

General data quality is audited annually and the trust has undertaken actions to improve the quality of its electronic patient record through better use of templates and the automation of data where appropriate. The trust assures the quality and accuracy of elective waiting time data through both its Business Intelligence reporting and the Patient Tracking List (PTL) that is distributed to, and discussed by, operational leads. Waiting times are individually monitored by both service lines and urgency. Alongside external data quality audits, data capture is continually reviewed by the applications team and any training requirements are subsequently assessed with resource then appropriately allocated.

2.3.13 Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the Executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Risk Committee and Quality Governance Committee and plans to address weaknesses and ensure continuous improvement of the system are in place.

The Board ensures the effectiveness of the system of internal control through clear accountability arrangements.

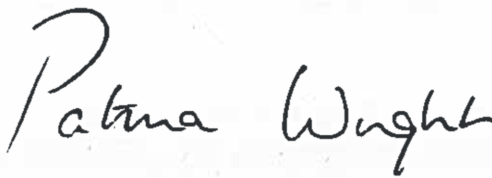
An annual "Head of Internal Audit Opinion" based on the work and audit assessments undertaken during the year for 2018-19 was issued and provided assurance that the organisation has an adequate and effective framework for risk management, governance and internal control.

Factors which helped to inform the Head of Internal Audit's Opinion included undertaking specifically requested management reviews with the aim of strengthening current practices. The conflicts of Interest audit has shown partial assurance and internal audit have provided recommendations to address and strengthen processes in line with current requirements. The Head of Internal Audit Opinion also identified further enhancements to Data Quality and Clinical audit to ensure that it remains adequate and effective.

I am confident that the internal audit reports undertaken were a true reflection of HRCH's position and that the updated action plans scrutinised at the Quality Governance Committee and Audit and Risk Committee reflect clear and concise progress in all areas

Conclusion

I confirm that no significant internal control issues have been identified.



Chief Executive Date: 28 May 2019

2.4 Remuneration and staff report

Remuneration report
Hounslow and Richmond Community Healthcare NHS Trust (HRCH) Nominations and Remuneration Committee is responsible for determining the pay and contractual arrangements for its most senior managers and for monitoring and evaluating their performance. Information relating to Executive and Non-Executive directors is therefore included in this report.

The committee comprises the Chairman and all Non-Executive Directors of the Board. The Nominations and Remuneration Committee reviews the salaries of its most senior managers annually. Cost of living awards are in accordance with the guidance issued by NHSi.

Standardised terms and conditions of service apply to the most senior managers, who are employed on contracts of employment. Performance of the most senior managers is assessed formally through an individual performance and development review process. Performance-related payments were made in the remuneration packages in 2018-19.

Details of directors' remuneration and pension entitlements are covered in the following tables. This has been subject to audit.

Information from the Register of Interests recorded by Board Directors during the year can be found within this report.

Starting salaries for Executive Directors are determined by the committee with reference to guidance from NHS Improvement (NHSi), independently obtained NHS salary survey information, internal relativities, and equal pay provisions and other labour market factors, where relevant.

Pay progression is determined by the committee for:

- annual inflation considerations in line with nationally published indices (RPI/CPI), Department of Health/NHSi guidance and other nationally determined NHS pay settlements

- specific review of the individual salaries in line with independently obtained NHS salary survey information, other labour and market factors where relevant, e.g. for cross sector functional disciplines, internal relativities and equal pay provisions. Such review is only likely where an individual director's portfolio of work or market factors change substantially.

Other senior managers are paid in accordance with the national NHS Agenda for Change pay system.

The remuneration of the chairman and the Non-Executive directors is set by NHSi.

Contracts

Contracts for directors are normally substantive (permanent) contracts subject to termination by written notice, by either party, except in cases of gross misconduct, when summary dismissal would be imposed. On occasion, as required by the needs of the organisation, appointments may be of a temporary or 'acting' nature in which case a lesser notice period may be agreed.

Termination liabilities for Executive Directors

There are no provisions for compensation for early termination for any Executive Directors, as detailed in the table below.

Other termination liabilities for all Executive Directors are the entitlements under the relevant NHS terms and conditions and the NHS Pension scheme. Statutory entitlement also applies in the event of unfair dismissal. The balance of annual leave earned but untaken would be due to be paid on termination.

Name	Post Title	Date of Contract	Unexpired Term	Notice Period	Provision for Compensation for Early Termination	Other Termination Liability
Patricia Wright	Chief Executive	1 November 2016[1]	Substantive	3 months	None	See text above
David Hawkins	Director of Finance and Corporate Services	1 April 2011[2]	Substantive	3 months	None	As above
Donna Lamb	Director of Nursing and Non-Medical Professionals	1 February 2018[3]	Substantive	3 months	None	As above
Anthony Snell	Medical Director (Interim)	25 July 2017 – 30 April 2018	Fixed Term	3 months	None	As above
John Omany	Medical Director	1 May 2018	Substantive	3 months	None	As above
Alison Heeralall	Director of Workforce	25 November 2015[4]	Substantive	3 months	None	As above
Monique Carayol	Director of Transformation	1 October 2016[5]	Substantive	3 months	None	As above
Anne Stratton	Director of Clinical Services	1 October 2016	Substantive	3 months	None	As above
Stephen Hall	Director of Clinical Services	3 January 2017	Substantive	3 months	None	As above

[1] interim fixed term CEO from October 2015 and fixed term from 1 May 2016 to 31 October 2016
[2] New VSM contract incorporating Corporate Services from 1 January 2016
[3] Acting Director of Nursing from 1 April 2017 to 31 January 2018
[4] New VSM contract incorporating Communication from 1 October 2016, substantive from 1 October 2018
[5] Substantive from 1 October 2018

Salaries and Allowances Entitlement of Senior Managers

Name	Title	2018-19						2017-18					
		Salary (bands of £5,000)	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5,000)	Long Term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)	Salary (bands of £5,000)	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5,000)	Long Term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)
Patricia Wright*	Chief Executive	155-160	0	15-20	0	0	170-175	150-155	0	0	0	0	150-155
David Hawkins	Director of Finance and Corporate Services	115-120	0	0	0	0	115-120	115-120	0	0	0	0	115-120
Siobhan Gregory **	Director of Quality and Clinical Excellence	0	0	0	0	0	0	70-75	0	0	0	0	70-75
John Omany***	Medical Director	70-75					70-75		0	0	0	0	0
Rosalind Ranson ****	Medical Director	0	0	0	0	0	0	135-140	0	0	0	0	135-140
Donna Lamb	Director of Nursing & Non-Medical Professionals	95-100	0	0	0	0	95-100	90-95	0	0	0	0	90-95
Tony Snell *****	Interim Medical Director	5-10	0	0	0	0	5-10	75-80	0	0	0	0	75-80
Alison Heeralall	Director of Workforce	90-95	0	0	0	0	90-95	90-95	0	0	0	0	90-95
Anne Stratton	Director of Clinical Services	90-95	0	0	0	0	90-95	85-90	0	0	0	0	85-90
Stephen Hall	Director of Clinical Services	95-100	0	0	0	0	95-100	90-95	0	0	0	0	90-95
Monique Carayol	Director of Transformation	90-95	0	0	0	0	90-95	90-95	0	0	0	0	90-95
Stephen Swords	Chairman	25-30	0	0	0	0	25-30	25-30	0	0	0	0	25-30
Ajay Mehta	Non-Executive Director	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Judith Rutherford	Non-Executive Director	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Phil Hall	Non-Executive Director	5-10	0	0	0	0	5-10	0-5	0	0	0	0	0-5
Joanne Hay	Non-Executive Director	5-10	0	0	0	0	5-10	0-5	0	0	0	0	0-5
Bindesh Shah	Non-Executive Director	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Virginia Colwell	Board Advisor	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10

* Bonus paid relates to two financial years **Director left October 2017, *** Director Started May 2018, **** Director left June 2017, ***** Interim Director started July 2017 left April 2018

Pension Benefits

Name and Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2019 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2018	Cash Equivalent Transfer Value at 31 March 2019	Real increase in Cash Equivalent Transfer Value	Real increase in Cash Equivalent Transfer Value after Deductions	Employer's contribution to stakeholder pension
	£'000	£'000	£'000	£'000	£'000	£'000	£'000		£'000
Patricia Wright Chief Executive	0-2.5	2.5-5	55-60	175-180	1,231	1,409	141	119	0
John Omany Medical Director	0-2.5	5-7.5	40-45	125-130	0	0	0	0	0
David Hawkins Director Of Finance and Corporate Services	0-2.5	0-2.5	40-45	100-105	679	808	109	92	0
Donna Lamb Director of Nursing & Non Medical Professionals	2.5-5	0-2.5	40-45	105-110	652	796	124	111	0
Anne Stratton Director of Clinical Services	0-2.5	2.5-5	35-40	110-115	704	858	133	120	0
Stephen Hall Director of Clinical Services	0-2.5	0-2.5	20-25	50-55	280	359	70	57	0
Alison Heeralall Director of Workforce	0-2.5	0-2.5	35-40	95-100	646	767	102	89	0
Monique Carayol Director of Transformation	0-2.5	0-2.5	15-20	35-40	202	260	53	40	0

Note that pension related benefits include the cash value of payments made in lieu of retirement benefits and any contributions made which are not part of the routine employer superannuation payments

As Non-Executive Directors do not receive pensionable remuneration, there will be no entries in respect of pensions for them. Pension details have only been disclosed for those Directors in post during 2018-19.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

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

Remuneration ratios

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

The banded remuneration of the highest paid director in Hounslow and Richmond Community Healthcare NHS Trust in the financial year 2018/19 was £142,032 (2017/18 - £139,957). This was 4.46 times (2017/18 – 4.7) the median remuneration of the organisation's workforce of £31,864 (2017/18 - £29,986). In 2018/19, Nil (2017/18 Nil), employees received remuneration in excess of the highest paid director. Remuneration ranged from £17,652 to £118,950 (2017/18 £15,671 to £116,515)

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.

Staff Costs

The following table sets out the costs of staff employed either permanently, on the bank or via agency during 2018-19.

			2018-19	2017-18
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	34,610	2,410	37,020	36,421
Social security costs	3,192	212	3,404	3,447
Apprenticeship levy	171	-	171	168
Employer's contributions to NHS pensions	4,476	156	4,632	4554
Pension cost - other	-	-	-	-
Other post-employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	-	-	-	-
Temporary staff	-	3,929	3,929	3695
Total gross staff costs	**42,449**	**6,707**	**49,156**	**48,285**
Recoveries in respect of seconded staff				
Total staff costs	**42,449**	**6,707**	**49,156**	**48,285**

Average number of employees (WTE basis)

			2018-19	2017-18
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	11	1	12	11
Ambulance staff	1	-	1	-
Administration and estates	111	21	132	137
Healthcare assistants and other support staff	315	29	344	346
Nursing, midwifery and health visiting staff	258	43	301	340
Nursing, midwifery and health visiting learners	6	-	6	4
Scientific, therapeutic and technical staff	253	30	283	290
Healthcare science staff	12	-	12	10
Social care staff	-	-	-	-
Other	2	-	2	1
Total average numbers	969	124	1,093	1,139
Of which:				
Number of employees (WTE) engaged on capital projects	1	-	1	1

Exit packages

Reporting of compensation schemes - exit packages 2018-19

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	0	-	0
£10,001 - £25,000	0	-	0
£25,001 - 50,000	-	0	0
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	0	0	0
Total resource cost (£)	£0	£0	£0

Reporting of compensation schemes - exit packages 2017-18

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	3	-	3
£10,001 - £25,000	3	-	3
£25,001 - 50,000	-	1	1
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	6	1	7
Total resource cost (£)	£48,000	£32,000	£80,000

Exit packages: other (non-compulsory) departure payments

	2018-19		2017-18	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	1	32
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	-	-	1	32
Of which:	-	-	-	-
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

For all off-payroll engagements as of 31 March 2019 for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2019	0
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

The trust can confirm that all existing off-payroll engagements have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

For all new off-payroll engagements between 1 April 2018 and 31 March 2019, for more than £245 per day and that last longer than six months:

Of which...

	Number
No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	0
Of which:	
No. assessed as caught by IR35	0
No. assessed as not caught by IR35	0
No. engaged directly (via PSC contracted to department) and are on the departmental payroll	0
No. of engagements reassessed for consistency/assurance purposes during the year.	0
No. of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll Board member/senior official engagements

For any off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019

	Number
No. of off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, during the financial year. (1)	0
No. of individuals that have been deemed "Board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both off-payroll and on-payroll engagements	16

SECTION 3 – FINANCIAL STATEMENTS

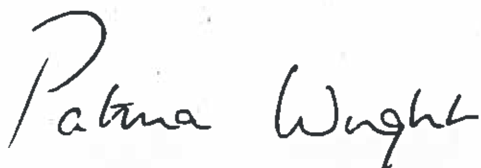
3.1 Accountability Statements

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum*. These include ensuring that:

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

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



Chief Executive **Date: 28 May 2019**

3.2 FINANCIAL accounts

The summary financial statements are shown below a full copy of the accounts can be obtained from the website: www.hrch.nhs.uk

The auditor's issued an unqualified opinion on the full accounts and stated that the strategic and Director's reports were consistent with the full accounts and annual report.

Hounslow and Richmond Community Healthcare NHS Trust
Summary Financial Statements 2018-19
Statement of Comprehensive Income for year ended 31 March 2019

	2018-19	2017-18
	£ 000	£ 000
Employee benefits	(49,156)	(48,285)
Other costs	(19,850)	(18,508)
Revenue from patient care activities	67,960	67,985
Other Operating revenue	5,893	3,477
Operating surplus/(deficit)	**4,847**	**4,669**
Investment revenue	102	33
Surplus/(deficit) for the financial year	**4,949**	**4,702**
Public dividend capital dividends payable	(691)	(691)
Retained surplus/(deficit) for the year	**4,258**	**4,011**
Other Comprehensive Income		
Revaluation of Assets	**(560)**	**443**
Total comprehensive income for the year	**3,698**	**4,454**

Statement of Financial Position as at 31 March 2019

	2018-19 £ 000	2017-18 £ 000
Non-current assets		
Property, plant and equipment	27,006	27,096
Trade and other receivables	0	0
Total non-current assets	27,006	27,096
Current assets		
Trade and other receivables	6,501	6,455
Cash and cash equivalents	21,872	15,942
Total current assets	28,373	22,397
Total assets	55,379	49,493
Current liabilities		
Trade and other payables	(11,275)	(9,156)
Provisions	(32)	(13)
Other Liabilities	(25)	
Total assets less current liabilities	44,047	40,324
Total non-current liabilities	(700)	(675)
Total Assets Employed	43,347	39,649
FINANCED BY		
Retained earnings	32,694	28,436
Revaluation reserve	10,653	11,213
Total Taxpayers' Equity	43,347	39,649

Chief Executive Date: 28 May 2019

Statement of Changes in Taxpayers' Equity at 31 March 2019

	Retained earnings £000
Changes in taxpayers' equity for 2018-19	
Balance at 1 April 2018	39,649
Retained surplus/(deficit) for the year	4,258
Revaluation of Assets	(560)
Balance at 31 March 2019	43,347

Statement of Cash Flows for the Year Ended 31 March 2019

	2018-19	2017-18
	£ 000	£ 000
Cash Flows from Operating Activities		
Operating Surplus/Deficit	4,847	4,669
Depreciation and Amortisation	2,080	2,015
Income recognised in respect of capital donations	(534)	0
Impairments and Reversals	0	0
PDC Dividend Paid	(691)	(691)
(Increase)/Decrease in Trade and Other Receivables	(46)	(1,409)
Increase/(Decrease) in Trade and Other Payables	2,644	1,843
Provisions Utilised	0	0
Increase/(Decrease) in Provisions	19	(401)
Net Cash Inflow/(Outflow) from Operating Activities	8,319	6,026
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest Received	102	33
Receipt of cash donations to purchase capital assets	534	0
(Payments) for Property, Plant and Equipment	(3,025)	(1,135)
Net Cash Inflow/(Outflow) from Investing Activities	(2,389)	(1,728)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	5,930	4,924
CASH FLOWS FROM FINANCING ACTIVITIES	0	0
Net Cash Inflow/(Outflow) from Financing Activities	0	0
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	5,930	4,924
Cash and Cash Equivalents (and Bank Overdraft) at beginning of the year	15,942	11,018
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies	0	0
Cash and Cash Equivalents (and Bank Overdraft) at year end	21,872	15,942

3.3 GLOSSARY OF FINANCIAL TERMS

Accruals
An accounting concept. In addition to payments and receipts of cash (and similar), adjustment is made for outstanding payments, debts to be collected, and stock (items bought, paid for but not yet used). This means that the accounts show all the income and expenditure that relates to the financial year.

Assets
An item that has a value in the future. For example, a debtor (someone who owes money) is an asset, as they will in future pay. A building is an asset, because it houses activity that will provide a future income stream.

Break-even (duty)
A financial target. Although the exact definition of the target is relatively complex, in its simplest form the break-even duty requires the NHS organisation to match income and expenditure, i.e. make neither a profit nor a loss.

Capital
In most businesses, capital refers either to shareholder investment funds, or buildings, land and equipment owned by a business that has the potential to earn income in the future. The NHS uses this second definition but adds a further condition – that the cost of the building/equipment must exceed £5,000. Capital is thus an asset (or group of functionally interdependent assets), with a useful life expectancy of greater than one year, whose cost exceeds £5,000.

Capital charges
Capital charges are a device for ensuring that the cost associated with owning capital is recognised in the accounts. A charge is made to the income and expenditure account on all capital assets except donated assets and those with a zero net book value. The capital charge comprises depreciation, and a return similar to debt interest. This rate of return is set by the Treasury and is currently 3.5%.

Capital resource limit (CRL)
An expenditure limit determined by the Department of Health for each NHS organisation limiting the amount that may be expended on capital purchases, as assessed on an accruals basis (i.e. after adjusting for debtors and creditors).

Cost improvement programme
The identification of schemes to reduce expenditure/increase efficiency.

Current assets
Debtors, stocks, cash or similar – i.e. assets that are, or can be converted into, cash within the next twelve months.

Depreciation
The process of charging the cost of an asset over its useful life as opposed to recording its cost as a single entry in the income and expenditure records. Depreciation is an accounting charge (i.e. it does not involve any cash outlay). Accumulated depreciation is the extent to which depreciation has been charged in successive years' income and expenditure accounts since the acquisition of the asset.

Financial reporting standard (FRS)	Issued by the Accounting Standards Board, financial reporting standards govern the accounting treatment and accounting policies adopted by organisations. Generally these standards apply to NHS organisations.
Fixed assets	Land, buildings or equipment that are expected to generate income for a period exceeding one year.
General medical services	Medical services provided by general practitioners (as opposed to dental, ophthalmic and pharmaceutical services provided by other clinical professions).
Governance	Governance (or corporate governance) is the system by which organisations are directed and controlled. It is concerned with how an organisation is run – how it structures itself and how it is led. Governance should underpin all that an organisation does. In the NHS this means it must encompass clinical, financial and organisational aspects.
Healthcare resource group (HRG)	HRGs are the 'currency' used to collate the costs of procedures/diagnoses into common groupings to which tariffs can be applied. HRGs place these procedures and/or diagnoses into bands, which are 'resource homogenous', that is, clinically similar and consuming similar levels of resources.
Indexation	A process of adjusting the value, normally of fixed assets, to account for inflation.
Net book value	The value of items (assets) as recorded in the balance sheet of an organisation. The net book value takes into consideration the replacement cost of an asset and the accumulated depreciation (i.e. the extent to which that asset has been 'consumed' by its use in productive processes).
Overheads	Overhead costs are those costs that contribute to the general running of the organisation but cannot be directly related to an activity or service. For example, the total heating costs of a hospital may be apportioned to individual departments using floor area or cubic capacity.
Payment by results	A financial framework in which providers are paid according to the level of activity undertaken. Payment is based on a national tariff system.
QIPP	Quality, Innovation, Productivity and Prevention: National Department of Health strategy involving all NHS staff, patients, clinicians and the voluntary sector. It aims to improve the quality and delivery of NHS care while reducing costs to make £20bn efficiency savings by 2014-15. These savings will be reinvested to support the front line.

Reference costs	NHS organisations are required to submit a schedule of costs of healthcare resource groups to allow direct comparison of the relative costs of different providers. The results are published each year in the National Schedule of Reference Costs.
Revenue	On-going or recurring costs or funding for the provision of services.
Tangible asset	A sub-classification of fixed assets, to exclude invisible items such as goodwill and brand values. Tangible fixed assets include land, buildings, equipment, and fixtures and fittings.
Variance	The difference between budgeted and actual income and/or expenditure. Variances are an accounting tool used to analyse the cause of over/under spends with a view to proposing rectifying action.
Working capital	Working capital is the money and assets that an organisation can call upon to finance its day-to-day operations (it is the difference between current assets and liabilities and is reported in the balance sheet as net current assets (liabilities). If working capital dips too low, organisations risk running out of cash and may need a working capital loan to smooth out the troughs.

Hounslow and Richmond Community Healthcare NHS Trust

Annual Accounts for the year ended 31 March 2019

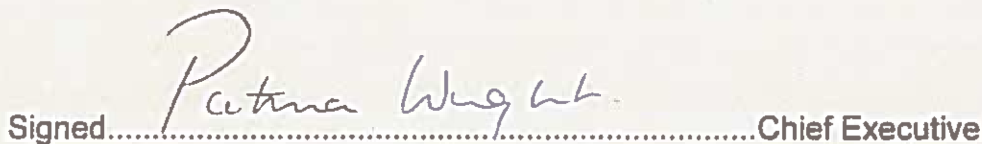
CONTENTS	PAGE
Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Trust	1
Statement of Directors' Responsibilities in Respect of the Accounts	2
Annual Governance Statement	3
Independent Auditors Opinion	17
Statement of Comprehensive Income	20
Statement of Financial Position	21
Statement of Change in Taxpayers' Equity	22
Statement of Cash Flows	25
Notes to the Accounts	26

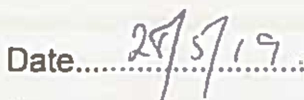
Statement of the chief executive's responsibilities as the accountable officer of the trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum.* These include ensuring that:

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

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

Signed  Chief Executive

Date 

Statement of directors' responsibilities in respect of the accounts

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

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

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.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy

By order of the Board

28/5/19 ....Date..Chief Executive

28/5/19 ....Date..Finance Director

Hounslow and Richmond Community Healthcare NHS Trust

Organisation Code: RY9

Annual Governance Statement for 2018-19

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies and strategic objectives of Hounslow and Richmond Community Healthcare NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Hounslow and Richmond Community Healthcare NHS Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust has a robust approach to risk management with:

- the Board holding an annual risk seminar to review risk management systems and processes and to agree the organisational risk appetite statement
- the Audit and Risk Committee assuming delegated authority from the Board for oversight and assurance on the management of strategic risks to the delivery of the Trust's objectives. The Audit and Risk Committee is supported in its oversight of strategic risks by the Finance and Performance, Executive, Quality Governance and Workforce and Education Committees which lead on specific strategic risks

- the Chief Executive has overall accountability for the development of risk management systems and delegates responsibility for the management of specific areas of risk to named Directors
- all staff being provided with risk management training as part of their induction to the Trust
- face-to-face training for those staff regularly involved in risk management being provided as appropriate
- specific training delivered face to face by the Head of Quality and Safety being available, upon request
- an open culture to empower staff to report and resolve incidents and risks through the Datix recording system and to share learning with teams

Managing Workforce Risks

HRCH has a five-year workforce strategy in place (2014-2019), which was co-developed with clinical and corporate staff and agreed by the Board

- the strategy and its associated action plans and workforce risks are monitored and assured through the Board's Workforce and Education Committee (WEC), which is a sub-committee of the Board. The WEC receives the workforce performance report that uses local and national metrics and triangulates with benchmark data and quality and financial data
- the workforce planning methodology entails firstly understanding the Trust strategy and how to best serve our vision that people will live healthier lives through high-quality, effective and co-ordinated care. Then follows a review of where the trust is and what gaps in skills and training are required to deliver that vision (such as digital and mobile technology and multi-agency transformation and engagement skills), followed by planning of the workforce required to meet the future strategy and activity assumptions in the most efficient way. The planning phase includes consideration of the needs of the local population in terms of workforce diversity, workforce supply (greater use of apprenticeships, 'retire and return' options and the development of new roles) and service transformation in line with the NHS Long Term Plan (greater use of on-line consultations etc.)

Managing Quality Risk

The clinical governance agenda is led by the Director of Nursing and Non-Medical Professionals and the Medical Director. Monitoring arrangements are delivered through a structure of committees, supporting clear responsibilities and accountabilities from board to front line delivery. The Quality Governance Committee (QGC) is a committee of the Board, which affords scrutiny and monitoring of the quality agenda.

- the Quality and Safety Committee (QSC) reports to the QGC. The Director of Nursing and Non-Medical Professionals chairs this committee; membership of the QSC's committees and working groups ensures senior leadership as well as frontline engagement with the governance agenda.
- the trust's clinical governance structure ensures there are robust systems in place for key governance and performance issues to be escalated from frontline services to Board and gives assurance of clinical quality. It gives a strong focus on service improvement and ensures high standards of delivery are maintained
- the Board and the relevant committees use a performance scorecard which has been developed to include a suite of quality indicators at trust and service level aligned to each of the Care Quality Commission's five domains of quality. Services are expected to provide exception reports for any indicators which are not performing as agreed and managers are held to account against action plans to ensure trajectories are maintained. This approach enables centralised reporting of performance and quality data and improved triangulation of information
- the trust's quality improvement strategy is encapsulated in the Journey to Outstanding (J2O) programme. The J2O programme is a structured quality improvement plan with quality improvement plans in all services to monitor and demonstrate compliance with the CQC's fundamental standards and against each of the CQC's domains and Key Lines of Enquiry (KLOE)

The risk and control framework

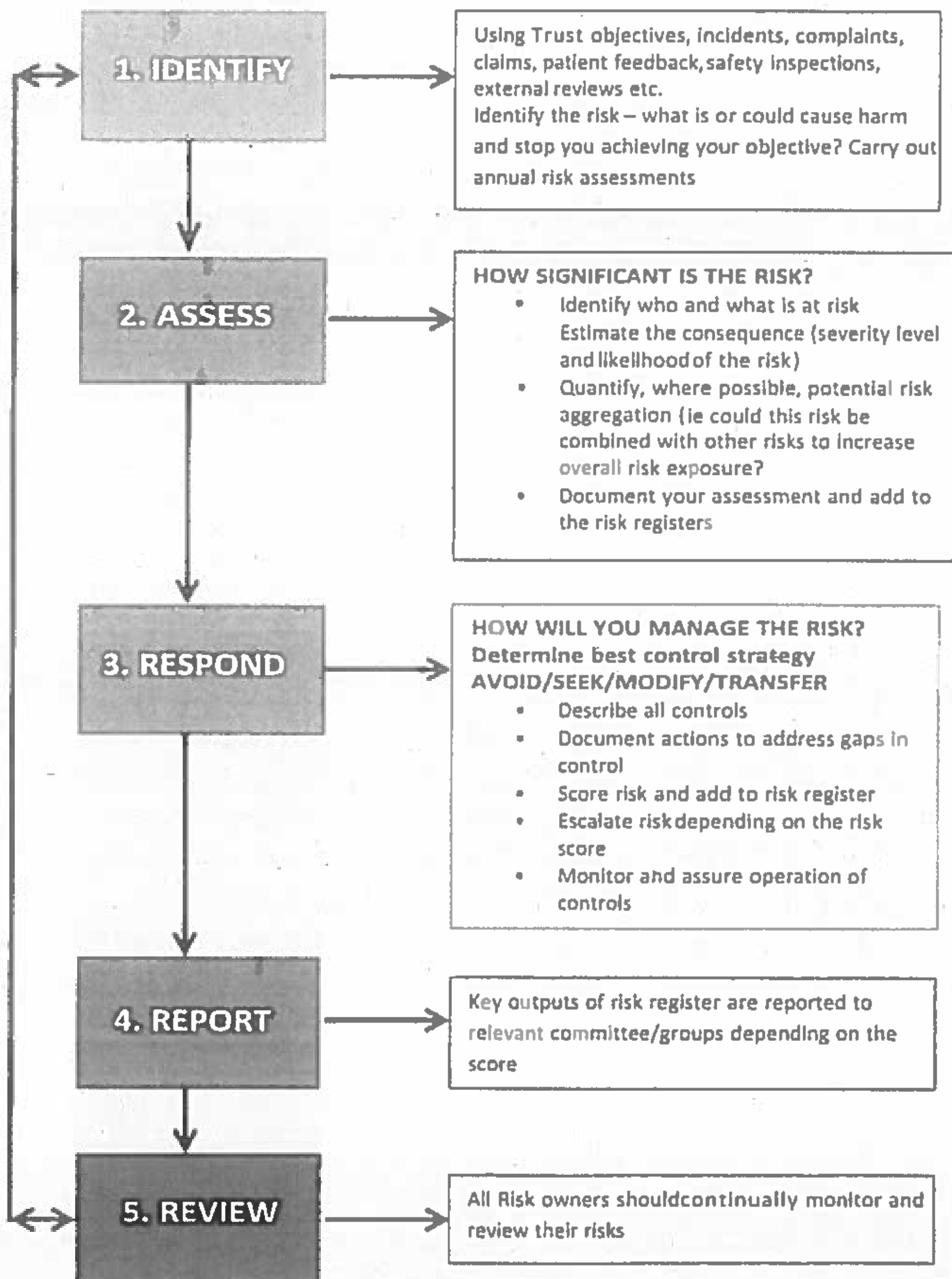
It is recognised risk management must be forward thinking, the responsibility of all, must be comprehensive and coordinated and that proactive and continuous identification and management of risk is essential to the delivery of high value healthcare. The trust is committed to a unified approach to risk management and has integrated safety and incident reporting systems. It has developed a governance system of internal control ensuring all strands of governance, financial, clinical and operations are brought together in a coherent way. The aim of the trust's risk management strategy is to support the delivery of organisational aims and objectives through the effective management of risks across all the Trust's functions and activities through effective risk management processes, analysis and organisational learning.

The Trust's approach to risk management aims to:

- embed the effective management of risk as part of everyday practice
- support a culture which encourages continuous improvement and development
- focus on proactive, forward looking, innovative and comprehensive (rather than reactive) risk management
- support well thought through decision making

- the Trust Board reviews its risk appetite at least annually when its tolerance for respective risks relating to quality, financial, workforce and system-wide objectives are discussed and set

It achieves this through a framework of committees and documents that ensure systematic identification and mitigation of risks at a strategic and operational level as described in more detail below



Trust Risk Registers (TRR) (incl. Board Assurance Framework (BAF))

Comprises the local risk registers, the trust risk register as well as the board assurance framework (BAF), which seek to present an overview of the main risks facing the organisation. The local risk registers are reviewed, updated and monitored regularly by the relevant directorate and, if necessary, a risk can be escalated onto the trust risk register, which is monitored each quarter by the Quality and Safety and Quality Governance Committees. The BAF is monitored by each Executive Director who assesses the status of their risk entry by having oversight of the OWRR. The BAF is monitored each month by the Executive Committee and quarterly by the Audit and Risk Committee and Trust Board.

The BAF provides a framework for reporting the principal strategic risks to the delivery of the trust's business. It identifies the controls and assurances in place to mitigate these risks, the gaps or weaknesses in controls and assurances, and actions required to further strengthen these mechanisms. The Audit and Risk Committee leads on oversight of the mitigation of risks to delivery of the trust's strategic objectives and is supported by other relevant Board Committees and the Executive Committee.

An annual advisory review on the BAF and Risk Management was carried out by RSM Risk Assurance Services LLP (who also provide our internal audit advice) and concluded the trust controls are robust and effectively designed. RSM confirmed the BAF is discussed at relevant committee meetings to ensure that risks included are up to date with regards to controls and assurances; and any progress against actions is also included.

Incident reporting

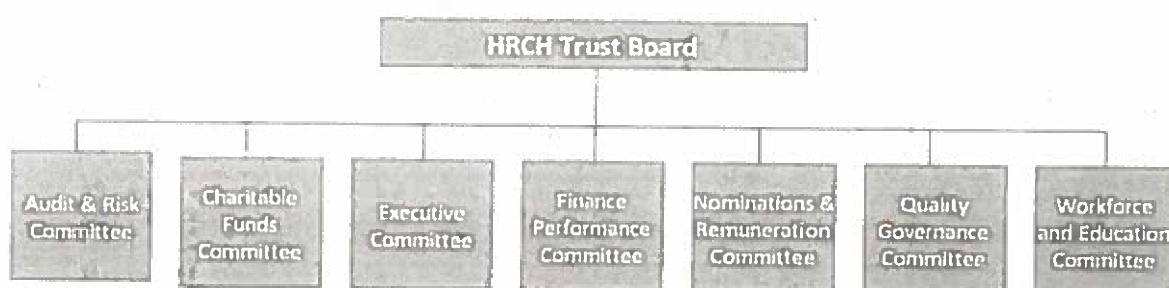
The trust follows the National Patient Safety Agency viewpoint that "Trusts that report incidents regularly suggest a stronger organisational culture of safety. They take all incidents seriously and link reporting with learning." All services and staff are trained to use the Datix system which facilitates linking of information across incident reporting, complaints and risk management. A monthly report of incidents and serious incidents is reported to the Quality and Safety Committee where it is discussed and analysed for themes and trends and assurance is sought that risk is being managed.

The trust is a learning organisation and uses all opportunities to learn from when things go wrong and to share that learning. It has embraced a 'being open' approach and the duty of candour. Organisational and service level learning is identified through incidents, audit and patient feedback and it reports lessons learned and monitor that any required changes in practice are implemented. The trust promotes a

culture of 'shared learning' that is embedded throughout the services and has a number of processes to enable this which includes a monthly 'Learn and Share' newsletter and reflective learning panels to ensure that staff are involved in the discussion and agreement of actions. This promotes clinical ownership, mitigates the risk of a Serious Incident reoccurring and promotes shared learning.

Board and Committee oversight and assurance

The Board of Directors leads on integrated governance and delegates key duties and functions to its sub-committees. In addition, the Board reserves certain decision making powers including decisions on strategy and budgets. The diagram below gives an overview of the trust's integrated governance structure



There are five key committees within the structure that provide assurance to the board of directors. These are: Audit and Risk; Quality Governance; Finance and Performance; Workforce and Education; and, the Executive Committee, reporting directly to the Board although not a Board sub-committee.

There are a range of mechanisms available to these committees to gain assurance that our systems are robust and effective. These include utilising internal and external audit, peer review, management reporting and clinical audit.

Committee structures
Each Committee Chair works within a framework which ensures a consistent approach across all committees, including terms of reference, upward reporting and review of effectiveness.

The Board of Directors
Membership of the board of directors is currently made up of the trust chairman, five independent, non-executive directors, a board advisor on clinical matters, and eight executive directors of which six are voting members of the board, two with a share of one vote. The key roles and responsibilities of the board are as follows:

- to set and oversee the strategic direction of the trust
- review and appraisal of financial and operational performance
- to review areas of assurance and concerns as detailed in the chair's assurance reports from its board committees

- to discharge its duties of regulation and control and meet statutory obligations
- to ensure the trust continues to deliver high quality patient care, with quality and safety as its primary focus, receiving and reviewing quality and patient safety reports and also a chair's report from the key board committee which deals with patient quality and safety – the Quality Governance Committee
- to receive reports from the Audit and Risk Committee, the annual internal auditor's report and external auditor's report and to take decisions, as appropriate
- to agree the trust's annual budget and plan and submissions to NHS Improvement
- to approve the annual report and annual accounts
- to certify against the requirements of NHS provider licence conditions

The Board of Directors meets in public bi-monthly and a breakdown of attendance for the Board's 2018-19 part I meetings is shown below:

Job Title and Name	Attendance
Chairman, Stephen Swords	6 of 6
Board Advisor, Virginia Colwell (non-voting)	6 of 6
Non-Executive Director, Phillip Hall	5 of 6
Non-Executive Director, Joanne Hay	5 of 6
Non-Executive Director, Ajay Mehta	5 of 6
Non-Executive Director, Judith Rutherford	5 of 6
Non-Executive Director, Bindesh Shah	5 of 6
Chief Executive, Patricia Wright	6 of 6
Director of Clinical Services, Stephen Hall (shared vote)	6 of 6
Director of Clinical Services, Anne Stratton (shared vote)	6 of 6
Director of Finance and Corporate Services, David Hawkins	6 of 6
Director and Nursing and Non-Medical Professionals, Donna Lamb	6 of 6
Director of Transformation, Monique Carayol (non-voting)	6 of 6
Director of Workforce, Alison Heeralall (non-voting)	5 of 6
Medical Director, John Omany	6 of 6

Audit and Risk Committee

The Audit and Risk Committee is a formal committee of the Board and is accountable to the Board for reviewing the establishment and maintenance of an effective system of internal control. The Committee holds five meetings per annum at appropriate times in the reporting and audit cycle.
Since December 2017, the Audit and Risk Committee leads on providing assurance to the Board on the mitigation of risks to the delivery of the Trust's strategic objectives. It is supported in this oversight and assurance role by the Finance and Performance, Quality Governance and Workforce and Education Board sub committees which lead on reviewing and updating key risks pertinent to their terms of reference. In addition, it receives support from the Executive

Committee's monthly oversight and review of progress with the effective mitigation of strategic BAF risks.

This committee also approves the annual audit plans for internal and external audit activities and ensures that recommendations to improve weaknesses in control arising from audits are actioned by executive management. The Audit and Risk Committee ensures the robustness of the underlying process used in developing the BAF and provides assurance to the Board. The Board monitors the BAF and progress against the delivery of strategic objectives each quarter, ensuring actions to address gaps in control and gaps in assurance are progressed.

Quality Governance Committee

The Quality Governance Committee (QGC) is a formal committee of the Board and is accountable to the Board for reviewing the effectiveness of quality systems, including the management of risks to the trust's quality and patient engagement strategic priorities as well as operational risks to the quality of services. The committee meets at least six times per year. It also monitors performance against quarterly quality indicators, the quality accounts and all aspects of the three domains of quality namely - patient safety, clinical effectiveness and patient experience.

Finance and Performance Committee

The finance and performance committee reviews financial and non-financial performance across the trust, reporting to the board. It also has lead oversight for risks to the delivery of trust's sustainability strategic priority, along with delivery of the trust's strategies for estates and information management and technology. The committee holds seven meetings each year.

Workforce and Education Committee
The workforce and education committee meets four times each year and leads on oversight of BAF risks which relate to the trust's staff engagement and recruitment and retention strategic priorities. It reviews performance against the delivery of key workforce plans which also cover staff engagement actions taken following the outcome of the annual NHS staff survey.

Executive Committee
The executive committee meets monthly and has delegated responsibility for the management of the trust. In particular, it reviews:

- the development and implementation of business plans, policies, procedures and budgets;

- operating and financial performance;
- the prioritisation and allocation of investment and resources within limits set down by standing financial instructions; and
- the effective mitigation of risks to the delivery of the trust's strategic priorities.

Nominations and Remuneration Committee
The Nominations and Remuneration Committee is responsible for determining the pay and contractual arrangements for Executive Directors and for monitoring and evaluating their performance and ensuring appropriate succession plans are in place for board members. It is also responsible for ensuring that Directors meet the Fit and Proper Person Test as required by the Health and Social Care Act 2008, (Regulated Activities), Regulations 2014.

Charitable Funds' Committee
Hounslow and Richmond Community NHS Trust, as an NHS body, holds the charitable funds in the capacity of a corporate trustee. The Board has delegated the powers and functions of the corporate trustee to the charitable funds' committee, to act on behalf of the corporate trustee and oversee money deemed to be used for charitable purposes within the organisation. The committee ensures that appropriate policies and procedures are in place to support the objects of the charity and ensures that donated funds and assets are properly spent, managed, invested and accounted for in line with guidance from the Charity Commission and in compliance with the Charities Act 2011, the Audit Commission, and the terms of the fund's governing documents.

Annual committee effectiveness reviews
In line with good governance practice and, as an integral part of being a well-led organisation, each board committee annually reviews its performance against its specific terms of reference and objectives. Each committee also comments on its oversight of performance against the delivery of the key work plans for the year. This information is then presented to the trust board with any revisions to the terms of reference and the forthcoming year's work plan. The trust board also considers the whole of its committee structure annually to ensure that it is delivering its requirements.

Provider licence conditions
In terms of the NHS provider license condition four, the Board confirmed that the trust applies principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of healthcare services. In particular, the Board is satisfied that the trust has established and implements:

- An effective Board and Committee structure;
- Clear responsibilities for the Board and Committees reporting to the Board and for staff reporting to either the Board or its Committees;

- Clear reporting lines and accountabilities throughout the organisation.

Equality analysis

Equality analyses (formerly known as equality impact assessments) are integrated into core business as a requirement for all trust decisions contained in its strategies, policies, procedures and protocols. The trust also has systems in place to ensure that it collects, analyses and acts on information relating to the legislation relating to equality and diversity of its workforce and the population it serves. Control measures are in place to ensure that all the organisation's obligations under quality, diversity and human rights legislation are complied with.

Care Quality Commission registration

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

NHS Pension Scheme

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

Miscellaneous

The trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The trust is fully compliant with emergency preparedness and civil contingency requirements.

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

The trust has in place a range of processes which help to ensure that resources are used economically, efficiently and effectively. These include:

- monthly reporting of financial and non-financial performance to the Board of Directors and the Finance and Performance Committee of the Board
- monthly Executive Performance review meetings where directorates are held to account for financial and non-financial performance
- the production of annual reference costs, including comparisons with national reference costs
- continuous benchmarking of costs and key performance indicators (KPIs) against community trusts and other providers

- standing financial instructions, standing orders and treasury management policy
- a budget holder's manual which sets out managers' responsibilities in relation to managing budgets
- policies covering the declaration of conflicts of interest, anti-fraud and anti-bribery measures, and also standards of business conduct
- reports by RSM Risk Assurance Services LLP as part of the annual internal audit work plan on control mechanisms which may need reviewing
- the Head of Internal Audit's draft and final opinions being presented to the Audit and Risk Committee
- external audit of our accounts by KPMG LLP who also provide an independent view of the trust's effective and efficient use of resources, particularly against value for money considerations
- good performance under NHS Improvement's Single Oversight Framework for NHS providers

Information governance

The NHS Information Governance Framework for health and social care is formed by those elements of law and policy from which applicable information governance standards are derived, and the activities and roles which individually and collectively ensure that these standards are clearly defined and met.

Whilst a key focus of information governance is the use of information about HRCH service users, it applies to information and information processing in its broadest sense and underpins both clinical and corporate governance. Accordingly this has been afforded appropriate priority.

The NHS Operating Framework requires NHS organisations to achieve compliance against all key requirements identified in the Data Security and Protection (DSP) Toolkit. This replaces the previous Information Governance Toolkit. The revised reporting toolkit reflects the new reporting requirements of the General Data Protection Regulation (GDPR), and for relevant organisations the Networks and Information System (NIS) Regulations.

The trust manages its risks to data security through a number of different approaches.

The trust has a Board level Senior Information Risk Owner (SIRO) – the Director of Finance and Corporate Services - who works closely with the Caldicott Guardian (Medical Director). The Information Governance Committee is responsible for setting the framework for information security standards in the trust and ensuring delivery of action plans to improve compliance. A key part of the group's work is to

review compliance against the Information Security requirements of the DSP Toolkit and to ensure the evidence is externally assured through audit. It is a sub-. committee of the Quality Governance Committee (QGC) and provides assurance to the QGC and the HRCH Board that the Trust is meeting the requirements of the DSP Toolkit and monitors any information incidents/issues.

The key strands of the trust's management of risk to data security are:

- ensuring that the trust has an Information Governance Policy that provides a framework for managing information risk that is in line with national guidance and the trust strategy, information security and overall Risk Management Policy
- developing a range of information governance training packages and literature, suitable to the needs of different staff groups and mandating this annually
- ensuring the trust's IT systems are physically secure and have sufficient password protection and firewalls to prevent harm from malware or external hacking. This also includes provision of encrypted portable devices and provision of email encryption facilities

The trust reports information governance "serious incidents" onto the national serious incident reporting system, STEIS, and to the Information Commissioners' Office (ICO).
In 2018-19, one IG incident was reported as an SI and so was reported to the ICO.

The ICO have advised that they are taking no further action because the incident was due to a human error, the risk of detriment to the data subjects as a result of the incident was regarded as low and we had taken appropriate actions to mitigate any further incidents occurring.

From 25 May 2018, the trust has been following General Data Protection Regulation guidance and reporting all incidents which have deemed to affect the rights and freedoms of an individual to the ICO within 72 hours.

Annual Quality Account
In line with the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) the trust prepares an annual Quality Account which is signed off by the Trust Board prior to it being shared with commissioners, Healthwatch and the local authority scrutiny committees.

The Quality Account is a summary of performance in the last year in relation to quality priorities and national requirements. The Account is not required to be audited however an internal process of scrutinising the data to ensure it is

consistent with the trust performance scorecard is used. The template used for the quality account meets statutory requirements and the trust reviews new guidance annually - for instance the inclusion of mortality data in the 2017-18 quality account.

General data quality is audited annually and the trust has undertaken actions to improve the quality of its electronic patient record through better use of templates and the automation of data where appropriate. The trust assures the quality and accuracy of elective waiting time data through both its Business Intelligence reporting and the Patient Tracking List (PTL) that is distributed to, and discussed by, operational leads. Waiting times are individually monitored by both service lines and urgency. Alongside external data quality audits, data capture is continually reviewed by the applications team and any training requirements are subsequently assessed with resource then appropriately allocated.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the Executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Risk Committee and Quality Governance Committee and plans to address weaknesses and ensure continuous improvement of the system are in place.

The Board ensures the effectiveness of the system of internal control through clear accountability arrangements.

An annual "Head of Internal Audit Opinion" based on the work and audit assessments undertaken during the year for 2018-19 was issued and provided assurance that the organisation has an adequate and effective framework for risk management, governance and internal control.

Factors which helped to inform the Head of Internal Audit's Opinion included undertaking specifically requested management reviews with the aim of strengthening current practices. The conflicts of Interest audit has shown partial assurance and internal audit have provided recommendations to address and strengthen processes in line with current requirements. The Head of Internal Audit

Opinion also identified further enhancements to Data Quality and Clinical audit to ensure that it remains adequate and effective.

I am confident that the internal audit reports undertaken were a true reflection of HRCH's position and that the updated action plans scrutinised at the Quality Governance Committee and Audit and Risk Committee reflect clear and concise progress in all areas

Conclusion

I confirm that no significant internal control issues have been identified.

Signed

Chief Executive Date: 28 May 2019

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF HOUNSLOW AND RICHMOND COMMUNITY HEALTHCARE NHS TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Hounslow and Richmond Community Healthcare NHS Trust ("the Trust") for the year ended 31 March 2019 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2019 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as being relevant to NHS Trusts in England and included in the Department of Health Group Accounting Manual 2018/19.

Basis for opinion

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

Going concern

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

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least a year from the date of approval of the financial statements. In our evaluation of the Director's conclusions we considered the inherent risks to the Trust's operations, including the impact of Brexit, and analysed how these risks might affect the Trust's financial resources, or ability to continue its operations over the going concern period. We have nothing to report in these respects.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

Other information in the Annual Report

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

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

information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health Group Accounting Manual 2018/19. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health Group Accounting Manual 2018/19.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 2, the directors are responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on Page 1 the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

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

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

We have nothing to report in this respect.

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

As explained in the statement set out on page 1, the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

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

Statutory reporting matters

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

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

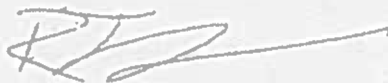
We have nothing to report in these respects.

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

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

CERTIFICATE OF COMPLETION OF THE AUDIT

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



Richard Hewes
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
15 Canada Square
London,
E14 5GL
28 May 2019

Statement of Comprehensive Income

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	67,960	67,985
Other operating income	4	5,893	3,477
Operating expenses	7, 9	(69,006)	(66,793)
Operating surplus/(deficit) from continuing operations		4,847	4,669
Finance income	12	102	33
PDC dividends payable		(691)	(691)
Net finance costs		(589)	(658)
Other gains / (losses)	14	-	-
Surplus / (deficit) for the year from continuing operations		4,258	4,011
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	15	-	-
Surplus / (deficit) for the year		4,258	4,011
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Revaluations	19	(560)	443
Total comprehensive income / (expense) for the period		3,698	4,454
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		4,258	4,011
Remove I&E impact of capital grants and donations		(516)	57
Adjusted financial performance surplus / (deficit)		3,742	4,068

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	16	-	4
Property, plant and equipment	17	27,006	27,092
Total non-current assets		27,006	27,096
Current assets			
Inventories	24	-	-
Receivables	25	6,501	6,455
Cash and cash equivalents	28	21,872	15,942
Total current assets		28,373	22,397
Current liabilities			
Trade and other payables	29	(11,275)	(9,156)
Provisions	34	(32)	(13)
Other liabilities	31	(25)	-
Total current liabilities		(11,332)	(9,169)
Total assets less current liabilities		44,047	40,324
Non-current liabilities			
Provisions	34	(675)	(675)
Other liabilities	31	(25)	-
Total non-current liabilities		(700)	(675)
Total assets employed		43,347	39,649
Financed by			
Public dividend capital		-	-
Revaluation reserve		10,653	11,213
Income and expenditure reserve		32,694	28,436
Total taxpayers' equity		43,347	39,649

The notes on pages 26 to 79 form part of these accounts.

Patricia Wright
Chief Executive
Date **28 May 2019**

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Financial assets reserve*	Other reserves	Merger reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	-	11,213	-	-	-	28,436	39,649
Impact of implementing IFRS 15 on 1 April 2018	-	-	-	-	-	-	-
Impact of implementing IFRS 9 on 1 April 2018	-	-	-	-	-	-	-
Surplus/(deficit) for the year	-	-	-	-	-	4,258	4,258
Transfers by absorption: transfers between reserves	-	-	-	-	-	-	-
Revaluations	-	(560)	-	-	-	-	(560)
Transfer to retained earnings on disposal of assets	-	-	-	-	-	-	-
Share of comprehensive income from associates and joint ventures	-	-	-	-	-	-	-
Other reserve movements	-	-	-	-	-	-	-
Taxpayers' equity at 31 March 2019	-	10,653	-	-	-	32,694	43,347

* Following the implementation of IFRS 9 from 1 April 2018, the 'Available for sale investment reserve' is now renamed as the 'Financial assets reserve'

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Available for sale investment reserve	Other reserves	Merger reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	-	10,770	-	-	-	24,425	35,195
Prior period adjustment	-	-	-	-	-	-	-
Taxpayers' equity at 1 April 2017 - restated	-	10,770	-	-	-	24,425	35,195
Surplus/(deficit) for the year	-	-	-	-	-	4,011	4,011
Transfers by absorption: transfers between reserves	-	-	-	-	-	-	-
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	-	-	-	-
Other transfers between reserves	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-
Revaluations	-	443	-	-	-	-	443
Transfer to retained earnings on disposal of assets	-	-	-	-	-	-	-
Other reserve movements	-	-	-	-	-	-	-
Taxpayers' equity at 31 March 2018	-	11,213	-	-	-	28,436	39,649

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Financial assets reserve / Available-for-sale investment reserve
This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevivable election at recognition.

Merger reserve
This reserve reflects balances formed on merger of NHS bodies.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		4,847	4,669
Non-cash income and expense:			
Depreciation and amortisation	7.1	2,080	2,015
Income recognised in respect of capital donations	4	(534)	-
(Increase) / decrease in receivables and other assets		(46)	(1,409)
(Increase) / decrease in inventories		-	-
Increase / (decrease) in payables and other liabilities		2,644	1,843
Increase / (decrease) in provisions		19	(401)
Net cash generated from / (used in) operating activities		9,010	6,717
Cash flows from investing activities			
Interest received		102	33
Purchase of intangible assets		-	-
Purchase of property, plant, equipment and investment property		(3,025)	(1,135)
Sales of property, plant, equipment and investment property		-	-
Receipt of cash donations to purchase capital assets		534	-
Net cash generated from / (used in) investing activities		(2,389)	(1,102)
Cash flows from financing activities			
PDC dividend (paid) / refunded		(691)	(691)
Net cash generated from / (used in) financing activities		(691)	(691)
Increase / (decrease) in cash and cash equivalents		5,930	4,924
Cash and cash equivalents at 1 April - brought forward		15,942	11,018
Prior period adjustments			-
Cash and cash equivalents at 1 April - restated		15,942	11,018
Cash and cash equivalents transferred under absorption accounting	46	-	-
Unrealised gains / (losses) on foreign exchange		-	-
Cash and cash equivalents at 31 March	28.1	21,872	15,942

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 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.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis.
HRCH continues to have turnover growth from one financial year to the next. A five year Outcome Based Contract with Richmond CCG signed in 2016 is still in place and we have agreed a one year contract with Hounslow CCG for 2019-20. We are working with Hounslow towards an alliance Integrated Care contract with a number of other NHS providers, which supports financial sustainability over the medium term horizon. The national directive and the local Sustainability and Transformation plans (STPs) are for Out of Hospital (OOH) care, and the focus on community services within the NHS Long Term plan supports a drive for activity to move from the acute sector to the community and primary care sector. A joint venture agreement with one local GP alliance and closer integrated working arrangements with another also points to a positive future for the Trust. The ongoing concern assessment is therefore positive. However, with more focus on joint working across systems rather than individual organisational plans and the proposed end of the control total regime, this brings a new level of uncertainty and challenge to ensure financial stability across the system rather than just at organisational level

Note 1.3 Interests in other entities

There are no interests in other entities

Note 1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

The Trust recognises contractual revenue over time on the basis that our Commissioners simultaneously receive and consume the benefits as we provide our services to the community. For contracts which are performance based, the Trust recognises the revenue based on performance obligations satisifed a point in time in year. Revenue accruals are made on the basis of our last period's performance, these are submitted for Commissioners's review at year end.

Non-NHS revenue relating to performance obligation to be satisified in future period(s) are deferred and recognised as current and non-current contractual liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract. Although CQUIN income is not material, only the value of income relating to satisfactory performance agianst these obligations has been recognised

Revenue from research contracts

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

The Trust does not have any material Research contracts

NHS injury cost recovery scheme

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, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4.2 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4.3 Other income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

- 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 be provided to, the trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- 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 cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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

Note 1.7.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs 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 valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable ie:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.7.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

The Trust does not currently have any PFI arrangements

Note 1.7.6 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	5	40
Dwellings	-	-
Plant & machinery	2	10
Transport equipment	2	10
Information technology	2	10
Furniture & fittings	2	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets

Note 1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the trust intends to complete the asset and sell or use it
- the trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
- the trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation
Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful economic life of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Information technology	-	-
Development expenditure	-	-
Websites	-	-
Software licences	5	5
Licences & trademarks	-	-
Patents	-	-
Other (purchased)	-	-
Goodwill	-	-

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Note 1.10 Investment properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

Note 1.11 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.

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

Note 1.12 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO_2 emissions. The trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO_2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO_2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO_2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

Note 1.13 Financial assets and financial liabilities

Note 1.13.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Note 1.13.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure. Financial liabilities classified as fair value through income and expenditure.

Financial assets and financial liabilities at amortised cost
Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets measured at fair value through other comprehensive income
A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

The Trust has irrevocably elected to measure the following equity instruments at fair value through other comprehensive income:

Financial assets and financial liabilities at fair value trough income and expenditure
Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

The Trust has irrevocably elected to measure the following financial assets / financial liabilities at fair value through income and expenditure.

Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.13.3 Derecognition
Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.14 Leases

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

Note 1.14.1 The trust as lessee

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

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

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

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.14.2 The trust as lessor

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

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

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 34.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling
The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution 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 when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 35 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 35, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital

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

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

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

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

Note 1.18 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.

Note 1.19 Corporation tax
The Trust has no corporation tax liability.

Note 1.20 Foreign exchange

The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.21 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 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).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.23 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.24 Transfers of functions [to / from] [other NHS bodies / local government bodies]

For functions that have been transferred to the trust from another body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain or loss corresponding to the net assets and liabilities transferred is recognised within income and expenditure, but not within operating activities.]

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the trust has transferred to another body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss or gain corresponding to the net assets and liabilities transferred is recognised within income and expenditure, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve. Adjustments to align the acquired function to the trust's accounting policies are applied after initial recognition and are adjusted directly in taxpayers' equity.

In 2018-19, Hounslow and Richmond Community Healthcare NHS Trust did not transfer or receive any assets from another body

Note 1.25 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

No significant critical judgements have been made in the process of applying the Trust's accounting policies

Note 1.26 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- Under the terms of the operating lease on one of the Trust's properties, the Hounslow & Richmond Community Healthcare NHS Trust was obliged to restore the building to its pre lease state at the end of the lease period in January 2019. The Trust had made an estimated provision for dilapidations based on current market benchmarks in 2015-16. An expert advisor was appointed to revise this provision and a report received in September 2016. The provision has been adjusted to reflect the valuations in this report, which is based on industry standards, however it remains an estimate until actual works are carried out. The value of the dilapidation provision has been left unchanged as at 31 March 2019. Substantial work is being undertaken in the building which could impact on any future dilapidation costs and we will review this provision once these are complete. The Trust has agreed a further extension to the lease and expects to sign a new 10 year lease from 1 May 2019 to 31 May 2029 with a five year break clause. There are some immediate refurbishment items to address and the Trust will then review the future dilapidation requirements of the new lease.

- The Trust's property assets were last subject to a full revaluation as at 31 March 2015. A desk top revaluation was carried out as at 31 March 2017 by the same valuer and using the same information provided for the full revaluation two year previously. An internal desk top valuation has been undertaken as at 31 March 2018 using location factor indices relevant to the locality and another desk top valuation as at 31 March 2019 using national indices. Although not expected to be materially different from a full revaluation exercise, there may be some element of uncertainty due to the method of revaluation used at this time.

- It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period. On the basis of existing knowledge, outcomes within the next financial year that are different from the assumption around the valuation of our land, property, plant and equipment could require a material adjustment to the carrying amount of the asset or liability recorded in note 17

Note 1.27 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.28 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Accounting for Leases is expected to apply from 1 April 2020, having been deferred from 1 April 2019.

Note 2 Operating Segments

The Trust operates as a single segment

A business segment is a group of assets and operations engaged in providing products or services that are subject to risk and returns that are different from other business segments. A geographical segment is engaged in providing products or services within a particular economic environment that is subject to risks and returns that are different from those segments operating in different economic environments. The directors consider that the Trust's activities constitute a single segment since they are provided wholly in the UK, are subject to similar risks and rewards and all assets are managed as one central pool

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1

Note 3.1 Income from patient care activities (by nature)	**2018/19**	**2017/18**
	£000	**£000**
Community services		
Community services income from CCGs and NHS England	57,488	56,150
Income from other sources (e.g. local authorities)	9,798	11,835
All services		
Private patient income	-	-
Agenda for Change pay award central funding	674	-
Other clinical income	-	-
Total income from activities	67,960	67,985

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2018/19**	**2017/18**
	£000	**£000**
NHS England	2,702	2,604
Clinical commissioning groups	54,786	53,546
Department of Health and Social Care	685	9
Other NHS providers	3,388	3,506
NHS other	-	-
Local authorities	5,747	7,420
Non-NHS: private patients	-	-
Non-NHS: overseas patients (chargeable to patient)	-	-
Injury cost recovery scheme	81	73
Non NHS: other	571	827
Total income from activities	67,960	67,985
Of which:		
Related to continuing operations	67,960	67,985
Related to discontinued operations	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

There is no Overseas Visitor income to disclose in 2018-19. Nil in 2017-18

Note 4 Other operating income

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	-	-
Education and training (excluding notional apprenticeship levy income)	790	531
Non-patient care services to other bodies	194	123
Provider sustainability / sustainability and transformation fund income (PSF / STF)	2,990	2,510
Other contract income	180	263
Other non-contract operating income		
Research and development (non-contract)	-	-
Education and training - notional income from apprenticeship fund	10	-
Receipt of capital grants and donations	534	-
Rental revenue from operating leases	1,195	50
Other non-contract income	-	-
Total other operating income	5,893	3,477
Of which:		
Related to continuing operations	5,893	3,477
Related to discontinued operations	-	-

Note 5.1 Additional information on revenue from contracts with customers recognised in the period

	2018/19
	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	-
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-

Note 5.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2019
	£000
within one year	-
after one year, not later than five years	-
after five years	-
Total revenue allocated to remainig performance obligations	-

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 6 Fees and charges

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income The cost associated with the service that generated the income is also disclosed.

The Trust has not incurred any fees or charges

Note 7.1 Operating expenses

	2018/19	2017/18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	2,288	2,258
Purchase of healthcare from non-NHS and non-DHSC bodies	314	413
Staff and executive directors costs	49,156	48,285
Remuneration of non-executive directors	70	66
Supplies and services - clinical (excluding drugs costs)	6,410	6,052
Supplies and services - general	325	247
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	138	160
Consultancy costs	353	568
Establishment	2,773	1,578
Premises	1,810	1,627
Transport (including patient travel)	32	28
Depreciation on property, plant and equipment	2,076	2,011
Amortisation on intangible assets	4	4
Audit fees payable to the external auditor		
audit services- statutory audit **	43	40
other auditor remuneration (external auditor only)	-	-
Internal audit costs	38	30
Clinical negligence	51	40
Legal fees	68	99
Insurance	51	41
Research and development	-	-
Education and training	10	-
Rentals under operating leases	2,984	3,184
Early retirements	-	-
Redundancy	-	48
Hospitality	5	8
Losses, ex gratia & special payments	7	6
Other	-	-
Total	69,006	66,793
Of which:		
Related to continuing operations	69,006	66,793
Related to discontinued operations	-	-

** Audit fee - fee payable to the external auditors is £35,600 (excluding VAT of £7,120)

Note 7.2 Other auditor remuneration

There was no other auditor remuneration paid to the external auditor

Note 7.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2018/19 or 2017/18.

Note 8 Impairment of assets

The Trust has not impaired any assets in 2018-19. Nil in 2017-18

Note 9 Employee benefits

	2018/19	2017/18
	Total	Total
	£000	£000
Salaries and wages	37,020	36,421
Social security costs	3,404	3,447
Apprenticeship levy	171	168
Employer's contributions to NHS pensions	4,632	4,554
Pension cost - other	-	-
Termination benefits	-	-
Temporary staff (including agency)	3,929	3,695
Total gross staff costs	49,156	48,285
Recoveries in respect of seconded staff	-	-
Total staff costs	49,156	48,285
Of which		
Costs capitalised as part of assets	-	-

Note 9.1 Retirements due to ill-health

During 2018/19 there were no early retirements from the trust agreed on the grounds of ill-health (none in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £0k (0k in 2017/18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 10 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 11 Operating leases

Note 11.1 Hounslow and Richmond Community Healthcare NHS Trust as a lessor

This note discloses income generated in operating lease agreements where Hounslow and Richmond Community Healthcare NHS Trust is the lessor.

	2018/19	2017/18
	£000	£000
Operating lease revenue		
Minimum lease receipts	1,195	50
Contingent rent	-	-
Other	-	-
Total	1,195	50

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	1,195	275
- later than one year and not later than five years;	-	-
- later than five years.	-	-
Total	1,195	275

Note 11.2 Hounslow and Richmond Community Healthcare NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Hounslow and Richmond Community Healthcare NHS Trust is the lessee.

Hounslow and Richmond Community Healthcare NHS Trust is the lessor for Thames House. Richmond CCG are occupying this property on a sub lease arrangement. HRCH are the head lease holders so the sub lease arrangement aligns with our agreement which will be renewed in June 2019 on a 10 year lease.

Your Healthcare CIC is the lessor for an in patient ward at Teddington Memorial Hospital. The lease is agreed on a rolling one year basis.

	2018/19	2017/18
	£000	£000
Operating lease expense		
Minimum lease payments	2,984	3,184
Contingent rents	-	-
Less sublease payments received	-	-
Total	2,984	3,184

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease payments due:		
- not later than one year;	2,685	2,534
- later than one year and not later than five years;	8,862	5,657
- later than five years.	701	18
Total	12,248	8,209
Future minimum sublease payments to be received	-	-

Note 12 Finance Income

Finance income represents interest received on assets and investments in the period.

	2018/19	2017/18
	£000	£000
Interest on bank accounts	102	33
Interest income on finance leases	-	-
Interest on other investments / financial assets	-	-
Other finance income	-	-
Total finance income	102	33

Note 13.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

The Trust did not incur any expenditure on interest and other charges relating to the borrowing of money

Note 13.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2018/19	2017/18
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 14 Other gains / (losses)

There are no Other Gains and Losses to report in 2018-19. Nil in 2017-18

Note 15 Discontinued operations

There were no discontinued operations

Note 16.1 Intangible assets - 2018/19

	Software licences £000	Internally generated information technology £000	Development expenditure £000	Websites £000	Intangible assets under construction £000	Other (purchased) £000	Total £000
Valuation / gross cost at 1 April 2018 - brought forward	-	15	-	-	-	-	15
Additions	-	-	-	-	-	-	-
Valuation / gross cost at 31 March 2019	-	15	-	-	-	-	15
Amortisation at 1 April 2018 - brought forward	-	11	-	-	-	-	11
Provided during the year	-	4	-	-	-	-	4
Amortisation at 31 March 2019	-	15	-	-	-	-	15
Net book value at 31 March 2019	-	-	-	-	-	-	-
Net book value at 1 April 2018	-	4	-	-	-	-	4

Note 16.2 Intangible assets - 2017/18

	Software licences £000	Internally generated information technology £000	Development expenditure £000	Websites £000	Intangible assets under construction £000	Other (purchased) £000	Total £000
Valuation / gross cost at 1 April 2017 - as previously stated	-	15	-	-	-	-	15
Prior period adjustments	-	-	-	-	-	-	-
Valuation / gross cost at 1 April 2017 - restated	-	15	-	-	-	-	15
Additions	-	-	-	-	-	-	-
Valuation / gross cost at 31 March 2018	-	15	-	-	-	-	15
Amortisation at 1 April 2017 - as previously stated	-	7	-	-	-	-	7
Prior period adjustments	-	-	-	-	-	-	-
Amortisation at 1 April 2017 - restated	-	7	-	-	-	-	7
Provided during the year	-	4	-	-	-	-	4
Amortisation at 31 March 2018	-	11	-	-	-	-	11
Net book value at 31 March 2018	-	4	-	-	-	-	4
Net book value at 1 April 2017	-	8	-	-	-	-	8

Note 17.1 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	6,627	16,220	-	435	103	906	6,514	304	31,109
Transfers by absorption	-	-	-	-	-	-	-	-	-
Additions	-	1,147	-	330	95	436	528	14	2,550
Revaluations	-	(1,055)	-	-	-	-	-	-	(1,055)
Reclassifications	-	65	-	(435)	307	-	63	-	-
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-	-	-	-	-
Valuation/gross cost at 31 March 2019	6,627	16,377	-	330	505	1,342	7,105	318	32,604
Accumulated depreciation at 1 April 2018 - brought forward	-	-	-	-	9	464	3,408	136	4,017
Transfers by absorption	-	-	-	-	-	-	-	-	-
Provided during the year	-	495	-	-	147	124	1,271	39	2,076
Revaluations	-	(495)	-	-	-	-	-	-	(495)
Accumulated depreciation at 31 March 2019	-	-	-	-	156	588	4,679	175	5,598
Net book value at 31 March 2019	6,627	16,377	-	330	349	754	2,426	143	27,006
Net book value at 1 April 2018	6,627	16,220	-	435	94	442	3,106	168	27,092

Note 17.2 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	6,627	15,817	-	293	16	790	5,817	283	29,643
Prior period adjustments	-	-	-	-	-	-	-	-	-
Valuation / gross cost at 1 April 2017 - restated	6,627	15,817	-	293	16	790	5,817	283	29,643
Transfers by absorption	-	-	-	-	-	-	-	-	-
Additions	-	523	-	142	87	116	697	21	1,586
Revaluations	-	(120)	-	-	-	-	-	-	(120)
Valuation/gross cost at 31 March 2018	6,627	16,220	-	435	103	906	6,514	304	31,109
Accumulated depreciation at 1 April 2017 - as previously stated	-	-	-	-	1	321	2,149	98	2,569
Prior period adjustments	-	-	-	-	-	-	-	-	-
Accumulated depreciation at 1 April 2017 - restated	-	-	-	-	1	321	2,149	98	2,569
Transfers by absorption	-	-	-	-	-	-	-	-	-
Provided during the year	-	563	-	-	8	143	1,259	38	2,011
Revaluations	-	(563)	-	-	-	-	-	-	(563)
Reclassifications	-	-	-	-	-	-	-	-	-
Accumulated depreciation at 31 March 2018	-	-	-	-	9	464	3,408	136	4,017
Net book value at 31 March 2018	6,627	16,220	-	435	94	442	3,106	168	27,092
Net book value at 1 April 2017	6,627	15,817	-	293	15	469	3,668	185	27,074

Note 17.3 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019									
Owned - purchased	6,627	16,169	-	161	349	470	2,426	143	26,345
Owned - government granted	-	-	-	-	-	-	-	-	-
Owned - donated	-	208	-	169	-	284	-	-	661
NBV total at 31 March 2019	6,627	16,377	-	330	349	754	2,426	143	27,006

Note 17.4 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	6,627	14,772	-	435	94	427	3,106	168	25,629
Owned - government granted	-	-	-	-	-	-	-	-	-
Owned - donated	-	1,448	-	-	-	15	-	-	1,463
NBV total at 31 March 2018	6,627	16,220	-	435	94	442	3,106	168	27,092

Note 18 Donations of property, plant and equipment

In 2018-19, the Trust received income from the Richmond League of Friends to purchase or contribute to the purchase of fixed assets. The League of Friends made a donation of £366k to fully fund the purchase of new radiology equipment in the unit based at Teddington Memorial Hospital. A further £168k will be used as a contribution to the refurbishment costs of the Urgent Treatment Centre at the same location.

Note 19 Revaluations of property, plant and equipment

The Trust's property assets were last subject to a full revaluation on 31 March 2015. A desk top revaluation was undertaken as at 31 March 2017. Both valuations were undertaken by the same District Valuer. At 31 March 2019 (as at March 2018) the assets were subject to a desk top valuation by Trust experts. At 31 March 2018 the Assets were valued using local indices which better reflected the property market at that time. In March 2019 we have used National indices to revalue the buildings which indicate a 0.9% increase in value. However after taking account of investment in the Trust properties during 2018-19, a loss on revaluation of 3.9% is reported. The Trust will commission a full external valuation in March 2020.

The useful economic lives are unchanged.

An assessment of the current local market to determine whether an increase in land value is appropriate has provided indications that land values have not materially changed over the last twelve months

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

Note 20.1 Investment Property

The Trust does not hold any investment property

Note 20.2 Investment property income and expenses

The Trust does not hold any investment property

Note 21 Investments in associates and joint ventures

The Trust does not have any investments in associates or joint ventures

Note 22 Other investments / financial assets (non-current)

The Trust does not have any other investments/financial assets (non current)

Note 22.1 Other investments / financial assets (current)

The Trust does not have any other investments/financial assets (current)

Note 25.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward		-
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	13	(13)
Transfers by absorption	-	-
New allowances arising	-	-
Changes in existing allowances	-	-
Allowances as at 31 Mar 2019	13	(13)

Note 25.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables
	£000
Allowances as at 1 Apr 2017 - as previously stated	
Prior period adjustments	
Allowances as at 1 Apr 2017 - restated	-
Transfers by absorption	
Increase in provision	
Amounts utilised	
Unused amounts reversed	
Allowances as at 31 Mar 2018	-

Note 25.4 Exposure to 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 2017 are in receivables from customers, as disclosed in the trade and other receivables note.

Note 26 Other assets

The Trust does not have any other financial assets - current at 31 March 2019 (nil at 31 March 2018)

Note 27 Non-current assets held for sale and assets in disposal groups

The Trust does not have any other financial assets - non current at 31 March 2019 (nil at 31 March 2018)

Note 27.1 Liabilities in disposal groups

The Trust does not have any liabilities in disposal groups

Note 28.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2018/19	2017/18
	£000	£000
At 1 April	15,942	11,018
Prior period adjustments	-	-
At 1 April (restated)	15,942	11,018
Transfers by absorption	-	-
Net change in year	5,930	4,924
At 31 March	21,872	15,942
Broken down into:		
Cash at commercial banks and in hand	-	-
Cash with the Government Banking Service	21,872	15,942
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	21,872	15,942
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	21,872	15,942

Note 28.2 Third party assets held by the trust

The Trust does not hold any third party assets

Note 29.1 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	3,338	3,132
Capital payables	186	661
Accruals	6,756	4,338
Receipts in advance (including payments on account)	-	75
Social security costs	556	535
VAT payables	-	-
Other taxes payable	373	349
PDC dividend payable	66	66
Accrued interest on loans*		-
Other payables	-	-
Total current trade and other payables	11,275	9,156
Non-current		
Trade payables	-	-
Capital payables	-	-
Accruals	-	-
Receipts in advance (including payments on account)	-	-
Total non-current trade and other payables	-	-
Of which payables from NHS and DHSC group bodies:		
Current	2,758	1,349
Non-current	-	-

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost Any accrued interest is now included in the carrying value of the loan within note . IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 29.2 Early retirements in NHS payables above

The payables note above does not include any amounts in relation to early retirements

Note 30 Other financial liabilities

There were no other financial liabilities at 31 March 2019 (nil at 31 March 2018)

Note 31 Other liabilities

The Trust does not have any other liabilities

Note 32 Borrowings

There were no borrowings at 31 March 2019 (nil at 31 March 2018)

Note 32.1 Reconciliation of liabilities arising from financing activities

The Trust does not have any liabilities arising from financing activities

Note 33 Finance leases

lessor

Future lease receipts due under finance lease agreements where Hounslow and Richmond Community Healthcare NHS Trust is the lessor.

The Trust does not have any finance lease obligations as a lessor

lessee

Obligations under finance leases where Hounslow and Richmond Community Healthcare NHS Trust is the lessee.

The Trust does not have any finance lease obligations as a lessee.

Note 34.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits*	Legal claims	Re-structuring	Equal Pay (including Agenda for Change)	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2018	-	-	13	-	-	-	675	688
Change in the discount rate	-	-	-	-	-	-	-	-
Arising during the year	-	-	5	-	-	27	-	32
Utilised during the year	-	-	(13)	-	-	-	-	(13)
Reversed unused	-	-	-	-	-	-	-	-
At 31 March 2019	-	-	5	-	-	27	675	707
Expected timing of cash flows:								
- not later than one year;	-	-	5	-	-	27	-	32
- later than one year and not later than five years;	-	-	-	-	-	-	-	-
- later than five years.	-	-	-	-	-	-	675	675
Total	-	-	5	-	-	27	675	707

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within Legal claims

Note 34.2 Clinical negligence liabilities

At 31 March 2019, £1,026k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Hounslow and Richmond Community Healthcare NHS Trust (31 March 2018: £768k).

Note 35 Contingent assets and liabilities

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
NHS Resolution legal claims	(5)	(3)
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	-	-
Gross value of contingent liabilities	(5)	(3)
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	(5)	(3)
Net value of contingent assets	-	-

Note 36 Contractual capital commitments

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	-	338
Intangible assets	-	-
Total	-	338

Note 37 Other financial commitments

The Trust does not have any other financial commitments at 31 March 2019 (nil at 31 March 2018)

Note 38 Defined benefit pension schemes

The Trust does not operate a defined benefit pension scheme

Note 38.1 Changes in the defined benefit obligation and fair value of plan assets during the year

The Trust does not operate a defined benefit pension scheme

Note 38.2 Reconciliation of the present value of the defined benefit obligation and the present value of the plan assets to the assets and liabilities recognised in the balance sheet

The Trust does not operate a defined benefit pension scheme

Note 39 On-SoFP PFI, LIFT or other service concession arrangements

The Trust has no obligations in respect of PFI, LIFT or other service concession arrangements

Note 39.1 Imputed finance lease obligations

Hounslow and Richmond Community Healthcare NHS Trust has no obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes

Note 39.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

The Trust has no obligations in respect of PFI, LIFT or other service concession arrangements

Note 39.3 Analysis of amounts payable to service concession operator

The Trust has no obligations in respect of PFI, LIFT or other service concession arrangements

Note 40 Off-SoFP PFI, LIFT and other service concession arrangements

Hounslow and Richmond Community Healthcare NHS Trust incurred no charges in respect of off-Statement of Financial Position PFI and LIFT obligations:

Note 41 Financial Instruments

Note 41.1 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 NHS Trust has with [commissioners] and the way those [commissioners] are financed, the NHS 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 NHS 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 NHS 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.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health and Social Care (the lender) at the point the borrowing is undertaken

The Trust therefore has low exposure to interest 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 2019 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 primary care Trusts, 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.

Note 41.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Carrying values of financial assets as at 31 March 2019 under IFRS 9	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	6,349	-	-	6,349
Other investments / financial assets	-	-	-	-
Cash and cash equivalents at bank and in hand	21,872	-	-	21,872
Total at 31 March 2019	28,221	-	-	28,221

Carrying values of financial assets as at 31 March 2018 under IAS 39	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available-for-sale £000	Total book value £000
Trade and other receivables excluding non financial assets	6,362	-	-	-	6,362
Other investments / financial assets	-	-	-	-	-
Cash and cash equivalents at bank and in hand	15,942	-	-	-	15,942
Total at 31 March 2018	22,304	-	-	-	22,304

Note 41.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Trade and other payables excluding non financial liabilities	9,550	-	9,550
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2019	9,550	-	9,550

	Other financial liabilities	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Other borrowings	-	-	-
Trade and other payables excluding non financial liabilities	9,156	-	9,156
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2018	9,156	-	9,156

Note 41.4 Fair values of financial assets and liabilities

Book value is a reasonable approximation of fair value for each relevant class of financial assets and liabilities.

Note 41.5 Maturity of financial liabilities

	31 March 2019	31 March 2018
	£000	£000
In one year or less	9,550	9,156
In more than one year but not more than two years	-	-
In more than two years but not more than five years	-	-
In more than five years	-	-
Total	9,550	9,156

Note 42 Losses and special payments

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	3	4	-	-
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	-	-	-	-
Stores losses and damage to property	1	-	-	-
Total losses	4	4	-	-
Special payments				
Compensation under court order or legally binding arbitration award	-	-	1	1
Extra-contractual payments	-	-	-	-
Ex-gratia payments	1	2	3	5
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	1	2	4	6
Total losses and special payments	5	6	4	6
Compensation payments received		-		-

Note 43 Gifts

There are no gifts to disclose

Note 44.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £0k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classifiction of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £0k

There is no material impact on the initial application of IFRS 9 on the Trust

Note 44.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

The Trust had applied IFRS 15 in relation to revenue deferral against a non-NHS Commissioner as a contractual liability in the accounts.

Note 45 Related parties

During the year none of the Department of Health and Social Care Ministers, Hounslow & Richmond Community Healthcare NHS Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Hounslow & Richmond Community Healthcare NHS Trust

The Department of Health and Social Care is regarded as a related party. During the year, Hounslow & Richmond Community Healthcare 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.

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£'000	£'000	£'000	£'000
Ealing CCG	0	431	0	90
Hounslow CCG	0	31,481	38	983
Richmond CCG	0	22,381	2	417
Kingston CCG	0	616	0	34
NHS England	0	5,692	2	2,198
Guys and St Thomas NHS Foundation Trust	1,727	28	486	114
Chelsea and Westminster NHS Foundation Trust	97	1,066	867	402
Kingston Hospital NHS Foundation Trust	44	181	41	285
Central London Community Healthcare NHS Trust	0	1,250	0	137
Croydon Health Services NHS Trust	0	142	0	206
Epsom & St Helier University Hospitals NHS Trust	0	200	0	0
St George's Healthcare NHS FT	25	263	56	349
South West London & St George's NHS Trust	0	83	0	7
West London Mental Health NHS Trust	207	21	70	7

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Local Authorities

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£'000	£'000	£'000	£'000
London Borough of Hounslow	0	4,784	262	237
London Borough of Richmond upon Thames	425	730	844	22
London Borough of Merton	0	230	0	39

The Trust has also received £9k payment (£9k in 2017-18) from the charitable fund it hosts for the administration and governance of the fund. The Trust Board is the trustee of the fund and some board members are also members of the Charitable Funds Committee. The summary financial statements of the Funds Held on Trust are not included in these accounts They are reported separately to the Charities Commission.

Note 46 Transfers by absorption

There are no transfers by absorption

Note 47 Prior period adjustments

There are no prior period adjustments

Note 48 Events after the reporting date

There were no events after the reporting period

Note 49 Final period of operation as a trust providing NHS healthcare

The Trust continues to operate as a trust of NHS healthcare

Note 50 Better Payment Practice code

	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	18,336	31,386	16,660	28,313
Total non-NHS trade invoices paid within target	17,434	30,740	15,881	27,700
Percentage of non-NHS trade invoices paid within target	95.1%	97.9%	95.3%	97.8%
NHS Payables				
Total NHS trade invoices paid in the year	699	7,201	649	6,776
Total NHS trade invoices paid within target	690	7,173	641	6,748
Percentage of NHS trade invoices paid within target	98.7%	99.6%	98.8%	99.6%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note.51 External financing

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

	2018/19 £000	2017/18 £000
Cash flow financing	(5,930)	(4,924)
Finance leases taken out in year	-	-
Other capital receipts		
External financing requirement	(5,930)	(4,924)
External financing limit (EFL)	(1,349)	69
Under / (over) spend against EFL	4,581	4,993

Note 52 Capital Resource Limit

	2018/19 £000	2017/18 £000
Gross capital expenditure	2,550	1,586
Less: Disposals	-	-
Less: Donated and granted capital additions	(534)	-
Plus: Loss on disposal from capital grants in kind	-	-
Charge against Capital Resource Limit	2,016	1,586
Capital Resource Limit	2,045	1,599
Under / (over) spend against CRL	29	13

Note 53 Breakeven duty financial performance

	2018/19 £000
Adjusted financial performance surplus / (deficit) (control total basis)	3,742
Remove impairments scoring to Departmental Expenditure Limit	-
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	-
Breakeven duty financial performance surplus / (deficit)	3,742

Note 54 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
		£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		-	-	1,667	704	2,792	679	1,919	2,962	4,068	3,742
Breakeven duty cumulative position	-	-	-	1,667	2,371	5,163	5,842	7,761	10,723	14,791	18,533
Operating income		-	-	54,480	59,339	64,212	65,816	68,489	70,511	71,462	73,853
Cumulative breakeven position as a percentage of operating income		0.0%	0.0%	3.1%	4.0%	8.0%	8.9%	11.3%	15.2%	20.7%	25.1%