NHS
Hounslow and Richmond Community Healthcare
NHS Trust

ANNUAL REPORT 2017-2018

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Introduction from the chairman and chief executive

Looking back at a very good year for Hounslow and Richmond Community Healthcare NHS Trust, we continue to be impressed by the dedication and effort our people put into their work every day. Over the past 12 months they played a vital role in improving the health and wellbeing of around 515,000 people living predominantly in the boroughs of Hounslow and Richmond, with 657,005 patient contacts here and across a wider range of locations in London.

Quality of care

We received some excellent news in the second quarter of the year, when Teddington Memorial Hospital's inpatient unit was rated as 'good' by the Care Quality Commission (CQC), as part of its re-inspection of the adult rehabilitation service. The report was published in August 2017. In addition, the CQC team identified an area of outstanding practice in the rapid response and rehabilitation team, which is a single point of access for admissions and ensures patients are supported with rehabilitation after going home.

Subsequently, the inpatient unit team were shortlisted for a Nursing Times Patient Safety Improvement Award for their work in transforming rehabilitation care and reducing length of stay from an average of 44 days to 17.

Meeting the people we serve

Around 70 people attended our annual general meeting in July 2017 at Montague Hall in Hounslow and our teams were able to showcase the range of services we provide in Hounslow and answer questions from the public.

Hundreds of local people came along to HRCH's first ever community health fair at Teddington Memorial Hospital in September. Colleagues from nearly 20 HRCH services set up stalls and activities outside Teddington Memorial Hospital and Teddington Health and Social Care Centre, joined by other local health providers, including London Ambulance, MIND, Diabetes UK, MS Society, Richmond Healthwatch, Richmond CCG, Teddington Girl Guides and many more. The feedback from this event was very positive and we plan to arrange other community events in 2018.

Our services

We are very proud of the high quality care provided by all of our services including colleagues in corporate services who support the running of the trust. Outlined over the page are some examples of the range and excellence of the services we provide.

Our audiology service was awarded Improving Quality in Physiological Services (IQIPS) accreditation for the third year in a row in October 2017. IQIPS is the only nationally recognised quality assurance scheme for audiology services in the UK.

Our clinical nurse specialists in intravenous therapy have been pioneering a new way of administering antibiotics injections in patients' homes, in collaboration with the outpatient antibiotic therapy service at West Middlesex University Hospital. The service is usually available only in acute hospitals, but is now keeping patients out of hospital and comfortable at home.

In October, young mums, dads and children joined us to celebrate the 6th anniversary of the Hounslow Family Nurse Partnership (FNP) at a Halloween party. The FNP is a home visiting programme for first-time young mums aged 19 or under, which has made a difference to the lives of more than 200 families since it started in the borough. The highly successful programme aims to help young mums have a healthy pregnancy, improve their child's health and development, plan their own futures and achieve their aspirations.

Among other great news, in January 2018 our tissue viability team won an Outstanding Practice in Wound Care Award from the Community Nursing Journal for implementing the Wound Care Buddy app, which gives district nurses instant access to specialist advice about treating leg ulcers and other wounds.

At the end of 2017, we were delighted to hear we had retained our Hounslow health visiting contract, including the family nurse partnership, and had won back the Hounslow school nursing service. The new contract started on 1 April 2018. However, sadly we lost the Richmond health visiting service, although we will work closely with Central London Community Healthcare Trust to ensure that women and children in Richmond continue to receive seamless services.

Our performance

Performance in 2017-18 was excellent, with the majority of targets being met by year end and continued improvement across the suite of quality, workforce, operational and finance indicators.

Of particular note is the dramatic reduction in vacancy rate from 23% in January 2016 to 10% by March 2018, even lower than the 13% final figure for 2016-17. We also reduced our rolling unplanned turnover to 17% in 2017-18. This good work was evidenced by the trust improving scores on overall staff engagement as part of our annual staff survey.

We also achieved the financial targets set by the Department of Health and significantly reduced expenditure on agency staff.

We continue to be committed to improving the quality and safety of care through our quality programme – Journey to Outstanding – and to focus on providing efficient and effective care to maximise the benefit for the people we serve. As we write, we are expecting an unannounced visit from the CQC in 2018 and are hoping to be rated 'Good' overall.

As we look forward to 2018-19, the challenges to provide high-quality care become even greater. To overcome these challenges, we continue to work closely with our local health and social care partners to deliver NHS England's vision for integrated care systems. Over 2017-18, we have worked proactively with our partners to look at new and innovative ways to deliver health and care services as part of two separate partnerships in north west London and south west London. This work will gather pace in 2018-19 and beyond.

Patricia Wright

Patricia Wright
Chief Executive

Stephen Swords
Chairman

Overview

515,000 population we serve

In 2017-18 **14,363** people told us about their care and treatment as compared to 14,411 in 2016-17

97.5% of patients said they were treated with respect and in dignified ways

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

Our services and staff came into contact with patients **657,005** times

This is an average of **1,765** patient contacts a day

Our health visitors had **99,885** appointments all together

244,515 The number of times our district nurses and community matrons visited patients

1,140 The number of staff by the end of March 2018

We had **353** admissions to Teddington Memorial Hospital's Inpatient Unit

Between them, patients occupied beds at the hospital for **8,917** days

Adult physiotherapy staff came into contact with patient **74,914** times

Patients attended our Urgent Care Centre in Hounslow and Walk In Centre at Teddington Memorial Hospital **130,281** times

About the trust

HRCH provides community health services for around 515,000 people registered with GPs in the London boroughs of Hounslow and Richmond, but also serves a wider population across south west London for a range of more specialist services.

Every day our professionals provide high-quality healthcare in people's homes and convenient local clinics. We help people to stay well in the community, manage their own health with the right support and avoid unnecessary trips to, or long stays in, hospital.

What we do and where we are

During 2017-18 HRCH provided and/or sub-contracted more than 60 community, urgent care and primary care-based NHS services. We believe community health services are key to ensuring people receive the right care, in the right place, at the right time.

We employ 1,140 people, who work across a wide range of health centres, hospitals, GP surgeries, children's centres, local council facilities and in community settings – including in people's homes.

We provide services over a wide geographical area across London boroughs – see our site map below for details.

A summary of the services we provide is outlined below and you can find out more about our community health services at: www.hrch.nhs.uk/our-services.

Adult services

- Community nursing, therapies, in-patient unit
- Urgent care and walk-in services
- Richmond Rapid Response Team, Hounslow Integrated Community Response Service, Community Recovery Service

Specialist services

- Neurorehabilitation, continence services and continuing care

Children's services

- Paediatric (child development; continuing care, therapies) universal children's services (health visiting, community nursing, Family Nurse Partnership), audiology, Hounslow school nursing (from April 2018)

Childhood immunisations

- Richmond, Kingston, Sutton, Merton, Bromley, Bexley, Lambeth and Southwark

Health and wellbeing

- One You Hounslow
- One You Merton
- Live Well Sutton

Services provided over a wide area

Our people

Our people are fundamental to our success in delivering high-quality patient care. We are proud of our 1,140 employees who recognise the important role they play in helping the people we serve live well in the community. The people we employ reflect the diverse backgrounds of the communities we serve and we have good representation of women and people from diverse ethnic backgrounds in senior positions in the trust.

Our approach to developing our workforce is set out in our workforce strategy (2014-19) which was co-developed with staff. During 2017-18 we continued to deliver on the ambition set out in the strategy and are pleased that a number of our performance indicators show how successful our plans have been.

In particular, the national NHS Staff Survey 2017 placed us above the national average for community trusts in England for staff engagement, with top scores nationally for staff feeling satisfied with the quality of work and care they are able to deliver – and staff feeling motivated and looking forward to going to work. The workforce strategy will be reviewed in 2018-19 to align it with the trust's 2018-23 strategy.

The NHS is facing unprecedented times, with an even greater focus on improving the way we run our services. 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 of this 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 priorities outlined in the north west and south west London partnerships.

Wellbeing matters

We continue to prioritise the health and wellbeing of employees through the staff health and wellbeing steering group. This group consists of employees from across the trust who are passionate about the wellbeing of everyone in the organisation. We publicise a range of activities via our dedicated Wellness News and wellbeing brand.

In September 2017, the group became part of a new London network of Healthy Living Ambassadors. The network and accompanying training helps to equip NHS staff with the tools, techniques and leadership skills to share their passion for health and wellbeing in the workplace, support colleagues to be healthier and lead and influence change in their organisation and beyond.

The trust was also awarded the London Healthy Workplace Charter award at 'commitment' level. The Healthy Workplace Charter is the first pan-London framework that supports and recognises investment in staff health and wellbeing. The verifiers were particularly impressed with:

- Annual and quarterly surveys resulting in wellbeing action plans
- Staff health and wellbeing group involving employees is action focussed
- Senior management involvement in the steering group and health and wellbeing activities
- Stress policy and measures to tackle work related stress
- Physical activity classes on site and mindfulness for stress at work

Rewarding and recognising our colleagues

Our annual staff awards event in November 2017 was an opportunity to celebrate and thank our people for their hard work and achievements. Patients and colleagues were asked to nominate employees who live our trust values. There were seven categories – outstanding employee; clinician; non-clinician; and leader/manager of the year; unsung hero; outstanding clinical team; and outstanding non-clinical team. More than 140 staff from a wide range of clinical and non-clinical professions were nominated for providing first class care and services.

The trust also introduced the HRCH champion awards programme this year. The champion awards take place quarterly to recognise and reward the hard work and accomplishments of people who go the extra mile for local patients. Winners of the first champion awards included Abigail Hulme, Community Learning Disability Nurse, and the Whitton Corner District Nursing Team for Caring; Stuart Holdaway, Richmond Response and Rehabilitation Team for Respect; the Sutton and Merton Immunisations Team for Communication and Innovation; and Selina Tamrat, Project Management Office, for Rising Star.

NHS Staff Survey 2017

The trust took part in the annual national NHS Staff Survey in October and November 2017. We have been participating in this survey for a number of years, which allows us to monitor trends and measure the impact of changes we have made in response to feedback. This year's results show we are above the community trust national average for 19 of the 32 key findings and improved in 22 out of 32 indicators. These results are very encouraging, but we don't plan to rest on our laurels and are continuing to work with staff to improve their working lives.

62% of our workforce completed the survey – national average is 50%

79% of our people felt engaged with the trust – national average is 76%

Best community trust nationally

68% of emloyees would recommend the trust as a place to work – national average is 57%

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

Equal best community trust nationally

81% of employees are satisfied with the quality of their work and care

78% would be happy with the standard of care provided by the trust if a friend or relative needed treatment

69% are satisfied with resources and support

35% felt unwell due to work-related stress – national average is 45%

81% felt motivated at work, better than last year

Continued to improve scores in most key areas, including

90% of the workforce said they had an appraisal in the previous 12 months

Areas of focus for improvement during 2018-19 following the staff survey

- employees believing the trust provides equal opportunities for career progression or promotion
- percentage of employees working unpaid extra hours
- percentage of colleagues reporting their most recent experience of harassment, bullying, abuse or discrimination at work

Staff Friends and Family Test

In addition to the annual NHS Staff Survey, our people provide their feedback and views via a quarterly Staff Friends and Family Test survey. By the end of 2017-18, 90% of colleagues told us they would recommend HRCH to friends and family as a place to receive care or treatment. This is higher than the national NHS trust average of 80%. Furthermore, 73.1% of people would recommend HRCH as a place to work, which is also higher than the national average of 63%.

People development

During 2017-18 we developed a Learning and Development Strategy to ensure that our people are supported to develop their knowledge and skills.

The trust is committed to the training, learning and development of all our people and offers a range of opportunities to support this. In 2017-18, we continued to improve our leadership and management capability and refined our internal Management Essentials Course – supporting managers to develop the right skills and behaviour to ensure we are able to adapt, innovate and provide high quality services.

Apprenticeships

The trust promotes apprenticeship opportunities in a variety of ways, such as during national apprenticeship week, at career fairs and through our own community fairs.

Over the last year we recruited four apprentices in administration and IT posts. Three have graduated and passed a Level 3 higher apprenticeship in business administration. All have permanent jobs with us now. They have received fantastic feedback from their colleagues and line managers and one was nominated in the Unsung Hero category for our annual staff awards.

We subsequently aim to recruit four more apprentices to support recruitment of staff from our local communities, plus more in 2019-20.

Our board

Our board reflects the diversity of the people we serve and is recognised nationally as one of the most diverse boards in London.

Executive directors


Patricia Wright, Chief Executive


David Hawkins, Director of Finance & Corporate Services


Alison Heeralall, Director of Workforce


Monique Carayol Director of Transformation


Donna Lamb, Director of Nursing and Non-medical Professionals


Tony Snell, Interim Medical Director


Anne Stratton, Director of Clinical Services (Hounslow borough / NW London)


Stephen Hall, Director of Clinical Services (Richmond borough / SW London)

Non-executive directors


Stephen Swords, Chairman


Ajay Mehta, Non Executive Director


Judith Rutherford, Non Executive Director


Bindesh Shah, Non Executive Director


Joanne Hay, Non Executive Director


Phil Hall, Non Executive Director


Ginny Colwell, Board Advisor

Our strategy

Our five-year strategy 2013-2018 set out the vision and direction for the trust. Much has changed over this period but we continue to be a high performing trust. Our strategy is underpinned by a vision, mission and values which outline what we aspire to achieve.

Our mission

To provide care and services that we and our families would want to use.

Our vision

Enabling people to live healthier and more independent lives through high quality seamless care

Our values

Care
HIGH QUALITY SAFE CARE WITH COMPASSION

Respect
DIGNITY AND RESPECT TO PATIENTS AND COLLEAGUES

Communication
LISTENING AND COMMUNICATING CLEARLY

Delivery of our strategy is supported by a set of four annual objectives which direct our activity in any given year.

Strategic objectives and goals 2017-18

This was a highly successful year, with the majority of our goals being achieved. The goals we set for ourselves for the past year were:

Quality

OBJECTIVES	GOALS	COMMENTS
• Patient quality and safety is our top priority. • We will strive to deliver outstanding care to the people we serve.	Q.1 For all core services to be rated 'Good' in all 5 domains and for each core service to achieve 'outstanding' in a minimum of 1 domain. Q.2 For all service to be safe today and every day.	• We hit 33 out of 41 targets against which we measure ourselves – please see more detail in the performance report further on in this report

People

OBJECTIVES	GOALS	COMMENTS
We will: • attract and develop a highly skilled and engaged workforce that champions our values and delivers on our vision. • actively engage with patients, public and carers to improve the care we provide at every level.	P1. Reduce vacancy rate to 10% with no service above 15% and turnover rate below 17%. P.2 Improve engagement with our staff. P.3 Improve engagement with the people we serve.	• We reached the 10% vacancy and 17% turnover targets • Our staff engagement score improved to 3.95/5 • By the end of the year we will revise our patient engagement strategy and have already undertaken three Always Events with patients

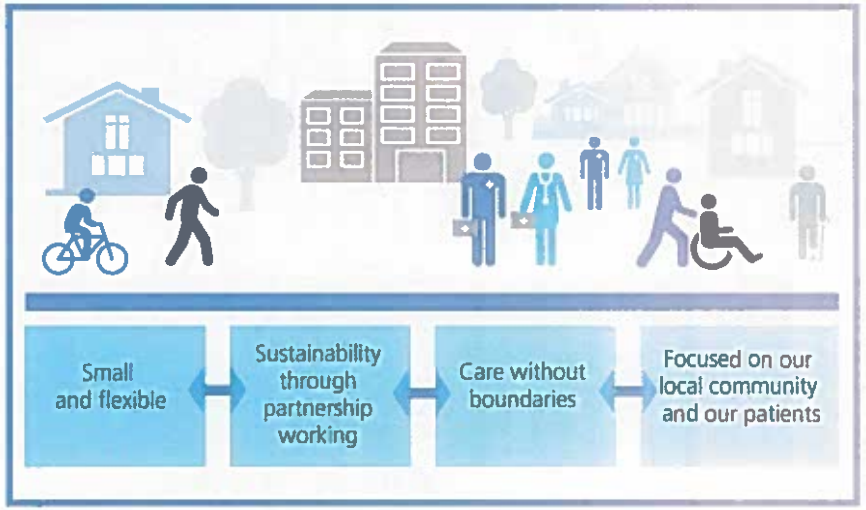
Whole system solutions

OBJECTIVES	GOALS	COMMENTS
• We will design services to meet the needs of our local population in health and illness, playing a key role in the delivery of plans to integrate health and social care services by 2020.	W1. We are active participants in and lead, where appropriate, on the development and delivery of integrated health and social care systems in Hounslow and Richmond in line with NWL and SWL STPs. W2. We continue to develop strong partnerships which support the delivery of the STP plans.	• We continue to be recognised for our active participation and leadership in the development and delivery of integrated health and social care systems • We work closely with health and social care partners to deliver the priorities outlined in the north west and south west London partnerships

Sustainable

OBJECTIVES	GOALS	COMMENTS
• As an agile, locally focussed community healthcare provider, we will use resources effectively and efficiently, working with partners to deliver the five year forward view.	S1. Achieve financial planned targets. S2. Identify new opportunities to be Better, Safer, Faster and Cheaper. S3. Achieve interoperability across care partners/care providers.	• We achieved our financial targets • We started a Small Changes – Big Difference efficiency campaign • We continue to strive for interoperability across care partners and providers

What makes us different



Key service changes and managing risk

The trust board has a responsibility to ensure the organisation is well governed and risks to quality of care and use of resources are identified, assessed, prioritised and managed to the lowest level possible.

The board carries out a trust-wide analysis of risk as part of the annual review of our risk strategy. Strategic risks are identified in the board assurance framework (BAF) and assurance that risks are appropriately managed is sought from external and internal sources, as appropriate. Operational risks are monitored through trust, directorate and service-level risk registers.

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

The board identified 10 risks for 2017-18 directly linked to the delivery of its strategic objectives and reported good management of the risks at year end. In particular, the risks related to quality, workforce and sustainability all reduced during the year as we continue on our Journey to Outstanding. There were no new strategic risks identified during the year.

Performance summary

Our board and the relevant committees use a performance scorecard which has been developed to include a suite of quality and other indicators at trust and service level – enabling centralised reporting of performance and quality data and improved triangulation of information. The scorecard is based on the Care Quality Commission's five domains of quality: safe, effective, caring, responsive and well led. The selection of indicators is based on NHS improvement guidance and the trust's priorities.

Performance against quality, workforce and business targets

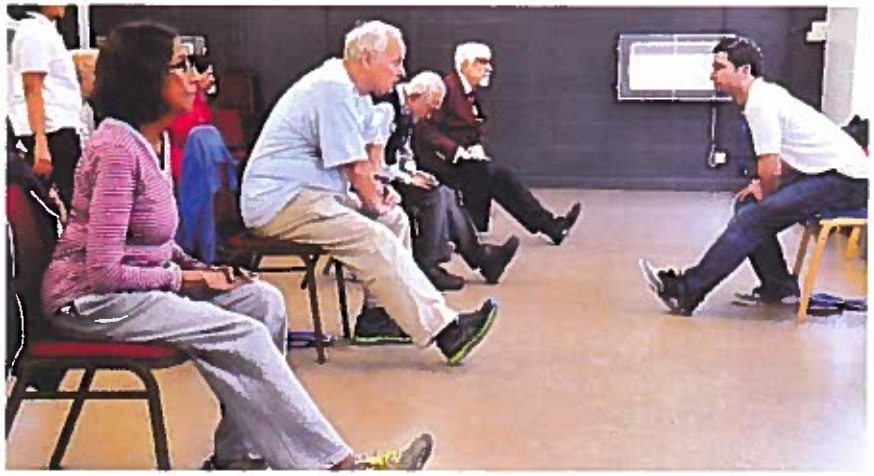
Having focused on a number of areas of improvement in 2016-17, the past year has largely been one of maintaining good performance. By the end of 2017-18 we rated ourselves green for the majority of targets (88%), while 12% of outcomes in the Safe, Effective and Caring domains were rated amber.

Although there is still room for improvement, we are pleased to see evidence of real progress on our Journey to Outstanding.

Performance against targets

88% **of targets in the safe, effective, caring, responsive and well led categories were fully met**

12% **of safe, effective and caring targets were partially met**



Financial performance

Our financial performance continues to be strong.

In 2017-18 the Trust:

- Received £71.5 million in income
- Exceeded our planned surplus of £1.276 million with an actual surplus of £1.501 million, including a requested contingency of £210k – this enabled the Trust to receive an additional £2.510 million of Sustainability & Transformation funding which is given as a "reward" to Trusts who meet their NHS budget targets. Our total surplus for the year, including this "reward" funding was therefore £4.011 million.
- Incurred £1.586 million of capital expenditure, just below our plan of £1.599 million.
- Contained our spending on agency staff within the cap set by NHS Improvement. Despite the need to cover for staff vacancies, we spent £3.695 million on agency staff which is 7.7% of our overall spending on pay, and significantly lower than the cap of £5.425 million. We have reduced our spending on agency staff through a number of measures, including increasing the number of staff who work for us through "bank" arrangements which is a positive movement in terms of quality of care as well as lower cost.
- Achieved the highest rating under NHS Improvement's "use of resources" framework which rates NHS Trusts against a range of financial management tests.

Performance analysis

Measuring and monitoring performance

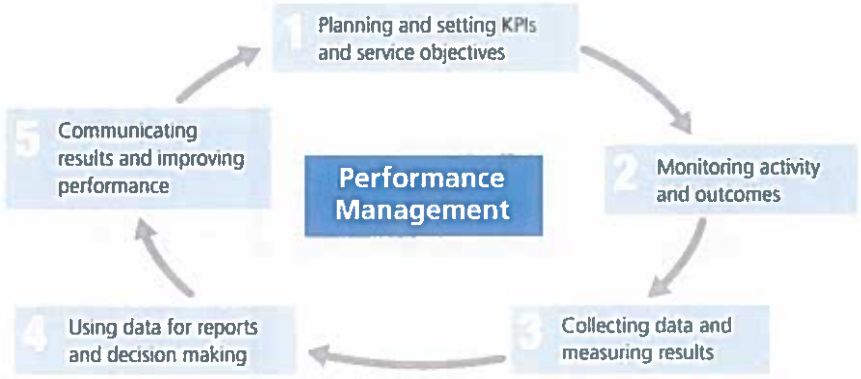
Measuring performance

Measurements of performance may be set nationally, agreed locally with commissioners, or devised by the trust itself to monitor constant improvements.

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 underperformance, as well as review progress of 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.

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 2017-18, 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.

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 2017-18

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.

Further detail is then provided under the headings of:

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

SAFE

People are protected from abuse and avoidable harm.

KPI DESCRIPTION	TARGET	ACTUAL	
Incidence of Clostridium difficile	1	0	
Incidence of MRSA	0	0	
Never events occurring in month	0	0	
Medication errors causing serious harm	0	0	
Overdue Central Alerting System (CAS) alerts	0	0	
Proportion of patients risk assessed for Venous Thromboembolism (VTE)	95%	100%	
Inpatient falls per 1,000 occupied bed days	8	8.5	
Percentage of harm free care (Safety Thermometer)	95%	94.4%	

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	90%	94.3%	
Percentage of staff - statutory & mandatory training	85%	91.37%	
Clinical supervision (% of staff)	90%	81.7%	
Patient outcomes - inpatient unit - % with improved functional outcome score on discharge (quarterly)	80%	79%	
Patient outcomes - Richmond Response & Rehabilitation Team (RRRT) - % leaving with no service or reduced service	75%	87%	
Proportion of all completed audits with an action plan	80%	97%	

CARING

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

KPI DESCRIPTION	TARGET	ACTUAL	
Inpatient Friends & Family Test (FFT) - % recommend	90%	95.4%	
A&E FFT Walk-In Centre (WIC) and Urgent Care Centre (UCC) - % recommend	90%	94%	
Community FFT - % recommend	90%	96.2%	
Trust Composite FFT - % recommend	90%	95.1%	
Staff FFT - % recommend the trust as a place to receive care & treatment (year end)	67%	90%	
Patient Survey: % patients who felt their privacy and dignity were respected	95%	96.6%	
Patient Survey: % of patients who felt they received their care in a way that was right for them	95%	95%	
Percentage of Richmond Response and Rehabilitation Team (RRRT) service users very satisfied /satisfied	90%	88.6%	
Mixed sex accommodation breaches	0	0	

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%	99.4%	●
RTT waiting times for non-admitted pathways: percentage within 18 weeks	95%	100%	●
RTT waiting times incomplete pathways: percentage within 18 weeks	92%	100%	●
RTT over 52 week waiters	0	0	●
Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	1%	0%	●
Percentage of Delayed Transfers of care	7.5%	4.9%	●
Activity against plan variance YTD - Hounslow CCG	-5 or above	-0.5%	●
Activity against Plan Variance YTD - Richmond CCG	-5 or above	18.4%	●
DNA Rate	6%	3.7%	●
Percentage of services meeting contractual waiting times targets	80%	90%	●

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%	75%	●
A&E FFT (Walk-In Centre (WIC) and Urgent Care Centre (UCC) response rate	5%	5.9%	●
Staff FFT - % recommend the trust as a place to work (year end)	61%	73.1%	●
Staff sickness	3.2%	3.17%	●
Staff turnover	17.5%	17%	●
Vacancy rate	10%	10%	●
Temporary costs and overtime as a percentage of total paybill (reported a month in arrears)	21%	14%	●
Temporary staff spend on agency staff (variance against cap)	+0% or below	-32%	●

Quality

We are on a Journey to Outstanding (J2O) to continually improve the quality and safety of our services, starting with an evidence-based assessment of our current position. The accountable officer for quality and the CQC is Donna Lamb, director of nursing and non-medical professionals.

Registration with the Care Quality Commission 2017-18

We are registered with the Care Quality Commission (CQC) without any conditions and did not participate in any special reviews or investigations between 1 April 2017 and 31 March 2018. Our last comprehensive CQC inspection in March 2016 identified that improvements were required in our inpatient unit. Following an unannounced inspection in January and February 2017, the CQC judged the unit as 'good' in all five domains of quality and 'good' overall.

We are very proud of our colleagues in the inpatient unit who rose to the challenge and drove forward significant improvements in such a short space of time.

The trust's overall rating remains as 'Requires Improvement', despite an increase in the number of 'good' ratings at service level and the improvement of two previously 'inadequate' ratings to 'good'. The trust is aspirational and our focus is on delivering consistently high-quality care while moving forwards to become an outstanding organisation.

Overarching Journey to Outstanding focus for 2017-18

Delivery of our Journey to Outstanding (J2O) action plan is one of the goals in our 2017-18 and 2018-19 strategic quality objectives. The main focus of the plan is outlined in the next section and included:

- continued self-assessment through a gap analysis
- quality improvement action plans to achieve 'good' in all areas
- a programme of peer review
- clear identification of domains that are the focus for 'outstanding' during 2017-18
- a programme to support readiness for CQC Inspection

Quality priorities

During the year, we set ourselves a number of priorities to improve the quality of our care for the people we serve. The three most important ones were:

PRIORITY 1: Early detection of the deteriorating patient

Keeping our patients safe is always our priority and the National Institute for Health and Care Excellence (NICE) recommends that an early warning score is used to detect when a patient's condition requires more intense observation and should be a trigger for further investigation. We have, therefore, committed to ensuring the early warning system is fully embedded in all services in a way that is appropriate for the way those services are delivered and the patients they see.

PRIORITY 2: Referrals management - improve the quality, timeliness and safety of internal and external referrals

We aim to improve the timeliness and quality of referral information to ensure a timely, safe and joined-up service for patients which provides a positive patient experience.

PRIORITY 3: Patient Engagement and Involvement – introduce 'Always Events' in priority clinical areas

We have committed to continually improving the quality of our services. Every day, for every one of our patients, we know it is essential to work with them and their families to understand what matters to them and use their feedback to plan and deliver better, more patient and family-centred services. For this reason in 2017-18 we introduced Always Events to priority clinical areas:

- End of life care
- Inpatient services
- Community nursing
- Urgent care

These have facilitated improved engagement with patients, families and carers and enable us to understand what matters to them. We will use this to plan and deliver better services that are more patient and family centred.

The figures below outline the important achievements made by the year end for 2017-18

0 medication errors causing serious harm

0 never events

95.3% of patients received harm-free care in March 2018 (target was 95%) compared with 93.1% in April 2017 – the average across the year was 94.4%, with, a high in March and a low of 93.3% in August

Number of patients who fell in our inpatient unit:

8.5 falls per 1,000 bed days

(target was 8) averaged across the year – the average figure disguises considerable variation across each quarter (Q1 6.1, Q2 9.8, Q3 10.6 and Q4 7.7. An in-depth review of falls was undertaken to understand reasons for falls and ensure they did not indicate poor practice.

91.4% of staff completed their statutory and mandatory training by the end of the year against a target of 85%

95.1% of patients reported they would recommend our services to their friends and family (target was 90%), rising to 95.4% by the end of March 2018

100% of patients, in March 2018, reported their privacy and dignity were respected (target was 95%), but the annual average was 96.6%

Monitoring quality performance

As reported previously in this report, we review all the information available to us about the quality of care in all the NHS 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 2017-2018, 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 feedback from patients, including patient surveys on iPads, kiosks, comment cards, electronic links and on our website. We also use paper surveys when electronic means are not appropriate and upload results into the system.

In 2017-18 14,363 people told us about their care and treatment as compared to 14,411 in 2016-17.

As part of this year's patient feedback:

97.5% of patients said they were treated with respect and in dignified ways, 0.5% higher than last year

97% of patients said they felt they had been listened to, the same as last year

Friends and Family Test (FFT)

Our patients are positive about our services and we have maintained the percentage of patients who would recommend our services to their friends and family should they require similar care or treatment. In 2017-18, 19 out of 20 patients said they would recommend our services to their friends and family. We have maintained this 95% satisfaction rate for the past three years.

We also have a children's specific comment card, designed with their input to ensure we are hearing their voice. In 2017-18, 98% 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 staff because they tell us. We record and report all compliments and are pleased to say we received 408 formal compliments compared to 419 in 2016-17.

These numbers do not capture the many lovely expressions of thanks that our people receive regularly from patients. 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 cloud right captures the prominence of words used most frequently in compliments we received during 2017-18.

Complaints

In 2016-17 we had 72 formal complaints and 116 enhanced PALS[1] which is a total of 188. In 2017-18 we had 43 formal complaints and 148 enhanced PALS a total of 191. Although this year we have had less formal complaints than last year the total of formal complaints and enhanced PALS compared to 2016-17 is essentially the same.

This change suggests that complainants wish for their complaint to be handled by the quickest route possible whilst still being 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 are the same as reported in 2016-17. These are 'staff attitude' at 28% of our total complaints for the year, 'treatment/ability' at 23% and diagnosis at 13%. Last year 93% of all formal complaints were responded to within 25 working days. This is a significant improvement of 70% on the previous year.

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. This year it was the turn of community nursing and we will report the learning from the feedback once the survey responses have been analysed.

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 also records deaths of any adults with learning disabilities through the LeDeR process, managed by the separate Hounslow and Richmond CCGs.

Adults 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 pragmatic 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 two were reviewed in line with the criteria.

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

Workforce

Our people

Our people are fundamental to our success in delivering high-quality patient care. We are proud of our 1,140 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 and we have good representation of women and people from diverse ethnic backgrounds in senior positions in the trust. In 2017-2018, the Trust Board had 15 directors, of whom eight were female and seven were male.

Our approach to developing our workforce is set out in our workforce strategy (2014-19) which was co-developed with staff. During 2017-18 we continued to deliver on the ambition set out in the strategy and are pleased that a number of our performance indicators show how successful our plans have been.

In particular, the national NHS Staff Survey 2017 placed us above the national average for community trusts in England for staff engagement, with top scores nationally for staff feeling satisfied with the quality of work and care they are able to deliver – and staff feeling motivated and looking forward to going to work. The workforce strategy will be reviewed in 2018-19 to align it with the Trust 2018-23 strategy.

The NHS is facing unprecedented times, with an even greater focus on improving the way we run our services. 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 of this 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 place to work. We have also undertaken a number of steps to proactively ensure we have a workforce that feels listened to and is engaged.

The trust has an open and honest culture and colleagues are actively encouraged to report incidents and near misses. We believe that by embedding this approach and our statutory Duty of Candour we will continually improve the safety of our services by learning from things that go wrong and making sure we do everything we can to prevent reoccurrence.

Workforce performance

Over the course of 2017-18, HRCH achieved a green rating for the majority of workforce indicators. The trust made significant improvements as a result of senior-level focus on this key priority area.

Staff turnover 17%, better than 17.5% target

Vacancy rate achieved 10% target

Staff numbers 27 fewer staff due to transfer of Richmond health visiting service

Staff sickness rates 3.17 by the year end, better than 3.2% target

NHS Staff Survey 2017

The trust took part in the annual national NHS Staff Survey in October and November 2017. We have been participating in this survey for a number of years which allows us to monitor trends and measure the impact of changes we have made in response to feedback.

This year's results show we are above the community trust national average for 19 of the 32 key findings and improved in 22 of the 32 findings. Findings overall across the NHS nationally showed a decline in 21 of the 32 areas, so our results are particularly good considering this climate. These results are very encouraging, but we don't plan to rest on our laurels and are continuing to work with staff to improve their working lives.

62% of our workforce completed the survey – national average is 50%

79% of our people felt engaged with the trust – national average is 76%

Best community trust

68% of employees would recommend the trust as a place to work – national average is 57%

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

Among best community trusts

81% of employees are satisfied with the quality of their work and care

78% would be happy with the standard of care provided by the trust if a friend or relative needed treatment

69% are satisfied with resources and support

35% felt unwell due to work-related stress – national average is 45%

81% felt motivated at work, better than last year

Continued to improve scores in most key areas, including

90% of the workforce had an appraisal in the past 12 months – 5% higher than 2017

Areas of focus for improvement during 2018-19 following the staff survey

- employees believing the trust provides equal opportunities for career progression or promotion
- percentage of employees working unpaid extra hours
- percentage of colleagues reporting their most recent experience of harassment, bullying, abuse or discrimination at work

Staff Friends and Family Test

In addition to the annual NHS Staff Survey, our people provide their feedback and views via a quarterly Staff Friends and Family Test survey. At the end of 2017-18, 90% of colleagues told us they would recommend HRCH to friends and family as a place to receive care or treatment. This is higher than the national NHS trust average of 80%. Furthermore, 73.1% of people would recommend HRCH as a place to work, which is also higher than the national average of 63%.

Embracing equality, diversity and inclusion

Our ambition remains to improve the health outcomes, access and experience of all of our patients, carers, visitors, volunteers and employees. During the past year, we have:

- Developed our patient and public engagement strategy to be inclusive by carrying out proactive outreach work with the local communities we serve to listen to their feedback and engage in the co-design of our services
- Continued to tackle local health inequalities for patients and the public through One You Hounslow, a new online programme to help people lose weight, eat well, be more active and stop smoking
- Addressed workforce health through a campaign of activities designed to improve wellbeing and mindfulness
- Worked with local schools and colleges to promote the full range of careers available in the NHS, including apprenticeships
- In partnership with local organisations, ensured information was available for the parents and families of children with a hearing impairment
- Held focus groups with our people to respond to NHS staff survey findings on bullying and harassment from patients and staff, with local actions to address specific issues
- Established a named non-executive director (NED) for equality and diversity, in addition to the respective executive leads for staff and patients
- Supported NHS Improvement's NExT NED programme, which helps develop future potential NEDs from diverse and under-represented backgrounds
- Ensured continued clear health and care information is available for people with disabilities and their carers by implementing the Accessible Information Standard
- Continued to operate an open and fair recruitment and selection policy for all applicants for jobs, and particularly welcomed applications from disabled applicants – indeed, as a disability confident employer, the Trust is open to discussing reasonable adjustments with disabled applicants and employees to help them deliver their best
- Submitted our annual Workforce Race Equality Standard outcome to NHS England in July 2017 and published our gender pay gap in March 2018. The Trust has an equality and diversity action plan, delivery of which is overseen by its Equality & Diversity Committee.
- Engaged with and involved staff in the review of behaviours linked to the values which form part of our annual performance appraisal process for all staff, as well as agreeing personal development plans and career discussions
- Had equality and diversity training as a mandatory requirement for staff and provided unconscious bias training for 119 managers
- Worked in partnership with staff side colleagues and unions and meet regularly via the Joint Negotiating and Consultative Committee

However, we know we can do more to build diversity into high-quality services and to meet the health needs of our diverse population. We will, therefore, use our move to locality-based working to better understand the needs of population groups 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 BME communities.

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

E-rostering

E-rostering technology records annual leave, shift preferences, sick leave, staff movement between patients, and staff skills. It can also help make payroll systems more accurate. We are proud of our achievement in implementing e-rostering in all departments and for 100% of all staff groups by the end March 2018.

Statutory and mandatory training

By the end of 2017-18, 91.37% of staff had carried out their statutory and mandatory training – significantly exceeding our target of 85%. Our statutory and mandatory training programme ensures the safety and wellbeing of all our people and patients. It includes national core skills modules which have a direct impact on patient safety, such as information governance, safeguarding adults and children and resuscitation. In addition, 96% of colleagues completed their information governance training.

Clinical Services

Management restructure

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

The aim is to prepare the trust for the journey towards multispecialty community providers (MCP) or other such collaborations, including primary and acute care systems (PACS).[1] The clinical services management restructure in 2017-18 is helping the trust to have strong visible leadership, together with a structure that supports succession planning and appropriately focused clinical services.

Community nursing review

Nationally, district nursing services have been reported as being at breaking point, while the Royal College of Nursing (RCN) has quoted statistics from the Health and Social Care Information Centre showing a 47% drop in district nurses between 2003-2013".[2]

This, combined with a predicted increase in the number of people with three or more long-term conditions, made us recognise that more complex patients will need to be cared for at home. Therefore, we undertook a review of community nursing, with the aim of creating a community nursing service that is fit for purpose and supports a move to multi-disciplinary working aligned with the vision of localities of care focused on populations of around 50,000 people.

Working with local GPs

We have been working with Hounslow GPs on the development of a number of services. This includes the Primary Care Patient Co-ordination Service, supporting all Hounslow GP practices to deliver joined-up, proactive and planned patient care. We also worked with the Hounslow Consortium, hosting an administrative support post.

[1] *england.nhs.uk/next-steps-on-the-nhs-five-year-forward-view.pdf*

[2] *nursingtimes/news/community/petition/article*

HRCH continues to work closely with primary care via our Richmond Community Healthcare in Partnership (RCHiP) with the Richmond GP Alliance. This has supported the implementation of new care pathways for diabetes, respiratory and cardiology patients, and working together with commissioners on the co-design of urgent care services in the borough.

Transformation

The trust launched a locality working transformation programme in the boroughs of Hounslow and Richmond and is working with health and care partners to deliver more co-ordinated, person-centred care across multi-disciplinary teams that are based on localities. The programme also aligns with our community nursing service review and redesign.

We continued work on our frail elderly and crisis response pathways and implemented the 'red bag' scheme across both boroughs. The scheme supports elderly residents from care homes who are transferred to A&E by ambulance, ensuring the safe transfer of important medical information and belongings, which helps to reduce length of time they stay in hospital after an emergency admission.

Services gained and lost

HRCH retained the Hounslow Health Visiting service, following a joint redesign programme, and was very pleased to regain the School Nursing Service contract. Last year we were also awarded the Hounslow Primary Care Patient Co-ordination Service and extended our 'One You' health and wellbeing services to Merton, which launched in April 2017.

However, we were very disappointed to lose the Richmond Health Visiting Service following the Richmond Council's decision to bring the Richmond and Wandsworth services together into a single contract.

Finance and information

Finance

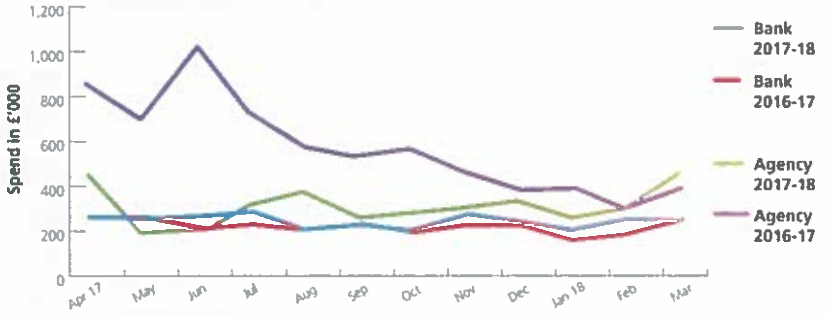
In 2017-18 the Trust:

- Received £71.5 million in income
- Exceeded our planned surplus of £1.276 million with an actual surplus of £1.501 million, including a requested contingency of £210k – this enabled the Trust to receive an additional £2.510 million of Sustainability & Transformation funding which is given as a "reward" to Trusts who meet their NHS budget targets. Our total surplus for the year, including this "reward" funding was therefore £4.011 million.
- Incurred £1.586 million of capital expenditure, just below our plan of £1.599 million.
- Contained our spending on agency staff within the cap set by NHS Improvement. Despite the need to cover for staff vacancies, we spent £3.695 million on agency staff which is 7.7% of our overall spending on pay, and significantly lower than the cap of £5.425 million. We have reduced our spending on agency staff through a number of measures, including increasing the number of staff who work for us through "bank" arrangements which is a positive movement in terms of quality of care as well as lower cost.
- 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 2018

Better Payment Policy Compliance (BPPC) – cumulative	Non NHS	NHS
By number	95.4%	98.2%
By Value	96.4%	97.4%

- Debtors due more than 90 days are £659,000 – considerable work was undertaken in 2017-18 to reduce debtors overall and this was successful
- Despite significant pressures on staffing, we reduced spending on agency staff and remained within pay rate caps, except for small numbers of specialist staff. The cap in 2017-18 was £5,425,000. We spent £3,695,000, which was 68% of the cap on agency spending and 7.7% of our overall pay bill. We spent 11% more on Bank staff than in the previous year. This is a positive reflection of our reduction in agency staff usage to improve the quality of our care and reduce costs
- Cash at 31 March was £15,900,000 against a target of £10,500,000 – cash balances were above plan, mainly as a consequence of a reduction in aged debt and additional STF monies paid in year but relating to the 2016-17 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 information governance toolkit helps us assess ourselves against the NHS information governance assurance framework.

We submitted a fully compliant level 2 IG Toolkit on 27th March 2018. Our overall compliance score for this annual submission was 78% (up from 66% in the previous year).

This was achieved through a variety of measures and actions, including:

- comprehensive data flow mapping which reviewed flows of information in and out of the organisation – we will follow up with an in-depth audit in the next financial year
- an audit of our corporate and clinical records
- an audit of our compliance against the standards set out in the IG Toolkit by our internal auditors
- helping colleagues to complete information governance e-learning: 96% of staff completed by 31 March 2018

Cyber security

We have assessed ourselves as compliant with the government's '10 steps to cyber security' and obtained Cyber Essentials certification in November 2017. This is a government-backed scheme to provide assurance of an organisation's cyber security readiness and security level.

Looking ahead to 2018-19, we will face challenges with IG compliance, especially:

- implementation of European General Data Protection Regulations on 25 May 2018
- implementation of the national data opt out programme
- increased cyber security threats
- the new Data Security and Protection Toolkit, which replaces the IG Toolkit

However, we have plans in place to manage these risks.

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 in highly efficient LED lighting and improved our heating systems through additional local control, which also impacts positively on patient and staff comfort. We have also invested in building management system (BMS) controls across our five sites to drive efficiencies.

Actions to encourage environmental sustainability

- HRCH operates a zero waste to landfill policy
- Monthly waste management training sessions are provided to ensure colleagues are aware of and follow correct waste sorting protocols; more than 1,000 people have done this training
- All domestic waste is burnt to generate energy, enabling zero landfill; this energy is then goes to the National Grid
- Our people are regularly reminded to ensure equipment is switched off before leaving their work stations
- Public transport is encouraged between sites, where possible
- Continuous auditing takes place to ensure legal compliance and capture 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

We have also moved more than 100 staff into our own buildings from satellite sites and new services that we have taken over, which has enabled us to record accurate staff consumption figures for the first time. Previously, we rented parts of other NHS trusts' premises. Electricity meters are hourly metered, so we can see daily peaks and troughs, enabling closer usage management.

However, gas usage has gone up due to having more people in our buildings, buildings being fully occupied, new buildings being taken over and the extreme cold weather we experienced during the year.

Water consumption has been tightly controlled with additional maintenance activities to check overflow functions and water storage systems which has led to reduced occasions of water wastage.

Waste

HRCH recycles just over 67% of its non-clinical waste, which is almost double the UK national average of 35%.

Staff engagement

Wherever possible, staff are actively consulted and asked for their involvement in new and innovative ideas. Our NHS Sustainability Day events in March each year are well attended and waste management sessions are well received, which is evidenced in the reduction of waste produced.

Our people and local partners are fundamental to delivering a sustainable service and we work diligently to encourage continuing engagement.

Mobile working is actively encouraged, with video conferencing facilities available, reducing the need to travel.

Transport

Walking and the use of public transport are encouraged whenever possible throughout the trust to reduce carbon. We have also commissioned a report to investigate the use of fuel-efficient pool cars and bought an electric vehicle, contributing to our goal of reducing our carbon footprint.

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.

Language support

We can help you if English is not your first language. If you would like to receive this report in a language or format of your choice, please contact the PALS team who will be happy to help:

Free phone: 0800 953 0363
Email: pals.hrch@nhs.net
Post: Patient Experience Team
Hounslow and Richmond Community Healthcare NHS Trust
Thames House
Teddington TW11 8HU

Arabic

يمكننا مساعدتك اذا لم تكن الانجليزية لغتك الأولى. إذا كنت ترغب في الحصول على هذا الكتيب بلغة أو صيغة من اختيارك تفضل بالاتصال بفريق PALS والذين سيسعدون بتقديم المساعدة.

Farsi

اگر انگلیسی زبان اول شما نیست میتوانیم به شما کمک کنیم. اگر مایلید این جزوه را به زبان و یا فرمت مورد نظر خود دریافت نمائید، لطفاً با تیم پالز PALS تماس بگیرید و انها در نهایت خوشوقتی شما را کمک مینمایند.

Polish

Możemy Państwu pomóc, jeśli angielski nie jest Państwa językiem ojczystym. Jeśli chcieliby Państwo otrzymać tę ulotkę w wybranym przez Państwa języku lub formacie, prosimy skontaktować się z zespołem PALS, który chętnie Państwu pomoże.

Punjabi

ਜੇ ਤੁਹਾਡੀ ਮੁੱਖ ਭਾਸ਼ਾ ਅੰਗਰੇਜ਼ੀ ਨਹੀਂ ਹੈ ਤਾਂ ਅਸੀਂ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ। ਜੇ ਤੁਸੀਂ ਇਹ ਪੁਸਤਿਕਾ ਆਪਣੀ ਮਨਪਸੰਦ ਭਾਸ਼ਾ ਜਾਂ ਰੂਪ ਵਿਚ ਪ੍ਰਾਪਤ ਕਰਨਾ ਚਾਹੋ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ PALS ਟੀਮ ਨਾਲ ਸੰਪਰਕ ਕਰੋ। ਤੁਹਾਡੀ ਮਦਦ ਕਰਕੇ ਉਹਨਾਂ ਨੂੰ ਖੁਸ਼ੀ ਹੋਵੇਗੀ।

Somali

Anaga waan ku caawinkarnaa hadii Ingiriis owsan aheyn luuqadaadda. Hadii aad ku dooneysit warqadan yari luuqad kale ama siyaaba kale ayaad u dooran kartaa in lagugu habayo fadlan la'xiriir kooxda ee PALS ee aad ugu faraxsan in ay ku cawiyaan.

SECTION 2 – ACCOUNTABILITY REPORT

2.1 Members of HRCH's Trust Board

Non-Executive Directors:

Stephen Swords, Chairman
Philip Hall (from August 2017)
Joanne Hay (from August 2017)
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
Siobhan Gregory, Director of Quality & Clinical Excellence (on secondment to NHS Improvement from 1 April 2017 to November 2017)
David Hawkins, Director of Finance & Corporate Services
Stephen Hall, Director of Clinical Services, Richmond and SWL
Alison Heeralall, Director of Workforce
Donna Lamb, Director of Nursing & Non-Medical Professionals (Acting from April 2017 to January 2018; permanent from February 2018)
Dr Rosalind Ranson, Medical Director (to 30 June 2017)
Tony Snell, Interim Medical Director (from July 2017)
Anne Stratton, Director of Clinical Services, Hounslow and NWL

Observers (non-voting):

The following are also able to attend our board meetings in a non-voting capacity, to represent the community's views:

- Sue Charteris - Healthwatch Hounslow representative
- Paul Pegden Smith - Healthwatch Richmond representative

Membership of board committees

The following committees reported to the board (* denotes committee chair):

Audit Committee (renamed Audit and Risk Committee from September 2017)

Philip Hall* (from August 2017)
Ajay Mehta* (for April 2017 meeting)
Stephen Swords* (for May 2017 meeting)
Bindesh Shah
Judith Rutherford

Charitable Funds' Committee

Ajay Mehta* (to September 2017)
Stephen Swords* (from September 2017)
Anne Stratton

Finance and Performance Committee

Judith Rutherford* (to July 2017)
Bindesh Shah* (from July 2017)
Philip Hall (from August 2017)
Joanne Hay (from August 2017)
David Hawkins
Stephen Hall

Quality Governance Committee

Ajay Mehta*
Ginny Colwell
Stephen Swords
Donna Lamb
David Hawkins
Dr Rosalind Ranson (to July 2017)
Tony Snell (from July 2017)
Anne Stratton

Nominations and Remuneration Committee

Stephen Swords*
Ajay Mehta
Judith Rutherford
Bindesh Shah
Phil Hall (from August 2017)
Joanne Hay (from August 2017)

Workforce and Education Committee

Stephen Swords* (to January 2018)
Joanna Hay* (from March 2018)
Ginny Colwell
Alison Heeralall
Donna Lamb
Stephen Hall

Richmond Community Healthcare in Partnership Committee (RCHIP)**

Judith Rutherford*
Monique Carayol
David Hawkins
Dr Kieran O'Flynn (Richmond GP Alliance (RGPA) Medical Director)
Penny Taylor, RGPA Business Director
Dr Darren Tymens, RGPA Chairman
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 and identify any areas for development. The chairman's appraisal review is led by the trust's senior independent director, Ajay Mehta, while the appraisal of the non-executive directors is carried out by the chairman. In addition, the chairman is subject to an annual appraisal by NHS Improvement.

2.1.1 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 a register of interests 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	JOB TITLE	INTERESTS DECLARED
Monique Carayol	Director of Transformation	Parent Governor, Southville Junior School
Ginny Colwell	Board Advisor	Non-Executive Director, Queen Victoria Hospital NHS Foundation Trust
Philip Hall	Non-Executive Director	Managing Director, PJH Management Consulting
Stephen Hall	Director of Clinical Services (Richmond and South West London)	None
David Hawkins	Director of Finance & Corporate Services	None
Joanne Hay	Non-Executive Director	Chief Executive & Company Secretary, Teens and Toddlers Charity
Alison Heeralall	Director of Workforce	None
Donna Lamb	Director of Nursing & Non-Medical Professionals	None
Ajay Mehta	Non-Executive Director	Managing Director, Ki-rin consultancy Non-Executive Director, The Hounslow Arts Trust Ltd Head of Foundation, The Chalker Foundation for Africa
Judith Rutherford	Non-Executive Director	Lead consultant, Anderford Ltd Lay member of Audit & Risk Committee, Royal College of Veterinary Surgeons
Bindesh Shah	Non-Executive Director	Chief Executive Officer, Amin Capital LLP Member, Primrose Hill Capital LLP
Tony Snell	Interim Medical Director	Wife, Patricia Snell, was engaged as an external consultant for a review of clinical governance arrangements in quarter four 2017-18
Anne Stratton	Director of Clinical Services (Hounslow and North West London)	None
Stephen Swords	Chairman and Non-Executive Director	None
Patricia Wright	Chief Executive	Member, Royal Pharmaceutical Society of Great Britain Member, General Pharmaceutical Council

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 trust has robust counter fraud and corruption policies, procedures and actively participates in national fraud initiatives. Counter fraud is a key part of the mandatory trust induction for all employees.

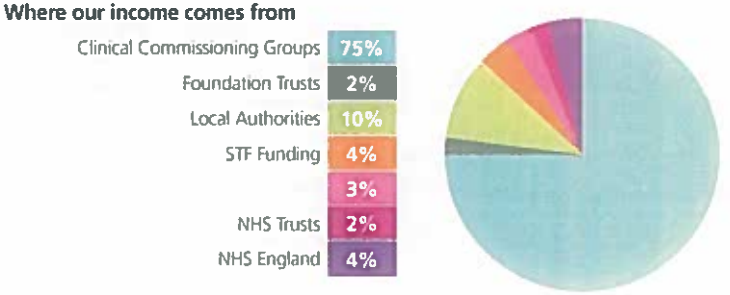
The trust has complied with HM Treasury's guidance on setting charges for information requests.

Financial Balance

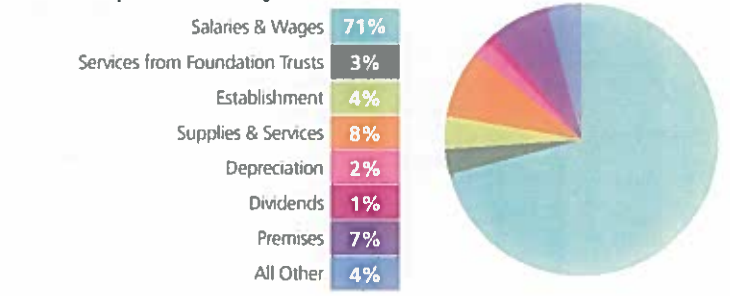
Hounslow and Richmond Community Healthcare NHS Trust planned for a control total of £2,178k (which included a £902k contribution from the Strategic Transformation Fund (STF)) and delivered a £4,011k surplus. This was achieved through sound financial planning and control by budget managers despite being faced with a number of in-year financial pressures. In addition to the original planned STF funding, the Trust received £225k STF financial incentive funding and £1,383k STF Bonus funding which contributed a further £1,608k to the surplus.

Total Income for 2017-18 was £71.5m with 75% of this coming from Clinical Commissioning Groups. Hounslow and Richmond CCGs were our two main commissioners.

Where our income comes from



Where we spend our money



Total Expenditure for 2017-18 was £67.5m and 71.0% 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 £4.5m to £39.6m due to new investment of £1.6m, mainly into buildings, and IT and a revaluation of assets worth £0.44m. Trust creditors and accruals have increased by £2.3m. The trust continues to have no borrowing.

Cash-flow

Cash increased by £4.9m in the year due to the high level of surplus delivered, a decrease in aged 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 95%.

	2017-18 NUMBER	2016-17 NUMBER
Non NHS Creditors		
Total bills paid in the year	16,671	20,000
Total bills paid within target	15,909	19,264
Percentage of bills paid within target	95.4%	96.3%
NHS Creditors		
Total bills paid in the year	826	796
Total bills paid within target	811	771
Percentage of bills paid within target	98.2%	96.9%
Overall		
Total bills paid in the year	17,497	20,796
Total bills paid within target	16,720	20,035
Percentage of bills paid within target	95.6%	96.3%

The trust has signed up to the Prompt Payments Code.

Auditors

The trust's external auditors for 2017-18 were KPMG. The cost of external audit for work undertaken in 2017-18 was £33,600 excluding VAT. (2016-17 £35,651 excluding VAT) see below:

	2017-18 £0,000s	2016-17 £0,000s
Statutory Audit	34	35
Charitable Funds Audit	1	2
Total	35	37

In addition to the statutory audit the external auditors undertook the audit of the charitable funds accounts which did not give rise to any conflict of interest or compromised the audit function.

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 us 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 2018 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 organisational risk appetite statement
- The Audit and Risk Committee taking 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
- Specific training delivered face to face by the Head of Quality & Safety being available, upon request
- Risk management training being provided for all executive and non- executive directors as part of the Board development programme and individual directors receiving risk training as required and/or as part of Trust induction
- An open culture to empower staff to report and resolve incidents and risks through the Datix recording system and to share learning with teams

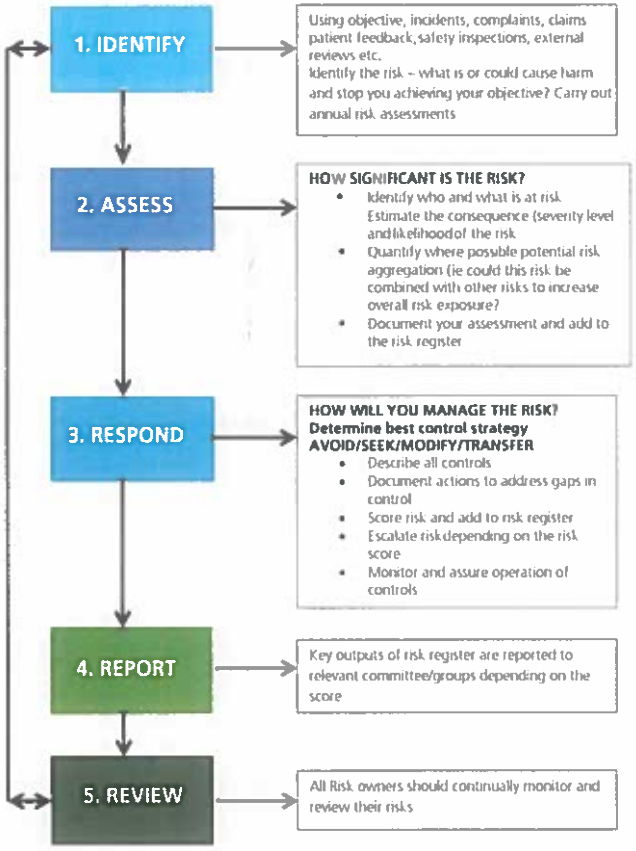
2.3.4 The risk and control framework

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 of 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

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



The trust's organisation wide risk register (OWRR), which comprises the local risk registers, the trust risk register as well as the board assurance framework (BAF), 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 & Risk Committee and trust board.

Board Assurance Framework

The Board Assurance Framework (BAF) provides a framework for reporting of 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 & 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 Board Assurance Framework (BAF) was carried out by RSM Risk Assurance Services LLP (who also provide our internal audit advice) and concluded the trust can take reasonable assurance that the controls upon which it relies to manage risks are suitably designed, consistently applied and operate effectively. In particular, RSM Risk Assurance Services LLP identified the following instances of good control at the Trust:

Structure and presentation:

- The BAF is based around the Trust's four strategic objectives (Quality, People, Sustainable, Whole system solutions).
- Risks are aligned with the strategic objectives (i.e the stated risks can be seen to impede achievement of objectives).

Number of risks and consistency of capture:

- The risks captured are in line with other organisations and are broken down at an appropriate level of detail

Ownership and oversight:

- Risks are allocated to lead directors and an oversight committee.
- The Audit and Risk Committee maintains oversight of the risk management process and requests updates from nominated risk leads at its meetings.

Internal and external influences:

The BAF captures both internal and external influences. External influences include tendering of services by customers, lack of engagement with patients and public and partners within the 'whole systems solutions' risks.

Roles and responsibilities:

- Roles and responsibilities are captured within the risk management strategy These cover

individual manager duties for administrative support and maintenance of the BAF, risk ownership, review and update of the BAF.

Within the Trust's governance structure, risks are overseen by the committee most directly interested in the risk area (e.g. objectives / risk relating to people – vacancies and reliance on temporary staffing – are overseen by the Workforce & Education Committee). Allocation of risks is explicitly set out across all risks in the BAF so that each risk is overseen by its nominated committee; the Audit & Risk Committee maintains oversight of the process and the Trust Board maintains overall accountability.

Assurances:

The BAF includes assurances and these were rated as relevant to the control/risk reported against. The assurances are timely and are also updated over time. Furthermore, there is allocated responsibility for submission and assessment.

Gaps in the assurance framework:

- The BAF also highlights gaps within assurances which trigger development of actions to improve assurances.

BAF review and update:

- A process is in place for monthly review and update of the BAF. This is led by Trust Secretary and Head of Quality & Safety who engage with risk leads to seek updates and to challenge performance as recorded in the BAF.

Risk appetite:

- In line with good practice, the Trust has a documented risk appetite based upon the impact on the Trust of risks materialising.
- Individual risks on the BAF are allocated a target score which is reported against each risk's actual score in the 'BAF Summary' snapshot.

Embedding risk management

Risk management is embedded throughout the organisation in a variety of ways including:

- Face-to-face training for key risk managers
- Monthly review of the Trust Risk register entries by the Quality & Safety Committee
- Month review of Board Assurance Framework (BAF) risk entries by the Executive committee
- Oversight of key BAF entries by Board Committees and the Executive Committee
- A review of the BAF each quarter by the Trust Board
- Key meeting agendas being set by BAF risks

In addition, the trust can highlight the following in its risk and control framework:

- 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.
- 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 our risk management process and has oversight of the quality agenda. Serious incidents and the monitoring of the Trust Risk Register (TRR) and Board Assurance Framework (BAF) are standing items.
- 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 our journey to outstanding (J2O) programme. The J2O programme is a structured quality improvement plan and we have 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).

Board and Committee oversight and assurance

- The principal risks to the delivery of the Trust's strategic priorities during the year covered the delivery of high quality care and services; the recruitment and retention of healthcare professionals; the need for effective engagement with the people we serve to deliver better patient-centred care; redesigning community nursing services to service needs; and address the 'out of hospital' agenda; being an effective partner helping to deliver the aims of the NW and SW London Sustainability and Transformation Partnerships; meeting our financial targets, including our annual cost improvement plan target; and helping to achieve interoperability of local service IT systems.
- 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.

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 groups, 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 their duties of regulation and control and meet our statutory obligations;
- To ensure the trust continues to deliver high quality patient 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 bi-monthly and a breakdown of attendance for the board's 2017-18 part I meetings is shown below:

JOB TITLE AND NAME	AMOUNT ATTENDED
Chairman, Stephen Swords	6 of 6
Non-Executive Director, Ajay Mehta	6 of 6
Non-Executive Director, Judith Rutherford	5 of 6
Non-Executive Director, Philip Hall (from August 2017)	4 of 4
Non-Executive Director, Joanne Hay (from August 2017)	4 of 4
Non-Executive Director, Bindesh Shah	3 of 6
Chief Executive, Patricia Wright	6 of 6
Director of Finance and Corporate Services, David Hawkins	5 of 6
Medical Director, Rosalind Ranson (to end June 2017)	0 of 1
Interim Medical Director, Tony Snell (from July 2017)	5 of 6
Director of Nursing & Non-Medical Professionals, Donna Lamb	5 of 6
Director of Clinical Services, Anne Stratton (shared vote)	5 of 6
Director of Clinical Services, Stephen Hall (shared vote)	5 of 6
Director of Workforce, Alison Heeralall (non-voting)	6 of 6
Director of Transformation, Monique Carayol (non-voting)	5 of 6
Board Advisor, Ginny Colwell (non-voting)	5 of 6

Audit and Risk Committee

The audit & 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 now 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 & performance, quality governance and workforce & education board 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 board assurance framework. The board monitors the BAF and progress against the delivery of annual 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 six full meetings each year. In between its full meetings, the committee holds six short meetings which focus purely on financial, workforce, quality and operational performance.

Workforce and Education Committee

The workforce and education committee meets five 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 the most senior managers and for monitoring and evaluating their performance and ensuring appropriate succession plans are in place for board members. Information relating to executive and non-executive directors is included in this Governance Statement.

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 trust 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 as laid out in their terms of reference. Each committee will also comment 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.

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 & Safety Committee where it is discussed and analysed for themes and trends and assurance is sought that risk is being managed.

This trust is a learning organisation and uses all opportunities to learn from when things go wrong and to share that learning. We have embraced a 'being open' approach and the duty of candour. Organisational and service level learning is identified through incidents, audit and patient feedback and we report lessons learned and monitor that any required changes in practice are implemented. We promote a culture of 'shared learning' that is embedded throughout the service and the Trust and have a number processes to enable this which includes a monthly 'Learn & 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.

2.3.5 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; and
- Clear reporting lines and accountabilities throughout the organisation.

2.3.6 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.

2.3.7 Care Quality Commission registration

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

2.3.8 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.

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 Miscellaneous

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

2.3.10 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 trust 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; and
- good performance under NHS Improvement's Single Oversight Framework for NHS providers.

2.3.11 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 minimum compliance level 2 score against all key requirements identified in the Information Governance Toolkit. HRCH is, thus, required to sign the *Information Governance Statement of Compliance (IGSoC)* to provide assurance that we are meeting these key requirements and must have robust improvement plans to address any shortfalls against other requirements.

The Information Governance Statement of Compliance (IG SoC) is the process by which organisations enter into an agreement with the Health and Social Care Information Centre (HSCIC) for access to the NHS National Network (N3). The process includes elements that set out terms and conditions for use of HSCIC systems and services including the N3, in order to preserve the integrity of those systems and services.

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, Contracts, Performance and Procurement 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 Information Governance 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 we are meeting the requirements of the IG 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.

HRCH was fully compliant at a level 2 of the IG Toolkit for 2017-18. Our overall compliance score for this annual submission was green rated.

There were a number of near-miss and minor Information Governance (IG) related incidents reported on Datix during 2017-18. These relate mostly to records management, where patient identifiable information was used inappropriately.

We report information governance "serious incidents" onto the national serious incident reporting system, STEIS, and to the Information Commissioners' Office (ICO).

In 2017-18, 13 incidents were reportable to STEIS, two of these were IG incidents which were also reported to the ICO.

The outcome of the two incidents reported to the ICO was that they were minor incidents attributable to human error and appropriate remedial action was taken, they therefore did not meet the criteria for formal enforcement action.

From 25 May 2018, the trust will be 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 our performance in the last year in relation to our 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 our trust performance scorecard is used. The template used for the quality account meets statutory requirements and we review new guidance annually for instance the inclusion of mortality data in the 2017-18 quality account.

General data quality is audited annually and we have undertaken actions to improve the quality of our 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 is 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 2017-18 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 a confirmation of no management actions needed as result of a review of cyber security arrangements where the trust's systems were not infected by the initial malware attack experienced across the NHS and steps were taken rapidly to isolate the trust's network from infected partners NHS organisations. In addition, reasonable assurance was identified following reviews of partnership working (contract management), procurement and financial and payroll feeder systems. The Head of Internal Audit Opinion did also identify that further enhancements to the framework of risk management, governance and internal control were required to ensure that it remains adequate and effective.

One report was issued during the year by the internal audit team which recommended that a full review of contracts currently entered into by the trust was undertaken and entered onto a contract register template which should also document the key review dates for each contract to ensure the timely commencement of necessary tendering processes. Progress on delivery of this action was reported to the audit and risk committee.

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: Patricia Wright

Chief Executive Date: 24 May 2018

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 our 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 the Department of Health.

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 our individual performance and development review process. No performance-related payments were made in the remuneration packages in 2017-18.

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.

Membership of the Remuneration committee comprises all non-executive directors including the trust chairman. The quorum of the committee is three.

During 2017-18 the following individuals were non-executive directors listed as members of the Remuneration committee:

S Swords
A Mehta
J Rutherford
P Hall
J Hay
B Shah

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*	Substantive	3 months	None	See text above
Hawkins David	Director of Finance and Corporate Services	1 April 2011[1]	Substantive	3 months	None	As above
Siobhan Gregory	Director of Quality and Clinical Excellence	1 April 2011- 31 October 2017[2]	Left	3 months	None	As above
Donna Lamb	Director of Nursing and Non-Medical Professionals	1 February 2018[3]	Substantive	3 months	None	As above
Rosalind Ranson	Medical Director	30 May 2012- 30 June 2017	Left	3 months	None	As above
Anthony Snell	Medical Director	25 July 2017- 30 April 2018	Fixed Term	3 months	None	As above
Alison Heeralall	Director of Workforce	25 November 2015[4]	Fixed Term	3 months	None	As above
Monique Carayol	Director of Transformation	1 October 2016	Fixed Term	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

* Interim/fixed term CEO prior from October 2015 and fixed term from 1 May 2016 to 3 October 2016

[1] New VSM contract incorporating Corporate Services from 1 January 2016
[2] Secondment to NHS I from 1 April 2017 to 30 September 2017
[3] Acting Director of Nursing from 1 April 2017 to 31 January 2018
[4] New VSM contract incorporating Communications from 1 October 2016

Salaries and Allowances Entitlement of Senior Managers

		2017-18						2016-17					
NAME	TITLE	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 benefit (bands of £2,500)	Total (bands of £5,000)
Patricia Wright	Chief Executive	150-155	0	0	0	0	150-155	170-175	0	0	0	0	170-175
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	70-75	0	0	0	0	70-75	115-120	0	0	0	0	115-120
Rosalind Ranson **	Medical Director	135-140	0	0	0	0	135-140	80-85	0	0	0	0	80-85
Donna Lamb**	Interim Director of Nursing & Non Medical Professionals	90-95	0	0	0	0	90-95	n/a	n/a	n/a	n/a	n/a	n/a
Tony Snell ****	Interim Medical Director	75-80	0	0	0	0	75-80	n/a	n/a	n/a	n/a	n/a	n/a
Alison Heeralall	Director of Human Resources	90-95	0	0	0	0	90-95	85-90	0	0	0	0	85-90
Anne Stratton	Director of Clinical Services	85-90	0	0	0	0	85-90	40-45	0	0	0	0	40-45
Stephen Hall	Director of Clinical Services	90-95	0	0	0	0	90-95	20-25	0	0	0	0	20-25
Monique Carayol	Director of Transformation	90-95	0	0	0	0	90-95	45-50	0	0	0	0	45-50
Stephen Swords	Chairman	25-30	0	0	0	0	25-30	15-20	0	0	0	0	15-20
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	0-5	0	0	0	0	0-5	n/a	n/a	n/a	n/a	n/a	n/a
Joanne Hay *****	Non-Executive Director	0-5	0	0	0	0	0-5	n/a	n/a	n/a	n/a	n/a	n/a
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	n/a	n/a	n/a	n/a	n/a	n/a

*Chief Executive permanent from November 2016 ** Director left April 2016, *** Director left October 2016, **** Director started October 2016
***** Non Executive Director left January 2017, ****** Non Executive Director left December 2016, ******* Board Advisor left July 2016
*The Interim Chief Executive was recruited via an agency, and the values are reported at full cost to the Trust in April 2016 including unrecoverable VAT expenses and agency fees. Transferred to payroll on 1 May 2016 on fixed term contract

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

Pension Benefits

NAME AND TITLE	Real increase in pension at age of 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 2018 (bands of £5,000)	lump sum at age 60 related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2017	Cash Equivalent Transfer Value at 31 March 2018	Real increase in Cash Equivalent Transfer Value	Employee's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Patricia Wright Chief Executive	0-2.5	0-2.5	55-60	165-170	1,177	1,231	42	0
Rosalind Ranson Medical Director	0-2.5	2.5-5	15-20	45-50	224	323	24	0
David Hawkins Director Of Finance and Corporate Services	0-2.5	0	35-40	100-105	626	679	46	0
Siobhan Gregory Director of Quality and Clinical Excellence	0-2.5	0-2.5	45-50	115-120	714	803	48	0
Anne Stratton Director of Clinical Services	2.5-5	10-12.5	30-35	100-105	581	704	117	0
Stephen Hall Director of Clinical Services	0-2.5	0-2.5	20-25	45-50	254	280	24	0
Donna Lamb Interim Director of Nursing & Non Medical Professionals	7.5-10	20-22.5	35-40	95-100	493	652	154	0
Tony Snell Interim Medical Director	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Alison Heeralall Director of Workforce	0-2.5	0-2.5	35-40	90-95	597	646	44	0
Monique Carayol Director of Transformation	2.5-5	5-7.5	15-20	35-40	148	202	52	0

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 2017-18.

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 2017-18 was £139,957 (2016-17 - £155,404). This was 4.7 times (2016-17 – 5.3) the median remuneration of the organisation's workforce of £29,986 (2016-17 - £29,252). In 2017-18, Nil (2016-17 Nil), employees received remuneration in excess of the highest paid director. Remuneration ranged from £15,671 to £116,515 (2016-17 £15,251 to £115,465)

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.

The decrease of 0.6 times is due to the appointment of a permanent Chief Executive from May 2016 who had previously been an interim appointment. The Interim Chief Executive was originally recruited via an agency, before a substantive appointment through due process in accordance with NHSI, and the values were reported at full cost to the trust in the first month of 2016-17 including unrecoverable VAT, expenses and agency fees. Costs reported in 2016-17 included one full month at agency rates, the remainder of the year was paid via payroll and this compares with a full year of costs paid via payroll in 2017-18.

Staff Costs

The following table sets out the costs of staff employed either permanently, on the bank or via agency during 2017-18.

	PERMANENT £000	OTHER £000	2017-18 TOTAL £000	2016-17 TOTAL £000
Salaries and wages	33,920	2,501	36,421	31,227
Social security costs	3,222	225	3,447	3,143
Apprenticeship levy	168	-	168	-
Employer's contributions to NHS pensions	4367	187	4554	4,312
Pension cost - other	-	-	-	-
Other post-employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	-	-	-	-
Temporary staff	-	3695	3695	9,556
Total gross staff costs	41,677	6,608	48,285	48,238
Recoveries in respect of seconded staff				
Total staff costs	41,677	6,608	48,285	48,238
Of which				
Costs capitalised as part of assets				

Average number of employees (WTE basis)

	PERMANENT NUMBER	OTHER NUMBER	2017-18 TOTAL NUMBER	2016-17 TOTAL NUMBER
Medical and dental	11	-	11	11
Ambulance staff	-	-	-	-
Administration and estates	104	33	137	194
Healthcare assistants and other support staff	323	23	346	289
Nursing, midwifery and health visiting staff	270	69	340	326
Nursing, midwifery and health visiting learners	4	-	4	8
Scientific, therapeutic and technical staff	249	42	290	288
Healthcare science staff	10	-	10	11
Social care staff	-	-	-	-
Other	1	-	1	-
Total average numbers	972	167	1,139	1,127
Of which:				
Number of employees (WTE) engaged on capital projects	1	-	1	-

Exit packages

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	£43,000	£91,000

Reporting of compensation schemes - exit packages 2016-17

There were no exit packages during the financial year ending 31 March 2017.

For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2018	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 2017 and 31 March 2018, 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 2017 and 31 March 2018

	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	17

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.

Signed

Patricia Wright

Chief Executive

24th May 2018

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

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

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

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

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

By order of the Board

Patricia Wright

Chief Executive

24 May 2018

Director of Finance

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.

Summary Financial Statements 2017-18

Statement of Comprehensive Income for year ended 31 March 2018

	2017-18 £ 000	2016-17 £ 000
Employee benefits	(48,285)	(48,238)
Other costs	(18,508)	(18,677)
Revenue from patient care activities	67,985	68,162
Other Operating revenue	3,477	2,349
Operating surplus/(deficit)	**4,669**	**3,596**
Investment revenue	33	19
Surplus/(deficit) for the financial year	**4,702**	**3,615**
Public dividend capital dividends payable	(691)	(653)
Retained surplus/(deficit) for the year	**4,011**	**2,962**
Other Comprehensive Income	**443**	**1,898**
Total comprehensive income for the year	**4,454**	**4,860**

Statement of Financial Position as at 31 March 2017

	2017-18 £ 000	2016-17 £ 000
Non-current assets		
Property, plant and equipment	**27,096**	**27,082**
Trade and other receivables	0	0
Total non-current assets	**27,096**	**27,082**
Current assets		
Trade and other receivables	6,455	5,046
Cash and cash equivalents	15,942	11,018
Total current assets	**22,397**	**16,064**
Total assets	**49,493**	**43,146**
Current liabilities		
Trade and other payables	(9,156)	(6,862)
Provisions	(13)	(414)
Total current liabilities	**(9,169)**	**(7,276)**
Total assets less current liabilities	**40,324**	**35,870**
Total non-current liabilities	**(675)**	**(675)**
Total Assets Employed	**39,649**	**35,195**
FINANCED BY		
Retained earnings	28,436	24,425
Revaluation reserve	11,213	10,770
Total Taxpayers' Equity	**39,649**	**35,195**

Statement of Changes in Taxpayers' Equity at 31 March 2018

	Retained earnings £000
Changes in taxpayers' equity for 2017-18	
Balance at 1 April 2017	35,195
Retained surplus/(deficit) for the year	4,011
Revaluation of Assets	443
Balance at 31 March 2018	**39,649**

Statement of Cash Flows for the Year Ended	**31 March 2017-18 £ 000**	2016-17 £ 000
Cash Flows from Operating Activities		
Operating Surplus/Deficit	**4,669**	3,596
Depreciation and Amortisation	**2,015**	1,139
Impairments and Reversals	**0**	0
PDC Dividend Paid	**(691)**	(625)
(Increase)/Decrease in Trade and Other Receivables	**(1,409)**	824
Increase/(Decrease) in Trade and Other Payables	**1,843**	(3,445)
Provisions Utilised	**0**	0
Increase/(Decrease) in Provisions	**(401)**	(9)
Net Cash Inflow/(Outflow) from Operating Activities	**6,026**	2,514
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest Received	**33**	19
(Payments) for Property, Plant and Equipment	**(1,135)**	(1,747)
Net Cash Inflow/(Outflow) from Investing Activities	**(1,728)**	(1,728)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**4,924**	161
CASH FLOWS FROM FINANCING ACTIVITIES	**0**	0
Net Cash Inflow/(Outflow) from Financing Activities	**0**	0
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	**4,924**	161
Cash and cash equivalents (and bank overdraft) at beginning of the year	**11,018**	10,857
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	**15,942**	11,018

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.

FINANCE

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.

NHS

Hounslow and Richmond Community Healthcare

NHS Trust

Hounslow and Richmond Community Healthcare NHS Trust
Thames House (Trust headquarters)
180 High Street
Teddington TW11 8HU
Tel: 020 8973 3000

www.hrch.nhs.uk

Providing care and services that we and our families would want to use

Care
High quality, safe care with compassion

Respect
Dignity and respect to patients and colleagues

Communication
Listening and communicating clearly

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Hounslow and Richmond Community Healthcare NHS Trust

Annual accounts for the year ended 31 March 2018

CONTENTS

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.....Patricia Laughlin.....Chief Executive

Date.....24 May 2018

Statement of directors' responsibilities in respect of the accounts

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

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

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

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

By order of the Board

24 May 2018 Date.....Patricia Laughlin.....Chief Executive

24 May 2018 Date.....Finance Director

Hounslow and Richmond Community Healthcare NHS Trust

Organisation Code: RY9

Annual Governance Statement for 2017-18

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 2018 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 organisational risk appetite statement
- The Audit and Risk Committee taking 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
- Specific training delivered face to face by the Head of Quality & Safety being available, upon request
- Risk management training being provided for all executive and non- executive directors as part of the Board development programme and individual directors receiving risk training as required and/or as part of Trust induction
- An open culture to empower staff to report and resolve incidents and risks through the Datix recording system and to share learning with teams

The risk and control framework

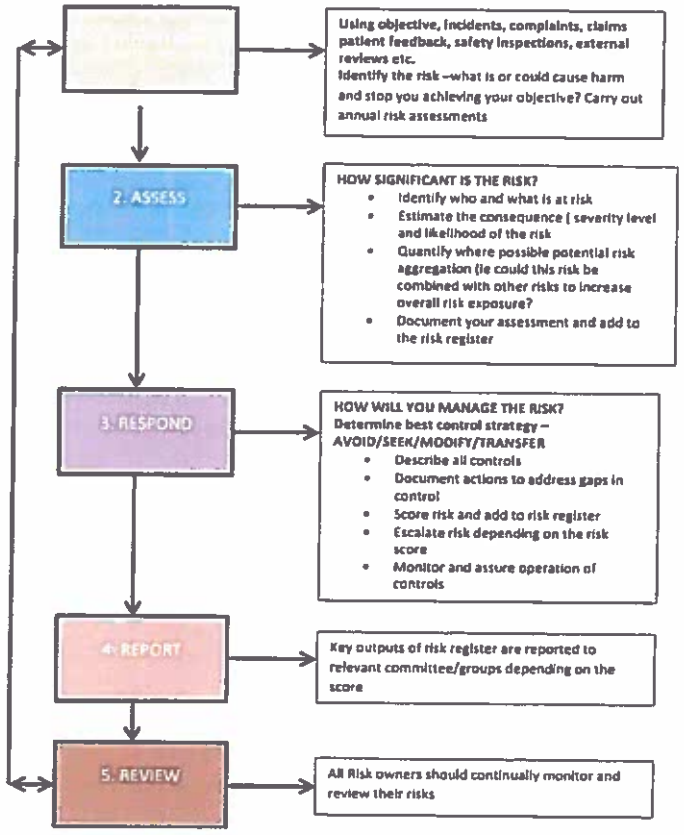
The aim of the trust's risk management strategy is to support the delivery of organisational aims and objectives through the effective management of risks across all of the Trust's functions and activities through effective risk management processes, analysis and organisational learning.

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

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

AT A GLANCE: SUMMARY OF THE RISK MANAGEMENT PROCESS



The trust's organisation wide risk register (OWRR), which comprises the local risk registers, the trust risk register as well as the board assurance framework (BAF), 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 & Risk Committee and trust board.

Board Assurance Framework

The Board Assurance Framework (BAF) provides a framework for reporting of 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 & 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 Board Assurance Framework (BAF) was carried out by RSM Risk Assurance Services LLP (who also provide our internal audit advice) and concluded the trust can take reasonable assurance that the controls upon which it relies to manage risks are suitably designed, consistently applied and operate effectively. In particular, RSM Risk Assurance Services LLP identified the following instances of good control at the Trust:

Structure and presentation:

- The BAF is based around the Trust's four strategic objectives (Quality, People, Sustainable, Whole system solutions).
- Risks are aligned with the strategic objectives (i.e. the stated risks can be seen to impede achievement of objectives).

Number of risks and consistency of capture:

- The risks captured are in line with other organisations and are broken down at an appropriate level of detail

Ownership and oversight:

- Risks are allocated to lead directors and an oversight committee.
- The Audit and Risk Committee maintains oversight of the risk management process and requests updates from nominated risk leads at its meetings.

Internal and external influences:

- The BAF captures both internal and external influences. External influences include tendering of services by customers, lack of engagement with patients and public and partners within the 'whole systems solutions' risks.

Roles and responsibilities:

- Roles and responsibilities are captured within the risk management strategy. These cover individual manager duties for administrative support and maintenance of the BAF, risk ownership, review and update of the BAF.
- Within the Trust's governance structure, risks are overseen by the committee most directly interested in the risk area (e.g. objectives / risk relating to people – vacancies and reliance on temporary staffing – are overseen by the Workforce & Education Committee). Allocation of risks is explicitly set out across all risks in the BAF so that each risk is overseen by its nominated committee; the Audit & Risk Committee maintains oversight of the process and the Trust Board maintains overall accountability.

Assurances:
The BAF includes assurances and these were rated as relevant to the control/risk reported against. The assurances are timely and are also updated over time. Furthermore, there is allocated responsibility for submission and assessment.

Gaps in the assurance framework:

- The BAF also highlights gaps within assurances which trigger development of actions to improve assurances.

BAF review and update:

- A process is in place for monthly review and update of the BAF. This is led by Trust Secretary and Head of Quality & Safety who engage with risk leads to seek updates and to challenge performance as recorded in the BAF.

Risk appetite:

- In line with good practice, the Trust has a documented risk appetite based upon the impact on the Trust of risks materialising.
- Individual risks on the BAF are allocated a target score which is reported against each risk's actual score in the 'BAF Summary' snapshot.

Embedding risk management

Risk management is embedded throughout the organisation in a variety of ways including:

- Face-to-face training for key risk managers
- Monthly review of the Trust Risk register entries by the Quality & Safety Committee
- Month review of Board Assurance Framework (BAF) risk entries by the Executive committee
- Oversight of key BAF entries by Board Committees and the Executive Committee
- A review of the BAF each quarter by the Trust Board
- Key meeting agendas being set by BAF risks

In addition, the trust can highlight the following in its risk and control framework:

- 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.
- 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 our risk management process and has oversight of the quality agenda. Serious incidents and the monitoring of the Trust Risk Register (TRR) and Board Assurance Framework (BAF) are standing items.

- 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 our journey to outstanding (J2O) programme. The J2O programme is a structured quality improvement plan and we have 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).

Board and Committee oversight and assurance

- The principal risks to the delivery of the Trust's strategic priorities during the year covered the delivery of high quality care and services; the recruitment and retention of healthcare professionals; the need for effective engagement with the people we serve to deliver better patient-centred care; redesigning community nursing services to service needs; and address the 'out of hospital' agenda; being an effective partner helping to deliver the aims of the NW and SW London Sustainability and Transformation Partnerships; meeting our financial targets, including our annual cost improvement plan target; and helping to achieve interoperability of local service IT systems.
- 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.

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 groups, 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 their duties of regulation and control and meet our statutory obligations;
- To ensure the trust continues to deliver high quality patient 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 bi-monthly and a breakdown of attendance for the board's 2017/18 part I meetings is shown below:

Job title and name	Amount Attended
Chairman, Stephen Swords	6 of 6
Non-Executive Director, Ajay Mehta	6 of 6
Non-Executive Director, Judith Rutherford	5 of 6
Non-Executive Director, Philip Hall (from August 2017)	4 of 4
Non-Executive Director, Joanne Hay (from August 2017)	4 of 4
Non-Executive Director, Bindesh Shah	3 of 6
Chief Executive, Patricia Wright	6 of 6
Director of Finance and Corporate Services, David Hawkins	5 of 6
Medical Director, Rosalind Ranson (to end June 2017)	0 of 1
Interim Medical Director, Tony Snell (from July 2017)	5 of 6
Director of Nursing & Non-Medical Professionals, Donna Lamb	5 of 6
Director of Clinical Services, Anne Stratton (shared vote)	5 of 6
Director of Clinical Services, Stephen Hall (shared vote)	5 of 6
Director of Workforce, Alison Heeralall (non-voting)	6 of 6
Director of Transformation, Monique Carayol (non-voting)	5 of 6
Board Advisor, Ginny Colwell (non-voting)	5 of 6

Audit and Risk Committee
The audit & 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 now 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 & performance, quality governance and workforce & education board 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 miligation 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 board assurance framework. The board monitors the BAF and progress against the delivery of annual 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 six full meetings each year. In between its full meetings, the committee holds six short meetings which focus purely on financial, workforce, quality and operational performance.

Workforce and Education Committee
The workforce and education committee meets five 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 the most senior managers and for monitoring and evaluating their performance and ensuring appropriate succession plans are in place for board members. Information relating to executive and non-executive directors is included in this Governance Statement.

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 trust 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 as laid out in their terms of reference. Each committee will also comment 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.

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 & Safety Committee where it is discussed and analysed for themes and trends and assurance is sought that risk is being managed.

This trust is a learning organisation and uses all opportunities to learn from when things go wrong and to share that learning. We have embraced a 'being open' approach and the duty of candour. Organisational and service level learning is identified through incidents, audit and patient feedback and we report lessons learned and monitor that any required changes in practice are implemented. We promote a culture of 'shared learning' that is embedded throughout the service and the Trust and have a number processes to enable this which includes a monthly 'Learn & 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.

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; and
- 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.

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.

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

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

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 trust 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; and
- 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 minimum compliance level 2 score against all key requirements identified in the Information Governance Toolkit. HRCH is, thus, required to sign the ***Information Governance Statement of Compliance (IGSoC)*** to provide assurance that we are meeting these key requirements and must have robust improvement plans to address any shortfalls against other requirements.

The Information Governance Statement of Compliance (IG SoC) is the process by which organisations enter into an agreement with the Health and Social Care Information Centre (HSCIC) for access to the NHS National Network (N3). The process includes elements that set out terms and conditions for use of HSCIC systems and services including the N3, in order to preserve the integrity of those systems and services.

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, Contracts, Performance and Procurement 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 Information Governance 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 we are meeting the requirements of the IG 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.

HRCH was fully compliant at a level 2 of the IG Toolkit for 2017/18. Our overall compliance score for this annual submission was green rated.

There were a number of near-miss and minor Information Governance (IG) related incidents reported on Datix during 2017/18. These relate mostly to records management, where patient identifiable information was used inappropriately.

We report information governance "serious incidents" onto the national serious incident reporting system, STEIS, and to the Information Commissioners' Office (ICO).

In 2017/18, 13 incidents were reportable to STEIS; two of these were IG incidents which were also reported to the ICO.

The outcome of the two incidents reported to the ICO was that they were minor incidents attributable to human error and appropriate remedial action was taken, they therefore did not meet the criteria for formal enforcement action.

From 25 May 2018, the trust will be following General Data Protection Regulation guidance and reporting all incidents which have deemed to affect the rights and freedoms of an individual will be reported 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 our performance in the last year in relation to our 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 our trust performance scorecard is used. The template used for the quality account meets statutory requirements and we review new guidance annually for instance the inclusion of mortality data in the 2017/18 quality account.

General data quality is audited annually and we have undertaken actions to improve the quality of our 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 is 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 2017/18 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 a confirmation of no management actions needed as result of a review of cyber security arrangements where the trust's systems were not infected by the initial malware attack experienced across the NHS and steps were taken rapidly to isolate the trust's network from infected partners NHS organisations. In addition, reasonable assurance was identified following reviews of partnership working (contract management), procurement and financial and payroll feeder systems. The Head of Internal Audit Opinion did also identify that further enhancements to the framework of risk management, governance and internal control were required to ensure that it remains adequate and effective.

One report was issued during the year by the internal audit team which recommended that a full review of contracts currently entered into by the trust was undertaken and entered onto a contract register template which should also document the key review dates for each contract to ensure the timely commencement of necessary tendering processes. Progress on delivery of this action was reported to the audit and risk committee.

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..... Patricia Laughlin

Chief Executive Date: 24 May 2018

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 2018 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 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 2018 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as being relevant to NHS Trusts in England and included in the Department of Health Group Accounting Manual 2017/18.

Basis for opinion

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

Going concern

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

Other information in the Annual Report

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

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

Annual Governance Statement

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

Remuneration and Staff Report

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

Directors' and Accountable Officer's responsibilities

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

25 May 2018

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	67,985	68,162
Other operating income	4	3,477	2,349
Operating expenses	6, 8	(66,793)	(66,915)
Operating surplus/(deficit) from continuing operations		4,669	3,596
Finance income	11	33	19
Finance expenses	12	-	-
PDC dividends payable		(691)	(653)
Net finance costs		(658)	(634)
Other gains / (losses)	13	-	-
Surplus / (deficit) for the year from continuing operations		4,011	2,962
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	14	-	-
Surplus / (deficit) for the year		4,011	2,962
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Revaluations	18	443	1,898
Total comprehensive income / (expense) for the period		4,454	4,860

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	15	4	8
Property, plant and equipment	16	27,092	27,074
Investment property	19	-	-
Total non-current assets		27,096	27,082
Current assets			
Inventories	23	-	-
Trade and other receivables	24	6,455	5,046
Cash and cash equivalents	27	15,942	11,018
Total current assets		22,397	16,064
Current liabilities			
Trade and other payables	28	(9,156)	(6,862)
Provisions	33	(13)	(414)
Other liabilities	30	-	-
Total current liabilities		(9,169)	(7,276)
Total assets less current liabilities		40,324	35,870
Non-current liabilities			
Provisions	33	(675)	(675)
Other liabilities	30	-	-
Total non-current liabilities		(675)	(675)
Total assets employed		39,649	35,195
Financed by			
Public dividend capital		-	-
Revaluation reserve		11,213	10,770
Income and expenditure reserve		28,436	24,425
Total taxpayers' equity		39,649	35,195

The notes on pages 27 to 76 form part of these accounts.

Patricia Wright
Chief Executive
Date 24 May 2018

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

	Public dividend capital £000	Revaluation reserve £000	Available for sale investment reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2017 - brought forward	-	10,770	-	-	-	24,425	35,195
Surplus/(deficit) for the year	-	-	-	-	-	4,011	4,011
Transfers by absorption: transfers between reserves	-	-	-	-	-	-	-
Other transfers between reserves	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-
Revaluations	-	443	-	-	-	-	443
Transfer to retained earnings on disposal of assets	-	-	-	-	-	-	-
Other recognised gains and losses	-	-	-	-	-	-	-
Public dividend capital received	-	-	-	-	-	-	-
Public dividend capital repaid	-	-	-	-	-	-	-
Public dividend capital written off	-	-	-	-	-	-	-
Other movements in public dividend capital in year	-	-	-	-	-	-	-
Other reserve movements	-	-	-	-	-	-	-
Taxpayers' equity at 31 March 2018	-	11,213	-	-	-	28,436	39,649

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

	Public dividend capital £000	Revaluation reserve £000	Available for sale investment reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2016 - brought forward	-	8,872	-	-	-	21,463	30,335
Prior period adjustment	-	-	-	-	-	-	-
Taxpayers' equity at 1 April 2016 - restated	-	8,872	-	-	-	21,463	30,335
Surplus/(deficit) for the year	-	-	-	-	-	2 962	2,962
Transfers by absorption: transfers between reserves	-	-	-	-	-	-	-
Other transfers between reserves	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-
Revaluations	-	1 898	-	-	-	-	1,898
Transfer to retained earnings on disposal of assets	-	-	-	-	-	-	-
Other recognised gains and losses	-	-	-	-	-	-	-
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	-	-	-	-
Public dividend capital received	-	-	-	-	-	-	-
Public dividend capital repaid	-	-	-	-	-	-	-
Public dividend capital written off	-	-	-	-	-	-	-
Other movements in public dividend capital in year	-	-	-	-	-	-	-
Other reserve movements	-	-	-	-	-	-	-
Taxpayers' equity at 31 March 2017	-	10,770	-	-	-	24,425	35,195

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.

Available-for-sale investment reserve
This reserve comprises changes in the fair value of available-for-sale financial instruments. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure.

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	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		4,669	3,598
Non-cash income and expense:			
Depreciation and amortisation	6.1	2,015	1,139
Net impairments	7	-	-
Income recognised in respect of capital donations	4	-	-
(Increase) / decrease in receivables and other assets		(1,409)	824
(Increase) / decrease in inventories		-	-
Increase / (decrease) in payables and other liabilities		1,843	(3,445)
Increase / (decrease) in provisions		(401)	400
Net cash generated from / (used in) operating activities		6,717	2,514
Cash flows from investing activities			
Interest received		33	19
Purchase of intangible assets		-	-
Purchase of property, plant, equipment and investment property		(1,135)	(1,747)
Sales of property, plant, equipment and investment property		-	-
Net cash generated from / (used in) investing activities		(1,102)	(1,728)
Cash flows from financing activities			
Other interest paid		-	-
PDC dividend (paid) / refunded		(691)	(625)
Net cash generated from / (used in) financing activities		(691)	(625)
Increase / (decrease) in cash and cash equivalents		4,924	161
Cash and cash equivalents at 1 April - brought forward		11,018	10,857
Prior period adjustments			-
Cash and cash equivalents at 1 April - restated		11,018	10,857
Cash and cash equivalents transferred under absorption accounting	44	-	-
Unrealised gains / (losses) on foreign exchange		-	-
Cash and cash equivalents at 31 March	27.1	15,942	11,018

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 2017/18 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 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 1.1.2 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. The signing of a five year Outcome Based contract with Richmond CCG and a two year contract (2017-18 to 2018-19) with Hounslow CCG provides financial stability and 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 therefore the drive is for activity to move from the acute sector to the community and primary care sector, which aligned with the joint venture agreement with a local GP alliance points to a positive future for HRCH. Therefore the going concern assessment is positive.

That said, the potential alignment of control totals and capital spend across STP footprints brings a level of uncertainty regarding long term financial planning. More focus is on joint working rather than individual organisational plans, and this naturally brings a level of uncertainty and challenge to ensure financial stability at a sector rather than an organisational level.

Note 1.2 Critical judgements in applying accounting policies

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

Note 1.2.1 Sources of estimation uncertainty

Under the terms of the operating lease on one of the Trust's properties, the Hounslow & Richmond Community Healthcare NHS Trust is 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 2018. Substantial work is being undertaken in the building which could impact on any future dilapidation costs and we will review this provision early in 2019 if the Trust agrees a further extension to the 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. 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.

Note 1.3 Interests in other entities
There are no interests in other entities

Note 1.4 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health care services. At the year end, the trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

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.

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

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 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 1.5 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 schemes are accounted for as though they are defined contribution schemes.

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 economic 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 that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:
- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost, modern equivalent asset basis.

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they 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 economic lives or low values or both, as this is not considered to be materially different from current value in existing use
An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Valuation
An item of property, plant and equipment 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

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 economic 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' ceases 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 Derecognition

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 dropped 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 economic 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 and the charges for services.

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

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	-	47
Dwellings	-	-
Plant & machinery	10	10
Transport equipment	7	10
Information technology	2	7
Furniture & fittings	2	10

Finance-leased assets (including land) are depreciated over the shorter of the useful economic 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 economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful economic lives of intangible assets
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic 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 using the first-in first-out formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

On sample testing stock levels and turnaround times, Hounslow & Richmond Community Healthcare NHS Trust concluded that these are not material in terms of net realisable value and therefore are not separately identified as a current asset on the Statement of Financial Position

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. The Trust does not hold any properties for investment

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 entity]'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 CO2 emissions. The trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 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.

CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS trust makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

Note 1.13 Financial instruments and financial liabilities
Recognition
Financial assets and financial liabilities which arise from contracts for 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, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership

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

Classification and measurement
Financial assets are categorised as "fair value through income and expenditure

Financial liabilities are classified as other financial liabilities.

Financial assets and financial liabilities at "fair value through income and expenditure"
Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and "other receivables"].

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available-for-sale financial assets

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of "other comprehensive income". When items classified as "available-for-sale" are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in "finance costs" in the Statement of Comprehensive Income.]

Other financial liabilities
All financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value
For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices or independent appraisals

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

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

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 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 net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trusts' 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 33.2 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 34 where an inflow of economic benefits is probable. The Trust does not have any contingent assets.
Contingent liabilities are not recognised, but are disclosed in note 34, 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 (other than financial instruments measured at "fair value through income and expenditure") 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 expenditure and income, 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 2017-18, Hounslow and Richmond Community Healthcare NHS Trust did not transfer or receive any assets transferred from another body.

Note 1.25 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

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

• IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
• IFRS 15 Revenue from Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
• IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

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

Note 3.1 Income from patient care activities (by nature)	2017/18 £000	2016/17 £000
Community services		
Community services income from CCGs and NHS England	56,150	55,050
Income from other sources (e.g. local authorities)	11,835	13,110
All services		
Private patient income	-	2
Other clinical income	-	-
Total income from activities	67,985	68,162

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18 £000	2016/17 £000
NHS England	2,604	1,669
Clinical commissioning groups	53,546	53,381
Department of Health and Social Care	9	8
Other NHS providers	3,506	3,129
NHS other	-	-
Local authorities	7,420	8,909
Non-NHS: private patients	-	2
Non-NHS: overseas patients (chargeable to patient)	-	-
NHS injury scheme	73	73
Non NHS: other	827	991
Total income from activities	67,985	68,162
Of which:		
Related to continuing operations	67,985	68,162
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 2017-18. Nil in 2016-17	-	-

Note 4 Other operating income

	2017/18 £000	2016/17 £000
Research and development	-	-
Education and training	531	548
Receipt of capital grants and donations	-	-
Charitable and other contributions to expenditure	-	-
Non-patient care services to other bodies	123	-
Support from the Department of Health and Social Care for mergers	-	-
Sustainability and transformation fund income	2,510	1,599
Rental revenue from operating leases	50	-
Rental revenue from finance leases	-	-
Income in respect of staff costs where accounted on gross basis	-	-
Other income	263	202
Total other operating income	3,477	2,349
Of which:		
Related to continuing operations	3,477	2,349
Related to discontinued operations	-	-

Note 5 Fees and charges

The Trust has not incurred any fees or charges

Note 6.1 Operating expenses

	2017/18 £000	2016/17 £000
Purchase of healthcare from NHS and DHSC bodies	2,258	2,399
Purchase of healthcare from non-NHS and non-DHSC bodies	413	512
Purchase of social care	-	-
Staff and executive directors costs	48,285	48,238
Remuneration of non-executive directors	66	52
Supplies and services - clinical (excluding drugs costs)	6,052	5,714
Supplies and services - general	247	242
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	160	248
Inventories written down	-	-
Consultancy costs	568	912
Establishment	1,578	2,657
Premises	1,627	787
Transport (including patient travel)	28	30
Depreciation on property, plant and equipment	2,011	1,135
Amortisation on intangible assets	4	4
Audit fees payable to the external auditor		
audit services- statutory audit	40	43
other auditor remuneration (external auditor only)	-	-
Internal audit costs	30	25
Clinical negligence - insurance costs	40	28
Legal fees	99	125
Insurance	41	32
Research and development	-	-
Education and training	-	-
Rentals under operating leases	3,184	3,718
Early retirements	-	-
Redundancy	48	-
Car parking & security	-	-
Hospitality	8	5
Losses, ex gratia & special payments	6	-
Other	-	14
Total	66,793	66,915
Of which:		
Related to continuing operations	66,793	66,915
Related to discontinued operations	-	-

** Audit fee - fee payable to the external auditors is £33,600 (excluding VAT of £6,720)

Note 6.2 Other auditor remuneration

There was no other auditor remuneration paid to the external auditor.

Note 6.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2017/18 or 2016/17.

Note 7 Impairment of assets

The Trust has not impaired any assets in 2017-18. Nil in 2016-17

Note 8 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	36,421	31,227
Social security costs	3,447	3,143
Apprenticeship levy	168	-
Employer's contributions to NHS pensions	4,554	4,312
Pension cost - other	-	-
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	-	-
Temporary staff (including agency) *	3,695	9,556
Total gross staff costs	**48,285**	**48,238**
Recoveries in respect of seconded staff	-	-
Total staff costs	**48,285**	**48,238**
Of which		
Costs capitalised as part of assets	-	-

* Temporary staff (including agency) in prior year 2016-17 included £2,634k relating to the Trust's own bank staff. In 2017-18 the cost of bank staff is included in the salaries and wages line and totals £2,501k with a further £225k in social security costs and £187k in NHS pensions.

Note 8.1 Retirements due to ill-health

During 2017/18 there were no early retirements from the trust agreed on the grounds of ill-health (none in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £0k (0k in 2016/17).

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

Note 9 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 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

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

Note 10 Operating leases

Note 10.1 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.

	2017/18 £000	2016/17 £000
Operating lease revenue		
Minimum lease receipts	50	-
Contingent rent	-	-
Other	-	-
Total	50	-

	31 March 2018 £000	31 March 2017 £000
Future minimum lease receipts due:		
- not later than one year;	275	-
- later than one year and not later than five years;	-	-
- later than five years.	-	-
Total	275	-

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 is due for renewal in February 2018

Note 10.2 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.

	2017/18 £000	2016/17 £000
Operating lease expense		
Minimum lease payments	3,184	3,718
Contingent rents	-	-
Less sublease payments received	-	-
Total	3,184	3,718

	31 March 2018 £000	31 March 2017 £000
Future minimum lease payments due:		
- not later than one year;	2,534	3,718
- later than one year and not later than five years;	5,657	11,156
- later than five years.	18	-
Total	8,209	14,874
Future minimum sublease payments to be received	-	-

Note 11 Finance income

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

	2017/18	2016/17
	£000	£000
Interest on bank accounts	33	19
Interest on impaired financial assets	-	-
Interest income on finance leases	-	-
Interest on other investments / financial assets	-	-
Other finance income	-	-
Total	33	19

Note 12.1 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 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2017/18	2016/17
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 13 Other gains / (losses)

There are no Other Gains or Losses to report in 2017-18. Nil in 2016-17

Note 14 Discontinued operations

There were no discontinued operations

Note 15.1 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 - brought forward	-	15	-	-	-	-	15
Additions	-	-	-	-	-	-	-
Gross cost at 31 March 2018	-	15	-	-	-	-	15
Amortisation at 1 April 2017 - brought forward	-	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 15.2 Intangible assets - 2016/17

	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 2016 - as previously stated	-	15	-	-	-	-	15
Prior period adjustments	-	-	-	-	-	-	-
Valuation / gross cost at 1 April 2016 - restated	-	15	-	-	-	-	15
Transfers by absorption	-	-	-	-	-	-	-
Additions	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-
Transfers to/ from assets held for sale	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-	-	-
Valuation / gross cost at 31 March 2017	-	15	-	-	-	-	15
Amortisation at 1 April 2016 - as previously stated	-	3	-	-	-	-	3
Prior period adjustments	-	-	-	-	-	-	-
Amortisation at 1 April 2016 - restated	-	3	-	-	-	-	3
Transfers by absorption	-	-	-	-	-	-	-
Provided during the year	-	4	-	-	-	-	4
Impairments	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-
Transfers to/ from assets held for sale	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-	-	-
Amortisation at 31 March 2017	-	7	-	-	-	-	7
Net book value at 31 March 2017	-	8	-	-	-	-	8
Net book value at 1 April 2016	-	12	-	-	-	-	12

Note 16.1 Property, plant and equipment - 2017/18

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2017 - brought forward	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 - brought forward	-	-	-	-	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)
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 16.2 Property, plant and equipment - 2016/17

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2016 - as previously stated	6,580	14,395	-	2,134	-	660	2,858	171	26,798
Valuation / gross cost at 1 April 2016 - restated	6,580	14,395	-	2,134	-	660	2,858	171	26,798
Transfers by absorption	-	-	-	-	-	-	-	-	-
Additions	-	410	-	455	16	130	663	112	1,786
Impairments	-	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-	-
Revaluations	47	1,012	-	-	-	-	-	-	1,059
Reclassifications	-	-	-	(2,296)	-	-	2,296	-	-
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-	-	-	-	-
Valuation/gross cost at 31 March 2017	6,627	15,817	-	293	16	790	5,817	283	29,643
Accumulated depreciation at 1 April 2016 - as previously stated	-	392	-	-	-	266	1,545	70	2,273
Prior period adjustments	-	-	-	-	-	-	-	-	-
Accumulated depreciation at 1 April 2016 - restated	-	392	-	-	-	266	1,545	70	2,273
Transfers by absorption	-	-	-	-	-	-	-	-	-
Provided during the year	-	447	-	-	1	55	604	28	1,135
Impairments	-	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-	-
Revaluations	-	(839)	-	-	-	-	-	-	(839)
Reclassifications	-	-	-	-	-	-	-	-	-
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals/ derecognition	-	-	-	-	-	-	-	-	-
Accumulated depreciation at 31 March 2017	-	-	-	-	1	321	2,149	98	2,569
Net book value at 31 March 2017	6,627	15,817	-	293	15	469	3,668	185	27,074
Net book value at 1 April 2016	6,580	14,003	-	2,134	-	394	1,313	101	24,525

Note 15.3 Property, plant and equipment financing - 2017/18

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2018									
Owned - purchased	6 627	14,772	-	435	84	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	84	442	3,106	168	27,092

Note 16.4 Property, plant and equipment financing - 2016/17

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2017									
Owned - purchased	6,627	14 405	-	293	15	439	3,668	185	25,632
Owned - government granted	-	-	-	-	-	-	-	-	-
Owned - donated	-	1,412	-	-	-	30	-	-	1,442
NBV total at 31 March 2017	6,627	15,817	-	293	15	469	3,668	185	27,074

Note 17 Donations of property, plant and equipment
There were no assets donated in 2017-18. In year depreciation of £14k was charged on equipment and buildings were revalued by £36k

Note 18 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 2018 the assets were subject to a desk top valuation by Trust experts. Using National and Local indices we compared the potential increase in valuation (using a similar methodology as previously adopted) with other local factors. The BCIS factors have been volatile and have been amended retrospectively but would give rise to a slightly higher revaluation. However property prices for office and residential properties are not rising in the boroughs where the Trust owns assets. The Trusts properties have therefore been updated using local indices which indicate a 2.85% increase in value
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 has not materialy 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 19.1 Investment Property

The Trust does not hold any investment property

Note 19.2 Investment property income and expenses

The Trust does not hold any investment property

Note 20 Investments in associates and joint ventures

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

Note 21 Other investments / financial assets (non-current)

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

Note 21.1 Other investments / financial assets (current)

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

Note 24.1 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	2,571	3,795
Capital receivables (including accrued capital related income)	-	-
Accrued income	3,777	1,132
Provision for impaired receivables	(13)	(13)
Deposits and advances	-	-
Prepayments (non-PFI)	-	-
PDC dividend receivable	-	-
VAT receivable	93	101
Corporation and other taxes receivable	-	-
Other receivables	27	31
Total current trade and other receivables	6,455	5,046
Non-current		
Trade receivables	-	-
Capital receivables (including accrued capital related income)	-	-
Accrued income	-	-
Other receivables	-	-
Total non-current trade and other receivables	-	-
Of which receivables from NHS and DHSC group bodies:		
Current	5,591	4,273
Non-current	-	-

Note 24.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	13	13
Prior period adjustments	-	-
At 1 April - restated	13	13
Transfers by absorption	-	-
Increase in provision	-	-
Amounts utilised	-	-
Unused amounts reversed	-	-
At 31 March	13	13

Note 24.3 Credit quality of financial assets

	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	£000	£000	£000	£000
0 - 30 days	-	-	-	-
30-60 Days	-	-	-	-
60-90 days	-	-	-	-
90- 180 days	-	-	-	-
Over 180 days	326	-	527	-
Total	326	-	527	-
Ageing of non-impaired financial assets past their due date				
0 - 30 days	-	-	-	-
30-60 Days	-	-	-	-
60-90 days	342	-	461	-
90- 180 days	106	-	581	-
Over 180 days	227	-	870	-
Total	675	-	1,892	-

Note 25 Other assets

The Trust does not have any other financial assets - current at 31 March 2018 (nil at 31 March 2017)

Note 26 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 2018 (nil at 31 March 2017)

Note 26.1 Liabilities in disposal groups

The Trust does not have any liabilities in disposal groups

Note 27.1 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.

	2017/18	2016/17
	£000	£000
At 1 April	11,018	10,857
Prior period adjustments	-	-
At 1 April (restated)	11,018	10,857
Transfers by absorption	-	-
Net change in year	4,924	161
At 31 March	15,942	11,018
Broken down into:		
Cash at commercial banks and in hand	-	-
Cash with the Government Banking Service	15,942	11,018
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	15,942	11,018
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	15,942	11,018

Note 27.2 Third party assets held by the trust

The Trust does not hold any third party assets

Note 28.1 Trade and other payables

	31 March 2018	31 March 2017
	£000	£000
Current		
Trade payables	3,132	771
Capital payables	661	210
Accruals	4,338	4,927
Receipts in advance (including payments on account)	75	-
Social security costs	535	526
VAT payables	-	-
Other taxes payable	349	362
PDC dividend payable	66	66
Accrued interest on loans	-	-
Other payables	-	-
Total current trade and other payables	9,156	6,862
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	1,349	1,267
Non-current	-	-

Note 28.2 Early retirements in NHS payables above

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

Note 29 Other financial liabilities

There were no other financial liabilities at 31 March 2018 (nil at 31 March 2017)

Note 30 Other liabilities

The Trust does not have any other liabilities

Note 31 Borrowings

There were no borrowings at 31 March 2018 (nil at 31 March 2017)

Note 32 Finance leases

Note 32.1 Hounslow and Richmond Community Healthcare NHS Trust as a lessor

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

Note 32.2 Hounslow and Richmond Community Healthcare NHS Trust as a lessee

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

Note 33.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs £000	Legal claims £000	Re-structuring £000	Continuing care £000	Equal Pay (including Agenda for Change) £000	Redundancy £000	Other £000	Total £000
At 1 April 2017	-	120	-	-	-	294	675	1,089
Transfers by absorption	-	-	-	-	-	-	-	-
Change in the discount rate	-	-	-	-	-	-	-	-
Arising during the year	-	13	-	-	-	-	-	13
Utilised during the year	-	(115)	-	-	-	(25)	-	(140)
Reclassified to liabilities held in disposal groups	-	-	-	-	-	-	-	-
Reversed unused	-	(5)	-	-	-	(269)	-	(274)
Unwinding of discount	-	-	-	-	-	-	-	-
At 31 March 2018	-	13	-	-	-	-	675	688
Expected timing of cash flows:								
- not later than one year;	-	13	-	-	-	-	-	13
- later than one year and not later than five years;	-	-	-	-	-	-	675	675
- later than five years	-	-	-	-	-	-	-	-
Total	-	13	-	-	-	-	675	688

Note 33.2 Clinical negligence liabilities

At 31 March 2018, £768k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Hounslow and Richmond Community Healthcare NHS Trust (31 March 2017: £2,131k).

Note 34 Contingent assets and liabilities

	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities		
NHS Resolution legal claims	(3)	(7)
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	-	-
Gross value of contingent liabilities	(3)	(7)
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	(3)	(7)
Net value of contingent assets	-	-

Note 35 Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	338	-
Intangible assets	-	-
Total	338	-

Note 36 Other financial commitments

The Trust does not have any other financial commitments at 31 March 2018 (nil at 31 March 2017)

Note 37 Defined benefit pension schemes

The Trust does not operate a defined benefit pensions scheme

Note 37.1 Changes in the defined benefit obligation and fair value of plan assets during the year

The Trust does not operate a defined benefit pensions scheme

Note 37.2 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 pensions scheme

Note 37.3 Amounts Recognised in the SOCI

The Trust does not have any defined benefits obligations to recognise in the SOCI

Note 38 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 38.1 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 38.2 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 38.3 Analysis of amounts payable to service concession operator

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

Note 39 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 40 Financial instruments

Note 40.1 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 (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 2017 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 40.2 Carrying values of financial assets

	Loans and receivables	Assets at fair value through the I&E	Held to maturity at	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2018					
Embedded derivatives	-	-	-	-	-
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

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2017					
Embedded derivatives	-	-	-	-	-
Trade and other receivables excluding non financial assets	3,796	-	-	-	3,796
Other investments / financial assets	-	-	-	-	-
Cash and cash equivalents at bank and in hand	11,018	-	-	-	11,018
Total at 31 March 2017	14,814	-	-	-	14,814

Note 40.3 Carrying value of financial liabilities

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018			
Embedded derivatives	-	-	-
Borrowings excluding finance lease and PFI liabilities	-	-	-
Obligations under finance leases	-	-	-
Obligations under PFI, LIFT and other service concession contracts	-	-	-
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

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Embedded derivatives	-	-	-
Borrowings excluding finance lease and PFI liabilities	-	-	-
Obligations under finance leases	-	-	-
Obligations under PFI, LIFT and other service concession contracts	-	-	-
Trade and other payables excluding non financial liabilities	6,171	-	6,171
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2017	6,171	-	6,171

Note 40.4 Fair values of financial assets and liabilities

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

Note 40.5 Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	9,156	6,171
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	9,156	6,171

Note 41 Losses and special payments

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	-	-	-	-
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	-	-	-	-
Stores losses and damage to property	-	-	-	-
Total losses	-	-	-	-
Special payments				
Compensation under court order or legally binding arbitration award	1	1	1	0
Extra-contractual payments	-	-	-	-
Ex-gratia payments	3	5	1	0
Special severence payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	4	6	2	0
Total losses and special payments	4	6	2	0
Compensation payments received		-		-

Note 42 Gifts

There are no gifts to disclose

Note 43 Related parties

During the year none of the Department of Health 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 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	-	454	-	77
Hounslow CCG	-	29,619	-	1,704
Richmond CCG	624	22,099	626	445
Kingston CCG	-	369	-	210
NHS England	-	2,603	-	583
Guys and St Thomas NHS Foundation Trust	1,595	30	86	83
Chelsea and Westminster NHS Foundation Trust	115	1,055	199	129
Kingston Hospital NHS Foundation Trust	92	175	18	114
Central London Community Healthcare NHS Trust	12	1,242	-	329
Croydon Health Services NHS Trust	-	180	-	120
Epsom & St Helier University Hospitals NHS Trust	-	208	-	20
St George's Healthcare NHS FT	27	273	27	113
South West London & St George's NHS Trust	-	84	-	14
West London Mental Health NHS Trust	223	47	29	2

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	-	4,458	57	143
London Borough of Richmond upon Thames	425	2,621	932	137
London Borough of Merton	-	231	-	21
London Borough of Sutton	-	150	-	0

The Trust has also received £9k payment (£10k in 2016-17) 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 44 Transfers by absorption

There are no transfers by absorption

Note 45 Prior period adjustments

There are no prior period adjustments

Note 46 Events after the reporting date

There were no events after the end of the reporting period

Note 47 Final period of operation as a trust of NHS healthcare

The Trust continues to operate as a trust of NHS healthcare

Note 48 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	16,671	28,802	20,000	31,012
Total non-NHS trade invoices paid within target	15,909	27,757	19,264	30,617
target	95.4%	96.4%	96.3%	98.7%
NHS Payables				
Total NHS trade invoices paid in the year	826	8,956	798	9,539
Total NHS trade invoices paid within target	811	8,726	771	9,328
Percentage of NHS trade invoices paid within target	98.2%	97.4%	96.9%	97.8%

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 49 External financing

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

	2017/18 £000	2016/17 £000
Cash flow financing	(4,924)	(161)
Finance leases taken out in year	0	0
Other capital receipts	0	0
External financing requirement	(4,924)	(161)
External financing limit (EFL)	69	(161)
Under / (over) spend against EFL	4,993	-

Note 50 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	1,586	1,786
Less: Disposals	-	-
Less: Donated and granted capital additions	-	-
Plus Loss on disposal of donated/granted assets	-	-
Charge against Capital Resource Limit	1,586	1,786
Capital Resource Limit	1,599	1,786
Under / (over) spend against CRL	13	-

Note 51 Breakeven duty financial performance

	2017/18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	4,068
Remove impairments scoring to Departmental Expenditure Limit	-
Add back income for impact of 2016/17 post-accounts STF reallocation	-
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	-
Breakeven duty financial performance surplus / (deficit)	4,068

Note 52 Breakeven duty rolling assessment

	2008/09	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000
Breakeven duty in-year financial performance		-	-	1,667	704	2,792	679	1,919	2,962	4,068
Breakeven duty cumulative position	-	-	-	1,667	2,371	5,163	5,842	7,761	10,723	14,791
Operating income		-	-	54,480	59,339	64,212	65,816	68,489	70,511	71,462
Cumulative breakeven position as a percentage of operating income		0.00%	0.00%	3.06%	4.00%	8.04%	8.88%	11.33%	15.21%	20.70%