Hounslow and Richmond Community Healthcare NHS Trust

Annual accounts for the year ended 31 March 2021

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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, other items of comprehensive income and cash flows for the year.

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

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.....Interim Chief Executive

Date...10th June 2021

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 and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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

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

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

By order of the Board

10th June 2021 ..... Date ..... Interim Chief Executive

10TH JUNE 2021 ..... Date ..... Finance Director

Hounslow and Richmond Community Healthcare NHS Trust

Organisation Code: RY9

Annual Governance Statement for 2020-21

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 policy 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 2021 and up to the date of approval of the annual report and accounts.

Risk Management

In 2019 as a trust on our Journey to Outstanding, we decided to take a fresh look at risk management to ensure that risk was further embedded into all decision making. To enable us to deliver the ambition set out in the trust strategy and the NHS Plan we decided it was timely to produce a risk management strategy to support our commitment to provide high quality services. We recognised that successful risk management must be forward thinking; the responsibility of all; comprehensive and coordinated; and that proactive and continuous identification and management of risk is essential to the delivery of high value healthcare.

The strategy sets out clear goals, achievements and timescales for implementation. This enables our people to work towards the same aims empowering innovation whilst ensuring patient quality and care are at the centre of delivery. Within the strategy we created a vision for risk management. Risk management will be everybody's business – integral to professional and operational practice at every level and across organisational/professional boundaries. We will continually strive to test the boundaries of practice, whilst ensuring that

we operate within legal and regulatory frameworks to reduce the exposure to risk to ensure that patients receive outstanding care.

Risk governance

The trust board is accountable to NHS England/Improvement (NHSE/I) for the trust's performance. The main governance committees are chaired by a Non-Executive Director and report directly to the board. Each committee is informed and supported by a variety of groups and local meetings.

Risk and control framework

The trust has a robust approach to risk management with:

- the board holding an annual risk seminar to review risk management systems and processes and to agree the organisational risk appetite statement
- the Audit and Risk Committee assuming delegated authority from the board for oversight and assurance on the management of strategic risks to the delivery of the trust's objectives. The Audit and Risk Committee is supported in its oversight of strategic risks by the Finance and Performance, Executive, Quality Governance and Workforce and Education Committees which lead on specific strategic risks
- the interim 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 are provided with risk management training as part of their induction to the trust
- face-to-face training for those staff regularly involved in risk management being provided as appropriate
- an open culture to empower staff to report and resolve incidents and risks through the Datix recording system and to share learning with teams

In April 2020 the trust on direction of NHS England/Improvement as part of the pandemic response implemented light and lean governance arrangements. The arrangements have ensured that the trust maintains oversight and assurance on equality and sustainability whilst providing patient care. The introduction of digital meetings brought with it new ways of working.

Managing workforce risks

HRCH has a five-year workforce strategy in place (2020-2024), which was co-developed with clinical and corporate staff and agreed by the board

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

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

Managing quality risk

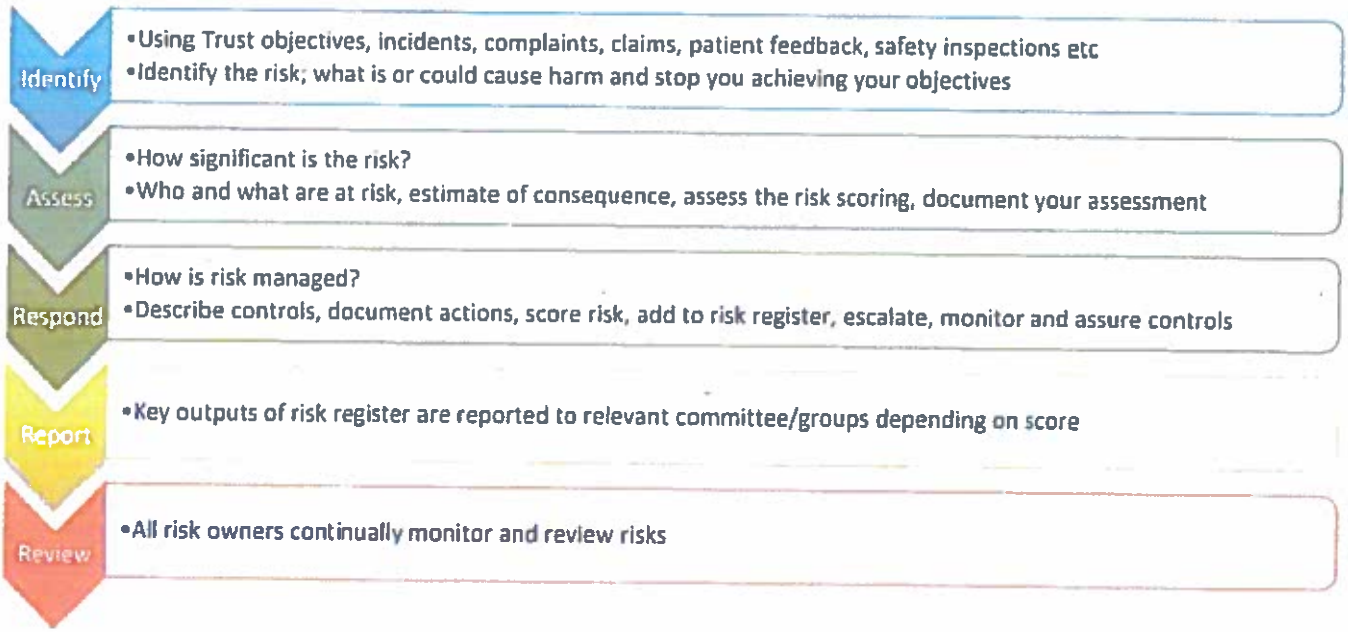
The clinical governance agenda is led by the Director of Nursing and Non-Medical Professionals and the Medical Director. Monitoring arrangements are delivered through a structure of committees, supporting clear responsibilities and accountabilities from board to front line delivery. The Quality Governance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

- the Quality and Safety Committee (QSC) reports to the QGC. The Director of Nursing and Non-Medical Professionals chairs this committee; membership of the QSC's committees and working groups ensures senior leadership as well as frontline engagement with the governance agenda
- the trust's clinical governance structure ensures there are robust systems in place for key governance and performance issues to be escalated from frontline services to the 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 has rolled out the Integrated Quality Assurance Dashboard. The dashboard highlights the trust's performance in a range of designated areas of quality. It visualises performance data and critical quality parameters in a single dashboard to simplify quality management analysis and reporting.
- the trust's quality improvement strategy is encapsulated in the Journey to Outstanding (J2O) programme. The J2O programme is a structured quality improvement plan with quality improvement plans in all services to monitor and demonstrate compliance with the CQC's fundamental standards and against each of the CQC's domains and Key Lines of Enquiry (KLOE)

Risk management process

The trust defines risk management as a process to identify factors which may possibly prevent us from providing an excellent, safe, efficient and effective place of work to deliver patient care and for staff to work. Risk management includes the process of identifying hazards, risk assessment, formulating a response, risk reporting and risk review. Risk management is as much about exploiting new business opportunities and innovation as mitigating risk.

Risk management process



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

Comprise of the local risk registers, the trust risk register as well as the board assurance framework (BAF), which seek to present an overview of the main risks facing the organisation. The local risk registers are reviewed, updated and monitored regularly by the relevant directorate and, if necessary, a risk can be escalated onto the trust risk register, which is monitored each quarter. The TRR is monitored monthly by the directorate management meeting (DMT), every 4-6 weeks at the Quality and Safety Committee and quarterly by the Quality Governance and the Audit and Risk Committees.

The BAF provides the trust with a simple but comprehensive method for effective and focused management 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 system of internal control is designed to manage risks to a reasonable level and not to eliminate all risk. The trust has a risk appetite which defines the risk tolerance with regards to its strategic objectives. These range of a low risk appetite for patient safety and quality to a high risk appetite for learning and development.

The BAF is monitored by each Executive Director who assess the status of their risk entry by having oversight of the Trust Risk Register. The BAF is monitored each month by the Executive Committee and quarterly by the Audit and Risk Committee on behalf of the trust board.

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

Incident reporting

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

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

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

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

Board and Committee oversight and assurance

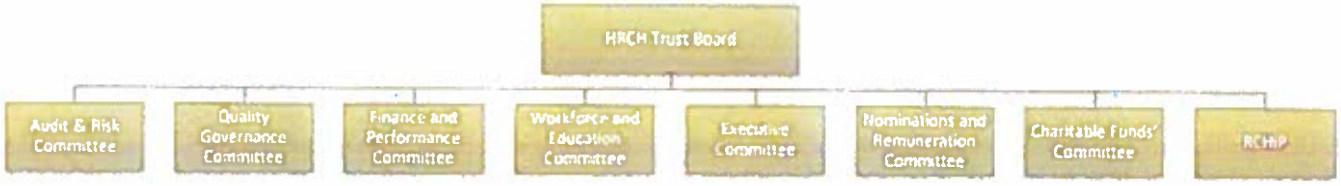
The board of directors leads on integrated governance and delegates key duties and functions to its sub-committees. In addition, the board reserves certain decision-making powers

including decisions on strategy and budgets. The diagram below gives an overview of the trust's integrated governance structure

Corporate governance framework

There are five key sub-committees with responsibility for receiving information on risk management within the structure that provide assurance to the board of directors. The Executive Committee reports directly to the board although not a board sub-committee.

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



Committee structures

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

The Board of Directors

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

- to set and oversee the strategic direction of the trust
- review and appraisal of financial and operational performance
- to review areas of assurance and concerns as detailed in the chair's assurance reports from its board committees
- to discharge its duties of regulation and control and meet statutory obligations
- to ensure the trust continues to deliver high quality patient care, with quality and safety as its primary focus, receiving and reviewing quality and patient safety reports and also a

chair's report from the key board committee which deals with patient quality and safety – the Quality Governance Committee

- to receive reports from the Audit and Risk Committee, which include the BAF and progress against the delivery of strategic objectives, 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 the requirements of NHS provider licence conditions is reviewed annually and the self-declaration is uploaded onto the website. This can be found on the 'Provider licence tab https://www.hrch.nhs.uk/about-us/trust-board-and-leadership/board-meetings

The board of directors meets in public bi-monthly and a breakdown of attendance for the board's 2019/20 part I meetings is shown below:

Job Title and Name	Attendance
Chairman, Sian Bates	6 of 6
Non-Executive Director, Ginny Colwell	6 of 6
Non-Executive Director, Phil Hall	5 of 6
Non-Executive Director, Joanne Hay	6 of 6
Non-Executive Director, Judith Rutherford	6 of 6
Non-Executive Director, Bindesh Shah	6 of 6
Chief Executive, Patricia Wright (to 29 November 2020)	4 of 4
Interim Chief Executive, David Hawkins (from 30 November 2020)	2 of 2
Director of Finance and Corporate Services, David Hawkins (to 29 November 2020)	4 of 4
Interim Director of Finance, Bridget Welch (from 30 November 2020)	2 of 2
Director of Clinical Services, Stephen Hall (shared vote)	6 of 6
Director of Clinical Services, Anne Stratton (shared vote)	6 of 6
Director and Nursing and Non-Medical Professionals, Donna Lamb (to 31 May 2020)	1 of 1
Director of Nursing and Non-Medical Professionals, Sarah Shingler (1 June 2020)	5 of 5
Director of Strategy and Transformation, Monique Carayol (non-voting) (to 12 March 2021)	5 of 5
Director of Workforce, Alison Heeralall (non-voting)	6 of 6
Medical Director, John Omany	6 of 6

At the end of March 2020 the government declared the COVID-19 pandemic. The NHS was under a structure of command and control requiring trusts to suspend certain functions including sub-committees. The trust continued to hold some committees to ensure that the quality and sustainability of the trust was closely monitored. The board has continued to meet during this time with presentation of a COVID-19 report which included, finance papers, the board scorecard, risk management and workforce data.

Audit and Risk Committee

The Audit and Risk Committee is a formal committee of the board and is accountable to the board for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the trust's activities both clinical and non-clinical, that supports the achievement of the trust's objectives. The committee continued to meet in a shortened form throughout the pandemic. It meets at least five meetings per year

Quality Governance Committee

The Quality Governance Committee (QGC) is a formal committee of the board which focuses on ensuring robust structures and processes are in place for governing the quality and clinical services and ensuring services are safe. The committee's role is to provide assurance on clinical quality, including clinical effectiveness, patient safety and patient experience.

It supports the board with an integrated approach to risk, control and governance, monitoring 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. The committee continued to meet in a shortened form throughout the pandemic to ensure the trust's focus on quality was maintained. It meets at least six times per year

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 was stood down at the start of the pandemic. The board received financial performance reports as part of the COVID-19 update. The committee restarted in September 2020. It is scheduled to meet at least four times per year.

Workforce and Education Committee

The Workforce and Education Committee is responsible for providing assurance that there are processes and plans in place to agree and achieve the workforce objectives. The committee oversees the trust's staff engagement and recruitment and retention strategic priorities that enables the trust to compete successfully for recruits in areas where there is a shortage of supply. 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. The committee was stood down at the start of the pandemic and has kept up to date via informal meetings. The monthly COVID-19 update presented to the board included workforce data. The committee restarted in September 2020 and will continue with a light-touch approach. The committee is scheduled to meet four times each year.

Executive Committee

The Executive Committee has delegated responsibility to oversee the effective operational management of the trust. The committee meets monthly to review and continued throughout the pandemic:

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

Nominations and Remuneration Committee

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

Charitable Funds' Committee

The Charitable Funds' Committee has been established by the board to make and monitor arrangements for the control and management of the trust's charitable fund. Key duties of the Committee are to apply the charitable funds in accordance with the charity's governing documents. 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 legal and regulatory requirements.

The trust's charitable funds saw an increase in funding with the trust joining NHS Charities Together which was responsible for administering the money raised by Sir Tom.

Richmond Community Healthcare in Partnership Committee (RCHiP)

RCHiP is a joint committee set up with the Richmond GP Alliance (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.

Annual committee effectiveness reviews

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

board also considers the whole of its committee structure annually to ensure that it is delivering its requirements.

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 has systems in place to ensure that it collects, analyses and acts on information relating to the legislation on equality and diversity of its workforce and the population it serves. Control measures are in place to ensure that all the organisation's obligations under quality, diversity and human rights legislation are complied with. Equality and diversity is overseen by the trust Equality, Diversity and Inclusion committee chaired by the Director of Workforce with a NED and patient executive lead. Assurance is reported via the trust executive committee.

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.

Carbon reduction

The trust has undertaken risk assessments, and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, based on UK Climate Projections 2018 (UKCP18) to ensure that 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 board of directors and the Finance and Performance Committee of the board
- monthly Executive Performance review meetings where directorates are held to account for financial and non-financial performance
- the production of annual reference costs, including comparisons with national reference costs
- continuous benchmarking of costs and key performance indicators (KPIs) against community trusts and other providers

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

Information governance and cyber security

Information governance (IG) 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. This has been a crucial element to support the new ways of working throughout the pandemic.

Due to our rigorous IG framework and data protection by design approach, we have been able to work across our boundaries, sharing key data with relevant and appropriate staff in partner organisations to help combat the virus. For example, the Trust Data Protection Officer has worked closely with IG colleagues, as part of a number of sector wide working groups to ensure that the trust can join the Connecting your Care project. This means that Richmond services have access to relevant and appropriate data from key health and care organisations at point of treatment.

Effective data security guidance has also enabled staff to work remotely using new software and business tools, while ensuring the security of patient data.

Throughout 2020, we still marked ourselves against the NHS Digital's annual Data Security and Protection Toolkit audit. The toolkit provides a benchmark for the trust against current data protection legislation and related regulations, giving either a pass or fail mark.

We did submit a fully compliant assessment in March 2020, however due to the Covid pandemic, the usual timetable for the toolkit submission was extended from March 2020 to September 2020. Therefore, the 20/21 baseline audit was submitted at the end of February 2021. The full submission is due at the end of June 2021.

We continue to maintain high standards of information governance through a variety of measures and actions, including:

- continued review of personal data flows to guarantee the trust operates in line with General Data Protection Regulations (GDPR), especially with regards to temporary Covid data processing, ensuring a register all activities is maintained and reviewed
- review of all GDPR rights requests, including the right of access, to ensure requests are answered within the legislated timeframe, to avoid breaching GDPR and incurring large fines from the ICO
- continuing review and revision of the trust privacy notice, giving assurance that the trust is transparent with all data processing, this is of particular importance during the pandemic
- completion of data protection impact assessment for all new research projects, services, systems and applications which involve the use of personal data
- an audit of our compliance against a small sample of standards from the NHS Digital toolkit by our internal audit
- continuing review of policies and staff guidance
- helping colleagues to complete information governance and security e-learning training
- attending team meetings to ensure data protection and security is a key element of all work and staff take responsibility for data in their teams

Annual Quality Account

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

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

Data quality

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

Review of effectiveness

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

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

An annual "Head of Internal Audit Opinion" based on the work and audit assessments undertaken during the year for 2020-21 was issued and provided assurance that the organisation has an adequate and effective framework for risk management, governance and internal control.

The Head of Internal Audit's Opinion is achieved through a risk-based plan of work included undertaking specifically requested management reviews with the aim of strengthening current practices - The Integrated Care Systems, providing substantial assurance; and The Board Assurance Framework and Risk Management, Freedom to Speak Up, Financial Governance, Equality and Diversity (draft) and Patient Experience audits all provided reasonable assurance. Controls were found to have been adequality designed and generally well applied to mitigate associated risks to the Trust. Internal audit has provided recommendations to address and strengthen processes in line with current requirements.

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.

Interim Chief Executive

Date: 10 June 2021

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 2021 which comprise the Trust Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note one.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2021 and of the Trust's 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 and Social Care Group Accounting Manual 2020/21.

Basis for opinion

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

Going concern

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

In our evaluation of the Directors' conclusions, we considered the inherent risks to the Trust's business model and analysed how those risks might affect the Trust's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified, and concur with the Directors' assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

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

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit as to the Trust's high-level policies and procedures to prevent and detect fraud as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reviewing the Trust's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we performed procedures to address the risk of management override of controls and the risk of fraudulent revenue recognition, in particular NHS and non-NHS revenue is recorded in the wrong period and the risk that Trust management may be in a position to make inappropriate accounting entries.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to year-end accruals.

We did not identify any additional fraud risks in response to the risk that non-pay expenditure may be manipulated in order to report that the control total has been met through manipulating accruals and prepayments at the end of the year to defer expenditure to the following year.

In determining the audit procedures, we took into account the results of our evaluation and testing of the operating effectiveness of some of Trust-wide fraud risk management controls.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included duplicate journals; journals posted and approved by the same user; the last five journals posted in the period; and journals with unusual accounts combination to cash and revenue.
- Assessing significant estimates for bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Agreeing a sample of year end accruals to relevant supporting documents, including actual invoices received post year end, where applicable.
- Performing cut-off testing of income and expenditure in the period before and after 31 March 2021 to determining whether amounts have been recorded in the correct period.

Identifying and responding to risks of material misstatement due to non-compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors and other management (as required by auditing standards), and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

As the Trust is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The Trust is subject to laws and regulations that directly affect the financial statements including financial reporting legislation. Under paragraph 2(1) of Schedule 5 to the National Health Service Act 2006 the Trust must ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to revenue account (the breakeven duty). In reporting on compliance with the breakeven duty the Trust is required to comply with the Department of Health and Social Care's 'Guidance on Breakeven Duty and Provisions', We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the Trust is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

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; and
- 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 and Social Care Group Accounting Manual 2020/21. 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 and Social Care Group Accounting Manual 2020/21.

Directors' and Accountable Officer's responsibilities

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

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

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

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure 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 and related statutory guidance having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. 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 NHS Trust for the year ended 31 March 2021 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Joanne Lees
for and on behalf of KPMG LLP
Chartered Accountants
15 Canada Square
London
E14 5GL

15 June 2021

Statement of Comprehensive Income

	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	3	79,871	74,341
Other operating income	4	5,834	3,325
Operating expenses	6, 8	(85,004)	(75,470)
Operating surplus/(deficit) from continuing operations		**701**	**2,196**
Finance income	11	6	159
PDC dividends payable		(691)	(691)
Net finance costs		**(685)**	**(532)**
Surplus / (deficit) for the year from continuing operations		**16**	**1,664**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	15	-	-
Surplus / (deficit) for the year		**16**	**1,664**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(358)	-
Revaluations	18	-	1,320
Total comprehensive income / (expense) for the period		**(342)**	**2,984**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		16	1,664
Remove I&E impact of capital grants and donations		60	57
Remove net impact of inventories received from DHSC group bodies for COVID response		-	
Adjusted financial performance surplus / (deficit)		**76**	**1,721**

Statement of Financial Position

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	15	-	-
Property, plant and equipment	16	28,342	28,264
Total non-current assets		28,342	28,264
Current assets			
Inventories	23	-	-
Receivables	24	6,497	7,372
Other investments / financial assets	21	-	-
Other assets	25	-	-
Non-current assets for sale and assets in disposal groups	26.1	-	-
Cash and cash equivalents	27	33,959	24,460
Total current assets		40,456	31,832
Current liabilities			
Trade and other payables	28	(20,305)	(13,008)
Provisions	33	-	-
Other liabilities	29	(1,518)	(53)
Liabilities in disposal groups	26.2	-	-
Total current liabilities		(21,823)	(13,061)
Total assets less current liabilities		46,975	47,035
Non-current liabilities			
Provisions	33	(986)	(704)
Other liabilities	29	-	-
Total non-current liabilities		(986)	(704)
Total assets employed		45,989	46,331
Financed by			
Public dividend capital		-	-
Revaluation reserve		11,615	11,973
Income and expenditure reserve		34,374	34,358
Total taxpayers' equity		45,989	46,331

The notes on pages 27 to 83 form part of these accounts.

Name
Position Interim Chief Executive
Date 10 June 2021

Statement of Changes in Equity for the year ended 31 March 2021

	Public dividend capital £000	Revaluation reserve £000	Financial assets reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2020 - brought forward	-	11,973	-	-	-	34,358	46,331
At start of period for new FTs	-	-	-	-	-	-	-
Surplus/(deficit) for the year	-	-	-	-	-	16	16
Impairments	-	(358)	-	-	-	-	(358)
Revaluations	-	-	-	-	-	-	-
Taxpayers' and others' equity at 31 March 2021	-	11,615	-	-	-	34,374	45,989

Statement of Changes in Equity for the year ended 31 March 2020

	Public dividend capital	Revaluation reserve	Financial assets reserve	Other reserves	Merger reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	-	10,653	-	-	-	32,694	43,347
Prior period adjustment	-	-	-	-	-	-	-
Taxpayers' and others' equity at 1 April 2019 - restated	-	10,653	-	-	-	32,694	43,347
At start of period for new FTs	-	-	-	-	-	-	-
Surplus/(deficit) for the year	-	-	-	-	-	1,664	1,664
Revaluations	-	1,320	-	-	-	-	1,320
Taxpayers' and others' equity at 31 March 2020	-	11,973	-	-	-	34,358	46,331

Information on reserves

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

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

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

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

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

Statement of Cash Flows

	Note	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Operating surplus / (deficit)		701	2,196
Non-cash income and expense:			
Depreciation and amortisation	6.1	1,786	1,899
Income recognised in respect of capital donations	4	-	-
(Increase) / decrease in receivables and other assets		875	(871)
(Increase) / decrease in inventories		-	-
Increase / (decrease) in payables and other liabilities		8,936	1,589
Increase / (decrease) in provisions		282	(3)
Net cash flows from / (used in) operating activities		12,580	4,810
Cash flows from investing activities			
Interest received		6	159
Purchase of intangible assets		-	-
Purchase of PPE and investment property		(2,396)	(1,624)
Sales of PPE and investment property		-	-
Receipt of cash donations to purchase assets		-	-
Net cash flows from / (used in) investing activities		(2,390)	(1,465)
Cash flows from financing activities			
PDC dividend (paid) / refunded		(691)	(757)
Net cash flows from / (used in) financing activities		(691)	(757)
Increase / (decrease) in cash and cash equivalents		9,499	2,588
Cash and cash equivalents at 1 April - brought forward		24,460	21,872
Prior period adjustments			-
Cash and cash equivalents at 1 April - restated		24,460	21,872
Cash and cash equivalents transferred under absorption accounting	44	-	-
Unrealised gains / (losses) on foreign exchange		-	-
Cash and cash equivalents at 31 March	27.1	33,959	24,460

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 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

HRCH continues to have turnover growth from one financial year to the next. A five-year Outcome Based Contract with Richmond CCG signed in 2016 is not being extended but replaced with a lead provider contract for the provision of community services across Richmond and Kingston, with Your Healthcare Community Interest Company operating as a sub-contracting partner. A financial agreement is in place with Hounslow CCG for 2021-22 while all commissioning arrangements are suspended due to the COVID-19 pandemic. Work has progressed on the integrated work within Hounslow with a number of other NHS providers and partners, including an HRCH executive director taking on the role of Borough Director, that supports financial sustainability over the medium-term horizon. The national directive and the local system plans are for Out of Hospital (OOH) care, rapid response teams and discharge hubs, where needs have increased over the last 12 months as an outcome from the COVID-19 pandemic, and the focus on community services within the NHS Long Term plan supports a drive for activity to move from the acute sector to the community and primary care sector. Continued collaborative work with one local GP alliance and integrated working arrangements with another also points to a positive future for the trust, as well as the establishment of Primary Care Networks. The going concern assessment is therefore positive. However, the recent government paper 'Integration and Innovation: working together to improve health and social care for all' brings more focus on joint working and collaboration across systems rather than individual organisational plans, including the commencement of a system control total regime. This will bring a new level of uncertainty and challenge to ensure financial stability across the system rather than just at organisational level. The future delivery of services and financial allocations in the aftermath of the coronavirus pandemic is still being fully worked through, with block payment arrangements due for the first six months of the financial year and then potentially reverting back to a more traditional contracting and commissioning picture in the latter half.

Note 1.3 Interests in other entities

Thee are no interests in other entities

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

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

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

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

Revenue from NHS contracts

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020/21

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at a ICS/STP level. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Comparative period (2019/20)

In the comparative period (2019/20), the trust's contracts with NHS commissioners included those where the trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

For 2020/21 and 2019/20

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.5 Other forms of income

Grants and donations

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. Where the grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

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 from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.6 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 two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The 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 1.7 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 1.8 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are 'machinery of government changes' and treated as continuing operations.

Note 1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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

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.

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.

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

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

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

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the trust.

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

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

Depreciation

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

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

Revaluation gains and losses

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

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.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

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 and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

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.

In 2020/21 this includes assets donated to the trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

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 HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

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

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.
The Trust does not currently have any PFI arrangements.

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

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	2	39
Dwellings	-	-
Plant & machinery	2	10
Transport equipment	5	10
Information technology	1	10
Furniture & fittings	5	10

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

Note 1.10 Intangible assets

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 where it meets the requirements set out in IAS 38.

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.

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 where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

Amortisation

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

Useful lives of intangible assets

The Trust is not currently holding any intangible assets having fully depreciated

Note 1.11 Inventories

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

In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.12 Investment properties

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

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

Note 1.13 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

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

Note 1.14 Financial assets and financial liabilities

Recognition

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

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

Classification and measurement

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

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

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

Financial liabilities classified as subsequently measured at fair value through income and expenditure.

Financial assets and financial liabilities at amortised cost

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

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

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

Financial assets measured at fair value through other comprehensive income

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

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

Financial assets and financial liabilities at fair value through income and expenditure

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

The Trust has irrevocably elected to measure the following financial assets / financial liabilities at fair value through income and expenditure: receivables (excluding non-finanical assets), cash and cash equivalents, trade and other payables (excluding non-financial liabilities).

Impairment of financial assets

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

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

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

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

Derecognition

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

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

Note 1.15 Leases

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

The trust as a 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 implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

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

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position 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.

The trust as a lessor

Finance leases

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

Operating leases

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

Note 1.16 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 HM Treasury's discount rates effective for 31 March 2021:

		Nominal rate
Short-term	Up to 5 years	-0.02%
Medium-term	After 5 years up to 10 years	0.18%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2020:

	Inflation rate
Year 1	1.20%
Year 2	1.60%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.95% in real terms.

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 1.17 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.
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 1.18 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.

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, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

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 calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.19 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 1.20 Corporation tax
The Trust has no corporation tax liability

Note 1.21 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.22 Foreign exchange

The functional and presentational currency of the trust is sterling.

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

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

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

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

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

Note 1.23 Third party assets

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

Note 1.24 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

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 1.25 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 1.26 Transfers of functions to or from other NHS bodies and local government bodies

For functions that have been transferred to the trust from another body, the transaction is accounted for as a transfer by absorption. The assets and liabilities transferred are recognised in the accounts using the book value 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 or 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 or liabilities transferred is recognised within income and expenditure, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve. [Adjustments to align the acquired function to the trust's accounting policies are applied after initial recognition and are adjusted directly in taxpayers' equity.]

In 2020-21 Hounslow and Richmond Community Healthcare NHS Trust did not transfer or receive any assets from another body

Note 1.27 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

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

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

Other standards, amendments and interpretations

IFRS 16 Accounting for Leases is expected to apply from 1 April 2022, having been deferred from 1 April 2019, April 2020 and again from April 2021

Note 1.29 Critical judgements in applying accounting policies

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

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

Note 1.30 Sources of estimation uncertainty

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

- Under the terms of the operating lease on one of the Trust's properties, the Hounslow & Richmond Community Healthcare NHS Trust was obliged to restore the building to its pre lease state at the end of the lease period in January 2019. The Trust had made an estimated provision for dilapidations based on current market benchmarks in 2015-16. An expert advisor was appointed to revise this provision and a report received in September 2016. The provision has been adjusted to reflect the valuations in this report, which is based on industry standards, however it remains an estimate until actual works are carried out. The value of the dilapidation provision was left unchanged as at 31 March 2019 and 31 March 2020. Substantial work is being undertaken in the building which could impact on any future dilapidation costs and we will review this provision once these are complete. Work continues in to 2021-22 and therefore the provision has again been left unchanged as at 31 March 2021. The Trust signed both an extension to the lease and then a new 10 year lease effective from 1 June 2019 to 31 May 2029 with a five year break clause. As soon as the refurbishment works are complete the Trust will then review the future dilapidation requirements of the new lease.

- The Trust's property assets were previously subject to a full revaluation as at 31 March 2020 issued alongside an RICS material valuation uncertainty statement. 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 years previously. Internal desk top valuation has been undertaken both as at 31 March 2018 using location factor indices relevant to the locality and as at 31 March 2019 using national indices. An internal desk top valuation was undertaken as at 31 March 2021 using National Indices. Due to the ongoing pandemic and market uncertainty, the Trust decided to undertake an internal desk top revaluation in March 2021 which will be followed up by another full revaluation. In 2020 the external valuer recommended an early impairment review and this will be undertaken before 31 March 2022.

The external valuation exercise was carried out in March 2020 with a valuation date of 31 March 2020. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global standards 2020 ('Red Book'), the valuer has declared a ' material valuation uncertainty' in the valuation report. This on the basis of uncertainties in markets caused by COVID 19 . The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust. the Trust has considered this revaluation and as at 31 March 2021 has determined that while the pandemic is ongoing, the full impact of any change in value of the Trusts assets cannot be measured. Therefore have taken the decision to undertake an internal desk top revaluation using national indices.

The trust has made an additional provision for dilapidations in 2020-21 for the Wheelchair Hub. A significant sum was spent in creating the Hub which is a leased property in Hounslow. The provision for dilapidations is an estimate based on the initial cost of creating the Hub but will be reviewed as part of negotiations for the renewal of the lease in 2021.

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

Note 2 Operating Segments

The Trust operated as a single segment in 2020-21

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

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	2020/21 £000	2019/20 £000
Community services		
Block contract / system envelope income*	69,441	63,509
Income from other sources (e.g. local authorities)	8,140	8,422
All services		
Private patient income	-	-
Additional pension contribution central funding**	2,290	2,120
Other clinical income	-	290
Total income from activities	79,871	74,341

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)	2020/21 £000	2019/20 £000
Income from patient care activities received from:		
NHS England	6,647	5,741
Clinical commissioning groups	65,134	60,178
Department of Health and Social Care	33	7
Other NHS providers	1,691	1,740
NHS other	35	-
Local authorities	6,025	5,934
Non-NHS: private patients	-	-
Non-NHS: overseas patients (chargeable to patient)	-	-
Injury cost recovery scheme	209	199
Non NHS: other	97	542
Total income from activities	79,871	74,341
Of which:		
Related to continuing operations	79,871	74,341
Related to discontinued operations	-	-

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

	2020/21	2019/20
	£000	£000
Income recognised this year	-	-
Cash payments received in-year	-	-
Amounts added to provision for impairment of receivables	-	-
Amounts written off in-year	-	-

Note 4 Other operating income

	2020/21			2019/20		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	-	-	-	-	-	-
Education and training	458	72	530	373	57	430
Non-patient care services to other bodies	60		60	149		149
Provider sustainability fund (2019/20 only)			-	1,326		1,326
Financial recovery fund (2019/20 only)			-	-		-
Marginal rate emergency tariff funding (2019/20 only)			-	-		-
Reimbursement and top up funding	4,421		4,421			-
Income in respect of employee benefits accounted on a gross basis	-		-	-		-
Receipt of capital grants and donations		-	-		-	-
Charitable and other contributions to expenditure		2	2		50	50
Support from the Department of Health and Social Care for mergers		-	-		-	-
Rental revenue from finance leases		-	-		-	-
Rental revenue from operating leases		748	748		1,267	1,267
Amortisation of PFI deferred income / credits		-	-		-	-
Other income	73	-	73	103	-	103
Total other operating income	5,012	822	5,834	1,951	1,374	3,325
Of which:						
Related to continuing operations			5,834			3,325
Related to discontinued operations			-			-

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2020/21 £000	2019/20 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end		
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods		

Note 5.2 Transaction price allocated to remaining performance obligations

	31 March 2021 £000	31 March 2020 £000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:		
within one year		
after one year, not later than five years		
after five years		
Total revenue allocated to remaining performance obligations	-	-

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

Note 5.5 Fees and charges

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

The Trust has not incurred any fees or charges

Note 6.1 Operating expenses

	2020/21	2019/20
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	3,907	2,554
Purchase of healthcare from non-NHS and non-DHSC bodies	380	247
Purchase of social care	-	-
Staff and executive directors costs	57,823	53,070
Remuneration of non-executive directors	95	77
Supplies and services - clinical (excluding drugs costs)	8,340	6,706
Supplies and services - general	429	256
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	195	157
Consultancy costs	188	115
Establishment	4,225	4,178
Premises	4,043	2,682
Transport (including patient travel)	100	47
Depreciation on property, plant and equipment	1,786	1,899
Amortisation on intangible assets	-	-
Audit fees payable to the external auditor		
audit services- statutory audit	52	45
other auditor remuneration (external auditor only)	-	-
Internal audit costs	30	37
Clinical negligence	75	85
Legal fees	196	199
Insurance	30	25
Research and development	-	-
Education and training	72	57
Rentals under operating leases	3,038	3,034
Early retirements	-	-
Redundancy	-	-
Car parking & security	-	-
Hospitality	-	-
Losses, ex gratia & special payments	-	-
Other	-	-
Total	**85,004**	**75,470**
Of which:		
Related to continuing operations	85,004	75,470
Related to discontinued operations	-	-

** Audit fee - fee payable to the external auditors is £43,100 (excluding VAT of £ 8,620)

Note 6.2 Nightingale hospital

During 2020/21 the Trust did not operate as a host Trust for a Nightingale facility as part of the regional coronavirus pandemic response.

Note 6.3 Other auditor remuneration

There was no other auditor remuneration paid to external auditor

Note 6.4 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2 million (2019/20: £2 million).

Note 7 Impairment of assets

The Trust has not impaired any assets in 2020-21. Nil in 2019-20.

Note 8 Employee benefits

	2020/21 Total £000	2019/20 Total £000
Salaries and wages	41,863	38,114
Social security costs	4,104	3,744
Apprenticeship levy	195	180
Employer's contributions to NHS pensions	7,548	6,963
Pension cost - other	-	-
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	-	-
Temporary staff (including agency)	4,113	4,069
Total gross staff costs	57,823	53,070
Recoveries in respect of seconded staff	-	-
Total staff costs	57,823	53,070
Of which		
Costs capitalised as part of assets	-	-

Note 8.1 Retirements due to ill-health

During 2020/21 there were no early retirements from the trust agreed on the grounds of ill-health (none in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is 0k (0k in 2019/20).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

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 2021, is based on valuation data as at 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due t the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

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.

	2020/21 £000	2019/20 £000
Operating lease revenue		
Minimum lease receipts	748	1,267
Total	748	1,267

	31 March 2021 £000	31 March 2020 £000
Future minimum lease receipts due:		
- not later than one year;	1,120	1,267
- later than one year and not later than five years;	4,480	1,488
- later than five years.	2,984	1,860
Total	8,584	4,615

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.

Hounslow and Richmond Community Healthcare NHS Trust is the lessor for Thames House. Richmond and Kingston CCGs 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 was renewed in June 2019 on a ten year lease.
Your Healthcare CIC is the lessor for an inpatient ward at Teddington Memorial Hospital. The lease is agreed on a rolling one year lease

	2020/21 £000	2019/20 £000
Operating lease expense		
Minimum lease payments	3,038	3,034
Total	3,038	3,034

	31 March 2021 £000	31 March 2020 £000
Future minimum lease payments due:		
- not later than one year;	2,201	3,124
- later than one year and not later than five years;	7,451	6,017
- later than five years.	2,220	3,273
Total	11,872	12,414
Future minimum sublease payments to be received	-	-

Note 11 Finance income

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

	2020/21	2019/20
	£000	£000
Interest on bank accounts	6	159
Total finance income	**6**	**159**

Note 12.1 Finance expenditure

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

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

The Trust did not incur any interest due to late payment of commercial debts

Note 13 Other gains / (losses)

There are no Other Gains and Losses to report in 2020-21. Nil in 2019-20

Note 14 Discontinued operations

There were no discontinued operations

Note 15.1 Intangible assets - 2020/21

	Software licences £000	Internally generated information technology £000	Development expenditure £000	Goodwill £000	Websites £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2020 - brought forward	-	15	-	-	-	-	15
Additions	-	-	-	-	-	-	-
Valuation / gross cost at 31 March 2021	-	15	-	-	-	-	15
Amortisation at 1 April 2020 - brought forward	-	15	-	-	-	-	15
Provided during the year	-	-	-	-	-	-	-
Amortisation at 31 March 2021	-	15	-	-	-	-	15
Net book value at 31 March 2021	-	-	-	-	-	-	-
Net book value at 1 April 2020	-	-	-	-	-	-	-

Note 15.2 Intangible assets - 2019/20

	Software licences £000	Internally generated information technology £000	Development expenditure £000	Goodwill £000	Websites £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2019 - as previously stated	-	15	-	-	-	-	15
Prior period adjustments	-	-	-	-	-	-	-
Valuation / gross cost at 1 April 2019 - restated	-	15	-	-	-	-	15
Additions	-	-	-	-	-	-	-
Valuation / gross cost at 31 March 2020	-	15	-	-	-	-	15
Amortisation at 1 April 2019 - as previously stated	-	15	-	-	-	-	15
Prior period adjustments	-	-	-	-	-	-	-
Amortisation at 1 April 2019 - restated	-	15	-	-	-	-	15
Provided during the year	-	-	-	-	-	-	-
Amortisation at 31 March 2020	-	15	-	-	-	-	15
Net book value at 31 March 2020	-	-	-	-	-	-	-
Net book value at 1 April 2019	-	-	-	-	-	-	-

Note 16.1 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020 - brought forward	6,789	18,234	343	505	1,418	7,635	324	35,248
Transfers by absorption	-	-	-	-	-	-	-	-
Additions	-	1,386	15	-	34	782	5	2,222
Impairments	-	(996)	-	-	-	-	-	(996)
Revaluations	-	-	-	-	-	-	-	-
Reclassifications	-	26	(202)	(102)	(303)	(2,435)	116	(2,900)
Valuation/gross cost at 31 March 2021	6,789	18,650	156	403	1,149	5,982	445	33,574
Accumulated depreciation at 1 April 2020 - brought forward	-	-	-	214	752	5,805	213	6,984
Provided during the year	-	638	-	45	151	888	64	1,786
Impairments	-	(638)	-	-	-	-	-	(638)
Revaluations	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	(102)	(303)	(2,457)	(38)	(2,900)
Accumulated depreciation at 31 March 2021	-	-	-	157	600	4,236	239	5,232
Net book value at 31 March 2021	6,789	18,650	156	246	549	1,746	206	28,342
Net book value at 1 April 2020	6,789	18,234	343	291	666	1,830	111	28,264

Within reclassifications is a net neutral transfer of £202k from AUC to buildings (£26k); furniture and fittings (£154k); and Information Technology (£22k). The balance of £2,900k on both reclassifications for gross cost valuation and for accumulated depreciation represents a correction to historical presentational differences between the brought forward values in the accounts and the trust's ledger and Fixed Asset Register.

Note 16.2 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - as previously stated	6,627	16,377	330	505	1,342	7,105	318	32,604
Prior period adjustments	-	-	-	-	-	-	-	-
Valuation / gross cost at 1 April 2019 - restated	6,627	16,377	330	505	1,342	7,105	318	32,604
Transfers by absorption	-	-	-	-	-	-	-	-
Additions	-	883	342	-	76	530	6	1,837
Revaluations	162	645	-	-	-	-	-	807
Reclassifications	-	329	(329)	-	-	-	-	-
Valuation/gross cost at 31 March 2020	6,789	18,234	343	505	1,418	7,635	324	35,248
Accumulated depreciation at 1 April 2019 - as previously stated	-	-	-	156	588	4,679	175	5,598
Prior period adjustments	-	-	-	-	-	-	-	-
Accumulated depreciation at 1 April 2019 - restated	-	-	-	156	588	4,679	175	5,598
Transfers by absorption	-	-	-	-	-	-	-	-
Provided during the year	-	513	-	58	164	1,126	38	1,899
Revaluations	-	(513)	-	-	-	-	-	(513)
Reclassifications	-	-	-	-	-	-	-	-
Accumulated depreciation at 31 March 2020	-	-	-	214	752	5,805	213	6,984
Net book value at 31 March 2020	6,789	18,234	343	291	666	1,830	111	28,264
Net book value at 1 April 2019	6,627	16,377	330	349	754	2,426	143	27,006

Note 16.3 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021								
Owned - purchased	6,789	18,355	156	246	315	1,746	206	27,813
Owned - donated/granted	-	295	-	-	234	-	-	529
NBV total at 31 March 2021	6,789	18,650	156	246	549	1,746	206	28,342

Note 16.4 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020								
Owned - purchased	6,789	17,938	343	291	389	1,830	111	27,691
Owned - donated/granted	-	296	-	-	277	-	-	573
NBV total at 31 March 2020	6,789	18,234	343	291	666	1,830	111	28,264

Note 17 Donations of property, plant and equipment

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

No further donations to purchase fixed assets have been made in 2020-21. Nil in 2019-20

Note 18 Revaluations of property, plant and equipment

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

The valuation as at 31 March 2020 had been prepared having regard to market evidence and other data available from the period prior and including BCIS and location factors. Full inspections during site visits were undertaken and clarification sought on land and GIA floor areas. Due account was taken of material asset changes and investment since the last desk top valuation in March 2017.

The external valuer considered as part of a RICS profession discussion forum, the potential impact of COVID 19 on asset valuations with a valuation date of 31 March 2020. They therefore issued an RICS material valuation uncertainty statement and recommended an early impairment review.

An internal desk top valuation was undertaken as at 31 March 2021 using National Indices and site data collected for the full external revaluation in March 2020. Due to the ongoing pandemic and market uncertainty, the Trust decided to undertake an internal desk top revaluation in March 2021 which will be followed up by another full revaluation. In 2020 the external valuer recommended an early impairment review and this will be undertaken before 31 March 2022.

The useful economic lives have not materially changed.

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 (current)

Note 22 Disclosure of interests in other entities

The Trust does not have any interests in other entities to disclose.

Note 23 Inventories

Inventories recognised in expenses for the year were £2k (2019/20: £0k). Write-down of inventories recognised as expenses for the year were £0k (2019/20: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £2k of items purchased by DHSC.

The deemed cost of these inventories was charged directly to expenditure on receipt with the corresponding benefit recognised in income.

Note 24.1 Receivables

	31 March 2021 £000	31 March 2020 £000
Current		
Contract receivables	6,413	7,220
Contract assets	-	-
Capital receivables	-	-
Allowance for impaired contract receivables / assets	(13)	(13)
Allowance for other impaired receivables	-	-
PDC dividend receivable	-	-
VAT receivable	-	134
Corporation and other taxes receivable	-	-
Other receivables	97	31
Total current receivables	6,497	7,372
Non-current		
Contract receivables	-	-
Capital receivables	-	-
VAT receivable	-	-
Corporation and other taxes receivable	-	-
Other receivables	-	-
Total non-current receivables	-	-
Of which receivable from NHS and DHSC group bodies:		
Current	3,773	5,725
Non-current	-	-

Note 24.2 Allowances for credit losses

	2020/21		2019/20	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	13	-	13	-
Prior period adjustments			-	-
Allowances as at 1 April - restated	13	-	13	-
Transfers by absorption	-	-	-	-
New allowances arising	-	-	-	-
Changes in existing allowances	-	-	-	-
Allowances as at 31 Mar 2021	13	-	13	-

Note 24.3 Exposure to credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2020 are in receivables from customers, as disclosed in the trade and other receivables note.

Note 25 Other assets

The Trust does not have any other financial assets - current at 31 March 2021 (nil at 31 March 2020)

Note 26.1 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 2021 (nil at 31 March 2020)

Note 26.2 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.

	2020/21	2019/20
	£000	£000
At 1 April	24,460	21,872
Prior period adjustments		-
At 1 April (restated)	24,460	21,872
Transfers by absorption	-	-
Net change in year	9,499	2,588
At 31 March	33,959	24,460
Broken down into:		
Cash at commercial banks and in hand	-	-
Cash with the Government Banking Service	33,959	24,460
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	33,959	24,460
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	33,959	24,460

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 2021 £000	31 March 2020 £000
Current		
Trade payables	7,913	6,089
Capital payables	225	399
Accruals	10,952	5,544
Receipts in advance and payments on account	-	-
PFI lifecycle replacement received in advance	-	-
Social security costs	668	595
VAT payables	16	-
Other taxes payable	467	381
PDC dividend payable	-	-
Other payables	64	-
Total current trade and other payables	20,305	13,008
Non-current		
Trade payables	-	-
Capital payables	-	-
Accruals	-	-
Receipts in advance and payments on account	-	-
PFI lifecycle replacement received in advance	-	-
VAT payables	-	-
Other taxes payable	-	-
Other payables	-	-
Total non-current trade and other payables	-	-
Of which payables from NHS and DHSC group bodies:		
Current	4,323	3,564
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 liabilities

	31 March 2021 £000	31 March 2020 £000
Current		
Deferred income: contract liabilities	1,518	53
Deferred grants	-	-
Deferred PFI credits / income	-	-
Lease incentives	-	-
Other deferred income	-	-
Total other current liabilities	1,518	53
Non-current		
Deferred income: contract liabilities	-	-
Deferred grants	-	-
Deferred PFI credits / income	-	-
Lease incentives	-	-
Other deferred income	-	-
Net pension scheme liability	-	-
Total other non-current liabilities	-	-

Note 30.1 Borrowings

There were no borrowings at 31 March 2021 (nil at 31 March 2020)

Note 30.2 Reconciliation of liabilities arising from financing activities - 2020/21

The Trust does not have any liabilities arising from financing activities

Note 30.3 Reconciliation of liabilities arising from financing activities - 2019/20

There were no other financial liabilities arising from finanncing activities at 31 March 2020

Note 31 Other financial liabilities

There were no other financial liabilities at 31 March 2021 (nil at 31 March 2020)

Note 32 Finance leases

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

Future lease receipts due under finance lease agreements where the trust is the lessor:

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

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

Obligations under finance leases where the trust is the 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	Pensions: injury benefits	Legal claims	Re-structuring	Equal Pay (including Agenda for Change)	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2020	-	-	29	-	-	-	675	704
Transfers by absorption	-	-	-	-	-	-	-	-
Change in the discount rate	-	-	-	-	-	-	-	-
Arising during the year	-	-	200	-	-	-	111	311
Utilised during the year	-	-	(29)	-	-	-	-	(29)
Reclassified to liabilities held in disposal groups	-	-	-	-	-	-	-	-
Reversed unused	-	-	-	-	-	-	-	-
Unwinding of discount	-	-	-	-	-	-	-	-
At 31 March 2021	-	-	200	-	-	-	786	986
Expected timing of cash flows:								
- not later than one year;	-	-	-	-	-	-	-	-
- later than one year and not later than five years;	-	-	-	-	-	-	-	-
- later than five years.	-	-	200	-	-	-	786	986
Total	-	-	200	-	-	-	786	986

Note 33.2 Clinical negligence liabilities

At 31 March 2021, £1,905k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Hounslow and Richmond Community Healthcare NHS Trust (31 March 2020: £1,585k).

Note 34 Contingent assets and liabilities

	31 March 2021 £000	31 March 2020 £000
Value of contingent liabilities		
NHS Resolution legal claims	-	-
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	-	-
Gross value of contingent liabilities	-	-
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	-	-
Net value of contingent assets	-	-

Note 35 Contractual capital commitments

The Trust does not have any Contractual Capital Commitments at 31 March 2021 (nil at 31 March 2020)

Note 36 Other financial commitments

The trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

The Trust does not have any other financial commitments at 31 March 2021 (nil at 31 March 2020)

Note 37 Defined benefit pension schemes

The Trust does not operate a defined benefit pension 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 pension 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 pension scheme

Note 37.3 Amounts recognised in the SoCI

The Trust does not operate a defined benefit pension scheme

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 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

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

Total future commitments under these on-SoFP schemes are as follows:

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 arrangements:

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

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2019 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

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

Note 40.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	6,384	-	-	6,384
Other investments / financial assets	-	-	-	-
Cash and cash equivalents	33,959	-	-	33,959
Total at 31 March 2021	40,343	-	-	40,343

Carrying values of financial assets as at 31 March 2020	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	7,251	-	-	7,251
Other investments / financial assets	-	-	-	-
Cash and cash equivalents	24,460	-	-	24,460
Total at 31 March 2020	31,711	-	-	31,711

Note 40.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	-	-	-
Obligations under finance leases	-	-	-
Obligations under PFI, LIFT and other service concession contracts	-	-	-
Other borrowings	-	-	-
Trade and other payables excluding non financial liabilities	18,683	-	18,683
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2021	18,683	-	18,683

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	-	-	-
Obligations under finance leases	-	-	-
Obligations under PFI, LIFT and other service concession contracts	-	-	-
Other borrowings	-	-	-
Trade and other payables excluding non financial liabilities	12,032	-	12,032
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2020	12,032	-	12,032

Note 40.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2021 £000	31 March 2020 £000
In one year or less	18,683	12,032
In more than one year but not more than five years	-	-
In more than five years	-	-
Total	18,683	12,032

The prior year comparator figures in this note were previously prepared on a discounted cash flow basis. In line with the recommendations of the Group Accounting Manual this has been updated to be shown on an undiscounted basis. This has no impact on the value of the liabilities within the Statement of Financial Position.

Note 40.5 Fair values of financial assets and liabilities

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

Note 41 Losses and special payments

	2020/21		2019/20	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	-	-	-	-
Fruitless payments and constructive losses	-	-	-	-
Bad debts and claims abandoned	-	-	-	-
Stores losses and damage to property	-	-	1	1
Total losses	-	-	1	1
Special payments				
Compensation under court order or legally binding arbitration award	-	-	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	-	-	1	-
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	-	-	1	-
Total losses and special payments	-	-	2	1
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 and Social Care Ministers, Hounslow & Richmond Community Healthcare NHS Trust board members or members of the key management staff, or parties related to any of them, have undertaken any material transactions with Hounslow & Richmond Community Healthcare NHS Trust

The Department of Health and Social Care is regarded as a related party. During the year, Hounslow & Richmond Community Healthcare NHS Trust has had a significant number of material transactions with the Department and with other entities for which the Department is regarded as the parent Department.

	Receipts from Related Party	Payments to Related Party	Amounts due from Related Party	Amounts owed to Related Party
	£'000	£'000	£'000	£'000
Ealing CCG	931	-	-	-
Hounslow CCG	34,313	-	16	-
South West London CCG	29,196	-	1,371	199
Surrey Heartlands CCG	695	-	10	-
NHS England	8,778	-	91	720
Guys and St Thomas NHS Foundation Trust	51	1,752	66	160
Chelsea and Westminster NHS Foundation Trust	808	1,554	831	832
Kingston Hospital NHS Foundation Trust	205	85	258	33
Croydon Health Services NHS Trust	161	-	162	80
Epsom & St Helier University Hospitals NHS Trust	-	-	379	-
St George's Healthcare NHS FT	240	100	430	85
South West London & St George's NHS Trust	87	-	-	-
West London Mental Health NHS Trust	32	293	6	11

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

	Receipts from Related Party	Payments to Related Party	Amounts due from Related Party	Amounts owed to Related Party
	£'000	£'000	£'000	£'000
London Borough of Hounslow	5,089	-	311	165
London Borough of Richmond upon Thames	736	781	1	647
London Borough of Merton	200	-	-	-

The Trust has also received £9k payment (£9k in 2019-20) 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 reporting period

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

The Trust continues to operate as a trust of NHS Healthcare

Note 48 Better Payment Practice code

Non-NHS Payables	2020/21 Number	2020/21 £000	2019/20 Number	2019/20 £000
Total non-NHS trade invoices paid in the year	15,713	34,061	16,157	32,368
Total non-NHS trade invoices paid within target	15,006	33,375	15,034	31,707
Percentage of non-NHS trade invoices paid within target	95.5%	98.0%	93.0%	98.0%
NHS Payables				
Total NHS trade invoices paid in the year	728	8,928	884	8,145
Total NHS trade invoices paid within target	714	8,792	842	7,718
Percentage of NHS trade invoices paid within target	98.1%	98.5%	95.2%	94.8%

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 limit

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

	2020/21 £000	2019/20 £000
Cash flow financing	(9,499)	(2,588)
Finance leases taken out in year	-	-
Other capital receipts	-	-
External financing requirement	(9,499)	(2,588)
External financing limit (EFL)	(374)	(1,659)
Under / (over) spend against EFL	9,125	929

Note 50 Capital Resource Limit

	2020/21 £000	2019/20 £000
Gross capital expenditure	2,222	1,837
Less: Disposals	-	-
Less: Donated and granted capital additions	-	-
Plus: Loss on disposal from capital grants in kind	-	-
Charge against Capital Resource Limit	2,222	1,837
Capital Resource Limit	2,595	1,890
Under / (over) spend against CRL	373	53

Note 51 Breakeven duty financial performance

	2020/21 £000
Adjusted financial performance surplus / (deficit) (control total basis)	76
Remove impairments scoring to Departmental Expenditure Limit	-
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	-
Breakeven duty financial performance surplus / (deficit)	76

Note 52 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		-	-	1,667	704	2,792	679
Breakeven duty cumulative position	-	-	-	1,667	2,371	5,163	5,842
Operating income		-	-	54,480	59,339	64,212	65,816
Cumulative breakeven position as a percentage of operating income		0.0%	0.0%	3.1%	4.0%	8.0%	8.9%

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	1,919	2,962	4,068	3,742	1,721	76
Breakeven duty cumulative position	7,761	10,723	14,791	18,533	20,254	20,330
Operating income	68,489	70,511	71,462	73,853	77,666	85,705
Cumulative breakeven position as a percentage of operating income	11.3%	15.2%	20.7%	25.1%	26.1%	23.7%

NHS
Hounslow and Richmond
Community Healthcare
NHS Trust

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Joanne Lees
Director
KPMG LLP
15 Canada Square
London
E14 5GL

10 June 2021

Dear Joanne

This representation letter is provided in connection with your audit of the Trust financial statements of Hounslow and Richmond Community Healthcare NHS Trust ("the Trust"), for the year ended 31 March 2021, for the purpose of expressing an opinion:

- as to whether these financial statements give a true and fair view of the state of the financial position of the Trust as at 31 March 2021 and of the Trust's income and expenditure for the financial year then ended; and
- whether the Trust's financial statements have been prepared in accordance with the Department of Health and Social Care Group Accounting Manual (GAM).

These financial statements comprise the Trust Statement of Financial Position, the Statement of Comprehensive Income, the Statement of Cash Flows, the Statement of Changes in Equity and notes, comprising a summary of significant accounting policies and other explanatory notes.

The Board confirms that the representations it makes in this letter are in accordance with the definitions set out in the Appendix to this letter.

The Board confirms that, to the best of its knowledge and belief, having made such inquiries as it considered necessary for the purpose of appropriately informing itself:

Financial statements

1. The Board has fulfilled its responsibilities, as set out in the terms of the audit engagement dated 21 March 2017, for the preparation of financial statements that:
   i. give a true and fair view of the financial position of the Trust as at 31 March 2021 and of the Trust's income and expenditure for that financial year; and
   ii. have been prepared in accordance with the GAM 2020/21.

   The financial statements have been prepared on a going concern basis.

2. The methods, the data and the significant assumptions used in making accounting estimates and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.

3. All events subsequent to the date of the financial statements and for which IAS 10 Events after the reporting period requires adjustment or disclosure have been adjusted or disclosed.

4. The effects of uncorrected misstatements are immaterial, both individually and in aggregate, to the financial statements as a whole. There are no uncorrected adjustments above £290K following audit of the 2020/21 financial statements.

Information provided

5. The Board has provided you with:

   - access to all information of which it is aware, that is relevant to the preparation of the financial statements, such as records, documentation and other matters;
   - additional information that you have requested from the Board for the purpose of the audit; and
   - unrestricted access to persons within the Trust from whom you determined it necessary to obtain audit evidence.

6. All transactions have been recorded in the accounting records and are reflected in the financial statements.

7. The Board confirms the following:

   i. The Board has disclosed to you the results of its assessment of the risk that the financial statements may be materially misstated as a result of fraud.

   Included in the Appendix to this letter are the definition of fraud, including misstatement arising from fraudulent financial reporting and from misappropriation of assets.

   ii. The Board has disclosed to you all information in relation to:

   a) Fraud or suspected fraud that it is aware of and that affects the Trust and involves:

      - management;
      - employees who have significant roles in internal control; or
      - others where the fraud could have a material effect on the financial statements; and

   b) allegations of fraud, or suspected fraud, affecting the Trust's financial statements communicated by employees, former employees, analysts, regulators or others.

   In respect of the above, the Board acknowledges its responsibility for such internal control as it determines necessary for the preparation of financial statements that are free from material misstatement, whether due to fraud or error. In particular, the Board acknowledges its responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

8. The Board has disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.

9. The Board has disclosed to you and has appropriately accounted for and/or disclosed in the financial statements, in accordance with IAS 37 Provisions, Contingent Liabilities and

Contingent Assets, all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

10. The Board has disclosed to you the identity of the Trust's related parties and all the related party relationships and transactions of which it is aware. All related party relationships and transactions have been appropriately accounted for and disclosed in accordance with IAS 24 Related Party Disclosures. Included in the Appendix to this letter are the definitions of both a related party and a related party transaction as we understand them and as defined in IAS 24.

11. The Board confirms that all intra-NHS balances included in the Statement of Financial Position (SOFP) at 31 March 2021 in excess of £300,000 have been disclosed to you and that the Trust has complied with the requirements of the Intra NHS Agreement of Balances Exercise. The Board confirms that Intra-NHS balances includes all balances with NHS counterparties, regardless of whether these balances are reported within those SOFP classifications formally deemed to be included within the Agreement of Balances exercise.

12. The Board confirms that:

    - The financial statements disclose all of the key risk factors, assumptions made and uncertainties surrounding the Trust's ability to continue as a going concern as required to provide a true and fair view and to comply with GAM.
    - No material events or conditions exist that may cast significant doubt on the ability of the Trust to continue as a going concern.
    - The Board confirms that the financial statements disclose its plans for future action relevant to the Trust's ability to continue as a going concern, and its assessment of the feasibility of these plans.

13. The Trust is required to consolidate any NHS charitable funds which are determined to be subsidiaries of the Trust. The decision on whether to consolidate is dependent upon the financial materiality and governance arrangements of the charitable funds. The Board confirms that, having considered these factors, it is satisfied that the charitable funds should not be consolidated.

14. The Board provides the following specific representations as follows:

    a) The Trust confirms that it has reviewed its Property, Plant and Equipment portfolio to ensure that it has been classified correctly in all material aspects. This includes the basis upon which the valuation has been determined and the identification of assets in use which drive the basis for valuation. The Board confirms that the valuation of land and buildings in the financial statements is appropriate and reflects all relevant factors impacting upon the valuation

This letter was tabled and agreed at the meeting of the Audit and Risk Committee on 8th June 2021.

Yours sincerely

David Hawkins, Deputy Chief Executive and Director of Finance and Corporate Services, for and on behalf of the Board of Hounslow and Richmond Community Healthcare NHS Trust

Appendix to the Board Representation Letter of Hounslow and Richmond Community Healthcare NHS Trust: Uncorrected audit differences

The following uncorrected audit differences have been presented as part of the Audit Report to those charged with governance and are considered by management to be immaterial to the Trust's financial statements:

Unadjusted audit differences (£m)				
No.	Detail	SOCI Dr/(cr)	SOFP Dr/(cr)	Comments
1	Dr Accruals Cr Receivables		997 (997)	The Trust has provided for a number of NHS balances which are in dispute and included within the accrual balance rather than an impairment to receivables.
Total		0	0	

Appendix to the Board Representation Letter of Hounslow and Richmond Community Healthcare NHS Trust: Definitions

Financial Statements

IAS 1.10 states that a complete set of financial statements comprises:

- a statement of financial position as at the end of the period;
- a statement of comprehensive income for the period;
- a statement of changes in equity for the period;
- a statement of cash flows for the period;
- notes, comprising a summary of significant accounting policies and other explanatory information;
- comparative information in respect of the previous period; and
- a statement of financial position as at the beginning of the earliest comparative period when an entity applies an accounting policy retrospectively or makes a retrospective restatement of items in its financial statements, or when it reclassifies items in its financial statements.

An entity may use titles for the statements other than those used in this Standard. For example, an entity may use the title 'statement of comprehensive income' instead of 'statement of profit or loss and other comprehensive income'."

Material Matters

Certain representations in this letter are described as being limited to matters that are

material. IAS 1.7 and IAS 8.5 state that:

"Information is material if omitting, misstating or obscuring it could reasonably be expected to influence decisions that the primary users of general purpose financial statements make on the basis of those financial statements, which provide financial information about a specific reporting entity.

Materiality depends on the nature or magnitude of information, or both. An entity assesses whether information, either individually or in combination with other information, is material in the context of its financial statements taken as a whole.

Information is obscured if it is communicated in a way that would have a similar effect for primary users of financial statements to omitting or misstating that information. The following are examples of circumstances that may result in material information being obscured:

a) information regarding a material item, transaction or other event is disclosed in the financial statements but the language used is vague or unclear;

b) information regarding a material item, transaction or other event is scattered throughout the financial statements;

c) dissimilar items, transactions or other events are inappropriately aggregated;

d) similar items, transactions or other events are inappropriately disaggregated; and

e) the understandability of the financial statements is reduced as a result of material information being hidden by immaterial information to the extent that a primary user is unable to determine what information is material.

Assessing whether information could reasonably be expected to influence decisions made by the primary users of a specific reporting entity's general purpose financial statements requires an entity to consider the characteristics of those users while also considering the entity's own circumstances.

Many existing and potential stakeholders cannot require reporting entities to provide information directly to them and must rely on general purpose financial statements for much of the financial information they need. Financial statements are prepared for users who have a reasonable knowledge of business and economic activities and who review and analyse the information diligently. At times, even well- informed and diligent users may need to seek the aid of an adviser to understand information about complex economic phenomena."

Fraud

Fraudulent financial reporting involves intentional misstatements including omissions of amounts or disclosures in financial statements to deceive financial statement users.

Misappropriation of assets involves the theft of an entity's assets. It is often accompanied by false or misleading records or documents in order to conceal the fact that the assets are missing or have been pledged without proper authorisation.

Error

An error is an unintentional misstatement in financial statements, including the omission of an amount or a disclosure.

Prior period errors are omissions from, and misstatements in, the entity's financial statements for one or more prior periods arising from a failure to use, or misuse of, reliable information that:

a) was available when financial statements for those periods were authorised for issue; and

b) could reasonably be expected to have been obtained and taken into account in the preparation and presentation of those financial statements.

Such errors include the effects of mathematical mistakes, mistakes in applying accounting policies, oversights or misinterpretations of facts, and fraud.

Management

For the purposes of this letter, references to "management" should be read as "management and, where appropriate, those charged with governance".

Related parties

A related party is a person or entity that is related to the entity that is preparing its financial statements (referred to in IAS 24 *Related Party Disclosures* as the "reporting entity").

a) A person or a close member of that person's family is related to a reporting entity if that person:

   i. has control or joint control over the reporting entity;

   ii. has significant influence over the reporting entity; or

   iii. is a member of the key management personnel of the reporting entity or of a parent of the reporting entity.

b) An entity is related to a reporting entity if any of the following conditions applies:

   i. The entity and the reporting entity are members of the same group (which means that each parent, subsidiary and fellow subsidiary is related to the others).

   ii. One entity is an associate or joint venture of the other entity (or an associate or joint

venture of a member of a group of which the other entity is a member).

iii. Both entities are joint ventures of the same third party.

iv. One entity is a joint venture of a third entity and the other entity is an associate of the third entity.

v. The entity is a post-employment benefit plan for the benefit of employees of either the reporting entity or an entity related to the reporting entity. If the reporting entity is itself such a plan, the sponsoring employers are also related to the reporting entity.

vi. The entity is controlled, or jointly controlled by a person identified in (a).

vii. A person identified in (a)(i) has significant influence over the entity or is a member of the key management personnel of the entity (or of a parent of the entity).

viii. The entity, or any member of a group of which it is a part, provides key management personnel services to the reporting entity or to the parent of the reporting entity.

Related party transaction

A transfer of resources, services or obligations between a reporting entity and a related party, regardless of whether a price is charged.

Performance analysis

Clinical Services

Following the publication of the NHS Long Term Plan and a recent White Paper, we continue to boost our out-of-hospital care and deliver urgent community response and recovery support in Primary Care Networks (PCNs).

HRCH is proud to be finalists in three categories of this year's 2021 Health Service Journal (HSJ) Value Awards for our work with Hounslow Integrated Care Partnership and the Trust's Integrated Community Recovery Service (ICRS).

Outcomes and benefits commended in our applications have highlighted:

- improved collaboration throughout the coronavirus pandemic
- reduced acute attendances and impact of high intensity users, as well as improving care for frail patients and those discharged from hospital
- improved person-centred/holistic care and patients' skills/confidence in managing their own long-term conditions
- quality improvement initiative on the intravenous therapy (IV) pathway from acute medical services to ICRS to prevent unnecessary hospital admissions

Primary care

Hounslow GP Consortium took a step forward in its partnership with HRCH in 2020. The Consortium asked us to host its management team and offer back office support to GP practices, providing holistic healthcare for local residents. This follows the setting up of our Hounslow Working Together partnership two years ago, out of a shared belief that we can provide better care for our patients by working more closely together.

The move is in line with the NHS Long Term Plan's aim to integrate primary and community care. It also offers individual practices back office support that smaller GP surgeries previously did not have, leaving them free to carry out their clinical work. Our shared goals are to work together to: improve healthcare for local people and make better use of our resources; join up and coordinate healthcare services in better ways for the borough; and break down organisational barriers by creating multidisciplinary teams who focus on patients' individual needs.

We already have a joint primary care networks (PCN) team of operational managers, plus clinical and practice support workers, who coordinate care and free up time for clinicians to concentrate on patients rather than paperwork. HRCH also recruits and hosts a range of people who work across PCNs, including physiotherapists, pharmacists, paramedics and project leads.

Care homes

During 2020-21, working closely with our commissioners, we set up a Care Home Support Team in Richmond. They support 17 care homes in the borough and help residents who need healthcare to stay safely in their homes, so they can avoid going to hospital if they do not need hospital care.

This team has been very successful and has seen a reduction in patients being admitted to Kingston Hospital. As a result, we entered the team for a Nursing Times Award in 2020.

We are proud the team went over and above during COVID-19, including providing mutual aid, eg, supporting with the provision of personal protective equipment (PPE). The team visited homes in person, helping to keep care safe for residents and supporting staff with expert training and advice.

Other outcomes were:

- decreased emergency admissions
- improved partnership working
- end-of-life improvements
- 24-hour support for homes through night nursing services, ensuring continuity
- supporting residents with dementia, linking with safeguarding/dementia teams
- supporting unqualified carers during COVID-19
- daily contact with homes during COVID-19, supporting complex residents/preventing admissions, including medication support
- building personal relationships, trust, credibility with homes/private providers

The team helped local councils and GP practices to provide education and clinical guidance to care homes to keep residents safe and also organised COVID-19 vaccinations for this particularly vulnerable group of people.

In Hounslow, 9 older people's care homes and 17 learning disability homes needed our skilled nurses and knowledge to work with GP leads to provide integrated care, including vaccinating residents with learning disabilities who commonly have severe needle phobia. The Hounslow Care Home Support Team vaccinated about 850 people who have learning disabilities.

Wheelchair Hub

Our Wheelchair Hub provides an exceptional service to users of all ages in the borough of Hounslow and we are extremely proud of its high quality. One area of outstanding practice is the team's innovative sleep system for children with complex conditions.

This helps prevent secondary complications and deformities, reducing hospital admissions and improving overall health and quality of life for service users. Parents report the positive impact this has had on children's lives, including being more relaxed at school and during personal care.

The Wheelchair Hub in Hounslow finished in the top three in the Evaluating Health and Social Care Practice category at the Advancing Healthcare Awards 2020.

The Hub's nomination was for its sleep system service, which caters for the needs of clients with some of the most complex disabilities. The system enables people to relax and manage their posture during the night. The team worked collaboratively with service users, using research and outcome measures to evaluate the effectiveness of the service, which has now been running for four years.

The Advancing Healthcare Awards recognise and celebrate the work of allied health professionals, healthcare scientists and pharmacists, and those who work alongside them in support roles, leading innovative healthcare practice across the UK.

One You

One You Hounslow and One You Merton have been supporting clients in the community throughout the pandemic on physical and mental wellbeing. Following research on the impact of COVID-19 across both boroughs, it was clearer than ever there was a need to raise awareness of local health inequalities. Research identified core groups not engaging or accessing services available to them due to like communication, lack of knowledge and cultural differences.

From this research, the services developed a wellbeing champion training programme for volunteers and community sector organisations to be able to support people in the local community by promoting local health and wellbeing services to help people make informed choices.

The training incorporates inequalities in health, importance of promoting improvements in health and wellbeing, how to effectively communicate health messages, and impact of behaviour change on health and wellbeing.

Wellbeing Champions take a proactive approach in the community or groups, to engage people to build and strengthen good health and wellbeing, build confidence, knowledge and skills in the community, and work with local organisations to improve community health and wellbeing.

National and local evidence shows engaging communities improves health and wellbeing as it:

- encourages health-enhancing attitudes and behaviour
- contributes to developing community cohesion
- increases confidence and self-esteem and gives communities an increased sense of control over decisions affecting their lives

Redeployment Hub

In response to the COVID-19 pandemic, we set up a Staff Redeployment Hub over 2020-21 to redeploy clinical and non-clinical staff into frontline services and support them in their new placements, such as in community nursing and our community hospital inpatient unit, where the demands and complexity of patient needs has increased over the year, as well as externally, eg, to the Nightingale Hospital. We have had the most amazing response from our staff in their flexibility, spirit and volunteering to work across roles (corporate, clinical, externally and internally).

Digital consultations for patients

We rolled out virtual patient consultations across the trust, using the Attend Anywhere platform. This allowed us to offer flexible assessments and care when face-to-face services were constrained. Since March 2020, we have offered about 25,000 virtual consultations, totalling about 11,000 hours. Feedback from patients has been overwhelmingly positive:

> ***"I was anxious of how the video would go but the therapists were brilliant and did a fantastic job and also gave me the information me and my son needed."***

Inpatient unit

The Pamela Bryant Unit for inpatients at Teddington Memorial Hospital supported patient flow across the local healthcare system by adapting from a rehabilitation ward to admit patients with a positive COVID-19 diagnosis who no longer needed acute hospital care. We also opened up additional surge beds by adapting one of our therapy gyms into a ward annex to support additional demand.

Over the last year, the ward staff cared for COVID-19 positive patients, working closely with our local hospitals and Your Healthcare in Kingston to manage patients safely with a range of post-COVID-19 needs at a crucial time for care.

COVID-19 recovery team

We worked in partnership with the Richmond Wellbeing Service to set up a COVID-19 multidisciplinary team to support continued recovery in the community. NHS England guidance suggests that for many of those who have survived, the virus and the required treatments will have a lasting impact on their health.

We set up a weekly virtual multidisciplinary team meeting with our Richmond Response and Rehabilitation Team (RRRT), Respiratory Care Team, Community Neuro Rehabilitation Team, and Richmond Wellbeing Service. Each patient has a management plan reviewed and coordinated between the services, with close links to our MSK Physiotherapy and Diabetes services.

Children's services

Children's audiology

During 2020-21 our paediatric audiology service was awarded the Improving Quality in Physiological Diagnostic Services (IQIPS) standard for the fifth year in a row. IQIPS is a professional assessment and accreditation scheme which recognises healthcare organisations that ensure patients receive consistently high-quality services, tests, examinations and procedures, delivered by competent staff working in safe environments.

The team was also shortlisted for the Team of the Year Award at the British Academy of Audiology Annual Awards 2020. This recognised the team's efforts to improve service and experiences for patients. In addition, team leader Bhavisha Parmar was nominated for Audiologist of the Year. It was an honour to be nominated for these awards, a testament to everyone's continued hard work and dedication to the service, which is recognised by all our stakeholders and service users.

Children's therapies

Over the past year we have worked closely with children and young people in Richmond, in partnership with Achieving for Children, seeking their feedback and engagement to improve their experiences of our services.

Through our Children and Young People's Participation meetings we:

- developed 'all about me' guides to support a positive experience when attending clinics
- co-created service information leaflet, eg, a trip to the hearing clinic
- created children's name badges
- developed appointment letters for children
- created a video about children's therapy appointments
- produced information for children about wearing PPE

In Hounslow, the Children's Occupational Therapy and Speech and Language Therapy Team were transferred from the Hounslow School's Education Therapy Hub and recommissioned from HRCH after a 6-year gap. This service cares for children with Education and Health Care Plans (EHCPs) in special schools and settings.

They provided advice for parents and families following telephone and virtual reviews and discussions. They also liaised regularly with school staff and made sure they knew how to contact therapists with any queries or concerns.

The team identified the most vulnerable children and have been providing virtual input and advice throughout the pandemic. Despite the challenges facing the team and the schools this year, they worked well together to support children and families.

Schools vaccination programmes

Our school age vaccination programme in nine south London boroughs was one of the few services to complete the Diphtheria, Tetanus and Polio (DTP) and Meningitis ACWY vaccination programmes, despite national lockdown and school closures, reducing the risk of the resurgence of these diseases. We vaccinated children in school and community settings, working closely with our public health partners to identify suitable venues.

When the flu vaccination programme was extended to include year 7, we recruited many more immunisation nurses and completed the programme on time, with higher-than-expected uptake, even with restrictions in place. The teams were congratulated by NHS England on their achievements during the pandemic and a second lockdown.

Schools vision screening

In April 2020 Hounslow School Nursing Service was commissioned to carry out vision screening in primary schools. Screening identifies vision impairments in children aged 4 to 5 who can then get the right treatment at the right time, as recommended by the UK National Screening Committee.

The School Nursing Service worked in partnership with the orthoptist-led service provided by Chelsea and Westminster Hospital Foundation NHS Trust. This gave them access to orthoptic-led screener training and the local community orthoptic provider, to develop referral pathways.

While the programme was delayed during the pandemic, due to school closures, our nurses regularly liaised with school staff and orthoptist leads and are working on vision screening now schools are open again.

Breast feeding

One of the services provided by our Health Visiting service is support for mums in breastfeeding their newborn babies. As a result of extra funding, we employed an Infant Feeding Lead. This led to Health Visiting, the Family Nurse Partnership and local children's centres being awarded UNICEF level 2 Baby Friendly status.

The Infant Feeding Lead trained staff, produced a joint Hounslow Council and HRCH infant feeding policy and developed strong links with National Childbirth Trust (NCT) Baby Café breastfeeding counsellors in Hounslow. As a result, new mums received the right support during the COVID-19 pandemic.

One NCT Baby Café breastfeeding counsellor said our staff and partners "all pulled together getting the support in place ... the HV team has been a pleasure to work with. Every single person who has rung me has been really respectful and checking that it was OK to ring and that I'm OK to talk. What lovely sensitive people they are." Compared to national figures, more new mums in Hounslow are still breastfeeding 6 to 8 weeks after birth (NHS Benchmarking Network 2019/20).

Children's nursing

Many of our Children's Community Nursing Service patients have complex health care needs. The challenges COVID-19 brought were widespread, not only for nursing staff but for families who look after children who need a lot of care.

We set up quality improvement projects, eg, teaching parents to insert their children's nasogastric tubes, administer injections, flush central lines, clean entry sites and change dressings, to name but a few. Our nurses were on hand but mostly carried out virtual visits to help with any problems, training needs, continuing care assessments and discharge planning.

We made rapid changes in the pandemic and some are likely to be here to stay. Remote discharge planning saves significant time that would ordinarily be spent travelling to various hospitals and educating families to look after children themselves. This makes time for seeing families and children at the right time and prevents the need to go to A&E or be admitted to hospital.

In addition, despite school closures during the third national lockdown, our Lead Asthma Nurse stayed in contact with Hounslow staff, trained them virtually and supported them in achieving Asthma Friendly School status, as part of an initiative across north-west London last winter.

During the pandemic, it was even more important to ensure pupils with asthma were effectively supported so they could play a full and active role in school life, remain healthy and achieve their academic potential. Poor control and management of asthma can lead to asthma attacks, which can be fatal, so it is important that parents feel confident their schools can provide effective support and pupils feel safe.

Part of this project relates to identifying children whose asthma is not well controlled. Intervention at an early stage will help children control their asthma and reduce school absences.

Family Nurse Partnership

Based on decades of international research, the effectiveness of the Family Nurse Partnership lies in its home visiting model. At a time when home visits were restricted during COVID-19, we quickly adapted to communicating via phone and video, but accessibility was a challenge for many.

Issues ranged from the practical lack of mobile phone data to lack of self-confidence to engage on calls. Confidentiality challenges and potential for increased risk of domestic abuse added to the new risks. Our quick fix was to offer accompanied walks to clients we were particularly concerned about, including parents with mental health concerns or who struggled with engaging via virtual methods, people in crowded, unsafe housing, those with child protection concerns and those with possible domestic abuse issues.

Benefits included:

- freer communication
- easier and more open dialogue
- role modelling – nurses able to discuss how to stimulate a child on a walk, maintaining limits outside and how to keep social distancing.
- easier management of anxiety
- stress busting
- in some of the home setting it is impossible to stop babies and children coming too close to them. but when they are strapped in a pushchair, this is not a risk.

Adult services

Hounslow Diabetes Service

The Diabetes Structured Education Team received an award for the greatest improvement in cardiovascular disease risk factor in an X-PERT annual audit.

They were also highly commended for HBA1c reduction. This was a great achievement for the people of Hounslow, whose multicultural communities are at high risk of diabetes and cardiovascular disease.

Musculoskeletal physiotherapy

Primary and community care providers are in the frontline of changes to how and where patients receive treatment. During 2020-21, we developed a First Contact Practitioner (FCP) role to support GP practices, as 30% of their patients have a musculoskeletal condition.

Expert MSK physiotherapists work in practices, with patients going straight to them rather than to a GP. This has reduced pressure on GPs, while improving patient experience and patient flow, relieving pressures on other parts of the NHS.

Adult learning disabilities

Our Hounslow Adult Learning Disabilities Health Team comprises specialist multidisciplinary health professionals. They support people with learning disabilities who are registered with a Hounslow GP and live locally, plus their families and carers.

In a switch to online services, the Hounslow Adult Learning Disability Health Team have been working to support people with learning disabilities via social skills groups during the pandemic. These proactive groups have provided direct and invaluable support in relation to issues of social isolation, anxiety, and wider emotional wellbeing for this cohort. The social skills groups have helped clients by easing the impact of the wider pandemic.

The team have also developed a range of online resources for families, carers and care providers to support people with learning disabilities in key areas, ranging from dysphagia information to face mask communication tips.

Community nursing

The community nursing service is made up of matrons and senior district nurses, plus their teams of community nurses and healthcare assistants. They provide community healthcare services for mainly housebound patients who may:

- be acutely unwell
- have long-term conditions
- need palliative care
- require intensive and technological care

During the pandemic the community nursing service has done an amazing job of caring for patients in their own homes, including patients with a COVID-19 diagnosis. The community nursing service in Hounslow and Richmond went above and beyond to care for their patients during the pandemic. The trust also acknowledges and thanks all our colleagues who were redeployed to this service to help support them during the pandemic.

Urgent care

Our Teddington and Hounslow Urgent Treatment Centres (UTC) had a challenging year managing patients without a known COVID-19 status. However, this did not deter our people from providing high-quality, safe patient care.

During the pandemic Teddington UTC saw fewer patients than usual, with 26,468 patients attending with a variety of complaints, including minor illnesses in adults and children, limb fractures and other minor injuries. The average performance for the UTC against the four-hour standard was 99.9%.

We would like to thank UTC staff who were redeployed to other services, such as our inpatient unit, during the pandemic.

Similarly, our Hounslow UTC at West Middlesex Hospital also had a challenging year, although it saw fewer patients than usual, with 66,574 patients, 99.4% of whom were seen within four hours.

Urgent care in the community: Richmond Rapid Response and Rehabilitation Team and Hounslow Integrated Community Response Service

These are multidisciplinary and multi-agency teams who work with patients referred to them by local hospitals and other community services. They aim to help people avoid unnecessary hospital care and can respond within two hours. Our response services have been involved in work to improve care and response to patients.

Both these teams were extremely busy during the pandemic, especially in supporting our local acute services with getting patients home safely and undertaking discharge to assess in the community. We would like to thank all our people redeployed to this service during the pandemic.

Shared care of community intravenous treatment service

Our Integrated Care Response Service launched a launched a shared care community IV service in collaboration with West Middlesex Hospital's Ambulatory Emergency Care Service. We now carry out intravenous treatment in patients' homes, including antibiotics and fluid therapy for conditions such as cellulitis, sepsis and dehydration.

It is more convenient for patients not to go to hospital for treatment, relieves pressure on busy hospitals and cuts unnecessary costs, even more important during the COVID-19 pandemic.

We also developed strong professional relationships, focused on patients, with a holistic and individualised care plan for everyone, agreed collaboratively, working as one team. Feedback from patients has been positive and the service has halved comparable costs. This service development has been shortlisted for the HSJ Value Awards 2021.

COVID-19 services – integrated discharge hub

Senior staff from the Hounslow Community Recovery Service and Continuing Health Care Team joined West Middlesex Hospital's Discharge Team to set up a discharge hub, along with Hounslow Council, Hounslow CCG and the voluntary sector.

We were asked to lead on helping patients with health or social care needs to leave hospital safely. The Hub provides clinical expertise, advice, support and planning for all patients leaving West Middlesex Hospital and has strong working relationships with community services and other local discharge hubs to help patients who don't live in our area.

From April 2020 to March 2021 it supported 7,000 patients. Alongside this, the Community Recovery Service set up a community referral hub as a coordination point for other hospitals discharging Hounslow patients.

Most patients with health and social care needs who left hospital had a same-day or next-day assessment at home, to ensure they were safe and plan next steps for their recovery. The Community Recovery Service completed about 2,000 of these visits.

For three months, with leadership from the Integrated Community Response Service and coordination support from the Primary Care Patient Coordination Service, the team worked on discharge planning, therapies and clinical leadership for residents at Coniston Lodge Care Home. All these initiatives have been supported by redeployed staff in both waves of the pandemic.

Working with partners

The NHS has a long-standing ambition to make integrated care a reality everywhere, with a focus on improving care and tackling health inequalities at borough level. Indeed, the publication of a recent white paper, which encourages structural change in the way services are delivered, proposes to bring commissioners and providers together across health and local government, as well as patients and the wider community.

This is in order to: better understand the needs of the local population, jointly plan how they can keep people healthy, treat them when they are unwell, reduce unwarranted variation, and ensure that care is delivered in the right care setting.

The spirit of this has never been more evident than through the COVID-19 pandemic. Different parts of the local health and care system have broken out of traditional models in the best interests of patients. HRCH has placed a huge emphasis on supporting local partners, seeking to be an indispensable provider across three boroughs, (Hounslow, Richmond and Kingston).

HRCH has not only offered outstanding quality care and areas of excellence, it has played major roles in systems leadership through significant times of change. At HRCH, we want to continue this momentum, ensuring the patient is at the centre of everything we do, co-producing services to meet the needs of local people in better ways.

Through the pandemic, examples of how HRCH offered support to partners in Hounslow, Richmond and Kingston boroughs included:

- joint planning with partners in our response and recovery during the COVID-19 pandemic
- supporting local care homes
- supporting vulnerable patients who were shielding at home
- ensuring patients had one contact person to liaise with health and social care services, streamlining face-to-face care and minimising potential risks to patients, families and carers
- collaborative development of COVID-19 rehabilitation pathways
- supporting the roll out of the COVID-19 vaccination programme

Hounslow

In Hounslow, the Integrated Care Partnership (ICP) has set out its vision for partnership working. This includes tackling population health and inequalities, integrated care for patients who are elderly and frail and a single-team approach at HRCH to delivering primary and community services.

In line with the North West London CCG leadership model for place-based partnership, Hounslow has an ICP senior leadership team. This is chaired by HRCH's Director of Clinical Services and Transformation for Hounslow and North West London, in a new system role of ICP Lead Director.

HRCH has also formalised joint working with Hounslow primary care networks and clinical directors via the Hounslow Working Together partnership. A joint PCN back office team (including a Director of Primary Care Networks, operational management, clinical, and practice support roles) has been working to coordinate care and free up capacity in primary care.

The partnership has jointly developed additional roles in GP practices, with support from HRCH. We are supporting recruitment and hosting roles like first contact physiotherapists, pharmacists, social prescribers, paramedics and clinical transformation project leads. Areas of focus include:

- recruiting additional clinical roles in line with the primary care Direct Enhanced Scheme (DES) requirements
- promoting and increasing use of Coordinate My Care (CMC) – a confirmed commitment by all partners in Hounslow
- joint planning of estates/sites and management of patient flow/prioritised patients

Further, HRCH and Hounslow GP Consortium have reviewed the benefits of an alliance, such as greater corporate integration, alignment in the delivery of primary and community care, and supporting/creating additional capacity for the consortium team. As such, the consortium has now been fully incorporated into HRCH.

Richmond

The Richmond Community in Health Partnership (RCHiP) was established in 2016 between HRCH and Richmond General Practice Alliance (RGPA). Through the partnership, a number of pathways and care models have been redesigned across health and care partners. The development of the locality model of care and more multidisciplinary team working has continued and moved into the development of primary care networks (PCNs).

HRCH continues to work closely with RGPA, PCN clinical directors and other primary care representatives via RCHiP at an executive, managerial and clinical level.

Key areas of focus during the pandemic have been on supporting COVID-19 and pos- COVID-19 patients in the community and in the inpatient ward at Teddington Memorial Hospital.

HRCH is also fully engaged in local transformation programmes and the Director of Clinical Services and Transformation for Richmond and South West London is leading the system's urgent and emergency care transformation programme.

Kingston

Over the last year, South West London (SWL) Clinical Commissioning Group (CCG) has supported a move towards a single community contract for Kingston and Richmond. HRCH and Your Healthcare are working in partnership to deliver community healthcare services in the boroughs of Kingston and Richmond.

This new partnership arrangement is a great opportunity to work together, taking best practice from both organisations and using expertise and resources to do more for local patients.

This is in line with the Government's recent white paper, which includes proposals to make integrated care a reality and encourages greater levels of collaboration between health and care organisations.

Next steps

Over the next year, alongside the white paper's aspirations for integrated provider groups and systems, HRCH will continue to prioritise partnerships and borough-based integrated transformation/recovery programmes on both sides of the river, creating organisational models that will ensure the sustainability of care closer to home for the future.

Measuring and monitoring performance

Measuring performance

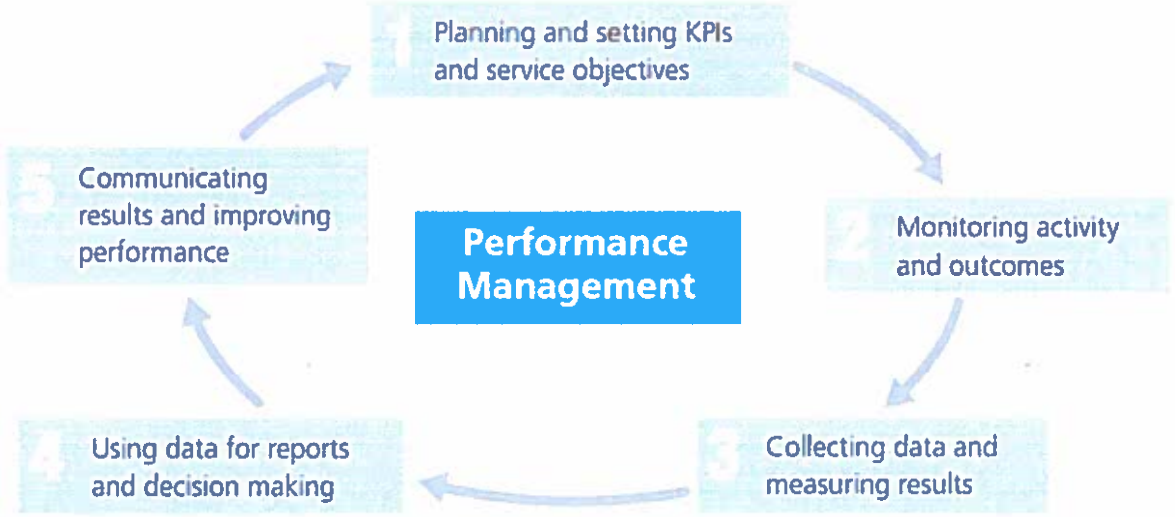
Measurements of performance may be set nationally, agreed locally with commissioners, or devised by the trust itself to monitor improvements in care, safety and service delivery. These were integral in supporting the trust in its response to the COVID-19 pandemic

In addition to producing regular, scheduled performance reports, the trust produces reports on request for managers. HRCH also has a business intelligence portal on the staff extranet, which allows managers to access useful performance information.

Monitoring performance

Our 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 performance management cycle, plus a system of performance reporting against agreed measures and quality priorities.

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



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

In addition, sub-committee chairs submit reports 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 issues that affect the delivery of high-quality care and has been commended by NHS England/Improvement for use of statistical process control (SPC) charts.

As part of a community benchmarking network, we are integrating benchmarking data into reports to provide greater assurance and contextualise our performance against peers and other local organisations.

Board sub-committees receive reports on subject areas within their terms of reference, such as quarterly performance reports on outcomes against quality priorities, patient experience, infection prevention and control, and safeguarding, together with annual reports in these areas.

Contractual performance reports are reviewed internally each month by the performance executive committee and finance and performance board sub-committee.

During the pandemic, commissioner meetings were temporarily suspended. Despite this, we maintained our internal performance management cycle. Using legacy metrics, the trust continued to monitor performance management cycle activity and waiting times, among other indicators.

We also discussed additional performance reports at COVID-19 working group meetings. These underpinned our response, supported staff in the delivery of essential clinical services and helped in our restart process.

Performance information was essential in the delivery of our vaccination programme, allowing us to be an essential contributor to vaccinations for staff, plus housebound and vulnerable patients.

During 2020-21, we reported monthly to NHS England/Improvement, which supports and holds NHS provider organisations to account for consistently safe, high-quality, compassionate care for patients in local health systems that are financially sustainable. NHS England/Improvement assessed HRCH on its financial outturn performance, including agency staffing expenditure.

The trust continues to use the national single oversight framework (SOF) as a fundamental structure on which it bases performance reports. Alongside this, model hospital indicators have expanded to include all areas of finance, workforce, operational delivery, and estates.

Finally, the trust publishes its annual outcomes on workforce race and disability equality standards (WRES and WDES) and against the NHS Equality Delivery System framework. It also publishes analysis and actions against all protected characteristic in its annual Public Sector Equality Report (PSED).

Please see more detail further on in this report in the Embracing equality, diversity and inclusion section.

Performance 2020-21

The trust reports performance against the five CQC quality domains to ensure a continued focus on quality. The year-end position against a suite of indicators used to measure performance is outlined in the following tables. Unless indicated otherwise, the figure quoted is the average for the year or the total number in 2020-21. Further detail is provided under the headings of:

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

SAFE

People are protected from abuse and avoidable harm.

KPI DESCRIPTION	TARGET	ACTUAL	
Incidence of Clostridium difficile	2	0	●
Incidence of MRSA	0	0	●
Never events occurring in month	0	0	●
Medication errors causing serious harm	0	0	●
Inpatient falls per 1,000 occupied bed days	8.6	9.37	●

Note: All areas rated red are scrutinised by senior managers and committees and assigned remedial action plans

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%	89%	●
Percentage of staff – statutory & mandatory training	90%	92%	●
Clinical supervision – % of staff)	90%	90.3%	●

Note: due to the coronavirus pandemic the Trust suspended appraisals Apr-Jul 2020 and Jan 2021.

CARING

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

KPI DESCRIPTION	TARGET	ACTUAL	
Trust composite FFT – % recommend	90%	94.4%	●
Trust composite FFT – % not recommend	10%	1.3%	●
Staff FFT – % recommend the trust as a place to receive care and treatment (average at year end)	67%	83.1%	●
Staff FFT – % not recommend the trust as a place to receive care and treatment (average at year end)	33%	3.3%	●
Patient Survey – % patients who felt their privacy and dignity were respected	95%	98%	●
Patient Survey – % of patients who felt they received their care in a way that was right for them	95%	98.6%	●

Note: during coronavirus pandemic FFT and patient survey data collections were paused. Patient FFT and patient survey resumed December 2020. Staff FFT figures are from national staff survey.

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%	99.8%	●
RTT waiting times for non-admitted pathways: percentage within 18 weeks	92%	86.9%	●
RTT waiting times incomplete pathways: percentage within 18 weeks	92%	83.7%	●
Percentage of delayed transfers of care	7.5%	1.4%	●

Note: All areas rated red are scrutinised by senior managers and committees and assigned remedial action plans

WELL LED

Leadership, management and governance of the organisation to 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%	54.3%	●
A&E FFT (Teddington urgent treatment centre and Hounslow urgent treatment centre response rate)	5%	4.3%	●
Staff FFT – % recommend the trust as a place to work (year-end)	61%	74.9%	●
Staff sickness	3.2%	4.1%	●
Staff turnover	15.5%	11.5%	●
Vacancy rate	10%	7.5%	●
Temporary costs and overtime as a percentage of total pay bill (reported a month in arrears)	20%	13.2%	●

Note: during coronavirus pandemic FFT data collections were paused. Patient FFT resumed in December 2020 and Staff FFT figures are from national staff survey.

Staff sickness figure is 3.6% if you discount COVID-19 sickness rates.

All areas rated red are scrutinised by senior managers and committees and assigned remedial action plans

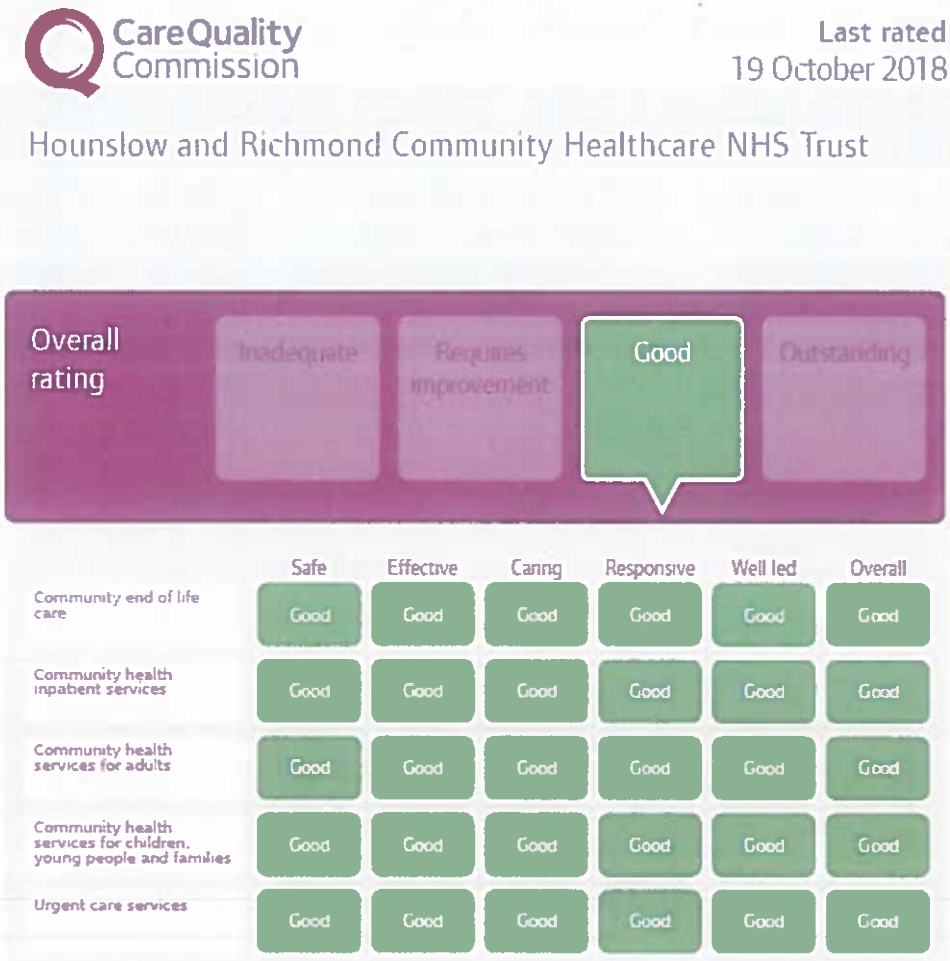
Quality

Our Journey to Outstanding (J2O) quality improvement programme is our framework for quality improvement and assurance of compliance with CQC standards. The accountable officer for quality and the CQC until May 2020 was Donna Lamb, director of nursing and non-medical professionals. She was succeeded by Sarah Shingler from May 2020 for a year.

Registration with the Care Quality Commission 2020-21

We are registered with the Care Quality Commission (CQC) without any conditions. With other NHS trusts, we participated in a review of COVID-19 PPE and infection prevention and control arrangements in 2020-21, which were commended by CQC inspectors. Our last full inspection was in 2018, in adult community services, end of life care, and urgent care services. We were rated Good in all services and domains of quality, safe, effective, caring, responsive, and well led.

We were anticipating an inspection in 2020-21 and submitted our Provider Information Request in March 2020, but the pandemic caused the CQC to reorganise its inspection regime. In addition, Teddington Memorial Hospital was registered as a temporary alternative discharge destination (TADD) as an interim measure, to support arrangements for patients before they tested negative for COVID-19 and could, therefore, return to their care homes.



Overarching Journey to Outstanding focus for 2020-21

Our quality and clinical strategy 2019-23 strengthens our mission to provide outstanding care and services that we and our families would want to use. Its purpose is to provide a clear framework for delivering outstanding services to our patients, service users, families and carers.

The overall trust strategy says that, by 2023, we will be at the forefront of improving the health and wellbeing of local people. Our patients and service users will be able to say they have had outstanding experiences and we will be able to demonstrate that care is consistently safe and effective.

Following on from that, our quality and clinical strategy supports our belief that being outstanding comes from a consistent approach and demonstrable evidence of:

- quality improvement
- patient and public engagement/co-production
- a strong safety culture

Our quality priorities align with annual deliverables from our quality and clinical strategy based on:

- patient safety – building a strong safety culture
- clinical effectiveness – embedding quality improvement
- patient experience – strengthening patient and public engagement and co-production

Patient safety	Clinical effectiveness	Patient experience
Build on our culture of keeping people safe and develop a safety culture which places a high level of importance on the management of safety, including beliefs, values and attitudes.	Staff to be trained and engaged in/using quality improvement methodology in our journey of continuous improvement.	Fully develop an approach that puts people at the heart of care, to improve service quality, engaging in continuing service delivery, making changes to services or redesigning care pathways.

Quality priorities

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

1. Improving patient safety

Areas of focus	Year 2 (2020-21) actions
Ensure staff receive feedback and learning is shared widely. Build on our culture of being open, honest and transparent when things go wrong. Build consideration of human factors into how we investigate incidents. Ensure we close the loop in our responses to patient safety alerts and NICE guidelines, to ensure assurance of continuous improvement.	Demonstrate a trend of increasing incident reporting and decreasing levels of harm from incidents. Provide a flexible and open approach to learning across the trust. Develop our learning and training from serious incidents and the role of human factors. Develop a process for assurance; closing of loops; implementing actions for continuous improvement, patient safety alerts (CAS) and NICE guidelines. Share learning between urgent care and rapid response (UTC, ICRS and RRRT).

2. Improving clinical effectiveness

Areas of focus	Year 2 (2020-21) actions
Ensure there is a flexible and responsive training programme, appropriate to all levels of staff. Provide quality improvement (QI) support through a network of champions and resources. Evidence that QI methodology has been used to drive improvement in care from audit and NICE review, demonstrating utilisation of evidence to drive improvement.	Have a training programme and awareness that deliver an appropriate level of training for all staff on QI. Support teams with their QI projects, using QI methodology. Develop internal support for QI, including a skills bank. Develop a central hub for registration of QI projects and outcomes.

3. Improving patient experience

Areas of focus	Year 2 (2020-21) actions
Embed and further develop Always Events, sharing learning from what we've done well. Develop an integrated model of public engagement with primary care and other stakeholders. Ensure we are inclusive in our approach to engagement. Scope the feasibility of collaborative working with local organisations, to enhance engagement work.	Have representation of various protected characteristics on the patient engagement forum. Involve patients and carers in co-design of any service changes. Develop a network of patient safety partners

Important achievements in 2020-21

0 medication errors causing serious harm

0 never events

94% of patients on average reported they would recommend our services to their friends and family (from December when FFT nationally restarted)

98% of patients, on average reported their privacy and dignity were respected

Monitoring quality performance

As reported elsewhere in this report, we review all the information available to us about quality of care in the services we provide. We produce a wide range of reports for internal and external monitoring and performance management each month, as well as action plans for rectifying any issues. For further details of improvements in 2020-21, our quality account will be available online at https://www.hrch.nhs.uk/about-us/quality from mid-December 2021.

Patient feedback

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

We also use paper surveys when electronic means are not appropriate and upload results to the system. Due to the pandemic, the collection of FFT feedback stopped in April 2020 and restarted in December 2020. This affected the amount of feedback we received. This year 7,525 people told us about their care and treatment, compared to 25,698 in 2019-20.

As part of this year's patient feedback:

98% **of patients said they were treated with respect and in dignified ways**

98.8% **of patients said they felt they had been listened to**

Friends and Family Test (FFT)

Our patients are positive about our services and would recommend our services to their friends and family if they needed similar care or treatment. In 2020-21, 94% of our patients said they would recommend our services to their friends and family.

Listening to what patients tell us

Compliments

Most patients appreciate the kindness, care and expertise of our colleagues and share their appreciation with us. We record and report all compliments and are pleased to report we received 542 formal compliments in 2020-21, compared to 434 in 2019-20.

These numbers do not capture the many lovely expressions of thanks patients regularly share with our teams. We are always grateful when patients and families take the time to tell us how much they appreciate our care, as we want to provide the kind of care we would want our families to receive. The word cloud below captures what people say about our services and our colleagues in feedback that we captured on our electronic patient feedback system in 2020-21.

Complaints

In 2020-21, we had 63 formal complaints and nine joint complaints that required detailed investigation, plus 199 enhanced PALS enquiries that were resolved at a local level, a total of 271. In 2019-20 we had 80 formal complaints and 187 enhanced PALS enquiries, a total of 267. This suggests complainants want their complaints to be handled as quickly as possible but 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 themes of complaint are the same as those in 2019-20. Complaints about treatment/ ability and diagnosis (provision of safe and high-quality care) together represent 44% of complaints for the year, with staff attitude at 25 %. Last year 97% of formal complaints were responded to within 25 working days, compared to 91% the previous year.

Patient survey

We undertake an annual postal survey of 1,000 patients, focusing on a specific service to provide a snapshot of patient satisfaction. The 2020-21 survey will survey children's community services in Hounslow and Richmond and we will report on learning from the feedback once responses have been analysed.

Embracing equality, diversity and inclusion

Equality, diversity and inclusion is overseen by the trust's Equality, Diversity and Inclusion (EDI) Committee, chaired by the Director of Workforce, with a Non-Executive Director EDI lead and the Director of Nursing as the patient executive lead. Assurance is reported via the trust's Executive Committee.

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

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

Our ambition remains to improve the health outcomes, access and experience of all our patients, carers, visitors, volunteers and employees. During the past year, we focused on a number of areas.

Working with patients and service users

Our Adult Learning Disability Heath Team set up The Good Chat Group, a name that service users chose for themselves. It is a group made up of young men who have varying communication skills.

Our children's services worked closely with children and young people in partnership with Achieving for Children. They were able to seek feedback and engagement from them to improve their experiences of accessing our services.

Through our children and young people's participation meetings we:

- developed 'all about me' guides to support a positive experience when attending clinics
- co-created service information leaflets, eg, A trip to the hearing clinic
- created name badges for children
- developed appointment letters for children
- created a video about children's therapy appointments
- developed information around for children about wearing PPE

The Family Nurse Partnership (FNP) team held their annual service review virtually and involved, a client. One of the Family Nurses attended the meeting from the client's house. The nurse, wearing full PPE, interviewed the client about her experiences of having a baby and receiving the service during the pandemic. This gave the client an opportunity to have a her say and share views with stakeholders, while also showing stakeholders the reality of client visits in PPE.

The Dementia Team advise a local charity, Brighter Together, which links care homes and nurseries. Nursery staff had training in communication and behaviour for people living with dementia. Two care homes have continued their visits in some form during lockdown, including Zoom singalongs or garden visits from the nurseries.

Working with the local community

The pandemic stopped our outreach work with the community, due to restrictions. However, services have continued to engage with their patients by using virtual methods such as using an online platform to carry on with clinics, called Attend Anywhere. This has really helped with patient experience and care, at a time when patients could not attend for clinic appointments.

As part of our embracing equality, diversity and inclusion – valuing our people work we:

- launched Race Equality and Inclusion Network (REIN) to provide an open forum for our colleagues to share their experience of the workplace in a supportive and safe environment
- launched DiverseAbilty Network to empower and support staff with a disability/ long-term health conditions to achieve and/or maintain their potential
- appointed a Head of Equality Diversity and Inclusion to drive and support the trust's equalities agenda
- commissioned a reverse mentoring scheme to give our staff an opportunity to share lived experiences, help shape and influence policies and procedures, while ensuring equality is proactively considered
- included black, Asian and minority ethnic staff as one of the considered factors in our risk assessment process
- ran listening in events and specific question and answer sessions to support staff groups
- facilitated educational talks on cultural adaptability for all staff, plus resilience and mental health awareness, and coffee break sessions for our shielding staff
- offered a diverse health and wellbeing programme, which is also covered as part of our corporate induction
- recruited three Freedom to Speak Up Champions to continue to encourage and support staff to feel comfortable with speaking up
- continued to publicise and promote training and development opportunities for minority ethnicity colleagues – this year several colleagues have enrolled on the black, Asian and minority ethnicity Capital Nurse, mental health first aiders, and strength coaching programmes
- continue to publicise and celebrate national equality and diversity initiatives such as LGBT+ History Month, Black History Month, menopause awareness, mental health awareness, and share staff stories
- set up a COVID-19 vaccine hesitancy Q&A session for all staff and the REIN created a factual information handout to help staff make informed decisions
- facilitated Microsoft Teams training and devised guidance to support home working

The 2020 national Workforce Race Equality Standard lists HRCH in the top performing trusts for percentage minority communities experiencing harassment, bullying or abuse from other staff.

Mortality review process

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

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

Adult Services

- All deaths of patients in our inpatient care or who have been discharged within 30 days are 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 screened once the service becomes aware of the death (reportable to the CQC)
- In addition to the mandatory list above, the trust takes a measured approach to identifying other groups for review (frontline clinicians and managers identify any case that might warrant review) and from which learning would be beneficial

Cases on the adult caseload are reviewed if:

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

In the past year no deaths met the criteria for review at the Teddington Memorial Hospital inpatient unit. More information is available on our website: http://www.hrch.nhs.uk/about-us/publications-declarations/

Our people

The NHS People Plan aims to make the NHS the best place to work, with compassionate and inclusive leadership and the delivery of 21st century care. Our people are fundamental to our success in delivering high-quality patient care.

We are immensely proud of our staff, the care we deliver and the fact that more than 95% of our patients consistently say they would recommend our services. We employ a skilled workforce of around 1,200. We support them in aiming to be the best they can be, across clinical and non-clinical services, and in contributing to the delivery of high-quality, patient-centred care.

The people we employ reflect the diverse backgrounds of the communities we serve. Our trust board is one of the most diverse boards in the country. We are proud to have diverse staff and board members to serve and engage with our diverse population. We celebrate diversity by encouraging staff to bring their authentic selves to work.

Percentage of employees, leaders and board members with black and minority ethnic backgrounds:

40.9% of employees
22.5% of leaders up to Band 8C
28.6% of executive directors
23.1% of board members

Gender

85.1% of employees are female
14.9% are male

Disability

12% of staff survey responders have declared a disability

Our approach to developing our workforce is set out in our Workforce Strategy and the supplementary Learning, Development & OD Strategy, which were co-developed with staff. We made progress on our vision of making HRCH a great place to work, but need to continually improve our services and workforce, helped by our quality improvement (QI) approach. This is vital as people and their health and social care needs change, along with their expectations.

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

Every single member of our staff is fundamental to our mission to provide care and services that we and our families would want to use.

We are committed to constantly improving HRCH as a great place to work. We have also taken steps to ensure we have an inclusive workforce that feels listened to and is engaged.

One of the key parts of our strategy has been to work in a more integrated way with local GPs in Hounslow and Richmond to design more seamless services, utilising the skills of all our workforces via Primary Care Networks (PCNs) in each borough.

In Hounslow we established joint PCN delivery resource teams, employed by us but working for the PCNs, which include primary care support, joint clinical transformation project leads, pharmacists and first contact physiotherapists. We also secured funding for delivery resource teams and infrastructure support.

Our partnership working via the Hounslow Working Together alliance was commended by the North West London sector. Joint working is well established between HRCH and PCN clinical directors, through strong relationships and joint resources.

In Richmond, we maintained our joint venture partnership with Richmond GP Alliance (RGPA) and Richmond Community Healthcare in Partnership (RCHiP) provides support to PCNs and integrated primary and community services.

Workforce performance

Over the course of 2020-21 the trust continued its senior-level focus on this key priority area.

Statutory & mandatory training 90.7%

Staff appraisals 89%

Vacancy rate 7.5%

Staff turnover 11.5%

Staff sickness rates 4.1%

Equality, diversity and inclusion

Our Race Equality and Inclusion Network and DiverseAbility Network aim to offer a safe space for staff to share their lived experiences and help shape and influence the Trusts equality and diversity agenda. We have had great feedback from all who have attended and will continue to provide a forum for pour staff to raise challenges and concerns.

Apprenticeships

We continued to promote apprenticeships as a gateway to careers in the NHS, including more non-clinical apprentices, such as master's degrees, learning and development level 3, as well as promoting new Nursing Associate apprentice roles.

e-Rostering

Our rostering system is embedded in the trust with 100% staff coverage and enables us to reduce unfilled shifts and use our Bank more for temporary cover, cutting down on agency costs.

Agile working

We reviewed all our estate to ensure it was fit for purpose for agile working, ensuring access to technology that aids remote working. Trainers were given "Deliver virtual training with confidence" training for mandatory and essential training through the pandemic. There are also monthly support sessions for trainers to improve virtual delivery. Trainers received excellent feedback from staff.

Wellbeing matters

The outbreak of COVID-19 saw an increased pressure on the NHS. As a trust, our focus remains on making staff wellbeing paramount. We adopted some innovative measures in response to the pandemic to support and improve services for staff wellbeing and time at work.

We increased focus on strong and visible leadership, communications and engagement, inclusion and diversity, and physical, mental and financial wellbeing.

Following the outbreak in March 2020, we set up regular virtual all staff question and answer sessions with the executive team and subject experts to discuss staff concerns. We created a dedicated COVID intranet page and published regular COVID newsletters, with a wellbeing section providing selfcare advice and tips.

We also collated and circulated an extensive information pack, with details of local and national wellbeing resources, apps and tools. These included a local helpline to listen to staff who feel overwhelmed or anxious and signpost them to relevant support.

We offered salary advances of £1,000 to staff (to repay within 6 months) to help alleviate increased financial pressure due to loss of earnings for some families. We engaged our minority communities staff and circulated information about taking vitamin D supplements, as recommended by Public Health England following the adverse impact of COVID on minority communities.

In line with social distancing rules, we moved our exercise and wellbeing classes online and staggered timings to accommodate work-life balance.

Our wellbeing programmes are aligned with national campaigns to support health promotion activities. Some examples include Dry January, Time to Talk in February, Ramadan and wellbeing in March (in advance of Ramadan), stress awareness in April, mental health awareness in May and October. Our staff health and wellbeing group are active and lead on improving wellbeing where they work.

Our specialist diabetes team have continued to run a weight management support programme to help employees lose weight on a low-carb diet and reduce the risk of developing type 2 diabetes and other weight-related illnesses. They have run three cohorts till date. We also started coffee break sessions, giving our staff an opportunity to decompress, connect and discuss wellbeing topics.

As part of our recovery plans, we are focusing on creating effective teams, so people benefit from peer support and support from managers. Wellbeing is part of our induction programme and we have a wellbeing checklist to support managers.

In recognition of efforts to support staff physical and mental health, particularly during COVID, we were awarded the London Healthy Workplace Foundation Award by the Mayor of London.

Organisers praised our considered and well-thought-out approach to tackling different issues, such as the stigma around mental health issues. We will continue to invest efforts in looking after our staff to improve their wellbeing.

Flu vaccinations for patient-facing employees

We continued to use electronic forms for employees to give their consent to having the flu vaccine and were pleased that about 93% of patient-facing colleagues were vaccinated – our best result ever and placing us number 2 in London and among community trusts nationally.

Valuing and recognising our colleagues

During the pandemic, we felt it was unfair to single out individuals and teams for our much-valued annual staff awards, so we found other ways of rewarding colleagues, including recognition packs, thank you cards, HRCH Hero 2020 badges, gift bags and free lunches, to name a few. We would like to thank NHS Charities Together for their donations to our Charitable Fund, which helped us reward colleagues in these ways.

We also regularly recognise and reward the hard work and accomplishments of people who go the extra mile for local patients through our quarterly HRCH Champion Awards programme, with individual awards for caring, respect and rising star, plus a team award for communication and innovation.

NHS Staff Survey 2020

Each year we take part in the annual national NHS Staff Survey to receive feedback from staff on their experience of working here, to monitor trends and measure the impact of changes we have made in response to feedback. The results from the staff survey are incredibly important to us, as we get to hear what people really think about working here.

The report is analysed by themes and individual questions. HRCH was the joint top trust in London, with a combined score of 7.69 for the ten key themes of:

- Equality, diversity and inclusion
- Health and wellbeing
- Immediate manager
- Morale
- Quality of care
- Safe environment – bullying and harassment
- Safe environment – violence
- Safety culture
- Staff engagement
- Team working

We also had the best response rate of all community trusts in England (72%) and were joint first for quality of care with a score of 7.8. We are proud to come top for a third year in a row for questions relating to quality. We also had one of the highest scores for safe environment – violence, and staff engagement.

We were pleased that 813 colleagues participated in the survey – our best result ever. This is brilliant and means we have some rich, valid data from which to pull out areas of improvement on which to focus.

We came top of all community trusts in the country in:

- ability to do my job to a standard I am personally pleased with (84.3%)
- opportunities to use my skills (76.3%)
- knowing what your responsibilities are (88.1%)
- ability to deliver care I aspire to (76.7%)
- satisfaction with quality of care I give (86.5%)
- the trust acting on concerns raised by patients (86.6%)

We improved in areas we particularly focused on last year. These include positive views about communication and engagement with senior managers, job quality, safety, and wellbeing. Overall, we have seen some great results and significant increases of 3% or 5%.

We were joint fourth nationally in the Freedom to Speak Up Index, which used the results of the previous year's staff survey to understand how staff perceive the 'speaking up' culture. We scored 85%, against the top score of 86.5%. This is not only a fantastic achievement but highlights efforts across the organisation to foster a culture in which we learn from mistakes and encourage reporting of incidents to improve safety.

We saw an improvement in the Freedom to Speak up index questions:

- 97% of respondents would know how to report if they were concerned about unsafe practice (same as last year)
- 81% would feel secure raising concerns about unsafe clinical practice (up from 79%)
- 73% were confident the trust would address their concerns (up from 71%)

Most importantly, the percentage of colleagues recommending HRCH as a place to work increased from 71% to 75% – 6% better than the national average of 69%. Colleagues who would be happy with the standard of care provided by the trust if a friend or relative needed treatment is up from 79% to 81%, better than the national average of 80% for community trusts.

Two additional questions were added to the survey to capture people's experiences of the COVID-19 pandemic. The questions were on safety.

In response:

- 84% of our staff said they feel safe at work
- 71% said they feel safe to speak about anything that concerns them in the organisation

Our staff who were required to work from home had an overall positive experience, unlike those shielding at home and those working in COVID specific areas, particularly morale and wellbeing.

We responded to this by talking to staff and making changes based on lessons learned. We provided team interventions and support like therapy and bereavement sessions, monthly coffee break sessions, including specific sessions for staff who are shielding, offering them an opportunity to connect and get support from our HR team and occupational health.
While most of our latest results remain positive, we still have areas for improvement, including:

- staff wellbeing especially managing work related stress and MSK problems
- work relationship and support from immediate managers
- equality, diversity and inclusion

Our trust board will use the feedback to support improvements based on key themes or areas that need more focused efforts from the trust. In addition, we have asked all teams to suggest at least one thing they can do themselves to make a difference to their teams and our patients.

People development

Our learning, development and organisational development strategy has now been integrated into the five pillars of the trust's Workforce Strategy. It was created to ensure our people get the right support for developing their knowledge, skills, and talent. We are committed to training, learning and development for all our people and offer a wide range of opportunities and courses to support a culture of continuous improvement and learning.

Through creating a conducive learning environment in which employees can challenge and reflect on their practices, we believe we can enable our staff to be the best they can be.
Many of our learning opportunities were put on hold during the pandemic and as such we have not been able to move forward many of our excellent programmes.

In 2020-21 we:

- continued to promote apprenticeships in the trust, offering more clinical apprenticeship opportunities – we have recruited 4 nursing associate apprentices and now have 16 apprentices across the trust including 5 staff undertaking master's degrees. Although low key national apprenticeship week was well received within the trust
- procured training to develop a cohort of 24 accredited coaches to build a coaching culture at HRCH
- we delivered "Deliver virtual training with confidence" training to enable mandatory and essential training workshops throughout the pandemic
- we delivered virtual customer service workshops using actors
- in March 2021, we launched a virtual leadership platform with NHS Elect to give staff the opportunity to attend online webinars, e-learning around developing their leadership skills
- procured a coaching and mentoring system to enable staff to access coaching, mentoring and an array of resources to support their development and increase performance
- evaluated and enhanced our in-house Management Essentials programme to include coaching and mentoring support and reflective study, with 66 managers enrolled
- launched our executive development programme in Spring 2020; all executive directors and their deputies completed the Outward Mindset Leadership development programme
- continued to improve clinical skills development, supporting colleagues at university with funding from Health Education England – supplemented by directly-funded development sessions for people applying through the training panel

Statutory and mandatory training

In 2020-21, 90.7% of colleagues completed their statutory and mandatory training, exceeding our target of 90%. Our training programme promotes the safety and wellbeing of all our people and patients. It includes national core skills which have a direct impact on patient safety, such as information governance, safeguarding adults and children, and resuscitation.

Finance and information

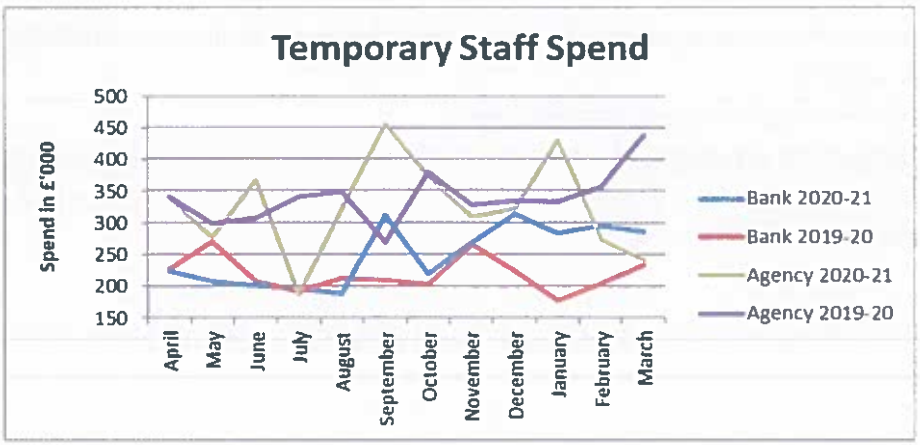
In 2020-21:

- We received £85.7 million in income, mainly in the form of block contracts under a temporary financial regime due to the COVID 19 Pandemic
- We achieved break even and delivered a small surplus of £16,000
- We invested £2.222 million of capital expenditure, all on purchased assets, just below our plan of £2.224 million
- We maintained our low spending on agency staff through a variety of measures, including increasing the number of staff who work for us through bank arrangements, a positive in terms of quality of care and lower costs; in addition, due to the pandemic, sometimes agency staff were not available
- HRCH achieved the highest rating under NHS England/Improvement's Use of Resources framework, which rates NHS trusts against a range of financial management tests

Accounts payable – position as at 31 March 2021

Better Payment Policy Compliance (BPPC) – cumulative	Non-NHS	NHS
By number	95.5%	98.1%
By Value	98.0%	97.7%

- Debtors due more than 90 days are £1.289m
- Despite significant pressure on staffing, we maintained low spending on agency staff and remained within pay rate caps, except for small numbers of specialist staff – the agency spend cap in 2020-21 was £4,134,000; we spent £4,112,304, which was 99.5% of the cap on agency spending and 7.1% of our overall pay bill
- Cash at 31 March was £33,959,000 against a target of £25,902,000



Information governance and cyber security

Information governance (IG) 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. This has been a crucial element to support the new ways of working throughout the pandemic.

Due to our rigorous IG framework and data protection by design approach, we have been able to work across our boundaries, sharing key data with relevant and appropriate staff in partner organisations to help combat the virus. For example, the Trust Data Protection Officer has worked closely with IG colleagues, as part of a number of sector wide working groups to ensure that the trust can join the Connecting your Care project. This means that Richmond services have access to relevant and appropriate data from key health and care organisations at point of treatment.

Effective data security guidance has also enabled staff to work remotely using new software and business tools, while ensuring the security of patient data.

Throughout 2020, we still marked ourselves against the NHS Digital's annual Data Security and Protection Toolkit audit. The audit assesses the trust against current data protection legislation and related regulations, giving either a pass or fail mark.

We did submit a fully compliant assessment in March 2020, but due to the Covid pandemic the usual timetable for the toolkit audit submission was extended from March 2020 to September 2020. Therefore, the 2020-21 baseline audit was submitted at the end of February 2021. The full assessment is due at the end of June 2021.

We continue to maintain high standards of information governance through a variety of measures and actions, including:

- continued review of personal data flows to guarantee the trust operates in line with General Data Protection Regulations (GDPR), especially with regards to temporary Covid data processing, ensuring a register all activities is maintained and reviewed
- review of all GDPR rights requests, including the right of access, to ensure requests are answered within the legislated timeframe, to avoid breaching GDPR and incurring large fines from the ICO
- continuing review and revision of the trust privacy notice, giving assurance that the trust is transparent with all data processing, this is of particular importance during the pandemic
- completion of data protection impact assessment for all new research projects, services, systems and applications which involve the use of personal data
- an audit of our compliance against a small sample of standards from the NHS Digital toolkit by our external auditors
- continuing review of policies and staff guidance
- helping colleagues to complete information governance and security e-learning training
- attending team meetings to ensure data protection and security is a key element of all work and staff take responsibility for data in their teams

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 an upgraded building management system (BMS) at Teddington Memorial Hospital. BMS refers to a computerised way of controlling and/or managing various electrical and mechanical components.

This has allowed the Estates Team to control the efficiency of our plant. We are replacing aging lighting systems with new LED efficient lighting systems at all our sites and carried out a survey on all-low use areas, planning to change to motion-detected lighting controls.

Staff engagement

This year the HRCH Board signed up to the Single-use Plastics Reduction Pledge, which has a range of milestones that we should meet.

We no longer buy single-use plastic stirrers and straws, except if someone has a specific need. We have already worked towards meeting next year's target of no longer buying single-use plastic cutlery, plates or single-use cups made of expanded polystyrene or oxo-degradable plastics.

We have removed plastic plates and single-use cups from our wards, staff rooms and meeting rooms. We plan to install dishwashers with a view to removing single-use cutlery. Wherever possible, colleagues are consulted and asked for their involvement in new and innovative ideas. Sustainability meetings with clinical teams help to gain ideas.

Actions to encourage environmental sustainability

- We have a zero-waste-to-landfill policy
- All domestic waste is burned to generate energy, enabling zero landfill – this energy is distributed to the National Grid
- We encourage use of public transport and agile working, adding agile working locations to the trust's property portfolio
- Continuous auditing and the introduction of ISO9001 processes ensures legal compliance and captures any missed carbon and/or financial saving opportunities
- Up-to-date reporting identifies trends in utility consumption and waste production and enables the estates team to take action to resolve issues

Utilities

Electricity is hourly metered, so we can see daily peaks and troughs, enabling closer usage management. With our efficient gas boilers and new BMS we anticipate our plant will allow us to maintain a consistent usage of gas which will put less strain on the main system. Water consumption has been tightly controlled, reducing stored water on site, while creating a more reliable water system of reducing leaks and water waste.

Waste

We recycle just about 68% of non-clinical waste, against the UK national average of 45.2%.

Transport

Through the rationalisation of our estate, we have created a lot of agile working spaces and reduced the need for colleagues to travel around our boroughs. Walking and public transport are encouraged whenever possible.

We have continued our partnership with AccessAble, which provides online information to help colleagues and patients with and without accessibility issues to plan their travel, particularly by public transport to all HRCH sites. This partnership with AccessAble has been well received and helped HRCH in coming first out of Community Trusts in a PLACE inspection under the disability category.

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: https://www.hrch.nhs.uk/about-us/corporate-information-and-assurance/modern-slavery

Interim Chief Executive, 10 June 2021

SECTION 2 – ACCOUNTABILITY REPORT
Corporate governance report

a. Directors' report

Board of Directors

The trust board of directors has overall responsibility for setting the corporate and clinical strategy of the trust, as well as overseeing performance, including finance.

The board meets in public 6 times per year to discuss performance across the trust, current and future challenges, and corporate and clinical strategy. When discussing issues of a confidential nature the trust board resolve to meet in private in accordance with the Public Bodies Act 1960.

The chairman Sian Bates is chair in common with Kingston Hospital Foundation Trust. This supports the Government's recent white paper, which includes proposals to make integrated care a reality and encourages greater levels of collaboration between health and care organisations.

Details of public board meetings and papers are available on the trust website Board meetings :: Hounslow & Richmond Community Healthcare

Changes to the trust board

During 2020/21 the following changes took place to the membership of the trust board:
On 30 November 2020 David Hawkins was appointed as interim Chief Executive.

Phil Hall and Joanne Hay both had their Terms of Office renewed until 31 July 2021.

Board members

The full list of members of the trust board who served in 2020/21, is as follows. Biographies of board members can be found on our website https://www.hrch.nhs.uk/about-us/trust-board-and-leadership

Chairman

Sian Bates

Non-Executive Directors

Judith Rutherford
Bindesh Shah
Joanne Hay
Phil Hall
Ginny Colwell

Executive Directors

Patricia Wright, Chief Executive (until 29 November 2020)
Monique Carayol, Director of Strategy & Transformation* (until 12 March 2021)
David Hawkins, Director of Finance & Corporate Services (until 29 November 2020)
David Hawkins, interim Chief Executive (30 November 2020)
Stephen Hall, Director of Clinical Services^, Richmond and South West London (SWL)
Alison Heeralall, Director of Workforce & Communications*
Rosalyn King, Director of Primary Care Networks (1 October 2020)
Donna Lamb, Director of Nursing & Non-Medical Professionals (until 31 May 2020)

Sarah Shingler, Director of Nursing & Non-Medical Professionals (1 June 2020)
Dr John Omany, Medical Director
Anne Stratton, Director of Clinical Services, Hounslow and North West London (NWL)^
Bridget Welch, interim Director of Finance (30 November 2020)
*Non-voting Directors, ^ Voting Directors who share a single vote

Observers (non-voting):

The following are also able to attend board meetings in a non-voting capacity, to represent the community's views:
John Marshall – Healthwatch Hounslow
Paul Pegden Smith – Healthwatch Richmond

The table below details board members' position at 31 March 2021 on the Sub-Committees of the trust board. Profiles of trust board members are available at https://www.hrch.nhs.uk/about-us/trust-board-and-leadership

Non-Executive Board Members	Committee membership (*chair)
Sian Bates	Trust Board* Nominations and Remuneration* Attends all committees at least once a year
Judith Rutherford	Trust Board Audit and Risk Charitable Funds* Nominations and Remuneration Richmond Community Healthcare in Partnership Committee (RCHIP)**
Bindesh Shah	Trust Board Audit and Risk Finance and Performance* Nominations and Remuneration
Joanne Hay	Trust Board Finance and Performance Nominations and Remuneration Workforce and Education*
Phil Hall	Trust Board Audit and Risk* Quality Governance Nominations and Remuneration
Ginny Colwell	Trust Board Quality Governance* Nominations and Remuneration Workforce and Education

** 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.

Executive Board Members	Committee membership (*chair)
Patricia Wright (until 29 November 2020)	Trust Board RCHIP Part II risk session of audit and risk Attends all committees at least once a year
Monique Carayol (until 12 March 2021)	Trust Board (RCHIP)**
David Hawkins (interim CEO 30 November 2020)	Trust Board* Finance and Performance (RCHIP)** Part II risk session of Audit and Risk
Stephen Hall	Trust Board Finance and Performance Workforce and Education (RCHIP)**

Alison Heeralall,	Trust Board Workforce and Education
Donna Lamb (until 31 May 2020)	Trust Board Quality Governance Workforce and Education (RCHIP)**
Rosalyn King (1 October 2020)***	Trust Board
Sarah Shingler (1 June 2020)	Trust Board Quality Governnace Workforce and Education (RCHIP)**
Dr John Omany	Trust Board Quality Governance
Anne Stratton	Trust Board Charitable Funds Quality Governance
Bridget Welch (30 November 2020)	Trust Board Finance and Performance Part II risk session of Audit and Risk

** 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.

***The hosted Director of Primary Care Networks (PCN) (Hounslow) is responsible for the successful running of the PCNs in Hounslow, with accountability to and scrutiny from the Hounslow Consortium Board. The postholder is invited to attend all public board meetings and to attend private sessions of the board meetings as and when required. The Director of PCNs (Hounslow) does not share corporate responsibility with Executive and non-executive directors of the Trust Board for the successful running of the trust under NHS Corporate Governance arrangements and has therefore been excluded from the governance and remuneration sections of this report.

The Register of Interest of Executive and Non-Executive Directors is published on the trust's website on the 'Our Board' tab https://www.hrch.nhs.uk/about-us/trust-board-and-leadership/board-meetings

From 1 April 2021, Jo Farrar joined the trust as interim CEO and David Hawkins was appointed as itnerim Deputy Chief Exeucitve in addition to his substantive role as the Director of Fiannce and Corporate Services.

Interim Chief Executive Date: 10 June 2021

b. Annual governance statement

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 policy 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 2021 and up to the date of approval of the annual report and accounts.

Risk Management

In 2019 as a trust on our Journey to Outstanding, we decided to take a fresh look at risk management to ensure that risk was further embedded into all decision making. To enable us to deliver the ambition set out in the trust strategy and the NHS Plan we decided it was timely to produce a risk management strategy to support our commitment to provide high quality services. We recognised that successful risk management must be forward thinking; the responsibility of all; comprehensive and coordinated; and that proactive and continuous identification and management of risk is essential to the delivery of high value healthcare.

The strategy sets out clear goals, achievements and timescales for implementation. This enables our people to work towards the same aims empowering innovation whilst ensuring patient quality and care are at the centre of delivery. Within the strategy we created a vision for risk management. Risk management will be everybody's business – integral to professional and operational practice at every level and across organisational/professional boundaries. We will continually strive to test the boundaries of practice, whilst ensuring that we operate within legal and regulatory frameworks to reduce the exposure to risk to ensure that patients receive outstanding care.

Risk governance

The trust board is accountable to NHS England/Improvement (NHSE/I) for the trust's performance. The main governance committees are chaired by a Non-Executive Director and report directly to the board. Each committee is informed and supported by a variety of groups and local meetings.

Risk and control framework

The trust has a robust approach to risk management with:

- the board holding an annual risk seminar to review risk management systems and processes and to agree the organisational risk appetite statement

- the Audit and Risk Committee assuming delegated authority from the board for oversight and assurance on the management of strategic risks to the delivery of the trust's objectives. The Audit and Risk Committee is supported in its oversight of strategic risks by the Finance and Performance, Executive, Quality Governance and Workforce and Education Committees which lead on specific strategic risks
- the Interim 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 are provided with risk management training as part of their induction to the trust
- face-to-face training for those staff regularly involved in risk management being provided as appropriate
- an open culture to empower staff to report and resolve incidents and risks through the Datix recording system and to share learning with teams

In April 2020 the trust on direction of NHS England/Improvement as part of the pandemic response implemented light and lean governance arrangements. The arrangements have ensured that the trust maintains oversight and assurance on equality and sustainability whilst providing patient care. The introduction of digital meetings brought with it new ways of working.

Managing workforce risks

HRCH has a five-year workforce strategy in place (2020-2024), which was co-developed with clinical and corporate staff and agreed by the board

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

Managing quality risk

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

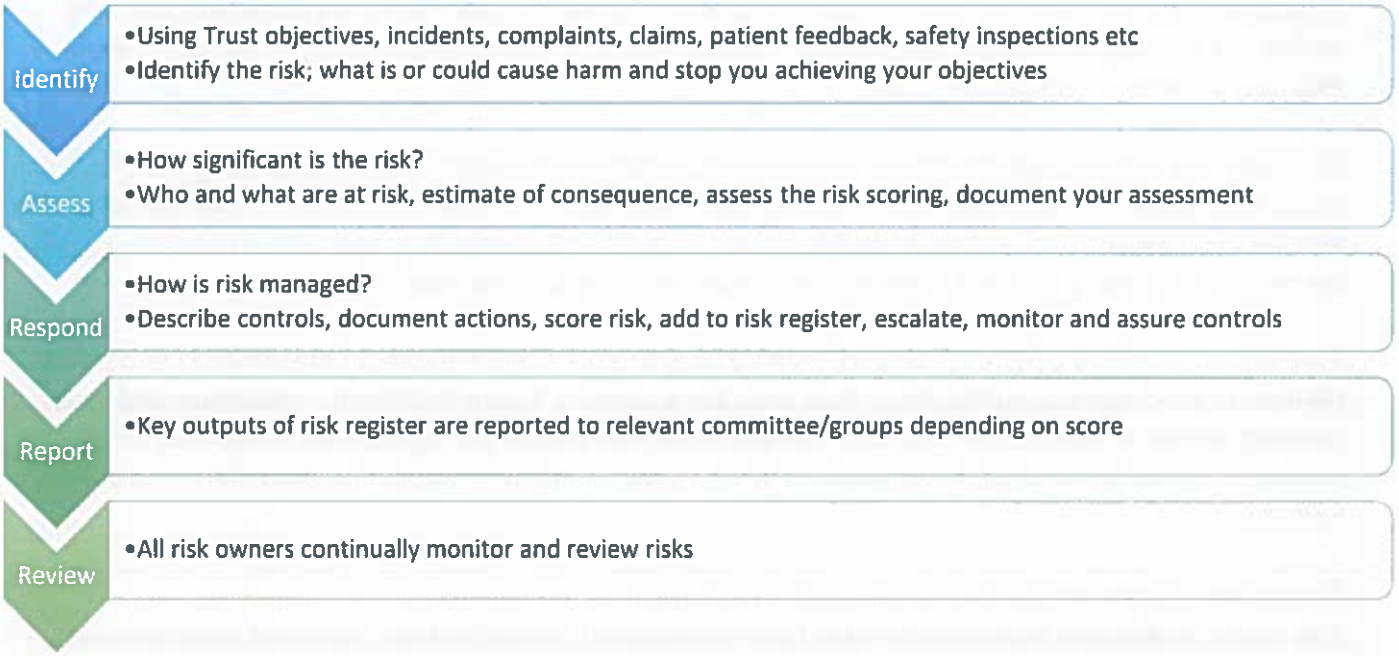
- the Quality and Safety Committee (QSC) reports to the QGC. The Director of Nursing and Non-Medical Professionals chairs this committee; membership of the QSC's committees and working groups ensures senior leadership as well as frontline engagement with the governance agenda
- the trust's clinical governance structure ensures there are robust systems in place for key governance and performance issues to be escalated from frontline services to the 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 has rolled out the Integrated Quality Assurance Dashboard. The dashboard highlights the trust's performance in a range of designated areas of quality. It visualises performance data and critical quality parameters in a single dashboard to simplify quality management analysis and reporting.
- the trust's quality improvement strategy is encapsulated in the Journey to Outstanding (J2O) programme. The J2O programme is a structured quality improvement plan with quality improvement plans in all services to monitor and demonstrate compliance with the CQC's fundamental standards and against each of the CQC's domains and Key Lines of Enquiry (KLOE)

Risk management process

The trust defines risk management as a process to identify factors which may possibly prevent us from providing an excellent, safe, efficient and effective place of work to deliver patient care and for staff to work. Risk management includes the process of identifying hazards, risk assessment, formulating a response, risk reporting and risk review. Risk management is as much about exploiting new business opportunities and innovation as mitigating risk.

Risk management process



Trust Risk Registers (TRR) (inc Board Assurance Framework (BAF))

Comprise of the local risk registers, the trust risk register as well as the board assurance framework (BAF), which seek to present an overview of the main risks facing the organisation. The local risk registers are reviewed, updated and monitored regularly by the relevant directorate and, if necessary, a risk can be escalated onto the trust risk register, which is monitored each quarter. The TRR is monitored monthly by the directorate management meeting (DMT), every 4-6 weeks at the Quality and Safety Committee and quarterly by the Quality Governance and the Audit and Risk Committees.

The BAF provides the trust with a simple but comprehensive method for effective and focused management 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 system of internal control is designed to manage risks to a reasonable level and not to eliminate all risk. The trust has a risk appetite which defines the risk tolerance with regards to its strategic objectives. These range of a low risk appetite for patient safety and quality to a high risk appetite for learning and development.

The BAF is monitored by each Executive Director who assess the status of their risk entry by having oversight of the Trust Risk Register. The BAF is monitored each month by the Executive Committee and quarterly by the Audit and Risk Committee on behalf of the trust board.

An annual assurance review on the BAF and Risk Management was carried out by Internal Audit. Which provided responsible assurance that the trust controls are robust and effectively designed. RSM confirmed the BAF is discussed at relevant committee meetings to ensure that risks included are up to date with regards to controls and assurances; and any progress against actions is also monitored.

Incident reporting

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

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

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

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

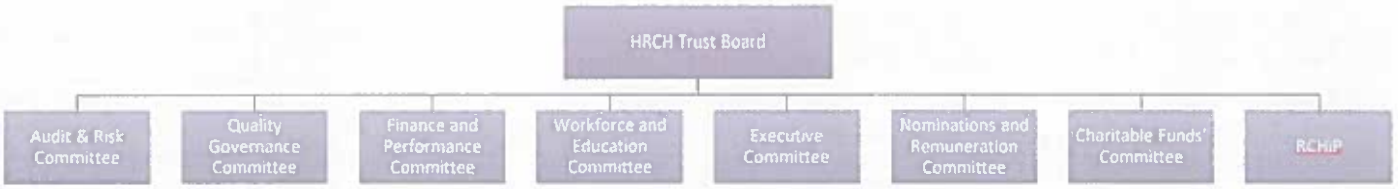
Board and Committee oversight and assurance

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

Corporate governance framework

There are five key sub-committees with responsibility for receiving information on risk management within the structure that provide assurance to the board of directors. The Executive Committee reports directly to the board although not a board sub-committee.

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



Committee structures

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

The Board of Directors

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

- to set and oversee the strategic direction of the trust
- review and appraisal of financial and operational performance
- to review areas of assurance and concerns as detailed in the chair's assurance reports from its board committees
- to discharge its duties of regulation and control and meet statutory obligations
- to ensure the trust continues to deliver high quality patient care, with quality and safety as its primary focus, receiving and reviewing quality and patient safety reports and also a chair's report from the key board committee which deals with patient quality and safety – the Quality Governance Committee
- to receive reports from the Audit and Risk Committee, which include the BAF and progress against the delivery of strategic objectives, 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 the requirements of NHS provider licence conditions is reviewed annually and the self-declaration is uploaded onto the website. This can be found on the 'Provider licence tab https://www.hrch.nhs.uk/about-us/trust-board-and-leadership/board-meetings

The board of directors meets in public bi-monthly and a breakdown of attendance for the board's 2020/21 part I meetings is shown below:

Job Title and Name	Attendance
Chairman, Sian Bates	6 of 6
Non-Executive Director, Ginny Colwell	6 of 6
Non-Executive Director, Phil Hall	5 of 6
Non-Executive Director, Joanne Hay	6 of 6
Non-Executive Director, Judith Rutherford	6 of 6
Non-Executive Director, Bindesh Shah	6 of 6
Chief Executive, Patricia Wright (to 29 November 2020)	4 of 4
Interim Chief Executive, David Hawkins (from 30 November 2020)	2 of 2
Director of Finance and Corporate Services, David Hawkins (to 29 November 2020)	4 of 4
Interim Director of Finance, Bridget Welch (from 30 November 2020)	2 of 2
Director of Clinical Services, Stephen Hall (shared vote)	6 of 6
Director of Clinical Services, Anne Stratton (shared vote)	6 of 6
Director and Nursing and Non-Medical Professionals, Donna Lamb (to 31 May 2020)	1 of 1
Director of Nursing and Non-Medical Professionals, Sarah Shingler (1 June 2020)	5 of 5
Director of Strategy and Transformation, Monique Carayol (non-voting) (to 12 March 2021)	5 of 5
Director of Workforce, Alison Heeralall (non-voting)	6 of 6
Medical Director, John Omany	6 of 6
Roz King, Director of Primary Care Networks	2 of 3

At the end of March 2020 the government declared the COVID-19 pandemic. The NHS was under a structure of command and control requiring trusts to suspend certain functions including sub-committees. The trust continued to hold some committees to ensure that the quality and sustainability of the trust was closely monitored. The board has continued to meet during this time with presentation of a COVID-19 report which included, finance papers, the board scorecard, risk management and workforce data.

Audit and Risk Committee

The Audit and Risk Committee is a formal committee of the board and is accountable to the board for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the trust's activities both clinical and non-clinical, that supports the achievement of the trust's objectives. The committee continued to meet in a shortened form throughout the pandemic. It meets at least five meetings per year

Quality Governance Committee

The Quality Governance Committee (QGC) is a formal committee of the board which focuses on ensuring robust structures and processes are in place for governing the quality and clinical services and ensuring services are safe. The committee's role is to provide assurance on clinical quality, including clinical effectiveness, patient safety and patient experience.

It supports the board with an integrated approach to risk, control and governance, monitoring 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. The committee continued to meet in a shortened form throughout the pandemic to ensure the trust's focus on quality was maintained. It meets at least six times per year

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 was stood down at the start of the pandemic. The board received financial performance reports as part of the COVID-19 update. The committee restarted in September 2020. It is scheduled to meet at least four times per year.

Workforce and Education Committee

The Workforce and Education Committee is responsible for providing assurance that there are processes and plans in place to agree and achieve the workforce objectives. The committee oversees the trust's staff engagement and recruitment and retention strategic priorities that enables the trust to compete successfully for recruits in areas where there is a shortage of supply. 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. The committee was stood down at the start of the pandemic and has kept up to date via informal meetings. The monthly COVID-19 update presented to the board included workforce data. The committee restarted in September 2020 and will continue with a light-touch approach. The committee is scheduled to meet four times each year.

Executive Committee

The Executive Committee has delegated responsibility to oversee the effective operational management of the trust. The committee meets monthly to review and continued throughout the pandemic:

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

Nominations and Remuneration Committee

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

Charitable Funds' Committee

The Charitable Funds Committee has been established by the board to make and monitor arrangements for the control and management of the trust's charitable fund. Key duties of the Committee are to apply the charitable funds in accordance with the charity's governing documents. 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 legal and regulatory requirements.

The trust's charitable funds saw an increase in funding with the trust joining NHS Charities Together which was responsible for administering the money raised by Sir Tom.

Richmond Community Healthcare in Partnership Committee (RCHiP)

RCHiP is a joint committee set up with the Richmond GP Alliance (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.

Annual committee effectiveness reviews

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

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 has systems in place to ensure that it collects, analyses and acts on information relating to the legislation on equality and diversity of its workforce and the population it serves. Control measures are in place to ensure that all the organisation's obligations under quality, diversity and human rights legislation are complied with. Equality and diversity is overseen by the trust Equality, Diversity and Inclusion committee chaired by the Director of Workforce with a NED and patient executive lead. Assurance is reported via the trust executive committee.

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.

Carbon reduction

The trust has undertaken risk assessments, and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, based on UK Climate Projections 2018 (UKCP18) to ensure that 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 board of directors and the Finance and Performance Committee of the board
- monthly Executive Performance review meetings where directorates are held to account for financial and non-financial performance

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

Information governance and cyber security

Information governance (IG) 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. This has been a crucial element to support the new ways of working throughout the pandemic.

Due to our rigorous IG framework and data protection by design approach, we have been able to work across our boundaries, sharing key data with relevant and appropriate staff in partner organisations to help combat the virus. For example, the Trust Data Protection Officer has worked closely with IG colleagues, as part of a number of sector wide working groups to ensure that the trust can join the Connecting your Care project. This means that Richmond services have access to relevant and appropriate data from key health and care organisations at point of treatment.

Effective data security guidance has also enabled staff to work remotely using new software and business tools, while ensuring the security of patient data.

Throughout 2020, we still marked ourselves against the NHS Digital's annual Data Security and Protection Toolkit. The toolkit provides a benchmark for the trust against current data protection legislation and related regulations, giving either a pass or fail mark.

We did submit a fully compliant assessment in March 2020, however due to the Covid pandemic, the usual timetable for the toolkit submission was extended from March 2020 to September 2020. Therefore, the 20/21 baseline was submitted at the end of February 2021. The full submission is due at the end of June 2021.

We continue to maintain high standards of information governance through a variety of measures and actions, including:

- continued review of personal data flows to guarantee the trust operates in line with General Data Protection Regulations (GDPR), especially with regards to temporary Covid data processing, ensuring a register all activities is maintained and reviewed
- review of all GDPR rights requests, including the right of access, to ensure requests are answered within the legislated timeframe, to avoid breaching GDPR and incurring large fines from the ICO

- continuing review and revision of the trust privacy notice, giving assurance that the trust is transparent with all data processing, this is of particular importance during the pandemic
- completion of data protection impact assessment for all new research projects, services, systems and applications which involve the use of personal data
- an audit of our compliance against a small sample of standards from the NHS Digital toolkit by our internal audit
- continuing review of policies and staff guidance
- helping colleagues to complete information governance and security e-learning training
- attending team meetings to ensure data protection and security is a key element of all work and staff take responsibility for data in their teams

Annual Quality Account

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

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

Data quality

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

Review of effectiveness

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

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

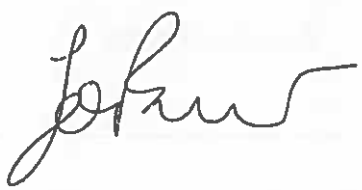
An annual "Head of Internal Audit Opinion" based on the work and audit assessments undertaken during the year for 2020-21 was issued and provided assurance that the organisation has an adequate and effective framework for risk management, governance and internal control.

The Head of Internal Audit's Opinion is achieved through a risk-based plan of work included undertaking specifically requested management reviews with the aim of strengthening current practices - The Integrated Care Systems, providing substantial assurance; and The Board Assurance Framework and Risk Management, Freedom to Speak Up, Financial Governance, Equality and Diversity (draft) and Patient Experience audits all provided reasonable assurance. Controls were found to have been adequality designed and generally well applied to mitigate associated risks to the Trust. Internal audit has provided recommendations to address and strengthen processes in line with current requirements.

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.



Interim Chief Executive Date: 10 June 2021

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 situation of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

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

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

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

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

By order of the trust

10 June 2021....Date — Interim Chief Executive

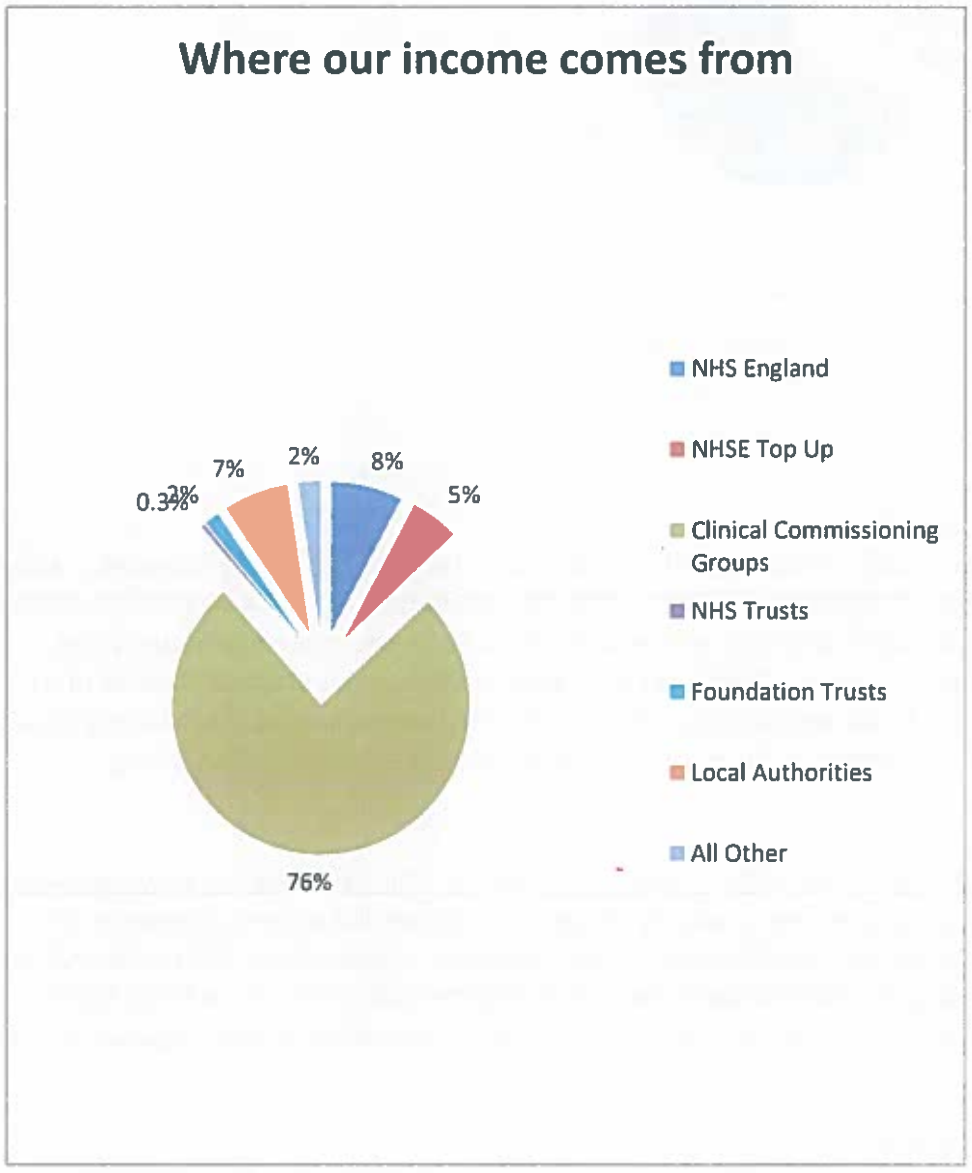
10 June 2021 Date — Finance Director

Financial Balance

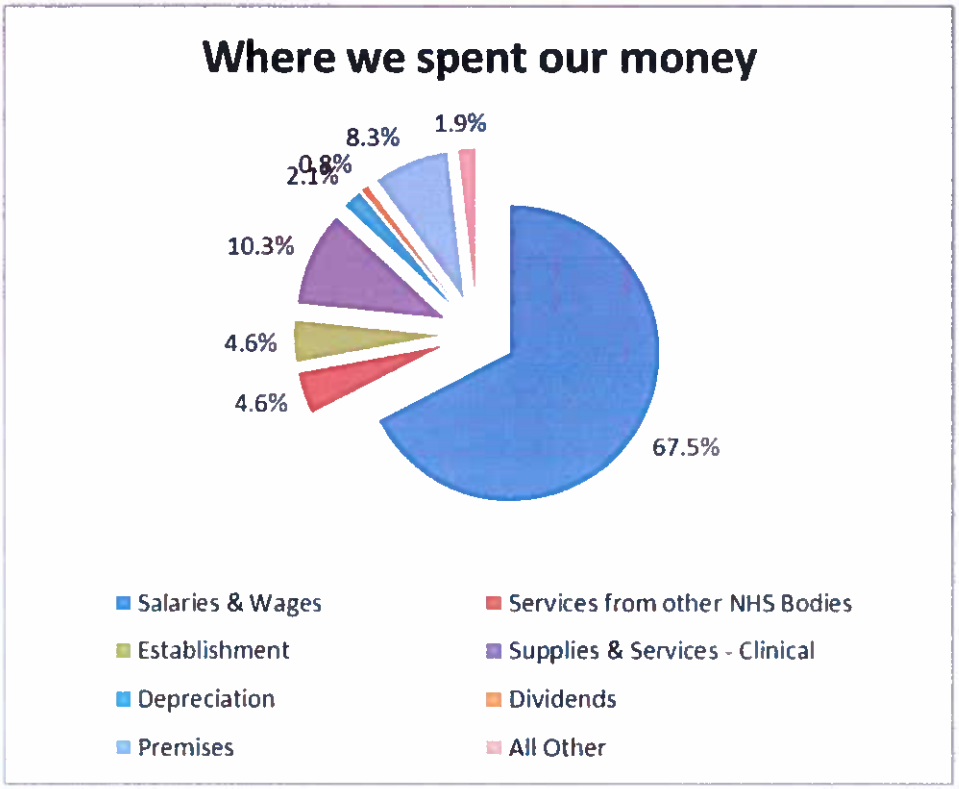
Hounslow and Richmond Community Healthcare NHS trust planned for a control total of £374k surplus early in 2020. However, the introduction of a new financial regime during the COVID 19 pandemic saw this reduced to a breakeven plan in the first six months followed by a £1.3m planned deficit in the final half of 2020-21. The trust delivered a £16k surplus. This was achieved through sound financial planning and control by budget managers despite being faced with several in-year financial pressures and unprecedented local and national challenges.

Total Income for 2020-21 was £85.7m with 76% of this coming from Clinical Commissioning Groups and 13% from NHS England. Hounslow and South West London CCGs were the trust's two main

commissioners. Included in this income is £2m of notional income representing the value of additional pension contributions paid centrally by NHS England. As a consequence of the pandemic, new block contracting arrangements were introduced early in 2020-21, combining all income sources into these payments and therefore limiting transactional activity. A system of top up funding from NHSE to cover most COVID related spend and any other shortfalls ensured that all trusts broke even in the first six months of 2020-21. Local system funding arrangements in the latter half of 2020-21 replaced this top up process



Total Expenditure for 2020-21 was £85.7m and 67.5% 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 decreased slightly by £0.34m to £46.0m due to new investment of £2.2m of capital schemes mainly into buildings and IT. Of this investment, £1.8m was funded from depreciation, the remainder from the Trust's cash balances. There was a revaluation of our land and buildings as at 31 March 2021 which decreased their overall values by £0.35m. Trust creditors and accruals have increased by £7.48m and debtors have decreased by £0.875m. The trust continues to have no borrowing.

Cash-flow

Cash increased by £9.1m in the year due to the increase in creditors. The cash balance may contribute positively towards future including spending on capital projects to improve the patient experience and enhance our technology and systems, However, this will be subject to approval from SW London CCG and future discussions regarding priorities for the local capital departmental expenditure limit (CDEL) allocations.

Better Payment Practice Code

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

Hounslow and Richmond Community Healthcare NHS trust recognises the need in the current economic climate to pay suppliers promptly and has continued to maintain good performance against this code, consistently achieving above the target of 95% throughout most of the year. Despite the pandemic we maintained the target at year end.

	2020-21	2019-20
	Number	Number
Non-NHS Creditors		
Total bills paid in the year	15,713	16,157
Total bills paid within target	15,006	15,034
Percentage of bills paid within target	**95.5%**	**93.0%**
NHS Creditors		
Total bills paid in the year	728	884
Total bills paid within target	714	842
Percentage of bills paid within target	**98.1%**	**95.2%**
Overall		
Total bills paid in the year	16,441	17,041
Total bills paid within target	15,720	15,876
Percentage of bills paid within target	**95.6%**	**93.2%**

The trust has signed up to the Prompt Payments Code.

Auditors

The trust's external auditors for 2020-21 were KPMG. The cost of external audit for work undertaken in 2020-21 was £43,100 excluding VAT. (2019-20 £37,100 excluding VAT). This included a sum of £10,000 plus VAT for a Value for Money audit undertaken

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

Looking forward

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

2.4 Remuneration and staff report

Remuneration report

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

The committee comprises the Chairman and all Non-Executive Directors of the board. The Nominations and Remuneration Committee reviews the salaries of its most senior managers annually. Cost of living awards are in accordance with the guidance issued by NHS England/Improvement (NHSE/I).

Standardised terms and conditions of service apply to the most senior managers, who are employed on contracts of employment. Performance of the most senior managers is assessed formally through an individual performance and development review process. Performance-related payments were made in the remuneration packages in 2020-21.

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.

Remuneration policy

The trust policy is to ensure fairness, equity and consistency is applied in the recruitment of Executive and Non-executive Directors and to make sure that there is sufficient leadership capacity and capability and diversity to deliver the Trust Strategy.

The trust's independent Non-Executive led committee advises the Board on the appropriate remuneration and terms of service for the Executive Directors and any substantive staff on Very Senior Managers terms and conditions.

The Trust keeps under review all aspects of the reward strategy for Executive Directors based on national guidance. Whilst ensuring that Directors are fairly rewarded for their individual contribution to the Trust having proper regard to local circumstances and benchmarking data and performance and to the provisions of any national arrangements for such staff where appropriate.

Starting salaries for Executive Directors are determined by the committee with reference to guidance from NHSE/I, 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/NHSE/I 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.

Contracts

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

Termination liabilities for Executive Directors

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

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

Name	Post Title	Date of Contract	Unexpired Term	Notice Period	Provision for Compensation for Early Termination	Other Termination Liability
Patricia Wright	Chief Executive	1 November 2016[1]	Substantive	3 months	None	See text above
David Hawkins	Director of Finance and Corporate Services	1 April 2011[2]	Substantive	3 months	None	As above
Donna Lamb	Director of Nursing and Non-Medical Professionals	1 February 2018[3]	Substantive	3 months	None	As above
Sarah Shingler	Director of Nursing and Non-Medical Professionals	18 May 2020	Substantive	3 months	None	As above
John Omany	Medical Director	1 May 2018	Substantive	3 months	None	As above
Alison Heeralall	Director of Workforce	25 November 2015[4]	Substantive	3 months	None	As above
Monique Carayol	Director of Transformation	1 October 2016[5]	Substantive	3 months	None	As above
Anne Stratton	Director of Clinical Services	1 October 2016	Substantive	3 months	None	As above
Stephen Hall	Director of Clinical Services	3 January 2017	Substantive	3 months	None	As above

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

Salaries and Allowances Entitlement of Senior Managers

Name	Title	2020-21						2019-20					
		Salary (bands of £5,000)	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5,000)	Long Term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)	Salary (bands of £5,000)	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5,000)	Long Term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)
Patricia Wright*	Chief Executive	105-110	0	0	0	0	105-110	155-160	0	5-10	0	0	165-170
David Hawkins**	Director of Finance and Corporate Services/Interim Chief Executive	125-130	0	0	0	0	125-130	120-125	0	0	0	0	120-125
John Omany	Medical Director	90-95	0	0	0	0	90-95	75-80	0	0	0	0	75-80
Donna Lamb***	Director of Nursing & Non Medical Professionals	15-20	0	0	0	0	15-20	95-100	0	0	0	0	95-100
Sarah Shingler****	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
Alison Heeralall	Director of Workforce	95-100	0	0	0	0	95-100	95-100	0	0	0	0	95-100
Anne Stratton	Director of Clinical Services	105-110	0	0	0	0	105-110	95-100	0	0	0	0	95-100
Stephen Hall	Director of Clinical Services	105-110	0	0	0	0	105-110	95-100	0	0	0	0	95-100
Monique Carayol*****	Director of Transformation	95-100	0	0	0	0	95-100	95-100	0	0	0	0	95-100
Bridget Welch******	Interim Director of Finance and Corporate Services	30-35	0	0	0	0	30-35	n/a	n/a	n/a	n/a	n/a	n/a
Sian Bates	Chairman	25-30	0	0	0	0	25-30	5-10	0	0	0	0	5-10
Judith Rutherford	Non-Executive Director	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Phil Hall	Non-Executive Director	10-15	0	0	0	0	10-15	5-10	0	0	0	0	5-10
Joanne Hay	Non-Executive Director	10-15	0	0	0	0	10-15	5-10	0	0	0	0	5-10
Bindesh Shah	Non-Executive Director	10-15	0	0	0	0	10-15	5-10	0	0	0	0	5-10
Virginia Colwell	Non-Executive Director	10-15	0	0	0	0	10-15	5-10	0	0	0	0	5-10

* Chief Executive left November 2020 ** Interim Chief Executive from December 2020 *** Director left May 2020 **** Director appointed May 2020 ***** Director left March 2021 ******Interim Director from December 2020

10 June 2021

Pension Benefits

Name and Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2021 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2021 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2020	Cash Equivalent Transfer Value at 31 March 2021	Real increase in Cash Equivalent Transfer Value	Real increase in Cash Equivalent Tranfer Value after Deductions	Employer's contribution to stakeholder pension
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Patricia Wright Chief Executive	2.5-5	10-12.5	65-70	200-205	n/a	n/a	n/a	n/a	0
John Omany Medical Director	0-2.5	2.5-5	40-45	125-130	n/a	n/a	n/a	n/a	0
David Hawkins Director Of Finance and Corporate Services	7.5-10	17.5-20	55-60	120-125	870	1078	194	177	0
Donna Lamb Director of Nursing & Non Medical Professionals	0	2.5-5	40-45	125-130	851	925	10	7	0
Anne Stratton Director of Clinical Services	5-7.5	10-12.5	45-50	125-130	907	1058	136	122	0
Stephen Hall Director of Clinical Services	2.5-5	5-7.5	30-35	55-60	393	461	61	47	0
Alison Heeralall Director of Workforce	2.5-5	5.-7.5	45-50	105-110	817	929	99	86	0
Monique Carayol Director of Transformation	0-2.5	0	20-25	35-40	290	322	26	13	0

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

- *Benefits and related CETVs do not allow for a potential future adjustment arising from the McCloud judgment.*
- *CETV values at 31 March 2020 and 31 March 2021 may have been calculated using different methodologies (due to the introduction of GMP indexation also known as GMP equalisation) and this change may have impacted the real increase in CETV figure.*
- *The NHS Pensions Agency do not provide a CETV value for those senior officers who are above the standard age of retirement. Comparative values for 2020-21 and the prior year are therefore not available.*

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 2020-21.

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 2020/21 was £145,000 (2019/20 - £143,907). This was 4.62 times (2019/20 – 4.59 times) the median remuneration of the organisation's workforce of £31,365 (2019/20 - £31,365). In 2020/21, Nil (2019/20 Nil), employees received remuneration in excess of the highest paid director. Remuneration ranged from £19,337 to £130,078 (2019/20 £13,816 to £128,752)

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

Staff Costs

The following table sets out the costs of staff employed either permanently, on the bank or via agency during 2020-21.

			2020-21	2019-20
	Permanent £000	Other £000	Total £000	Total £000
Salaries and wages	39,324	2,539	41,863	38,114
Social security costs	3,839	265	4,104	3,744
Apprenticeship levy	195		195	180
Employer's contributions to NHS pensions	7,278	270	7,548	6,963
Pension cost - other	-	-	-	-
Other post-employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	-	-	-	-
Temporary staff	-	4,113	4,113	4,069
Total gross staff costs	**50,636**	**7,187**	**57,823**	**53,070**
Recoveries in respect of seconded staff				
Total staff costs	**50,636**	**7,187**	**57,823**	**53,070**

Average number of employees (WTE basis)

			2020-21	2019-20
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	9	2	**11**	**11**
Ambulance staff	3	0	**3**	**2**
Administration and estates	122	23	**145**	**133**
Healthcare assistants and other support staff	321	17	**338**	**335**
Nursing, midwifery and health visiting staff	280	41	**321**	**312**
Nursing, midwifery and health visiting learners	6	-	**6**	**6**
Scientific, therapeutic and technical staff	245	32	**277**	**274**
Healthcare science staff	15	0	**15**	**15**
Social care staff	-	-	**-**	**-**
Other	-	-	**-**	**-**
Total average numbers	**1,001**	**115**	**1,116**	**1,088**
Of which:				
Number of employees (WTE) engaged on capital projects	2	-	**2**	**2**

Exit packages

Reporting of compensation schemes - exit packages 2020-21

	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	-	-	-
£10,001 - £25,000	-	-	-
£25,001 - 50,000	1	-	1*
£50,001 - £100,000	1	-	1
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	2	-	2
Total resource cost (£)	£96,000	£0	**£96,000**

*Relates to a historical redundancy payment from 2017/18

Reporting of compensation schemes - exit packages 2019-20

	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	-	-	-
£10,001 - £25,000	-	-	-
£25,001 - 50,000	-	-	-
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type			
Total resource cost (£)	£0	£0	**£0**

Exit packages: other (non-compulsory) departure payments

	2020-21		2019-20	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	-	-	-	-
Of which:	-	-	-	-
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

For all off-payroll engagements as of 31 March 2021 for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2021	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 2020 and 31 March 2021, 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 2020	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 2020 and 31 March 2021

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

SECTION 3 – FINANCIAL STATEMENTS

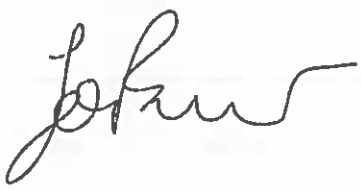
3.1 Accountability Statements

STATEMENT OF THE INTERIM 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 Interim 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, other items of comprehensive income and cash flows for the year.

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



Interim Chief Executive **Date: 10 June 2021**

3.2 FINANCIAL accounts

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

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

Hounslow and Richmond Community Healthcare NHS Trust

Summary Financial Statements 2020-21

Statement of Comprehensive Income for year ended 31 March 2021

	2020-21	2019-20
	£ 000	£ 000
Employee benefits	(57,823)	(53,070)
Other costs	(27,181)	(22,400)
Revenue from patient care activities	79,871	74,341
Other Operating revenue	5,834	3,325
Operating surplus/(deficit)	**701**	**2,196**
Investment revenue	6	159
Surplus/(deficit) for the financial year	**707**	**2,355**
Public dividend capital dividends payable	(691)	(691)
Retained surplus/(deficit) for the year	**16**	**1,664**
Other Comprehensive Income		
Revaluation of Assets	**(358)**	**1,273**
Total comprehensive income for the year	**(342)**	**2,937**

Statement of Financial Position as at 31 March 2021

	2020-21 £ 000	2019-20 £ 000
Non-current assets		
Property, plant and equipment	**28,342**	**28,264**
Trade and other receivables	0	0
Total non-current assets	**28,342**	**28,264**
Current assets		
Trade and other receivables	6,497	8,355
Cash and cash equivalents	33,959	24,460
Total current assets	**40,456**	**32,815**
Total assets	**68,802**	**61,079**
Current liabilities		
Trade and other payables	(20,305)	(13,991)
Provisions	0	0
Other Liabilities	(1,518)	(53)
Total assets less current liabilities	**46,775**	**47,035**
Total non-current liabilities	**(986)**	**(704)**
Total Assets Employed	**45,989**	**46,331**
FINANCED BY		
Retained earnings	34,374	34,358
Revaluation reserve	11,615	11,973
Total Taxpayers' Equity	**45,989**	**46,331**

Interim Chief Executive Date: 10 June 2021

Statement of Changes in Taxpayers' Equity at 31 March 2021

	Retained earnings £000
Changes in taxpayers' equity for 2020-21	
Balance at 1 April 2020	46,331
Retained surplus/(deficit) for the year	16
Revaluation of Assets	(358)
Balance at 31 March 2021	**45,989**

Statement of Cash Flows for the Year Ended 31 March 2021

	2020-21 £ 000	2019-20 £ 000
Cash Flows from Operating Activities		
Operating Surplus/Deficit	**701**	**2,196**
Depreciation and Amortisation	**1,786**	**1,899**
Income recognised in respect of capital donations	**0**	**0**
Impairments and Reversals	**0**	**0**
PDC Dividend Paid	**(691)**	**(757)**
(Increase)/Decrease in Trade and Other Receivables	**875**	**(1,854)**
Increase/(Decrease) in Trade and Other Payables	**8,936**	**2,572**
Provisions Utilised	**0**	**0**
Increase/(Decrease) in Provisions	**282**	**(3)**
Net Cash Inflow/(Outflow) from Operating Activities	**11,889**	**4,053**
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest Received	**6**	**159**
Receipt of cash donations to purchase capital assets	**0**	**0**
(Payments) for Property, Plant and Equipment	**(2,396)**	**(1,624)**
Net Cash Inflow/(Outflow) from Investing Activities	**(2,390)**	**(1,465)**
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**9,499**	**2,588**
CASH FLOWS FROM FINANCING ACTIVITIES	**0**	**0**
Net Cash Inflow/(Outflow) from Financing Activities	**0**	**0**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	**9,499**	**2,588**
Cash and Cash Equivalents (and Bank Overdraft) at beginning of the year	**24,460**	**21,872**
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	**33,959**	**24,460**

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 departmental expenditure limit	The Department of Health (DH) sets a capital departmental expenditure limit (**CDEL**), which covers the capital spend of **NHS** trusts and is used by DH and HM Treasury to monitor and manage capital expenditure within the sector
Capital resource limit (CRL)	An expenditure limit determined by the Department of Health for each NHS organisation limiting the amount that may be expended on capital purchases, as assessed on an accruals basis (i.e. after adjusting for debtors and creditors).
Cost improvement programme	The identification of schemes to reduce expenditure/increase efficiency.
Current assets	Debtors, stocks, cash or similar – i.e. assets that are, or can be converted into, cash within the next twelve months.

Depreciation	The process of charging the cost of an asset over its useful life as opposed to recording its cost as a single entry in the income and expenditure records. Depreciation is an accounting charge (i.e. it does not involve any cash outlay). Accumulated depreciation is the extent to which depreciation has been charged in successive years' income and expenditure accounts since the acquisition of the asset.
Financial reporting standard (FRS)	Issued by the Accounting Standards Board, financial reporting standards govern the accounting treatment and accounting policies adopted by organisations. Generally these standards apply to NHS organisations.
Fixed assets	Land, buildings or equipment that are expected to generate income for a period exceeding one year.
General medical services	Medical services provided by general practitioners (as opposed to dental, ophthalmic and pharmaceutical services provided by other clinical professions).
Governance	Governance (or corporate governance) is the system by which organisations are directed and controlled. It is concerned with how an organisation is run – how it structures itself and how it is led. Governance should underpin all that an organisation does. In the NHS this means it must encompass clinical, financial and organisational aspects.
Healthcare resource group (HRG)	HRGs are the 'currency' used to collate the costs of procedures/diagnoses into common groupings to which tariffs can be applied. HRGs place these procedures and/or diagnoses into bands, which are 'resource homogenous', that is, clinically similar and consuming similar levels of resources.
Indexation	A process of adjusting the value, normally of fixed assets, to account for inflation.
Net book value	The value of items (assets) as recorded in the balance sheet of an organisation. The net book value takes into consideration the replacement cost of an asset and the accumulated depreciation (i.e. the extent to which that asset has been 'consumed' by its use in productive processes).
Overheads	Overhead costs are those costs that contribute to the general running of the organisation but cannot be directly related to an activity or service. For example, the total heating costs of a hospital may be apportioned to individual departments using floor area or cubic capacity.
Payment by results	A financial framework in which providers are paid according to the level of activity undertaken. Payment is based on a national tariff system.

QIPP	Quality, Innovation, Productivity and Prevention: National Department of Health strategy involving all NHS staff, patients, clinicians and the voluntary sector. It aims to improve the quality and delivery of NHS care while reducing costs to make £20bn efficiency savings by 2014-15. These savings will be reinvested to support the front line.
Reference costs	NHS organisations are required to submit a schedule of costs of healthcare resource groups to allow direct comparison of the relative costs of different providers. The results are published each year in the National Schedule of Reference Costs.
Revenue	On-going or recurring costs or funding for the provision of services.
Tangible asset	A sub-classification of fixed assets, to exclude invisible items such as goodwill and brand values. Tangible fixed assets include land, buildings, equipment, and fixtures and fittings.
Variance	The difference between budgeted and actual income and/or expenditure. Variances are an accounting tool used to analyse the cause of over/under spends with a view to proposing rectifying action.
Working capital	Working capital is the money and assets that an organisation can call upon to finance its day-to-day operations (it is the difference between current assets and liabilities and is reported in the balance sheet as net current assets (liabilities). If working capital dips too low, organisations risk running out of cash and may need a working capital loan to smooth out the troughs.