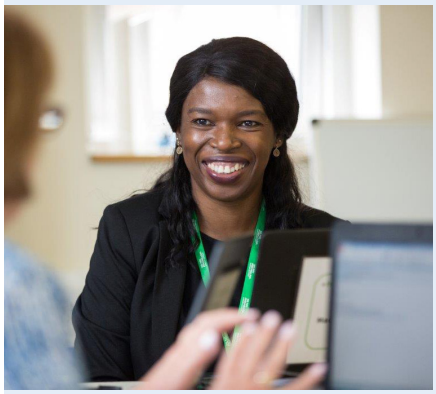
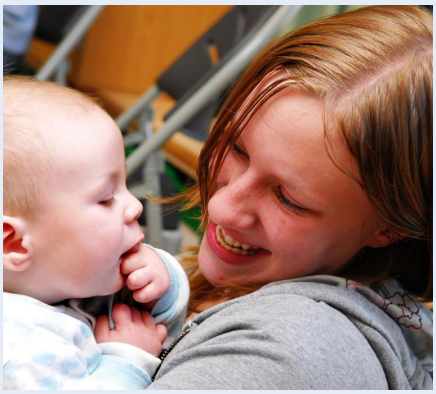
2017/18

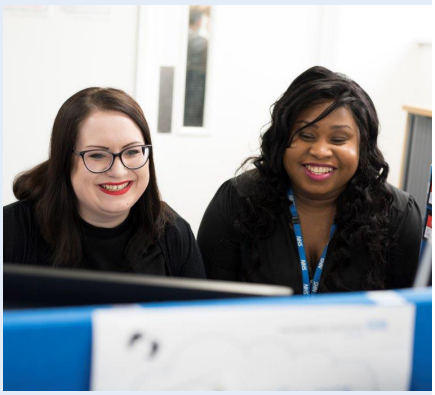
NHS
Hertfordshire Community
NHS Trust

Annual Report & Accounts





Proud to care for you



"We will maintain and improve the health and wellbeing of the people of Hertfordshire and other areas served by the Trust."

About this Report

Our Annual Report follows best practice in corporate governance by reporting our performance against strategic objectives and national targets, and presenting information about our services and financial performance transparently and honestly.

The structure of the report and accounts also follows the requirements of the Companies Act 2006 and consists of a Performance Report, an Accountability Report, Remuneration and Staff Report and the Financial Statements.

Contents

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Foreword by the Chairman

I am pleased to present our Annual Report and Accounts for 2017/18. It has been another busy year for the NHS in Hertfordshire, and we have continued to play a vital and significant role in the local health and social care economy. You can read about many of our achievements in this Report. A few in particular stand out for me as Chair, as I think they reflect not only the quality of our services and the dedication of our staff, but also the variety of ways in which our teams support the wider system in which we operate.

Inclusion is a key part of providing effective healthcare for the whole of our population, in particular finding innovative ways to support marginalised and “hard to reach” communities, some of whom have the poorest health outcomes. Working in partnership with health and social care organisations across the county, we established Gypsy and Traveller Empowerment (GATE) Hertfordshire, an initiative aimed at providing practical steps to help gypsy and traveller communities to take control of their health needs as well as improving other key skills such as numeracy and literacy. You can read more about this initiative on pages 34 and 35. It is a great example of how communities and health/social care professionals can work and plan together to improve outcomes and people’s lives. For me, it is also a key illustration of how our services are truly supporting community healthcare and wellbeing.

We were asked by NHS England to present our unique electronic consent form for school flu vaccinations to a national audience. The system has all but eliminated time-consuming paperwork, saving effort and input for colleagues working in education and making it much easier for our clinical teams to identify children who may require additional support in having the vaccine because of other underlying health needs.

We continued to work with our commissioners and partners to deliver improvements to services for adults in Hertfordshire, in particular people who most need support and intervention to manage their health conditions on a daily basis. By redesigning our core adults service in the Herts Valleys area in partnership with GP leads, we are improving outcomes and increasing efficiency, whilst our central referral hub for Herts Valleys is helping to free up our front line clinical staff so they can spend more time with patients.

We were successful in securing a major contract from Hertfordshire County Council to provide a county-wide public health nursing service for six years, effective from October 2018. We will deliver this service in partnership with three other providers who will run family centre services alongside. This is a major vote of confidence in the quality of our services, our clinical leadership and our ability as an organisation to identify and respond to the needs of our local population. We also retained contracts to provide domiciliary dental services and school-aged immunisation.

Within HCT, we have seen further changes within our Executive team. Whilst changes in our leadership team can bring uncertainty, it is a natural part of the process of running any significantly-sized organisation and it gives other colleagues the opportunity to step into more senior roles, aiding their development whilst bringing fresh perspective. During our Chief Executive David Law’s long term absence, other colleagues are acting up into larger

roles and doing so with great effect at a time when there is ever increasing pressure on our leadership team.

At the same time, we remain in a very strong position going into the future, having achieved all our financial targets with no audit recommendations for the seventh year running, retained our top Single Oversight Framework rating and maintained a positive relationship with the Care Quality Commission.

The year has not been without its challenges of course. Recruiting and retaining high quality staff is a challenge for all healthcare organisations in Hertfordshire as we are within easy commuting distance of London where staff can expect a higher salary in larger organisations. Thankfully, many don't choose this option, and we regularly promote the attractions of Hertfordshire as a place to live and work. However, maintaining rotas and working patterns is a daily challenge for some of our teams, and this continues to be a major focus in the next year.

Retaining staff has been a particular challenge for our Nascot Lawn respite service for children and young people with complex needs. A changing commissioning environment has brought uncertainty for our team and the families we support there, but our staff have worked tirelessly to maintain a safe service whilst we work with our commissioners and partners to transfer families to other services outside HCT.

I also want to pay my own tribute to David Law, who led the organisation so successfully from 2012 until his recent decision to step down in order to recover from a period of ill health. David is well known to many people across Hertfordshire, having worked in the NHS here for over 15 years. David joined HCT at a critical time for the Trust when it was still bedding down following the divestment of community services from the former local primary care trusts. He brought a steady and effective leadership style along with a real passion for community services. He remains universally liked by HCT staff, our patients and stakeholders and deservedly so. His open and congenial manner has helped us to build lasting and effective relationships which underpin much of our continued success. Under David's leadership, we also attained and have sustained a Single Oversight Framework (SOF) rating of One from NHS Improvement – the highest possible rating and one which gives us the maximum autonomy possible over our financial and operational activities – as well as an overall rating by the CQC of "Good".

During David's absence over the past year, Clare Hawkins, our Director of Quality and Governance and Chief Nurse, has acted into the Chief Executive role admirably and with great effect. Clare has built on and extended our relationships with our partners and commissioners, with many commenting on the high regard in which they hold HCT. We know there is more we need to do here – and we will be focusing on closer working with key partners such as our GP colleagues in particular over the next year.

I also have to thank my NED colleagues on the Trust Board. Their dedication and support to both the Trust and to me personally has yet again been exemplary. They hold the executive team to account and demonstrate constructive challenge as "critical friends" in a way which makes our Board truly a "Unitary Board". Through their sincere commitment

and belief in the Trust and indeed the NHS, they also give their time and expertise willingly and to an extent which is well over and above the call of duty. It is a Board of which I am very proud to be the Chair.

I end with a tribute to all our staff. Our teams provide expert care and support in people's own homes and their service is often unseen. They work tirelessly and put the needs of our patients first above all else. The care they provide every day supports people's rehabilitation from illness, injury or surgery. It enables people to continue to live independently in their own homes, to manage long term conditions and to retain their dignity, self-respect and enthusiasm for life. This is about the most important gift any of us can have, and I am incredibly proud to lead an organisation which makes this possible.

Declan O'Farrell
Chair

Performance Report

Overview

The purpose of this section of the Report is to provide a short summary that provides information to understand the Trust, our purpose, the key risks to the achievement of our objectives and how we have performed during the year.

About the Trust

The History of the Trust

The Trust was established on 1st November 2010 by virtue of Statutory Instrument 2010 No. 2464 made under the National Health Service Act 2006. Prior to this it was the "provider services arm" of the then Hertfordshire Primary Care Trust.

The Trust's Principal Activities

Hertfordshire Community NHS Trust (HCT) had an income of £143.3 m during 2017/18 (2016/17 = £148.3m) and employed around 2,800 staff. (2016/17 = approx 3,000).

The Trust is the principal provider of community-based healthcare to the 1.2m residents of Hertfordshire. The Trust provides community-based services for adults and older people, children and young people, and a range of specialist care services. The Trust also provides the healthcare service to the Mount Prison in Bovingdon. We had around 1.7 million contacts with people during the course of the year (2016/17 = 1.9m) and were dealing with people from before birth until death.

The Trust operates its services through two business units and the services they provide and in which areas are set out in the Service Portfolio on pp.8 -9.

The Trust's Vision, Values and Strategic Objectives

The Trust's Vision, Values and Strategic Objectives as follows:

Vision

We will maintain and improve the health and wellbeing of the people of Hertfordshire and other areas served by the Trust.

Values

The vision is underpinned by the Trust's Values, which complement the NHS Constitution, supporting patients' rights and in particular the need to treat patients with dignity and respect:

Care	We put patients at the heart of everything we do.
Respect	We treat people with dignity and respect.
Quality	We strive for excellence and effectiveness at all times.
Confidence	We do what we say we will do.
Improvement	We will improve through continuous learning and innovation.

Strategic Objectives

To support the Vision and Values, HCT has developed five strategic objectives:

1 We will support the people we serve to manage their own health and wellbeing.

2 We will improve clinical outcomes and enhance patient safety.

3 We will support the substantial expansion of community services through the delivery of excellent core services for adults and children.

4 We will use resources efficiently to enhance our ability to improve services.

5 We will develop the organisational capacity to deliver our vision and objectives.

High Value Healthcare and Quality Improvement

As a Trust we are also committed to delivering ‘High Value Healthcare’:

- Excellent clinical outcomes.
- An outstanding patient experience.
- Consistent and improving patient safety.
- Highly efficient and cost-effective services.

These support the quality principles set out by the National Quality Board, as well as encompassing the need to deliver ever more efficient and cost effective services. We use these principles to drive the focus of our staff, frame a single approach to quality and efficiency, and demonstrate the value we deliver.

Service Portfolio

The following is a list of the services provided by the Trust and the locations where they are provided as at 31st March 2018.

Adult Community Services (East & North Hertfordshire)	
Acute Therapies Service	East & North
Bladder & Bowel Care Service	Countywide
Community Neurological, including Early Supported Discharge	Countywide
Foot Health Service (Podiatry)	Countywide
Integrated Community Teams	East & North
HomeFirst (Rapid Response and Virtual Ward)	North Herts, Lower Lea Valley, Welwyn & Hatfield, Stevenage
Rapid Response only	Upper Lea Valley, Stort Valley, Stevenage
Integrated Discharge Team (East & North Herts NHS Trust)	East & North
Hospital Day Service (Cheshunt)	East & North
Intermediate Care Bed-Bases (Community Hospitals)	East & North
Lymphoedema Services	Countywide and West Essex
Minor Injuries Unit	East & North and West Essex
Musculoskeletal Services	Countywide
Pain Management and Chronic Fatigue Service	Countywide
Neurological Bed-Bases	Countywide
Respiratory Service	East & North
Pulmonary Rehab	East & North
Skin Health Services	East & North
Speech & Language Service	Countywide
Tissue Viability and Leg Ulcer Service	Countywide
Navigator Project	East & North
Overnight Service	East & North and Herts Valley
Discharge Home to Assess	North Herts, Stevenage & Welhat
IMC Beds	East & North

Adult Community Services (Herts Valleys)	
Cardiology Services (including Cardiac Rehabilitation and Heart Failure)	Herts Valleys
Diabetes Community Service	Countywide
Diabetic Retinopathy Service	Herts Valleys
Integrated Community Teams	Herts Valleys
Rapid Access Unit (RAU), St Albans	Herts Valleys
Potters Bar Community Hospital Day Services	
Intermediate Care Bed-Bases (Community Hospitals)	Herts Valleys
Nutrition & Dietetics Service	Countywide
Prison Healthcare Services (HMP The Mount)	
End of Life and Specialist Palliative Care	Countywide
Discharge Home to Assess	Herts Valleys

Children And Young People's Services	
Children's Hearing Service (Audiology)	Herts Valleys
Child Health Information Service	Countywide
Children's Eye Services	St Albans & Harpenden, Dacorum
Children's Community Nursing	Herts Valleys and West Essex
Continuing Care Service	Herts Valleys
Community Medical Service	Herts Valleys and West Essex
Dental Services	Countywide
Family Nurse Partnership	Countywide (ceased mid-year)
Health Visiting	Countywide
School Nursing	Countywide
Looked After Children Service	Countywide
Nascot Lawn Respite Care	Countywide
Occupational Therapy Service	Countywide and West Essex
PALMS (Positive Behaviour, Autism, Learning Disability and Mental Health Service)	Countywide
Physiotherapy Service	Countywide and West Essex
Special School Nursing Service	Herts Valleys
Specialist Diabetes Nursing Service	Herts Valleys (ceased mid-year) and West Essex
Specialist Nurse Coordinators (Transition and Sickle Cell)	Countywide
Speech & Language Therapy Service	Countywide and West Essex
Step2 Service	Countywide

The Performance of the Trust in 2017/18 - The Chief Executive's Overview

The performance of Hertfordshire Community NHS Trust (HCT) has remained strong during 2017/18, against the continued challenge of meeting the demand for health care and the pressures this places upon our staff.

The Trust maintains its "Good" CQC rating and remains designated in the highest performing category by the body, NHS Improvement, to which we are accountable; continued to deliver on its quality requirements, achieving excellent performance on the standards set by our commissioners; continued to deliver existing and transformed services to people in our communities; saw improvements for the sixth year running in the annual staff survey and carefully managed our finances so that we delivered the small planned surplus required of NHS Trusts, topped up by central funding at year end.

The last year has seen HCT staff embrace the pace of change and transformation required to meet the challenges of capacity and demand, service redesign, re - commissioning and the delivery of new specifications. This has required agility, innovation, responsiveness and cooperation, alongside effective leadership and high levels of staff engagement. Everyone in HCT has been working extremely hard to sustain our services and to deliver on our commitment to maintain and improving the health and wellbeing of the communities we serve.

The market environment has not necessarily made this easy. Herts Valleys Clinical Commissioning Group's intention to market test and tender Adult Community Services, MSK, Nutrition and Dietetics, along with the requirement for HCT to redesign and meet a new specification for Adult Community Nursing and Therapy Services (previously called the Integrated Community Teams, and now called Community Adult Health Services) has impacted on staff morale and retention rates. A number of our staff were transferred to a new provider of MSK services in the Herts Valleys area and we were sorry to see them leave HCT.

Despite this environment we remain firmly committed to working in partnership and collaborating effectively. We are active partners in the Hertfordshire and west Essex Sustainability and Transformation Partnership, working closely with others to increase our contribution to the health and wellbeing of the wider population. By organising our services around local communities and GPs we are helping to build stronger primary and community services. Identifying and responding to those most in need remains at the heart of our work.

We continued to build a strong collaborative approach with a range of health, social care and third sector partners over the last year. We were delighted to be awarded a number of new contracts including one for Public Health Nursing by Hertfordshire County Council for the next six years. We already provide public health nursing and the new contract is a great opportunity for us to increase service integration and closer working with colleagues in education, Family Support services and other local organisations.

Recruiting, retaining and supporting our workforce remains a key challenge for all health and social care providers. In HCT our participation in a Retention Improvement Collaborative, along with increased management support and a passion from all our staff to provide the best possible services, despite challenges, has seen our recruitment and retention rates improve.

Staff tell us that opportunities for learning and development are highly valued, and we know this has a positive effect on retention rates, good clinical outcomes and operational productivity. Work to ensure we are using the time and skills of our staff to best effect continues. We have upskilled healthcare assistants to undertake a range of treatments previously provided by Registered Nurses. 42% of routine insulin injections are safely administered by healthcare assistants, freeing up senior clinicians to deliver more complex care.

We recognise that supporting people to manage their own care effectively results in better health and reduced demand on our services. We implemented a staff training programme to equip staff to work in partnership with service users to increase confidence in managing their own health and wellbeing. 90% of our staff who provide adult services have completed level one training.

Performance Summary 2017/18

We maintain our CQC rating of “Good” and continue to deliver safe, effective, responsive, caring and well led services. We are preparing for our re-inspection in 2018/19 with enthusiasm and a recognition that there is always an opportunity for improvement.

The main performance highlights throughout the year have been:

- The Trust successfully competed for, and won, a contract commissioned by Hertfordshire County Council to provide public health nursing to children in Hertfordshire for six years, with effect from October 2018. This will be provided in conjunction with identified partners.

- Transforming the way adult community health services (CAHS) are delivered in west Hertfordshire, with a new model of service delivery which brings benefits to patients and GPs.

- Continuing to work closely with East & North Hertfordshire CCG to redesign community frailty services in order to provide an equitable service across each locality in east and north Hertfordshire.

- Successful tenders for the Trust to provide Domiciliary Dental Services and a School Age Immunisation Service across Hertfordshire.

- After a 3 year plan, delivered ahead of target, HCT successfully secured stage 3 (full accreditation) in March 2017 for the UNICEF Baby Friendly Initiative with special recognition as “outstanding” from the UNICEF assessment team.

- The successful transfer of management of Simpson ward, Hemel Hempstead Hospital, from West Hertfordshire Hospital Trust (WHHT) to HCT. The ward is now being used as Pathway 3 in the nationally recognised Discharge to Assess (DTA) model which is assisting WHHT with patient flow from the acute site and we have improved quality outcomes and increased staff engagement.

- The introduction and implementation of a new, comprehensive, Health & Wellbeing Strategy, aligned to that of our commissioners.

- Effective mobilisation from 1st April 2017 of the Hertfordshire, Luton, Bedfordshire and Milton Keynes Child Health Information System. (CHIS)

- Meeting our financial targets and retaining a ranking of 1 (the lowest risk level) under NHS Improvement's "Single Oversight Framework".

- Involvement at all levels and working closely with our health and social care partners to take forward delivery of the Hertfordshire and West Essex Sustainability and Transformation Partnership (STP).

- Supporting our health and social care partners with various initiatives and actions to mitigate the effects of "winter pressures" on the NHS, including the delivery of new "Discharge Home to Assess" models.

- Effective engagement and delivery of initiatives to increase operational productivity as part of the NHS Improvement "Carter Review".

The main performance challenges throughout the year have been:

- Workforce levels remain a challenge in several areas, in particular Watford & Hertsmere CAHS, Specialist Palliative Care, and PALMs.

- Health Visiting and safeguarding workload, mitigated by an effective recruitment approach whereby we are at 96.22% establishment.

- Nascot Lawn Children's Respite– securing staff to deliver a service during a period of uncertainty as to the future of the service.

- The management of patient "flow" and particularly delayed transfers of care (DTOCs).

- The high demand on services for community paediatrics, skin health and community cardiology/heart failure.

- The loss of being the MSK services provider in West Hertfordshire and the transition to a new provider.

None of our achievements or rising to challenges presented could be achieved without the efforts, enthusiasm and commitment of my 3000 colleagues in the Trust. They work extremely hard for the people we serve, doing so with care and compassion.

Our service users tell us how much they appreciate what we do, with around 75 compliments for every complaint we received in 2017/18. (176 complaints and 13,138 compliments). In addition, colleagues will often say that HCT is a very special place to work, with an equal focus on compassion, support and constructive challenge to each other as we go about our daily work.

Partnership & Engagement

Working in Partnership

Building on the transformation programme and delivery of the themes of improving health and wellbeing, care coordination and self-management 2017/2018 was a year which HCT further developed its approach to locality working, delivery of integrated services and contributing to transforming the system to become more resilient and sustainable.

Working in partnership has been a key characteristic throughout the organisation with further aspiration to be realised within 2018/19 and beyond.
Examples of working in partnership have been:

- **Place based care**

  The Trust has led this Sustainability and Transformation Partnership (STP) work stream. In addition, the Trust's Director of Service Development and Partnerships has chaired the system East and North Hertfordshire Delivery Board, delivering a system-wide development event to initiate place based care leadership in localities.

  Following this, examples of HCT leaders' contributions to locality service improvements are:

  - Transformation mangers and all ten Locality managers have actively contributed to locality projects to deliver service and patient experience improvements.

  - Extensive engagement with the community and voluntary sector organisations within Stort Valley locality, enhancing the breadth of service offered within the locality.

  - Leading a multi-agency falls prevention campaign project within Hertsmere locality.

  - Leading a multi-agency project involving primary care, acute care, social care, mental health and hospice care alongside HCT services to reduce admissions to hospital for people with COPD, delivering a 16% reduction in admissions in Stevenage locality.

  - Also in Stevenage Locality, leading work to reduce admissions to hospital for clients with catheters and clients who had recurrent urinary tract infections. This has shown a 33% reduction in admissions to hospital.

- **Managing winter pressures**

  Adult community and bed based services supported the system with managing the demand pressures over winter: opening additional bed capacity,

flexibly delivering some social personal care for clients in their own homes to support their discharge from hospital and rapid mobilisation of discharge to assess in partnership with social care. We also took over managing and delivering care on Simpson ward based at Hemel Hospital from West Herts Hospital Trust, for those clients requiring on going complex care enabling the hospital teams to focus on those that require acute care.

- **Developing skills to support change**

  In partnership with Hertfordshire Partnership University NHS Foundation Trust (HPFT) we coordinated 40 clinicians across the system from community services, mental health services, primary care, social care and hospices to attend a 5 days NHSI QSIR (Quality Service Improvement, Redesign) training programme that trained in the skills of innovation and change management. The Trust's Transformation Programme Manager went on to be trained as a trainer of the programme and has commenced offering training to more leaders.

- **Redesigning services**

  In Herts valley the diabetes services previously delivered by separately commissioned agencies was redesigned in partnership with a consultant, the acute diabetes team from West Herts Hospital Trust, Hertfordshire Partnership University NHS Foundation Trust IAPT services (Improving Access to Psychological Therapies), and the HCT community diabetes, podiatry and nutrition and dietetic services, to deliver a single integrated diabetes service.

- **Working in partnership with primary care**

  During this year Hertsmere locality worked with Herts Health GP federation in Hertsmere to agree a Transformation collaborative agreement – this saw the piloting of a GP clinical leadership role and a GP service transformation role to work alongside the Trust's locality managers in improving the relationships across our services and the improvement of the service offer. In particular this included a co-designed complex case management model to improve avoidance of admissions to hospital.

- **Working in partnership with West Hertfordshire Hospital Trust**

  We have established a system with our hospital colleagues where data for A&E attendances is uploaded into our Child Health Information System to ensure that children with high rates of attendance can be automatically identified and followed up by Health Visitors/school nurses to provide relevant support and advice.

- **Partnership with children's centres**

  We have established a pilot of group reviews for 2/12 year old development reviews with Health Visitors and Children's centre staff. This was shortlisted

for a Nursing times awards and is now being rolled out and extended to the 1 year developmental review as part of the new Family Centre Services model.

- **Partnership with schools**

  Since September 2017, our Speech and Language Service have been leading on an integrated partnership approach to supporting children and young people with social communication difficulties across Hertfordshire. This SCERTS episode of care approach is delivered by Autistic Spectrum Disorder Link Speech and Language Therapists working in community teams across early years settings, mainstream schools and special schools within Hertfordshire. Educational psychologists and advisory teachers from the Communication and Autism Team are also involved in these episodes of care.

- **Working across the system**

  Our children's Sickle cell nursing service works in partnership across the system including in Acute Trusts and with GPs to coordinate care and share specialist advice and support and schools and nurseries to offer training to staff and put in place a Health Care Plan in their education setting.

Engagement with Stakeholders

The Trust takes a proactive approach to engaging patients, carers, members of the public and other stakeholders in how services are planned, delivered and evaluated. HCT believes that only by involving the people that we serve will we truly be able to provide responsive, high quality services that reflect the needs of the people who use them.

- **Involving the local community and service users in the development of new provision**

  Two public open events have been held in Harpenden. Residents were invited to hear more about the plans for the new health and wellbeing centre on the site of the Harpenden Memorial Hospital and to provide their feedback. HCT are working in partnership with the Harpenden society and the town council to jointly deliver effective communications and engagement for the local community.

  During the year leading up to the opening of the Marlowes Health and Wellbeing Centre, bi-monthly focus groups were held as well as a stall in the town centre. This provided the opportunity to give information, gain feedback and respond to questions. Importantly it also focused on how HPFT and HCT will work together to meet the needs of people with physical and mental health needs.

- **Engaging with Carers**

  The Carers Leads from HCT, East and North Herts Trust, West Herts Hospital Trust, Hertfordshire Partnership Foundation Trust together with Carers in

Herts have been working in partnership to engage with Carers. This has involved focus groups to explore what matters most in relation to transition between acute and community care and on-going work is addressing this issue. In addition, Carers and the different NHS provider organisations across the Sustainable Transformation Partnership (STP) footprint, have coproduced an information booklet for carers.

- **Trust Membership**

  Trust membership has been promoted at every opportunity and over sixty new members have joined this year. A membership survey indicated interest in a variety of volunteering activities within the Trust such as involvement in quality assurance visits which will be taken forward during 2018.

- **Engaging with Children and young people**

  Engagement activity with children and young people's services has included several focus groups with parents whose children access Physiotherapy, Occupational Therapy, Speech and Language Therapy, Health Visiting and School Nursing services. A result from this engagement has been the development of a Patient Centred outcome measurement tool for use in the Health visiting and School Nursing Service. Young people have been engaged in focus groups to understand how they access health information and to promote the Health for Teens website to their peers.

- **NHS England (NHSE) Always Events**

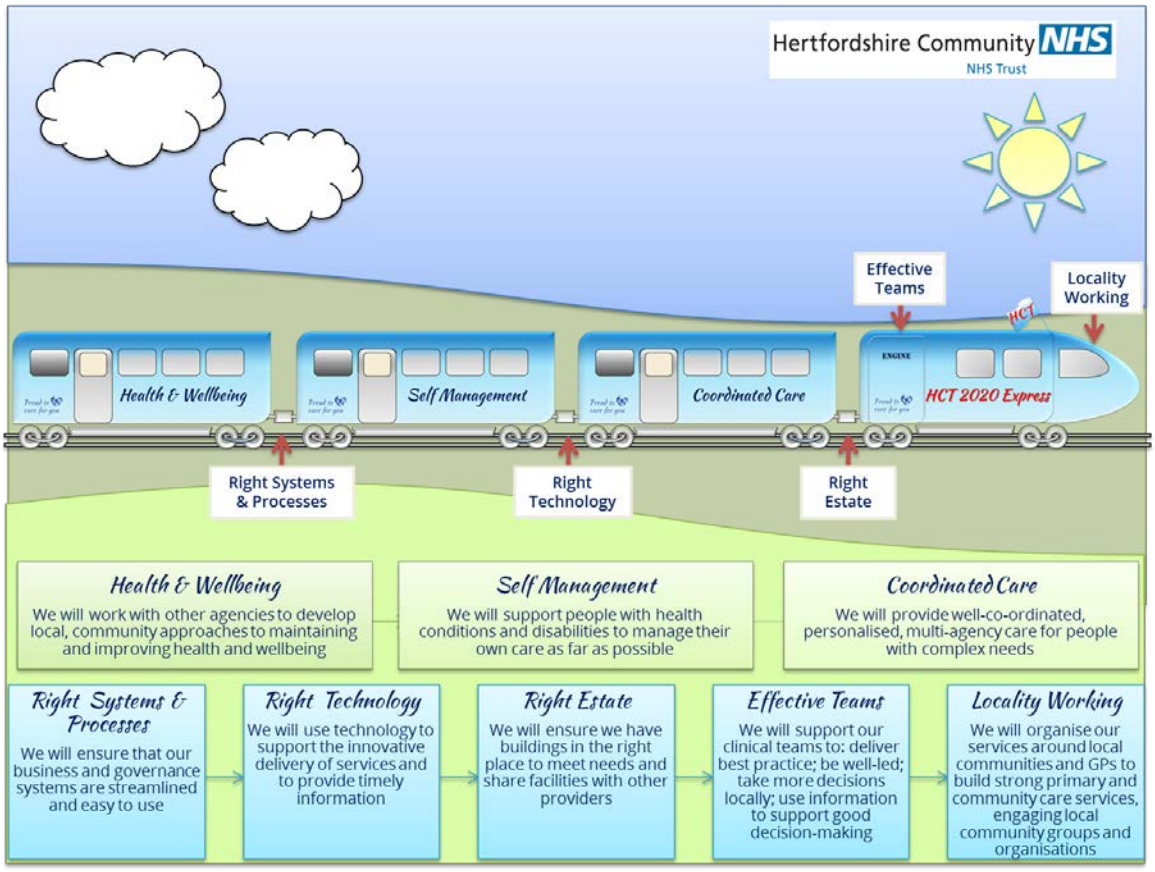
  The NHSE Always Events framework has been adopted in the Trust to support coproduction with service users. This is currently focusing on improved communication with carers at the point of transition from the acute to community setting and carer and patient awareness of their named key worker in end of life care.

- **Promoting the importance of engagement**

  Training sessions have been delivered to managers to promote the importance and value of engagement with service users and to ensure staff are aware of the resources available to support them with this.

Strategy & Developments

Our strategy remains as before, illustrated below. It is geared towards improving the health and wellbeing of people in Hertfordshire and delivering on the national commitments to move our attention more to the maintenance of good health, so that people live better lives and we reduce demand for the NHS as a consequence.



Co-ordinated Care: We continue to work closely with other organisations, through the Sustainability and Transformation Partnership, to co-ordinate care for people with a higher level of need. We have adopted a principle of creating health and social care teams, working closely with GPs, for populations of around 50,000. People with a broad range of needs require continuity of care and we have worked with GPs, mental health and social services to develop that co-ordination. The benefits for the people who need our services are obvious when you hear the stories of improvement in their experience of the services and their own health. This work of identifying and responding to those most in need remains at the heart of our work.

Self-Management: Another element of our strategy is to support people to manage their own care effectively themselves, particularly those with long term conditions, whose needs account for around 70% of health care time and money. The two powerful reasons for this focus are that people have better health when they can and do take on greater responsibility. The other reason is to reduce demand on our services so that we can sustain the NHS.

To support this focus, a staff training programme has been developed which is equipping staff to work in partnership with service users to build their confidence in managing their own health and wellbeing. So far 90% of our staff who provide services to adults have completed a programme of e-learning (level one training). In addition, 56% of relevant staff have completed the half–day level two training which is being rolled out to nurses and therapists in adults' specialist services and community teams. Finally health coaching (level three training) continues to be delivered to key staff and 92% of specialist nurses and allied health professionals have completed this.

Health and Wellbeing: The third element of our strategy is to maintain and improve the broader population's health and wellbeing.

Our services for children have a strong focus on maintaining health and giving children a good start in life. They do this very successfully and we are therefore delighted that in March 2018 Hertfordshire County Council awarded HCT the contract to provide public health nursing in Hertfordshire for the next six years. We already provide public health nursing (health visiting and school nursing) in Hertfordshire and the new contract is a great opportunity for us to work even more closely with our colleagues in education, family support services and other local organisations. We will be working to deliver great outcomes for all children and young people based on the County Council's six key outcomes – be happy, be resilient, be independent, be ambitious, be safe and be healthy. Ultimately, our aim is to enable all children to become healthy, resilient adults who are able to contribute to their community.

We also want to increase our contribution to the health and wellbeing of the wider population through working with local authorities, voluntary and statutory bodies and community organisations to promote activity, community support and healthy lifestyles.

Supporting areas of our strategy

We have also taken forward actions in the supporting areas of our strategy:

Effective Teams: We retain a strong focus on teams and their leadership and have been working with our community nursing and therapy teams to ensure we are using their time and skills to best effect. Examples of this work include upskilling healthcare assistants to undertake compression bandaging and insulin and anticoagulant administration. 42% of routine insulin injections are now delivered by healthcare assistants, freeing up senior clinicians to deliver more complex care.

Locality Working: We continue to organise our services around local communities and GPs to build strong primary and community services, engaging local community groups and organisations. Localities have identified their priorities and HCT is working with other organisations to address these. For example, in Hertsmere HCT has been working in partnership with local GPs in an enhanced case management service. HCT's Community Matrons and GPs have

been meeting twice a week to collectively care for patients in the community. Interventions have included enhancing patient independence and self-care, optimising medication, preventing falls, addressing loneliness and social isolation, providing prompt response to urgent problems and focusing on prevention to reduce the chances of future hospital admission. The service showcases the benefits of collaborative working - not only through enhancing relationships between healthcare professionals but also through the difference we can make to patient care through a shared lens.

Right Estate: There is an extensive development programme for our estate, which over the next few years will make a big difference to the experience of our service users. These changes will ensure that we have buildings in the right place to meet service users' needs and we will share facilities with other providers to deliver a more joined up approach to healthcare for local people. This programme has seen us move out of buildings which were not meeting needs and into community hubs, including most recently the new state-of-the-art Marlowes Health and Wellbeing Centre in the heart of Hemel Hempstead. This newly refurbished building is home to community health services for adults and children provided by HCT, along with a range of mental health services provided by Hertfordshire Partnership Foundation Trust (HPFT).

Right Technology: We continue to have a strong technology base with extensive use of mobile working and a drive for exploring how we can use technology to improve services. We have now rolled out our electronic patient record system to all services; most recently to our community hospital wards in Hemel Hempstead. This year we also introduced the country's first electronic consent form for delivering the school-age flu vaccination. Our school nursing teams work with schools and families to deliver the flu vaccination for local children every year and a vital part of the process is securing consent from parents and carers. In the past, this has been a cumbersome, paper-based process but this year the easy to complete electronic form improved the experience of parents, schools and our teams and helped us deliver the flu vaccine to more children than ever before.

Right systems and processes: We are committed to ensuring that our business and governance systems are streamlined and easy to use. An important element of this is our Customer Service Transformation (CST) programme which is re-designing our administrative services in order to provide excellent customer service to service users and referrers. The first stage of this work has been delivered with the establishment of the Community Adult Health Service Referral Hub and the approach will be extended to other services over the next year. We have also made improvements to internal processes to make them more efficient and cost effective and to improve staff experience. These changes include a streamlined recruitment process and a new financial ledger and e-procurement system.

Key Strategic Risks and Uncertainties

Risks to the achievement of the Trust's strategic objectives are identified by the Executive Team and entered on the Trust's Board Assurance Framework (BAF).

The BAF is submitted for review and discussion by the Audit Committee and the Trust Board. Risks or implications are also considered by the Healthcare Governance Committee and Strategy and Resources Committee.

Risks identified at Business Unit Level are entered on Business Unit Risk Registers. Risks scoring 15 or over, are then recorded on a "High Level Risk Register" (HLRR).

The HLRR is considered monthly by the Executive Team and is submitted to the Healthcare Governance Committee, Audit Committee and the Board meeting in public.

Risks on the HLRR are linked to the BAF and those that are considered by the Executive Team to have a strategic impact are escalated to the Board Assurance Framework.

A summary of the strategic risks on the BAF as at 31st March 2018 were as below.

Rank	Summary Description	*Overall Risk Score*
1	**National and local system-generated pressures.** *The Trust's ability to achieve its strategic objectives and / or maintenance of the quality and safety of healthcare services provided to the population served may be significantly impacted upon by organisational unsustainability, transition, change to the structure of the Trust's business or organisational form arising from a current environment of (i) national / local financial and demand pressures (ii) possible loss of current business (iii) known / possible commissioning intentions and (iv) (Longer term), system development of ICS / ICO.*	18 (6+6+6)
2	**Workforce** *Workforce resources are (1) insufficient to meet demands and (2) in need of re-modelling roles, to avoid impacting adversely on (i) capacity to maintain / expand services (ii) the health, wellbeing and morale of staff (iii) staff retention; thereby resulting in a significant challenge to (a) the retention / recruitment of staff in specific areas/specialties and (b) providing safe, affordable and effective services which are "fit for purpose"*	16 (6+6+4)
3	**Fundamental Standards and Regulatory Compliance**	12

	Not meeting CQC Fundamental Standards or other regulatory compliance may result in regulatory action or failure to maintain a CQC rating of "good" (or above) thereby having an adverse impact on (i) improving patient care (ii) reputation with stakeholders and (iii) strength in the competitive market.	(4+2+6)
4	**Not being able to evidence improved outcomes** *Not being able to adequately evidence improved patient health and wellbeing outcomes from HCT interventions leads to not being able to measure success or otherwise against the strategic objective and may result in (i) questions as to clinical effectiveness and value (ii) vulnerability for meeting outcomes-based contracts and (iii) inability to compete competitively for new business / retaining current business.*	10 (2+ 4+4)
5	**Reliance on other orgs/ agencies for integrated service delivery (including partnerships).** *Differences in organisational expectations, priorities, perceptions or governance lead to barriers to integrated, collaborative or partnership working resulting in inability to achieve the strategic objective of developing patient self-managed care (and other healthcare efficiency initiatives or successful tender bids).*	9 (2+3+4)
6	**Underdeveloped / ineffective use of technology and Cyber Security Risks.** *Underdeveloped / ineffective / insecure technology will result in having antiquated (or vulnerable) technical systems and /or working practices thereby (i) hindering delivery of modern, effective healthcare and (ii) presenting barriers to (a) efficiency or (b) operational viability / vulnerability or (c) market competitive advantages.*	9 (2+4+3)

The overall risk score is calculated as the sum of ratings for current status, current likelihood and current impact (maximum score of 6 for each rating).

“Even the smallest act of caring for another person is like a drop of water – it will make ripples throughout the entire pond.” (Jessy & Bryan Matteo)

Performance Analysis

Measuring and Monitoring Performance

Measuring Performance

Metrics for the measurement of performance may be set nationally, contractually agreed locally with commissioners or devised internally by the Trust as a self-imposed means of delivering and monitoring constant improvements.

In addition to producing regular, scheduled performance reports, the Trust's Performance and Information Team also produce ad hoc performance reports on request for managers. 2017/18 has seen the continued development of our "Business Intelligence Portal", whereby managers can access useful data.

2017/18 saw the launch of Tableau Visual reporting. This provides an interactive approach for the end user, enabling filtering within active reports with information represented much more graphically.

Through Tableau, HCT will produce state of the art reporting with greater emphasis on visualisations which will allow enhanced analysis of data. This will include geographical mapping and inter-related graphs and charts, allowing increased focus on specific areas. This will allow the Trust to manage and present its information more effectively to internal and external shareholders.

2017/18 will see a relaxing of certain national standards as the NHS struggles to manage demand on its services. The Trust currently has no plans to lower performance standards.

Monitoring Performance

Internally

The Trust has a number of means of monitoring performance internally. These are:

- A comprehensive Integrated Business Performance Report (IBPR), which covers performance over all aspects of the Trust's activities, is compiled monthly and reported to the Executive Team, Strategy and Resources Committee (SRC) and the Board

- Business Unit Performance Review sessions are held monthly for the two front line service business units (Adults and Children's and Young Peoples' services). A report on outcomes is submitted to the Executive Team, Strategy & Resources Committee (SRC) and Healthcare Governance Committee (HGC)

- Board Committee Chairs submit a "Committee Chair's Assurance Report" to the Trust Board after each committee meeting. Chairs of Groups which

report to the Executive Team also submit similar assurance reports

- Any areas of particular performance concern are identified by the Executive Team as “hot topics” and reports are submitted to Executive Team meetings at an agreed frequency (e.g. fortnightly, monthly, etc.). These reports remain programmed until concerns are addressed to the Executive Team’s satisfaction

- In addition to the IBPR, there are area specific reports to Board Committees and the Board e.g. a monthly finance report and a number of quality-related reports , including a quarterly quality report

- All executive directors address performance-related headlines (positive or adverse performance) in their individual director’s reports which go to each meeting of the Trust Board.

There is also a Board escalation process, whereby exception reports on any significant issues (performance-related or otherwise), can be reported directly to the Board between Board or committee meetings.

Externally

The Trust’s performance is monitored by NHS Improvement (NHSI), under their “Single Oversight Framework” (SOF), which was introduced in October 2016 and which replaced the Trust Development Authority’s (TDA) Accountability Framework.

The SOF is aimed at helping Trusts to achieve or maintain a rating of “Outstanding” or “Good” from the Care Quality Commission (CQC) and Trusts are assessed over five themes:

• Quality of Care
• Finance and Use of Resources
• Operational Performance
• Strategic Change
• Leadership and Improvement Capability (Well-Led)

Based on assessment of information collected, providers are “segmented” into one of four groups based on the degree of support or intervention required from NHSI. Since its introduction, the Trust has been in Segment 1. This is the lowest risk segment and is defined as “Providers with Maximum Autonomy”. This means that no support needs have been identified by NHSI. “Universal Support” is offered, but there is no requirement for targeted or mandated support.

As part of the Framework, the Trust has also had a financial rating score of 1,which is indicative of good financial sustainability, efficiency and controls. The Trust also has aspects of performance monitored by others, including commissioners (under contract monitoring), regulatory bodies such as the Care Quality Commission (CQC) and the local, County Council led Health Scrutiny Committee.

Quality Performance

Detailed information and analysis on the Trust's performance and objectives in relation to the quality and safety of our services is contained in our Quality Account for 2017/18. This is available on the NHS Choices website at *https://www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=3381* and also the Trust's own website at *http://www.hct.nhs.uk/about-us/our-publications/*

The Trust has continued to build a strong framework for ensuring the quality of our services over the last year and we define quality as being:

- Excellent clinical outcomes
- An outstanding patient experience
- Consistent and improving patient safety.

Quality performance and initiatives are driven and assessed by a number of sources, including:

Internally

- The Trust's Care Quality Commission (CQC) Quality Improvement Plan, Risk Management and Health & Wellbeing strategy (and policies).
- Publication of an annual Quality Account.
- Reports on all aspects of quality improvement and performance submitted to the Trust's Healthcare Governance Committee and Trust Board (including incidents, serious incidents and complaints).
- Escalation and management of patient care concern.
- Identification and management of quality-related risks.
- Quality assurance visits, internal peer reviews, risk reviews and "Deep Dives" of clinical services.
- The performance monitoring of the quality of services delivered as part of Business Unit Performance Reviews.
- The Quality Governance, Well Led Framework and Memorandum.
- Internal audit informed by BAF risk and clinical audits informed by national & professional standards.
- Staff appraisal, Continuing Professional Development, mandatory training and supervision.
- Use of the responses to patient surveys / questionnaires, including the national "Friends and Family" test.
- Review of the Trust performance against the national Safety Thermometer.
- Staff survey outcomes – national and our PULSE survey.
- Patient Led Assessment of the Care Environment (PLACE) assessment.
- Mortality Review Group investigates all deaths occurring in our community hospitals and has recently commenced investigation of deaths occurring in the

community where our staff are delivering care.

- Setting our own Quality Priorities supporting local population health and well-being.
- Professional Clinical Leaders Group.

By Commissioners and Other Statutory / Regulatory Bodies

- Quality key performance indicators agreed in our contracts with commissioners (Plus monitoring through regular meetings and quality assurance visits by the commissioners).
- Commissioning for Quality and Innovation (CQUIN) schemes agreed with commissioners.
- Monitoring of key national targets by NHS Information and NHS Digital.
- Joint local area Special Educational Needs (SEND) inspection carried out by Ofsted and CQC (Children's Services).
- Liaison and review of complaints and improvements with CQC liaison lead.
- The information governance toolkit supports the management and reporting to the ICO office. Annual Information governance self-assessment, with level 2 achievement.
- Health and Justice Clinical Quality Visit to HMP The Mount Healthcare Service.
- Risk management through the National Reporting & Learning System (NRLS).
- Accounting to the Local Authority's Health Scrutiny Committee.
- NHS England national screening programme quality assurance visits.
- Attendance by representative from Healthwatch Hertfordshire at Board and Healthcare Governance Committee and Patient Safety and Experience subgroup meeting.
- Section 11 audit of Safeguarding Children services and annual review to provide assurance of compliance with Safeguarding Adults best practice carried out by commissioners.

National Initiatives, Reports, Guidance and Legality

- External, national initiatives such as the national Nursing Framework "Leading Change, Adding Value", NHS England's "Allied Health Professions into Action", and the national "NHSi Nurse retention Programme".
- The NHS Outcomes Framework.
- National Institute for Health and Care Excellence (NICE) guidance and standards.
- WHO surgical checklist re audit.
- "A review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged" (Public Health Service Ombudsman 2017).
- Public Sector Equality Duty (PSED) and the national NHS Workforce Race Equality Standard (WRES).
- New legislation, regulations or court judgements.

- Specialist or themed reports reviewed and local initiatives aligned including :

  Promoting professionalism, reforming regulation report, National Apprenticeship scheme, Facing the Facts, shaping the future, National Audit of Intermediate Care, National Diabetes Audit, CQC State of Care, Better Care in my Hands.

Care Quality Commission (CQC)

The CQC carried out a focused inspection to HCT in April 2016 and the final report was published in October 2016, confirming an overall rating of “Good”.

This focused inspection formally reviewed the majority of areas reported as requiring improvement in the previous inspection, carried out in February 2015. All previous issues of safety in the areas visited had been resolved.

However, there was recognition that, due to the timing of the focused inspection, there was limited evidence to demonstrate improvements in end of life care, thus this element continued to require improvement. A formal action plan was developed to improve safety in areas not visited by the focused inspection and also the end of life care of our patients.

The Trust awaits a further inspection in 2018/19.

The Operational Performance of the Trust

Activity

Patient Activity Figures	2015/16	2016/17	2017/18	
Total face to face contacts	1,747,697	1,707.202	1,598,304	↓
Total non-face to face contacts	153,364	167,103	180,584	↑
Total contacts	1,907,061	1,874,305	1,747,845	↓
Total referrals received	412,338	417,511	391,724	↓
Occupied bed days	70,423	67,512	66,174	↓
Minor injuries attendances	9,544	10,439	10,839	↑
Total Admissions	2,402	2,180	2,193	↑

National / Regional Performance Targets

National targets and KPIs have been met in 2017/18, including:

- 95.9% Patient waiting within 18 weeks (including Consultant & Non-consultant led services)
- Minor Injuries four hour access – 99.8% achievement
- National Child Measurement programme (NCMP)
- Human Papilloma Virus (HPV)

Performance against indicators set with the NHS improvement and Clinical Commissioning Groups have been within target levels.

These include:

- MRSA cases – Zero cases reported for the year (for sixth consecutive year)
- 1 C.diff confirmed case reported against the threshold of 6 for the year. (2 other cases are undergoing investigation and appeal, thus the maximum number of cases the trust could incur for the year is 3)
- HCT has had zero mixed sex accommodation breaches
- Achieving length of stay targets for stroke patients at 35 days (YTD position) compared to a target of 42 days and an improvement of 4 days on last year
- Venous Thromboembolism assessments completed for 100% of admitted patients
- Both Retinal screening targets of Offered and Screened were missed by 1% in 2017/18

The Trust continues to perform strongly in 2017/18. In particular, HCT achieved all but one of the regional/ national indicators and National child health measurement programme KPIs. 99.8% of patients that attended our minor injuries unit were seen within the national standard of 4 hours. HCT achieved 95.9% for our Referral to Treatment (RTT) indicator for consultant led services. Only Retinal screening targets were down for the first time and the targets were missed respectively for both offer and screening measures by 1%. HCT also performed strongly within the NHSI and local CCG targets and in particular the Trust's Stroke pathway average length of stay was improved further this year to 35 days against the national target of 42 days,

The following table sets out performance against our main targets. Further information on performance against quality standards is included in the Quality Account.

Key Performance Indicators	2017/18 Targets/Thresholds	2017/18 Performance
Indicator		
Minor injuries patients seen < 4 hours	95%	99.8%
Mixed sex accommodation breaches	0	0
Avoidable MRSA Bacteraemia	0	0
C. difficile infections	6	1*
Venous thromboembolism assessments	100%	100%
Retinal screening - % of diabetic cohort that has been offered an annual screen	100%	99%
Retinal screening - % of diabetic cohort that has been screened in 2014/2015	80%	79%
Patient waiting within 18 weeks (including Consultant & Non-consultant led services)	95%	95.9%
Human Papilloma Virus (HPV)	Dose1 80%	83%
NHS delayed transfer of care	5%	10.5%
School Nursing - % of children who have had height and weight monitored in reception and year 6	90%	95.1%
% of children in reception year who have received vision and audiology screening (subject to school participation)	90%	98.8%
Stroke Patients Average Length of Stay (ALOS)	42 days	35 days
CQC Registration	Registered no conditions	Good

*Two further C.Diff cases are currently undergoing further investigation and appeal.

Financial Performance

This section is a summary and overview only and further details of the Trust's financial position for the financial year 2017/18 can be seen in the financial statements and notes to the accounts in section of this Report.

Financial Reporting

The Trust reports under the National Health Service Act 2006 c. 41 Schedule 15: Preparation of annual accounts.

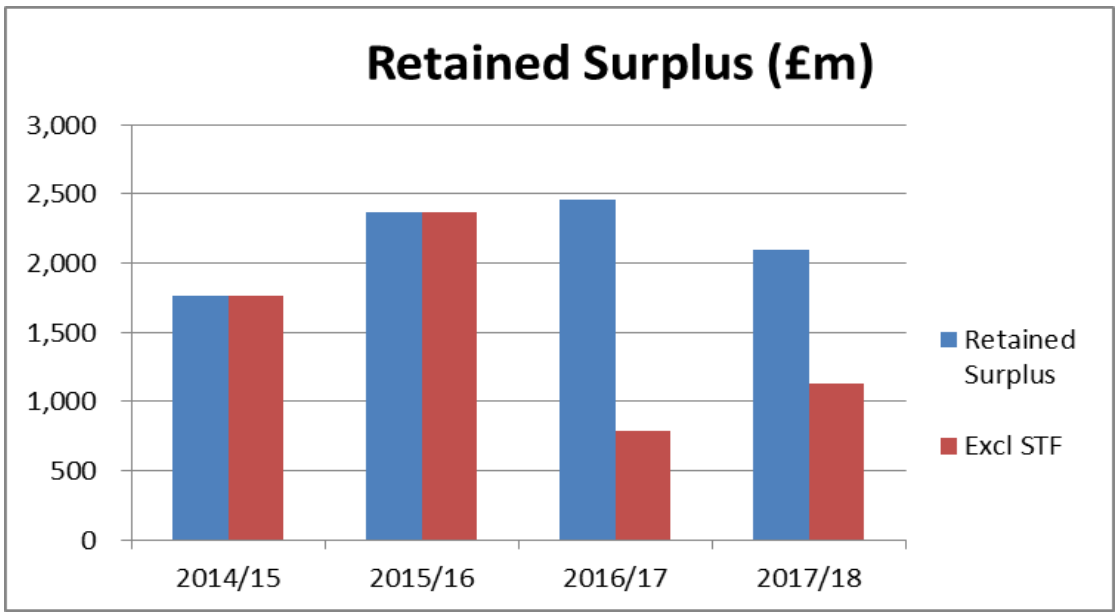
Sources of Finance

The Trusts funding comes from contracts with commissioners, to provide health services. Funding remains on a block basis for the majority of its services, i.e. the Trust is paid a fixed sum of money to deliver a range of services, with an agreed level of activity.

Summary of Financial Performance

The Trust is reporting a retained surplus for the current year of £2.093m which is £346K ahead of plan.

The surplus generated is a combination of the Trust delivering a surplus of £1.135m from continuing operations and £2.215m central funding received from NHS England relating to the Sustainability and Transformation Fund (STF) for achieving and over performing our agreed control total. The total retained surplus of £3.350m was adjusted for the £1.206m deficit on transfer by absorption of Parkway Health Clinic property to NHS Property Services.



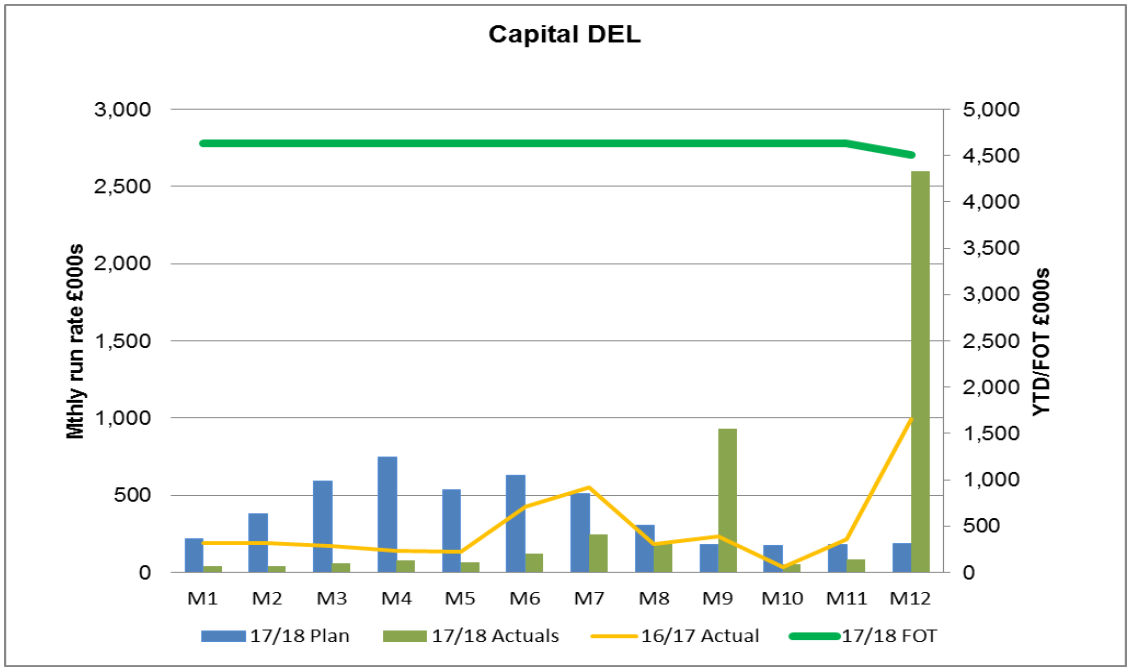
A comparison of planned and actual performance is shown in the table below. The reported surplus is significant improvement on the original plan. This is as a result of an additional incentive payment of £1.3m received from NHS England relating to the STF bonus scheme.

Statement of Comprehensive Income	2016/17	2017/18 financial performance		
	Accounts £000s	Plan £000s	Actual £000s	Variance £000s
Gross Employee Benefits	(106,965)	(102,657)	(105,560)	(2,903)
Other Operating Costs	(37,235)	(32,312)	(32,806)	(494)
Revenue from Patient Care Activities	144,807	135,283	138,876	3,593
Other Operating Revenue	3,474	2,242	4,409	2,167
OPERATING SURPLUS/(DEFICIT)	**4,081**	**2,556**	**4,919**	**2,363**
Investment Revenue	43	31	47	16
Other Gains and (Losses)	(63)	958	(52)	(1,010)
Finance Costs (including interest on PFIs/Finance Leases/DH Financing/PDC Commitment Fee)	(45)	(49)	(28)	21
SURPLUS/(DEFICIT) FOR THE PERIOD	**4,016**	**3,496**	**4,886**	**1,390**
Dividends Payable on Public Dividend Capital (PDC)	(1,555)	(1,749)	(1,587)	162
Net gains/ (loss) on transfers by absorption	0	0	(1,206)	(1,206)
RETAINED SURPLUS/(DEFICIT) FOR THE PERIOD	**2,461**	**1,747**	**2,093**	**346**
Prior Period Adjustment	0	0	0	0
RETAINED SURPLUS/(DEFICIT) FOR THE PERIOD (AFTER PRIOR PERIOD ADJUSTMENTS)	**2,461**	**1,747**	**2,093**	**346**

Capital Investment

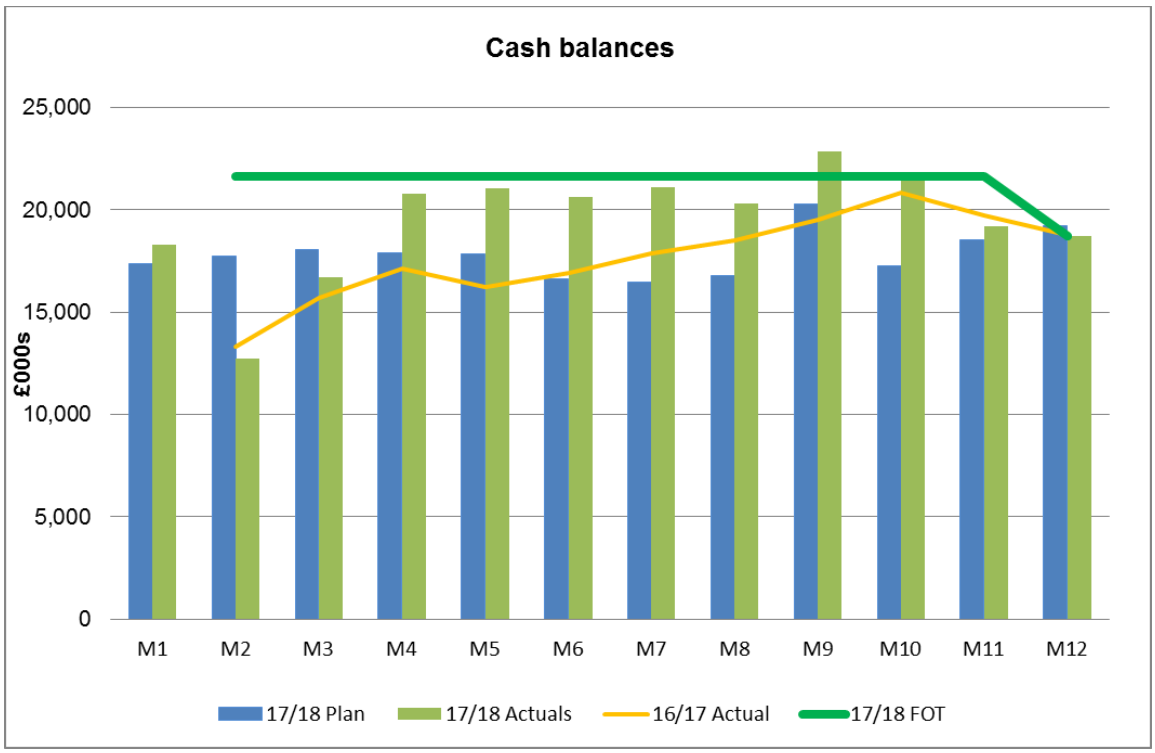
During the year we invested £4.6m in capital schemes. The original plan was to spend £5.4m, however NHS Improvement set a Capital Resource Limit of £4.6m for the Trust where no overspend is permitted.

Almost £2.8m of this allocation was spent on programmes upgrading our estate and the balance investing in information technology and medical equipment.



Cash

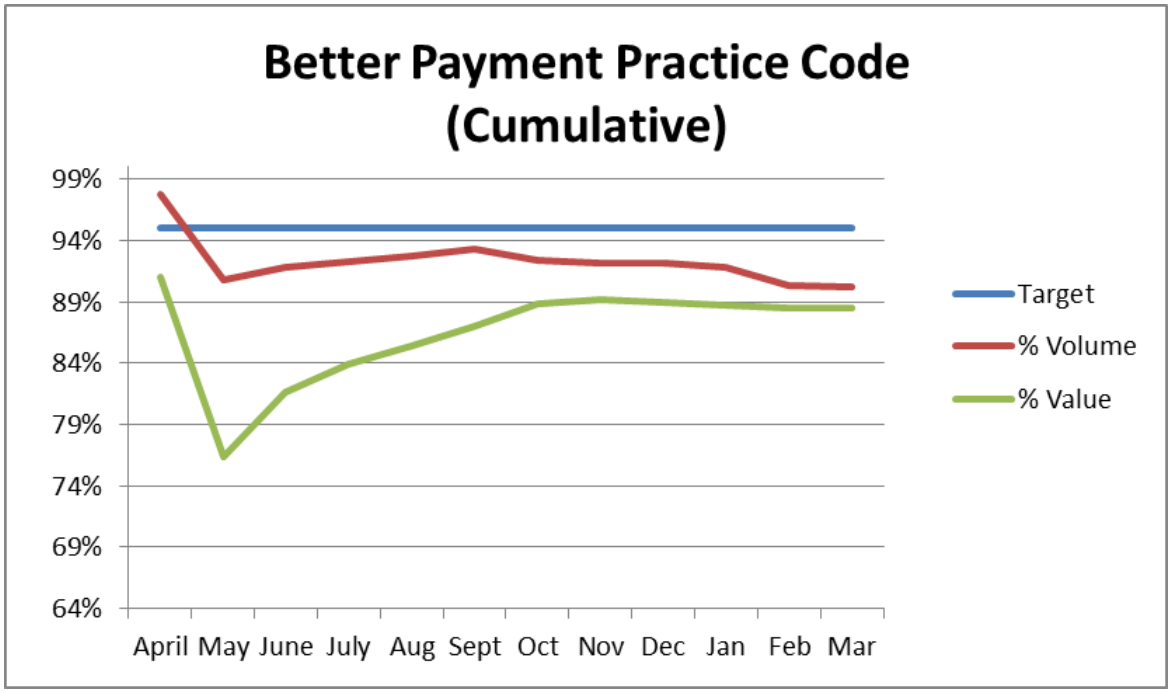
NHS Trusts are required to manage cash within their notified External Financing Limit (EFL). This limit is set by the Department of Health and determines how much cash a Trust may spend beyond that generated by its normal day to day operations. It is a breach of its financial duty to overspend against the EFL. We delivered an under spend of £137k, which means that we have met that obligation. We had £18.7m cash in the bank at the end of the year which was £1.2m below the plan which was due Principal Health Centre sale not being completed in the 2017/18 financial year as previously planned.



Better Payments Practice Code

The Trust is required to comply with the Better Practice Payment Code (BPPC). The code requires organisations to pay 95% of suppliers within 30 days of receiving a valid invoice. The cumulative position below shows under achievement of the target by volume of 5% (2017 - 3%) and the target by value by 6% (2017 - 5%). The movement was mainly due to change of the financial system and our shared services provider which happened in December 2017.

Better Payment Practice Code - % by Value and Volume of Invoices paid within 30 days.



The Trust's Estate

HCT occupies space in over 50 sites across Hertfordshire. The property portfolio is diverse and includes freehold assets, commercial leases and space owned by other NHS organisations. This portfolio delivers office and clinical space as well as inpatient accommodation.

The Trust's 2014/21 estate strategy proposed a reduction of estate and investment in retained assets as well as new development proposals. These have now been or are in the process of being delivered.

The Trust estate has reduced by ten operating sites over the past four years. This has introduced efficient operating practices and a reduction in liability.
The estate structure as well as the internal environment has improved as significant investment has enabled poor quality estate and safety to be addressed.
The current opportunities offer an integrated approach with other healthcare providers.
The integration of the estates function with HPFT has enabled the delivery of a

The development and opening of the new integrated Health & Wellbeing Centre within the centre Hemel Hempstead has offered mental health and community services an seamless solution to health delivery.

Sustainability

Background

NHS Trusts are required to comply with a number of statutory obligations relating to sustainability. These include:

The Climate Change Act 2008

This act sets a legal obligation for organisations to achieve a 34% reduction in carbon emissions by 2020, a 50% reduction by 2025, and an 80% reduction by 2050 compared to1990 levels.

The NHS Carbon Reduction Strategy 2009

This strategy was published by the NHS Sustainable Development Unit (SDU) in 2009. It requires NHS organisations to achieve a 10% reduction in emissions by 2015 based on a baseline of 2007.

Current Position

The investment in building structures and electrical and mechanical systems has delivered a carbon reduction. The surrender of poor quality inefficient sites has also enabled the carbon output to be reduced.

HCT are currently calculating the impact of these developments and investments in partnership with Hertfordshire Partnership University NHS Foundation Trust (HPFT) to enable a combined carbon reduction target.

Specific initiatives have included:

- An ongoing programme of new-build and refurbished premises to incorporate green energy systems. These include solar energy and ground or air source heat pumps.
- Full recycling facilities are provided in all premises.
- LED low energy lighting is being progressively introduced.
- Non-medical disposable plastics are being phased out.
- Secure bicycle storage is proved at key locations to encourage the use of green transport.

Equality, Diversity and Human Rights

HCT is committed to promoting equality and diversity amongst its staff and also seeking out areas of focus to improve equality of services for those who find it harder to access services and therefore experience poorer health outcomes.

Our achievements

During 2017/18 we took the following steps to promote equality and diversity:

- Unconscious bias awareness slides have been incorporated into a 1-day recruitment and selection training course for managers since November 2016.
- A 'Recruitment Handbook' was issued in August 2016 covering policy, guidance and tips on fairness in recruitment.
- An audit of interview scoring sheets has been completed to ensure fairness of the recruitment process.
- The operational HR team have worked hard to review staff turnover in respect of the reasons for staff leaving and how these may be addressed. There are now several options for completing the leaver questionnaire, via paper or online, anonymously or with full details, which the team can then follow up as appropriate.
- A 'Staff Handbook' was developed which contains a short introduction to both the Equality & Diversity and the Anti-Bullying & Harassment policies.
- Membership of the Equality & Community Engagement Forum has grown and now also includes Gypsy and Traveller and LGBT members. Forum meetings have included presentations from:
  - a representative of the Transgender Herts community, who told us about the drive to increase awareness of Transgender needs within Hertfordshire
  - HCT's Podiatry Team Leader, who outlined the changes the service has made, which have led to significant improvements in the experience of patients with a learning disability.
- The Podiatry Team's work has been so successful that it has been recognised by the presentation of a Purple Star Award from the county's Health Liaison Team.

Interpreting support for patients

HCT recognises its diverse patient population and is committed to ensuring that there is effective communication with non-English speakers, people for whom English is a second language, and those patients with a sensory impairment who require communication support.

Staff who have patient contact are required to make every effort to understand the communication needs of the patients.

We also aim to ensure all patient information leaflets, booklets and posters advise that patient information can be made available in Braille, large print or audio version.

Improving the care of people with learning disabilities

Our service provision is designed around the needs of patients with learning disabilities

and their families and carers. Significant progress during 2016/17 includes:

- As part of the Trust's commitment to increase employment of people with learning disabilities, we worked with our Equality & Community Engagement Forum to co-design an easy read application form for people with learning disabilities across the county as part of HCT's drive to make the recruitment process more accessible for a diversity of candidates.
- Work continues in Purple Star areas - Special Dental Care and Podiatry Services - to ensure the delivery of high quality care to learning disability service users
- The Purple Star strategy has been promoted across the Trust.
- HCT has actively participated in the Hertfordshire-wide Improving Health Outcomes Group for Learning Disabilities.
- Easy read Friends and Family Test comment cards have been rolled out for use by all HCT services if required.

Equality & Community Engagement Forum

HCT's Equality & Community Engagement Forum is where senior leaders meet and plan service improvements with a wide range of representatives from Hertfordshire community organisations. The principle of community engagement has been an essential component of Hertfordshire Community NHS Trust's Patient Experience approach and strategy.

Community Forum members include representatives from the Herts Interfaith Group, the Deaf community, Gypsy and Traveller Empowerment Hertfordshire (GATE), Herts AID (a HIV & Sexual Health Charity), Carers in Herts, Healthwatch Hertfordshire, Community Development Action, and MIND. The Forum has a positive and progressive atmosphere where diversity is embraced and difficult issues are discussed. Forum meetings take place once every three months chaired by the Tricia Wren, Director of Nursing & Quality (Acting). Partnership with grassroots organisations has been central to the success of the forum to date.

Gypsy and Traveller Empowerment Hertfordshire

In May 2017, the Trust established a Task and Finish group bringing together Gypsy and Traveller Empowerment (GATE) Hertfordshire, health and social care organisations. The GATE has provided a strong voice in identifying the most pressing issues related to improving the health of Gypsy and Traveller people and helping to decide what core areas of change should be prioritised. GATE's increased level of trust in HCT has allowed us to facilitate dialogue with other health and social care partners. This is a very different conversation with GATE around what we can collectively create or adapt to meet their needs using the resources we have.

This programme of work with the Gypsy and Traveller communities is focused on the implementation of practical steps to building community capacity, support self-management, and help people take control. Examples of the work to date include a focus on:

- End of Life
- A work experience Scheme for Gypsies and Travellers launched
- Training for Carers

- Domestic Abuse links with the council:

GATE Herts Josie O'Driscoll on the project:

"Gypsies and Travellers have some of the poorest health outcomes and therefore are a key priority. We welcome the effective commissioning of health services to our communities, we aim to improve health outcomes for Gypsy Roma Travellers through the work GATE Herts Task & Finish group and HCT are doing.

Together we will develop and promote opportunities for Gypsy and Traveller community members to identify and meet their own health needs.

We support Gypsy and Traveller community members to overcome literacy and other barriers in order to access and effectively utilise primary and secondary health services. These include GP's, community healthcare, mental health services, drug and alcohol, domestic abuse, hospital trusts, and carer support, and end of life care.

We are particularly grateful to the HCT for establishing the trainee work experience programme with our youth Team at GATE. It's a unique initiative and as far as we are aware the first of its kind in the UK. We will continue to work together with HCT ensure equal access into mainstream community based, CCG and hospital trust healthcare".

Equality & Diversity training

Equality and diversity training is part of the Trust's induction process for new staff. All permanent, fixed-term, bank and agency staff receive equality and diversity training every three years. The training covers:

- Responsibilities under the Equality Act 2010 covering all nine protected characteristics
- Inappropriate behaviour and personal responsibility
- Unconscious bias in decision making
- Equality objectives.

Our aim is to encourage self-awareness in order to facilitate change in individuals, in teams and departments, focusing on 'engaging hearts and minds' and to equip staff with the key principles of inclusive practice. We also aim to provide staff with practical actions that will assist them in contributing towards a more inclusive culture at the Trust.

Roll out of new national NHS Workforce Race Equality Standard

The national NHS Workforce Race Equality Standard (WRES) came into effect in 2015. It is designed to improve the representation and experience of Black and Minority Ethnic (BME) staff at all levels of the organisation. There are a total of nine indicators that make up the WRES, split across workforce data, the national NHS Staff Survey and Trust Board composition.

Performance data for 2016/17, published in 2017, showed an improvement in the scores in relation to 6 WRES indicators:

- Relative likelihood of staff being appointed from shortlisting across all posts
- Relative likelihood of staff accessing non-mandatory training and CPD
- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
- Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
- Percentage believing that Trust provides equal opportunities for career progression or promotion
- In the last 12 months have you personally experienced discrimination at work from any of the following - Manager/team leader or other colleagues

Performance against 3 of the 9 WRES Indicators was broadly similar to the previous year's data. There was no deterioration in the Trust's performance in any of the indicators.

The Trust is especially keen to improve the representation of BME staff at all levels of the organisation. The 2016/17 WRES data and action plans to improve the representation and experience of BME staff can be accessed here: https://www.hct.nhs.uk/about-us/equality-and-diversity.

Recruitment & Selection training

The Trust has continued with training for recruiting managers to raise awareness of unconscious bias and to ensure recruitment and selection (R&S) processes are fair and transparent. We also completed an audit of interview scoring sheets and published a Recruitment handbook.

Disability Confident scheme

The Disability Confident scheme supports employers to make the most of the talents disabled people can bring to your workplace. The scheme aims to help successfully recruit and retain disabled people and those with health conditions. The Trust was successful at achieving Level 2 Disability Confident Employer status. Our plan for 2018 is to apply for level 3, the highest level possible

Gender Pay Gap information

In March 2018, the Trust published Gender Pay Gap information relating to its staff, in the first of what will become an annual cycle of reporting. As an employer with over 250 staff, the Trust is required by law to carry out Gender Pay reporting under the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017.

The gender pay gap between men and women working at HCT is currently 14.1%, against a current national mean of 17.4%.

The median hourly pay for women is 1.0% less than men. This compares favourably to the national median hourly pay where women earn 18.4% less than men.

As with many organisations, gender pay and bonus gaps arise because of the disproportionate number of men in senior positions.

Perfomance Report signed by the (Acting) Chief Executive

Clare Hawkins
(Acting) Chief Executive

24th May 2018

Accountability Report

Corporate Governance Report

This section of the Annual Report explains the composition and organisation of the Trust's governance structures and how they support the achievement of the Trust's objectives.

Directors' Report

The Board 2017/18

The Trust Board as at 31st March 2018 consists of a chair, appointed through NHS Improvement (NHSI) four non-executive directors (also appointed through NHSI), and four voting executive directors.

The Board is also supported by a non-voting non-executive director (designate) and four non-voting executive directors.

The Board is responsible for setting and developing the strategic direction of the organisation, sustaining business viability and holding the executive directors to account for all aspects of the organisation's activities, including quality and safety of patient services, financial management and legal compliance. The role also includes seeking assurances from the executive directors that risks to the organisation are being appropriately assessed and managed.

In 2017/18, the HCT Board met formally in public on 6 occasions. This was on alternate months between May 2017 and March 2018. The annual public meeting to present the 2016/17 Annual Report and Accounts was held on 28th September 2017.

The Board also holds "Board Briefing" or "Board Development Sessions" and themed "Engagement Events" with patients, carers and other stakeholders.

The Board has a duty to operate in a way that is transparent and to comply with best practice in probity. To this end, the Board signs up annually to following the "Nolan Principles" of good governance, The NHS Code of Conduct and Accountability, the NHS Code of Openness and the NHS Constitution. The Board has also subscribed to principles of Board Etiquette as set out in the NHS Integrated Governance Handbook.

Throughout 2017/18, the Board has undertaken a continued programme of collective and individual development, and this will continue through 2018/19.

In addition, and to ensure Board awareness of issues at operational level as affecting patients, the Board has been hearing "patient" and "service" stories" at the start of Board meetings in public.

The voting members of the Board also form the corporate trustee for Hertfordshire NHS charitable funds, in respect of which a separate report and accounts are published.

Changes to the Board and NED Appointments in 2017/18

The following changes to the Board occurred in 2017/18:

September 2017: On account of David Law, CEO, being on long-term sickness absence, Clare Hawkins, Director of Nursing and Quality, was appointed as (Acting) CEO and Accountable Officer. Tricia Wren, Deputy Director of Nursing & Quality, was appointed as (Acting) Director of Nursing & Quality.

December 2017: Phil Bradley, Director of Finance, went on secondment as Interim Director of Finance to Northampton General Hospital NHS Trust.

The Director of Finance's portfolio was split and

(i) Kevin Curnow, Deputy Director of Finance, was appointed as (Acting) Director of Finance. (Voting Board member) and
(ii) Antonia Robson, Assistant Director of Planning & Contracting, was appointed as (Acting) Director of Business Services. (Non-voting Board member).

The following Non-Executive Director Appointments were extended by NHSI:

Declan O'Farrell	Chair	01/04/17 - 31/03/19
Alan Russell	NED	01/04/17 - 31/03/19
Anne McPherson	NED	01/04/17 - 31/03/19
Jeff Phillips	NED	13/09/17 - 13/09/19
Dr. Linda Sheridan	NED	31/05/17 - 30/11/17 And post-election "purdah period" amended reappointment 31/05/17 – 30/5/19

The following Trust appointment was extended:

Brenda Griffiths	NED (Designate) (Non-voting)	01/06/17 – 30/11/17 And post-election "purdah period" amended reappointment 1/12/17 – 30/05/19

Board and Committee Meeting Attendance 2017 /18

In 2017/18, the Trust Board was supported by the following committees, with membership and attendance records for meetings in 2017/18 as indicated (number attended/total meetings held in year eligible to attend as a committee member).

Committee:	Trust Board	Audit	Healthcare Governance	Strategy & Resources	Remun-eration	Community Engage-ment	Partnership & Engagement	Charitable Funds Trustees	Charitable Funds Committee
Chair and Non- Executive Directors									
Total no. of meetings held in Year:	***6***	***5***	***6***	***12***	***6***	***1***	***2***	***1***	***1***
Declan O'Farrell Trust Chair	*(6)*	*(1) Non Member*	*(2) Non Member*	*(10/12) Non Member*	*(6 Member*	*(0) Non Member*	*(1/2) Non Member*	*(1/1) Member*	*(0) Non Member*
Alan Russell Non-Executive Director and Vice Chair	*(6/6) Member*	*(0) Non Member*	*(2/6) Non Member*	*(11/12) Member*	*(0) Non Member*	*(1) Member*	*(2) Chair*	*(1/1) Member*	*(0) Non Member*
Anne McPherson Non-Executive Director	*(5/6) Member*	*(5/5) Member*	*(6/6) Chair*	*(10/12) Member*	*(6) Chair*	*(0) Non Member*	*(0) Non Member*	*(1/1) Member*	*(0) Non Member*
Jeff Phillips Non-Executive Director	*(6/6) Member*	*(5/5) Chair*	*(4/6) Member*	*(9/12) Member*	*(5) Member*	*(0) Non Member*	*(0) Non Member*	*(1/1) Member*	*(1/1) Member*
Dr Linda Sheridan Non-Executive	*(6/6) Member*	*(5/5) Non Member*	*(3/6) Member*	*(12/12) Chair*	*(0) Non Member*	*(0) Member*	*(2) Member*	*(1/1) Member*	*(1/1) Chair*
Brenda Griffiths Non-Executive Director Designate	*(5/6) Non-Voting Member*	*(5/5) Member*	*(1/6) Non Member*	*(8/12) Member*	*(0) Non Member*	*(1) Chair*	*(2) Member*	*(1/1) Non Member*	*(1/1) Member*

Committee:	Trust Board	Audit	Healthcare Governance	Strategy & Resources	Remun-eration	Community Engage-ment	Partnership & Engagement	Charitable Funds Trustees	Charitable Funds Committee
Executive Directors:									
David Law Chief Executive *(Long term sick leave 11 .9.2017)*	*(0/2)* *Member*	*(0/2)* *Non Member*	*(0/2)* *Non Member*	*(4/5)* *Member*	*(0)* *Non Member*	*(1/1)* *Non Member*	*(0)* *Non Member*	*(0/1)* *Member*	*(0)* *Non Member*
Phil Bradley Director of Finance (on secondment from 1.12.2017)	*(4/4)* *Member*	*(2/3)* *Non Member*	*(0)* *Non Member*	*(7/8)* *Member*	*(0)* *Non Member*	*(0)* *Non Member*	*(0)* *Non Member*	*(1/1)* *Member*	*(1/1)* *Member*
Kevin Curnow Acting Director of Finance (from 1.12.2017)	*(2/2)* *Member*	*(2/2)* *Non Member*	*(0)* *Non Member*	*(4/4)* *Member*	*(0)* *Non Member*	*(0)* *Non Member*	*(0)* *Non Member*	*(0)* *Member*	*(0)* *Member*
Dr John Omany Medical Director	*(6/6)* *Member*	*(1/5)* *Non Member*	*(4/6)* *Member*	*(0)* *Non Member*	*(0)* *Non Member*	*(0/0)* *Non Member*	*(0)* *Non Member*	*(1/1)* *Member*	*(0)* *Member*
Clare Hawkins Director of Quality & Governance / Chief Nurse *Acting Chief Executive (from 17.9.2017)*	*(1/2)* *Member* *(4/4)* *Member*	*(1/2)* *Non Member* *(0/3)* *Non Member*	*(2/2)* *Member* *(0)* *Non Member*	*(1/4)* *Non Member* *(7/8)* *Non Member*	*(0)* *Non Member* *(0)* *Non Member*	*(0)* *Non Member* *(0)* *Non Member*	*(0)* *Member* *(2/2)* *Member*	*(0)* *Member* *(1/1)* *Member*	*(0/0)* *Member* *(0)* *Non Member*
Julie Hoare Director of Service Development and Partnership	*(5/6)* *Non-Voting Member*	*(0)* *Non Member*	*(0)* *Non Member*	*(10/12)* *Non Member*	*(0)* *Non Member*	*(0)* *Non Member*	*(2/2)* *Member*	*(1/1)* *Non Member*	*(0)* *Non Member*
Marion Dunstone Director of Operations	*(5/6)* *Non-Voting Member*	*(0)* *Non Member*	*(5/6)* *Member*	*(9/12)* *Non Member*	*(0)* *Non Member*	*(0)* *Non Member*	*(0)* *Non Member*	*(1/1)* *Non Member*	*(0)* *Non Member*
Debbie Eyitayo Interim Director of HR & OD *(Secondment from 1 March 2017)*	*(6)* *Non-Voting Member*	*(1/5)* *Non Member*	*(4/6)* *Member*	*(10/12)* *Member*	*(5/6)* *Non Member*	*(0)* *Non Member*	*(1/2)* *Member*	*(1/1)* *Non Member*	*(0)* *Non Member*
Tricia Wren Acting Director of Nursing & Quality (from 28.9.2017)	*(4/4)* *Member*	*(0)* *Non Member*	*(3/3)* *Member*	*(1/4)* *Non Member*	*(0)* *Non Member*	*0)* *Non Member*	*(0)* *Non Member*	*(0/0)* *Member*	*(0)* *Non Member*
Antonia Robson Acting Director of Business Services (from 1.122017)	*(2/2)* *Non-Voting Member*	*(0/0)* *Non Member*	*(0/0)* *Non Member*	*(4/4)* *Non Member*	*(0)* *Non Member*	*(0)* *Non Member*	*(1/2)* *Member*	*(0/0)* *Non Member*	*(0)* *Non Member*

The Board of the Trust as at 31 March 2018 consisted of:
(= voting member)*

Declan O'Farrell (FCCA, CBE)
Chair (*)

Declan was appointed Chair of HCT in February 2010. He was previously Chair of West Herts College in Watford for eight years from 2003, leading its transformation from a failing college to an OFSTED outstanding one. Formerly he was Chair of the Training & Enterprise Council in NW London and of Business Link London. He was awarded a CBE in 2000 for services to businesses in London. ACCA qualified he held senior financial roles in Grand Metropolitan Group and London Transport, becoming MD of a bus division, which following privatisation, was successfully listed on the London Stock exchange. He has maintained an interest in product development in music and retail.

In addition to Chairing the Trust Board, Declan is a member of the Remuneration Committee. He has also represented HCT on the strategic oversight group for the emerging Hertfordshire/West Essex transformation partnership for health and well-being organisations.

Period of Appointment:01/11/10 - 31/03/13 (Re-appointed in 2013 to 31/03/15;extended in 2015 to 31/03/17 and extended in 2017 to 31/03/19)

Anne McPherson MBE (RFN, RN, RM, DipN, MA, MBE)
Non-Executive Director (*)

A nurse and midwife, with extensive board level experience as Chief Nurse for Hertfordshire Health Authorities in the East and the West of the county, as well as several of Director of Nursing posts including an integrated NHS Trust. Executive Officer for the Nurse Directors Association, and Associate Consultant for the International Hospitals Group commissioning new hospitals overseas.

Anne has served as a Non-Executive Director for Dacorum PCT, West Hertfordshire PCT, and as a Trustee for Isabel Hospice. Most recently as an Independent Lay Chair for NHS England Central Midlands and East Performers List Decision Panel. In January 2015 Anne was awarded the MBE for services to nursing and healthcare.

Anne is Chair of the Healthcare Governance and Remuneration Committees and is a member of the Audit Committee and Strategy and Resources Committee. She is the Freedom to Speak Up Guardian and the lead for Patient Safety and Experience.

Period of Appointment: 01/11/10 - 31/03/13 (Re-appointed in 2013 to 31/03/15; extended in 2015 to 31/03/17 and extended in 2017 to 31/03/19).

Jeff Phillips (BSc, ACMA, FCT)
Non-Executive Director (*)

Jeff was appointed in September 2011 and is a qualified accountant. He has had a wide and varied career in the telecommunication and chemical industries. He has also served as a non-executive director for Luton Community Services and is currently a director of CHUMS, the bereavement and trauma social enterprise based in Bedfordshire. He is a governor of Manland School Harpenden and a member of Hertfordshire County Council Schools' Appeals Panel.

Jeff was appointed as Chair of the Trust's Audit Committee from March 2012 and he is a member of the Healthcare Governance Committee, Strategy and Resources Committee, Charitable Funds Committee and Remuneration Committee.

Period of Appointment: 01/09/11 – 13/09/15 (Re-appointed in 2015 to 13/09/17 extended on 2017 to 13/09/19)

Alan Russell (HND)
Non-Executive Director (*)

Alan was appointed NED in April 2010. He was previously Managing Director of Logica Consulting UK, prior to which he was the MD of Atos Consulting and Chair of its global consulting Board. Both companies engaged in complex transformational change programmes for public and private sector organisations. He was a Director of the Management Consultancies Association and President in 2005.

Alan is Vice Chair of the Trust Board and Senior Independent Director (SID). He is also Chair of the Partnership and Engagement Committee and a member of the Strategy and Resources Committee.

Period of Appointment: 01/11/10 - 31/03/13 (Re-appointed in 2013 to 31/03/15; extended in 2015 to 31/03/17 and extended in 2017 to 31/03/19).

Dr Linda Sheridan (FFPH, MRCGP, MSc)
Non-Executive Director (*)

Linda joined Hertfordshire Community NHS Trust as a non-executive director in June 2013. Linda qualified as a doctor from Trinity College, Dublin and moved to the UK for post-graduate training in general practice. Linda worked in primary care in Bedfordshire for over 15 years, before training to be a public health medicine consultant and worked in that capacity in London, Hertfordshire, Cambridgeshire and East of England region. She retired from her post as deputy regional director in March 2013.

During her time in both specialties, she has led many programmes aimed at improving the quality and resilience of health services, including GP prescribing, diabetes care, cancer screening, child health, maternity services, healthcare associated infection, emergency planning, the 2009 'flu pandemic and NHS preparedness for the 2012 Olympic Games.

Linda chairs the Strategy & Resources Committee and Charitable Funds Committee. She is also a member of the Healthcare Governance Committee and Foundation Trust Committee.

Period of Appointment: 01/06/13 - 30/05/17 (Re-appointed in 2017 to 30/05/19)

Brenda Griffiths
Non-Executive Director (Designate)

Brenda joined Hertfordshire Community NHS Trust as a non-executive director (designate) in June 2013. A trained nurse, she worked in the NHS for 25 years until 2003 when she was appointed as an Independent member of Hertfordshire Police Authority. She remained on the Authority until its abolition in 2012.

She was Chair of the Standards Committee of Hertsmere Borough Council 2005 – 2011.

Brenda is a member of St Bartholomew's Hospital League of Nurses. She sits on the local committees for both Peace Hospice Care Watford and the Royal Medical Benevolent Fund. In February 2016 Brenda was elected as Foundation Master of The Guild of Nurses in the City of London. Brenda is Chair of the Board of Trustees of the Company of Nurses Charitable Trust. She is an Associate Member of the College of Policing and acts as an Assessor for senior selection, promotion, graduate and direct entry candidates.

Brenda is a member of the Strategy & Resources, Audit, Partnership & Engagement and Charitable Funds Committees.

Period of Appointment: 01/06/13 - 31/05/15 and extended in 2015 to 31/05/17 (Honorary Contract) (Re-appointed in 2017 to 30/05/19)

David Law (BA Hons)
Chief Executive (*)

David took up post as Chief Executive in March 2012 and he has extensive knowledge of the health service in Hertfordshire. He has also worked in primary care and community services in London prior to working in Hertfordshire. He worked in a number of planning roles in health organisations in the County during the 1990s before joining West Hertfordshire Hospitals NHS Trust in 2001 as Director of Strategy. In 2004 he was appointed Chief Executive of the Trust, a post he held till 2007. After leaving Hertfordshire, David worked at Healthcare for London, initially focusing

on the organisation of acute services in the capital and then on end of life care. He worked extensively for the NHS Institute for Innovation and Improvement. Before coming to Hertfordshire Community Trust he worked on the Transforming Community Services programme in Lambeth and Southwark and in Tower Hamlets.

David was on long-term sickness absence from the Trust from September 2017.

David's Portfolio: Overall leadership of HCT; Trust strategy; Communications and engagement.

Clare Hawkins (BSc, RN, NDN, Dip Nurse Practitioner)
Chief Executive (Acting) (*)

Clare joined HCT as Director of Quality and Governance in March 2011, having previously worked as Deputy Director and Director of Nursing and Quality in NHS Hertfordshire. Clare is a Registered Nurse, District Nurse and Nurse Practitioner.

Since 1995 her NHS management experience includes a number of posts in London and as Director of Nursing and Operations and Deputy Chief Executive for Dacorum PCT.
Her particular areas of interest are patient safety, patient experience and Clare is the executive lead for nurses and Allied Health Professionals on the Board.
Clare's role as Deputy Chief Executive was confirmed in March 2017. Clare has been on secondment to the nursing directorate at NHS Improvement for a day a week since January 2017 providing community services advice and expertise to the national team.

Substantively Director of Nursing & Quality, Clare was appointed (Acting) Chief Executive in September 2017.

Clare's Portfolio: Overall leadership of HCT; Trust strategy; Communications and engagement.

Tricia Wren, RN,QN
Director of Nursing & Quality (Acting) (*)

Tricia joined the Trust in 2012 as Deputy Director of Quality & Governance/Deputy Chief Nurse. Prior to this, Tricia held a number of senior management posts in neighbouring Community Trusts.

Tricia has over 30 years' experience of working across acute, community and primary care as a Registered Nurse, Health Visitor and Nurse Practitioner.

Tricia holds a Masters in Clinical Leadership and in October 2018 was awarded the title of Queens Nurse in recognition of her commitment to maintaining high standards of patient care, learning and leadership.

Substantively Deputy Director of Nursing & Quality, Tricia was appointed (Acting) Director of Nursing & Quality in September 2017.

Tricia's Portfolio:
Quality & Governance; Clinical leadership; Patient safety; Patient experience; Safeguarding lead; Risk management; Nurse and AHP advisor to the board; Director of Infection Prevention and Control.

Dr John Omany (FRCP, MBCHB, MSc, DipPallMed, DMRT.)
Medical Director (*)

John has a wealth of experience having previously worked as a Medical Director in Primary Care Trusts and NHS England. John is a practicing clinician as a Consultant in Palliative Medicine with experience of working in the voluntary sector, community and secondary care. He brings experience of working with community services and a good working knowledge of the relationship between acute and community services and primary care.

He has as strong focus on patient care and constantly strives to improve the quality of care for patients and their families. He believes that community services working collaboratively and in partnership with other stakeholders offers the best chance of addressing some of the challenges in healthcare delivery today. He provides a real drive around the development of our services, continuing to improve our working relationships with general practice and leadership of our medical.

John's Portfolio: Professional leadership for medical staff; Clinical effectiveness, outcomes and audit; Research & Development lead; Medical advisor to the board; Caldicott Guardian, Controlled drugs Accountable officer, Medical revalidation.

Phil Bradley (FCPFA, Dip.M, MCIM)
Director of Finance (*)

Phil joined the Trust as interim Director of Finance in January 2015 and was appointed as substantive Director from 1st April 2015. He has worked in healthcare since 1982 and has held a number of Director roles in both NHS Commissioning and Provider organisations. Phil has also worked within the local Hertfordshire Health Economy previously. From 2004-2005 he worked at the Bedfordshire & Hertfordshire Strategic Health Authority based in St Albans and from 2005-2011 at West Hertfordshire Hospitals NHS Trust.

Phil is a qualified member of both the Chartered Institute of Public Finance & Accountancy and the Chartered Institute of Marketing, and sits as a member on the Healthcare Financial Management Association's national Policy & Research Committee.

Phil went on secondment to Northampton NHS Trust in December 2017.

Phil's Portfolio: Financial management; Performance information; Contract management; Business planning; IM&T; Senior Information Risk Owner (SIRO); Estates; Financial Governance; Business and Commercial development.

Kevin Curnow (ACCA)
Director of Finance (Acting) (*)

Kevin joined the Trust in 2015 as Deputy Director of Finance. Kevin has been the acting Director of Finance since December 2017.
Kevin has been in the NHS since 2008, with the last 7 years at Deputy Director level.
Prior to joining the NHS, Kevin trained and qualified as an Associate Chartered Certified Accountant within a Public Practice and has a broad range of experience of many different industries including working for a commercial organisation as Head of Finance.

Substantively Deputy Director of Finance, Kevin was appointed as (Acting) Director of Finance in December 2017.

Kevin's Portfolio:
Financial management; financial services; performance and information; estates management.

Julie Hoare (RGN, RSCN, Dip.HV)
Director of Service Development and Partnerships

Julie was appointed as Director for Service Development and Partnerships in 2016. She joined the organisation as Assistant Director of Operations in September 2009, and was appointed Director of Operations in March 2012. Since starting in the NHS after qualifying as a general nurse she specialised in paediatrics before going on to be a Health Visitor. Julie has spent recent years working in management roles, across Children's and Adult's Services in both community and acute settings in London, Cambridgeshire and Hertfordshire. Julie is particularly interested in service transformation and effective partnership working between those delivering services and essentially with local people.

Julie's Portfolio: Service transformation, Business management, Sustainability and Partnership working

Marion Dunstone (BSc (Hons), DMS)
Director of Operations

Marion took on the role of Director of Operations in January 2016, having undertaken the role on an interim basis for the previous six months. Prior to this Marion was the General Manager for Children's Services in HCT.

She has 28 years of experience in the NHS, initially as a Dietitian and has managed adult and children's services in both the hospital and community sector.

Marion leads the operational delivery of adult and children's services across HCT and is the Emergency Planning lead for the organisation.

Marion's Portfolio: Operational management; Service transformation improvement; Emergency planning and resilience; General Practitioner communications; Integrated care.

Debbie Eyitayo (Chartered MCIPD, PGDip HRM)
(Interim) Director of Human Resources and Organisational Development

Debbie joined the Trust on secondment as Interim Director of HR and OD in March 2017. She has worked in healthcare since 2000 and has held a number of roles as a Human Resources professional in Provider Organisations, with the most recent as Deputy Director of Workforce at Lewisham and Greenwich NHS Trust.

Prior to joining the NHS, Debbie was a civil servant from 1992 – 2000, working for the Crown Prosecution Service

Debbie's Portfolio: Human resources; Organisational development; Staff engagement; Staff education and development; Workforce informatics; Trade union relationships; Equality and diversity

Antonia Robson (MBA, DipM, BSc)

Director of Business Services (Acting)

Antonia joined the Trust in January 2015 as interim Assistant Director of Planning before also taking responsibility for contracting at the start of 2016 and being appointed substantively as Assistant Director of Planning and Contracting in 2017. She has been acting Director of Business Services since December 2017, taking director responsibility for business development as well as planning and contracting, following the secondment of the Trust's Director of Finance to another trust.

Antonia has worked for the NHS since 2009, initially as Associate Director of Corporate Services at NHS Luton Primary Care Trust and then as Director of Business Services for the both Luton and Bedfordshire Primary Care Trusts when the trusts became a PCT cluster in 2011. She has also worked for NHS Central Eastern Commissioning Support Unit supporting commissioners across Hertfordshire, Bedfordshire and Essex and leading the Trust's strategic development and tender preparation.

Prior to joining the NHS, Antonia worked for Barclays Corporate Banking for twelve years predominantly in strategic marketing and planning and latterly in sales management. She brings commercial experience to the Trust from these roles and has a post-graduate diploma in marketing as well as an MBA.

Substantively Assistant Director of Planning & Contracting, following the external secondment of Phil Bradley, Director of Finance, and a subsequent split in portfolios, Antonia was appointed (Acting) Director of Business Services in December 2017.

Antonia's portfolio:
Contract management; Business planning; Business and Commercial development

The Board Register of Interests

Board Members and interests declared as at 31st March 2018

Name	Position	Interests Declared
Declan O'Farrell (*)	Chair	Director: Castletown Corporation Ltd, Beatselecta Limited Director and Chairman of Catena Publications Limited
Alan Russell (*)	Non- Executive Director	(Prospective FT) Member of West Herts Hospitals NHS Trust. Member of Herts Urgent Care.
Anne McPherson (*)	Non- Executive Director	Friend of Parkwood Surgery, Hemel Hempstead, Herts. Specialist Adviser for the Care Quality Commission (CQC)
Jeff Phillips (*)	Non -Executive Director	School Governor, Manland School, Harpenden. Lay Member HCC Schools Admissions Appeals Panel. Vice Chair of CHUMS (Mental Health & Emotional Wellbeing Service for Children and Young People) Member of Davenport House Patient Group, Harpenden Treasurer and Trustee of Shelter Cymru.
Dr Linda Sheridan (*)	Non- Executive Director	Team leader and peer reviewer for External Quality Assurance reviews of non-cancer screening services for the National Screening Programmes, Public Health England (Occasional role). Professional appraiser for PH directors, consultants and academics on behalf of Public Health England. (Cambridgeshire County Council and Peterborough City Council PH team) up to end of March 2018. Daughter Employed in Operations Directorate, NHS Midlands and East

Name	Position	Interests Declared
Brenda Griffiths	Non- Executive Director (Designate)	Member East and North Herts NHS Trust. Member Red House (Radlett) Patient Reference Group. Associate Member, The College of Policing. Husband employed by UCL on Royal Free Campus. Foundation Master of The Guild of Nurses in the City of London Member of the Royal Free London NHS Foundation Trust Member of the Executive Committee of the Royal British Nurses Association. Chair of the Board of Trustees of the Company of Nurses Charitable Trust.
David Law (*) (1)	Chief Executive	Wife is working part-time for Questback
Clare Hawkins (*) (2)	Deputy Chief Executive and Director of Quality & Governance / Chief Nurse Acting Chief Executive	Community Services adviser. NHSI Nursing Directorate.
Tricia Wren (*) (3)	Acting Director of Nursing & Quality	None
Dr John Omany (*)	Medical Director	Omany Medical Ltd
Phil Bradley (*) (4)	Director of Finance	Director, Bradley Slade Consulting Limited.
Kevin Curnow (*) (5)	Acting Director of Finance	None
Julie Hoare	Director of Service Development and Partnerships	None
Marion Dunstone	Director of Operations	None
Debbie Eyitayo	Interim HR Director	None
Antonia Robson (6)	Acting Director of Business Services	None

Notes:

(*) = Voting Board member

(1) On long-term sickness absence from September 2017
(2) Appointed Acting Chief Executive / Accountable Officer 17/09/2017
(3) Appointed Acting Director of Nursing & Quality from 28/09/2017
(4) Left the Trust on Secondment to Northampton General Hospital NHS Trust on 01/12/2017
(5) Appointed Acting Director of Finance from 01/12/2017
(6) Appointed Acting Director of Business Services from 01/12/2017

Audit

The Trust has an audit committee which is chaired by a financially qualified non- executive director and has two other non-executive directors as members.

As at 31st March 2018, membership is:

Chair: Jeff Phillips (Non-Executive Director)

Members: Anne McPherson (Non-Executive Director) (*)
Brenda Griffiths (Non-Executive Director Designate)

(*) Also Chairs the Trust's Healthcare Governance and Remuneration committees. Conversely, the Chair of the Audit Committee sits on the Trust's Healthcare Governance Committee.

The Audit Committee met five times in respect of 2017/18. This was four standing meetings and an extra-ordinary meeting to review the Trust's annual accounts, annual report, quality account and other mandatory submissions.

In 2017/18 internal audit services have been provided by RSM and the external auditors were Grant Thornton UK LLP.

The cost of external audit for work undertaken in 2017/18 was £39,500 plus VAT (2016/17 = £42,728 plus VAT.) The external auditors have not undertaken any non-audit work which may have given rise to conflict of interest or compromised the audit function.

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

Personal Data Related Incidents

During 2017/18, the Trust had 5 lapses of data security which was reported to the Information Commissioner's Office:

- May 2017 - Patient NHS Numbers, Date of Birth and full postcode for 13,380 patients sent to recipients from @hct.nhs.uk account to @nhs.net accounts.

- October 2017 - Caseload table found in patients home by non-NHS care / home help provider.

- January 2018 - Records of 191 patients sent to new provider before expiry of opt out period.

- January 2018 - Electronic records of 603 patients disclosed in error to new provider of clinical service

- February 2018 – Unsecured email sent to Public Health England Commissioner containing details of patients who had not taken up immunizations. This should not have been sent to them.

In all cases the Information Commissioners Office felt the Trust had taken all reasonable steps to ensure data security and no further action has been taken against the Trust. All staff continue to be reminded of the need for vigilance when handling and sending confidential data.

All information governance incidents are taken seriously and advice is taken as appropriate from the Medical Director, as Caldicott Guardian, and/or the Director of Finance, as Senior Information Risk Owner (SIRO). Incidents are fully investigated, remedial action is taken and lessons learned are applied across the organisation.

The Trust's Information Governance Group, which includes the SIRO and Caldicott Guardian, reviews all data security incidents. Changes in practice have been made in some cases to minimise the risk of repetition, a standard operating procedure has been adopted across the Trust for the handling and processing of correspondence that includes Personal Confidential Data.

Information Governance policies have been updated during the year to meet the requirements of Level 2 of the NHS "Information Governance Toolkit".

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

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

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

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

Clare Hawkins (Acting) Chief Executive

24th May 2018

Annual Governance Statement 2017/18

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Hertfordshire Community 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 Hertfordshire Community NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The governance structure within the Trust enables an embedded risk management approach across all corporate and operational services, with discussions being reflected at the key governance Committees.

This ensures identification, assessment, management and monitoring of strategic and operational risks at all levels. In addition an annual audit cycle of 'governance due diligence' is undertaken by the internal auditors who report to the Audit Committee and provide assurance on the efficacy of the Trust governance programme. The annual audit cycle includes an audit of the risk management process, including escalation/ de-escalation of risk to and from the High Level risk register and the impact upon the Board Assurance Framework (BAF).

The risk architecture/ risk management process is supported by clearly-defined leadership roles in all levels of the Trust from staff to Board members. Every staff member is responsible for identifying, escalating and managing risks within their sphere of competency. Managers from line manager, through to locality manager, service manager, deputy general and general manager-level are responsible for the management of risks based on clear criteria outlined in the Risk Management Policy.

These managers are also required to demonstrate that appropriate control measures are in place and actions are being undertaken to mitigate negative risk and enable positive risk achievement, reporting to their respective lead Executive Director responsible for the aligned portfolio of services.

The Trust uses an electronic risk management system. All staff undertake generic risk management awareness training and an introduction to the electronic risk management system as part of their induction. Focused risk management training in risk assessment, recording, management and monitoring risk is arranged with all new staff relevant to their area of responsibility with refresher training provided for existing system users. In addition there is a programme of risk management, incident and patient experience training delivered in year with additional support provided directly to staff when requested. The training programme is also supported with guidance tools embedded into the electronic risk management system utilised by the Trust.

There are named key specialists within the Trust who offer further specialist risk management training and guidance to all Trust employees i.e. health and safety, back awareness, patient handling training, infection prevention and control, safeguarding adults and children, information governance.

The Trust annual training programme reflects this training with key elements recorded within mandatory training which is monitored at Executive Team and Board.

The risk and control framework

The Trust has a five year risk management strategy which is annually reviewed and refreshed at Board, this ensures both national and local changes in health and social care developments are given due consideration and inform both the strategy and implementation milestones . (During the 2017-18 annual review, Healthwatch Hertfordshire helped to develop a simplified public format to be made available on the Trust's website).

The Board also reviews and agrees the risk appetite annually to inform the risk framework for the following 12 months.

Policies and standard operation procedures to support effective risk management in practice are developed, reviewed and refreshed in line with national guidance and support the overall risk strategy and workforce and organisational development Trust training programmes.

Risks to the achievement of the Trust's strategic objectives are identified by the Executive Team and entered on the Board Assurance Framework (BAF). The BAF is submitted for review and discussion by (i) the Board and (ii The Healthcare Governance and The Strategy and Resources Committees. It is also assessed annually for "fitness for purpose" by the Audit Committee

Risks identified at Business Unit Level are entered on Business Unit Risk Registers. Risks scoring 15 or over, are then recorded on a "High Level Risk Register" (HLRR).

The HLRR is considered monthly by the Executive Team and is submitted to the Healthcare Governance Committee and Audit Committee. The Board receives a summary at meetings in public and the full version is considered in Part 2 (Confidential) Board meetings.

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Risks on the HLRR are linked to the BAF and those that are considered by the Executive Team to have a strategic impact are escalated to the Board Assurance Framework.

Local risk activity is reviewed at service and business unit performance meetings and risk summits, and high-level risks are scrutinised further at committee, Executive Team and Board level with a remit to challenge where appropriate, and receive assurance on the efficacy of controls and actions. High level risks are reviewed and aligned with the BAF.

Business unit performance reviews and focused reviews enable lessons to be shared in the identification and management of risk while supporting the alignment of resources to optimise the impact of the Trust to achieve its objectives. These lessons are shared through a variety of communication tools, newsletters, bulletins, and operational forums.

As at March 31st 2018, the Trust has 115 risks actively being managed across all business units, and the Trust's Risk team work with risk owners to ensure they are being reviewed, managed and updated appropriately.

The Board cycle ensures there is oversight, review and challenge of both the High Level Risk register and the BAF.

Risk management is seen as an integral part of everyday clinical and non-clinical practice supporting delivery of the Trusts strategic objectives.

Lessons learned from risks which materialise plus sources such as complaints, claims, incidents and internal or external reports highlighting any areas of weakness are shared throughout the organisation.

Strategic risks

The strategic risks on the BAF as at 31st March 2018 were:

Rank	Summary Description	*Overall Risk Score*
	National and local system-generated pressures. *The Trust's ability to achieve its strategic objectives and / or maintenance of the quality and safety of healthcare services provided to the population served may be significantly impacted upon by organisational unsustainability, transition, change to the structure of the Trust's business or organisational form arising from a current environment of (i) national / local financial and demand pressures (ii) possible loss of current business (iii) known / possible commissioning intentions and (iv) (Longer term), system development of ICS / ICO.*	18 (6+6+6)
	Workforce *Workforce resources are (1) insufficient to meet demands and (2) in need of re-modelling roles, to avoid impacting adversely on (i) capacity to maintain / expand services (ii) the health, wellbeing and morale of staff (iii) staff retention; thereby resulting in a significant challenge to (a) the*	16 (6+6+4)

	retention / recruitment of staff in specific areas/specialties and (b) providing safe, affordable and effective services which are "fit for purpose"	
	Fundamental Standards and Regulatory Compliance *Not meeting CQC Fundamental Standards or other regulatory compliance may result in regulatory action or failure to maintain a CQC rating of "good" (or above) thereby having an adverse impact on (i) improving patient care (ii) reputation with stakeholders and (iii) strength in the competitive market.*	12 (4+2+6)
	Not being able to evidence improved outcomes *Not being able to adequately evidence improved patient health and wellbeing outcomes from HCT interventions leads to not being able to measure success or otherwise against the strategic objective and may result in (i) questions as to clinical effectiveness and value (ii) vulnerability for meeting outcomes-based contracts and (iii) inability to compete competitively for new business / retaining current business.*	10 (2+ 4+4)
	Reliance on other orgs/ agencies for integrated service delivery (including partnerships). *Differences in organisational expectations, priorities, perceptions or governance lead to barriers to integrated, collaborative or partnership working resulting in inability to achieve the strategic objective of developing patient self-managed care (and other healthcare efficiency initiatives or successful tender bids).*	9 (2+3+4)
	Underdeveloped / ineffective use of technology and Cyber Security Risks. *Underdeveloped / ineffective / insecure technology will result in having antiquated (or vulnerable) technical systems and /or working practices thereby (i) hindering delivery of modern, effective healthcare and (ii) presenting barriers to (a) efficiency or (b) operational viability / vulnerability or (c) market competitive advantages.*	9 (2+4+3)

The overall risk score is calculated as the sum of ratings for current status, current likelihood and current impact. (Max score of 6 for each rating)

Quality governance

The NED-chaired, Healthcare Governance Committee (HGC) monitors arrangements and seeks assurance on behalf of the Board in respect of the quality and safety of services provided by the Trust. (Including follow-up actions as necessary). These include:

- Standing reports on serious incidents and complaints (including follow-up actions)
- Clinical audit and clinically-related internal audits
- Quality Improvement Plan
- Quality priorities for each year (and action plan)
- Production and content of the Trust's Quality Account
- CQUINS
- Clinical policies
- CQC registration compliance
- Control of Infection
- Safeguarding
- Safe Staffing levels
- Mortality Review
- Response to external reports and initiatives
- Monitoring progress against relevant action plans.
- Assessment and challenge of quality information
- Assurance on compliance with CQC registration requirements.

The Healthcare Governance Committee also undertakes periodic "Operational Reviews", which involves reviewing specific services or specialties in depth. This includes making visits to the sites or services.

In 2017/18 the Healthcare Governance Committee was supported by Groups (which are accountable to the Executive Team), with associated Forums as follows:

Group	**Associated Forums**
Clinical Effectiveness	Medicines Management Clinical Effectiveness Research & Development Equality & Community Engagement Forum
Patient Safety & Experience	Safeguarding Adults Safeguarding Children Infection Control Medical Devices Mortality Review Serious Incident Panel
Professional Leaders Group	Professional Forums: Nurses Allied Health Professionals Doctors and Dentists
Medical Revalidation Decision Making Group	

In addition to HGC Chair's assurance report and minutes of HGC meetings, the Board receives (i) quarterly quality reports and (ii) regular reports on complaints, incidents and

safe staffing. Quality issues and risks also feature in the Director of Nursing & Quality's reports which go to each Board meeting.

Data security

The Director of Finance, as the Trust's Senior Information Risk Owner (SIRO), has accountability for data security. In this role he is supported by the work of the Assistant Director of Performance and Information, The Head of Performance and Information and The Head of Information Governance.

Management and control of data security risks is also undertaken by the Trust's out-sourced IT service supplier. Oversight of data security is through the Trust's Information Governance Group, which reports to the Executive Team.

Risks to data security identified are, in common with other risks, entered on the appropriate risk register, as relevant to the risk.

NHS provider licence condition FT4

While NHS trusts are exempt from the requirement to apply for and hold the NHS Provider Licence, directions from the Secretary of State require NHS TDA to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate. This includes compliance with Provider Licence Condition FT4.

In June 2017 the Board confirmed self-certification of compliance with NHS provider licence condition 4. This included consideration of assurances / evidence, identification of risks and actions identified to mitigate these risks, as matched against 20 prescribed statements which form the Licence Condition.

Compliance with the requirement to self-certify condition 4 was checked in July 2017 by NHS Improvement (NHSI) as part of an audit of selected providers.

More specifically in respect of (i) the effectiveness of governance structures (ii) the responsibilities of directors and subcommittees (iii) reporting lines and accountabilities between the board, its subcommittees and the executive team (iv) the submission of timely and accurate information to assess risks to compliance with the conditions of the licence and (v) the degree and rigour of oversight the board has over the trust's performance, the following was the outcome of self-assessment:

Ref.	Corporate Governance Statement	Assurance / Evidence	Confirmed / Unconfirmed	Risks (*)	Mitigating Actions (*)
3	**The Board is satisfied that the Licensee has established and implements:**				
3(a)	Effective board and committee structures	• Committee Structure reviewed annually by The Audit Committee and The Board	Confirmed	Ineffectiveness contributes to failure in achieving the Trust's objectives or being weak with respect to	Keep Board and Committee structure under review and periodically test effectiveness. Entry on BAF or High Level Risk Register as

Ref.	Corporate Governance Statement	Assurance / Evidence	Confirmed / Unconfirmed	Risks (*)	Mitigating Actions (*)
				assurance.	appropriate.
3(b)	Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and	• Scheme of Reservation & Delegation • Terms of Reference for all Committees • Committee Chair's Assurance Reports to Board • Standing Orders • Standing Financial Instructions • Trust Policies	Confirmed	Lack of clarity results in confusion, duplication, gaps and lack of clear accountability.	Review Committee Terms of Reference if evident that responsibilities are not clear. Entry on BAF or High Level Risk Register as appropriate.
3(c)	Clear reporting lines and accountabilities throughout its organisation.	• Job Descriptions • Scheme of Reservation and Delegation • Operational Scheme of Delegation • Trust Policies • Structure Charts	Confirmed	As above	Review and amend evidence documents as necessary. Entry on BAF or High Level Risk Register as appropriate.
4	**The Board is satisfied that the Licensee has established and effectively implements systems and/or processes:**				
4(b)	For timely and effective scrutiny and oversight by the Board of the Licensee's operations;	• Part 1 and Part 2 Board Meetings every other month. • Board Escalation Reports • IBPR • Miscellaneous standing reports to Board. (eg Quarterly Quality Report, safe staffing, serious incidents, complaints, mortality review, finance, business opportunities, contracting, etc.) • Board Committee papers • Committee Chair's Assurance Reports	Confirmed	Information required for effective scrutiny and oversight is of poor quality, isn't timely or, doesn't reach the Board.	Board and Committee review after each meeting of agenda and quality and timeliness of papers Increased reporting frequency to Executive Team/Committees/Board as required. Ability to call additional meetings if required for specific issues or concerns Entry on BAF or High Level Risk Register as appropriate.

(*) *For the avoidance of doubt the Risks and Mitigating Actions columns depict risks which may arise in the event of not complying with the Licence Condition and they do not reflect the current position of the Trust.*

The Well-Led Framework

HCT undertook a self-assessment against the CQC Well Led Framework in October 2016. Subsequently CQC and NHSI consulted on a revised approach to the framework with responses published by NHSI in June 2017 and CQC October 2017.

There were three key outcomes from the consultation:

(1) Changes to the structure and content of the Framework to provide a single set of eight Key Lines of Enquiry (KLOEs). The KLOEs include strengthened themes relating to leadership behaviours and culture, finance and resource governance, and system governance and leadership. The WLF will apply at all levels of the organisation not just at Board level

(2) CQC confirmed its intention to assess Well Led at Board level in each Trust on a regular basis, approximately annually. Where CQC identify significant concerns NHSI would commission a more detailed governance review

(3) NHSI confirmed all Trust will be required to undertake a developmental review on a comply or explain basis every three to five years. Developmental reviews have three stages – an internal self-assessment, externally facilitated review and development of a development plan. The self-assessment should provide the basis for the external review and should focus on identifying the areas of leadership and governance that would benefit from further targeted work to secure and sustain future performance.

In response to the revised guidance HCT is currently mid-way through a refreshed self-assessment using the new WLF (step 1 of the NHS developmental review process). Following an initial desk-top review the senior management team are undertaking a self-assessment for each of their services. This will then be collated with the initial desk-top review to provide an overall self-assessment for presentation to the Healthcare Governance Committee and Trust Board in May.

CQC

The trust is fully compliant with the registration requirements of the Care Quality Commission and currently holds a CQC rating of “Good”. A further, full CQC inspection is awaited in 2018/19.

NHS pension scheme rules

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.

Equality, diversity and human rights

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

Emergency preparedness, civil contingency and climate change

The trust works closely with partner agencies and external organisations to ensure resilience in the event of flood or severe weather events. Robust plans are in place to provide critical services including flexible working where possible, relocation of services in the event of building or infrastructure failures and special measures to protect patients where extreme temperatures (heat or cold) are predicted.

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

The Trust's financial performance is monitored at the monthly Strategic and Resources Committee. This committee monitors this financial performance in its broadest sense and is concerned with the overall efficiency and effectiveness relating to the deployment of Trust resources. This committee is a sub-committee of the Trust board where further assurance is sought.

The Trust's Audit Committee also performs a pivotal role is providing the board with assurance on the use of resources. Each year the Audit Committee commissions the internal auditors to undertake reviews of key internal risks with a view to gaining assurance that there are sufficient and appropriate processes in place to demonstrate the economic, efficient and effective use of resources.

To ensure that the Trust is able to demonstrate the effectiveness of its services, it participates in local and national benchmarking exercises. Linked to this, the Trust is a member of the Lord Carter Model Hospital cohort for community trusts. This group enables the Trust to compare itself with peer organisations and allows conversation between Trusts on best practice.

In addition to the previous mentioned approach, the Trust also participates in the national reference costs collection process. For the year 2017-18 the Trust has a reference cost index of 91 which is below the national average indictor set at 100. Any score below 100 indicates a more efficient provider for the amount of activity delivered.

Information governance

During 2017/18, the Trust had 5 lapses of data security which was reported to the Information Commissioner's Office:

- May 2017 - Patient NHS Numbers, Date of Birth and full postcode for 13,380 patients sent to recipients from @hct.nhs.uk account to @nhs.net accounts.

- October 2017 - Caseload table found in patients home by non-NHS care / home help provider.

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- January 2018 - Electronic records of 603 patients disclosed in error to new provider of clinical service

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In all cases the Information Commissioners Office felt the Trust had taken all reasonable steps to ensure data security and no further action has been taken against the Trust. All staff continue to be reminded of the need for vigilance when handling and sending confidential data.

All information governance incidents are taken seriously and advice is taken as appropriate from the Medical Director, as Caldicott Guardian, and/or the Director of Finance, as Senior Information Risk Owner (SIRO). Incidents are fully investigated, remedial action is taken and lessons learned are applied across the organisation.

The Trust's Information Governance Group, which includes the SIRO and Caldicott Guardian, reviews all data security incidents. Changes in practice have been made in some cases to minimise the risk of repetition, a standard operating procedure has been adopted across the Trust for the handling and processing of correspondence that includes Personal Confidential Data.

Information Governance policies have been updated during the year to meet the requirements of Level 2 of the NHS "Information Governance Toolkit".

Annual Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

During the financial year the Trust has a formal reporting process to collate the quality data (both quantitative and qualitative) which forms the basis of information provided in the end of year quality account. This quarterly quality report and the Trust IBPR data is reviewed and validated internally through the relevant Trust performance and quality governance committee/ groups, including the Executive Team prior to sign off. In addition it is shared with our commissioners and is incorporated within our contract review meetings, this supports external data validation.

The quality account development is a robust process which commences early in quarter 4 each year, with named Executive Leads and named leads providing clear guidance and timelines enabling completion, and is shared with our key stakeholders for comment, enabling an external view of content balance, prior to final sign off by the Executive leads and the Board.

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 committee, the healthcare governance committee and other sources, and plans to address

weaknesses and ensure continuous improvement of the system are in place.

The Head of Internal Audit opinion for 2017/18

The Head of Internal Audit opinion for 2017/18 is that:

The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified that further enhancements are required to the framework of risk management, governance and internal control to ensure that the framework remains adequate and effective.

Most particularly, these related to the areas of Medicines Management, Partnerships, Procurement and Key Financial Controls. Actions have been identified which the Trust has either implemented or is in the process of implementing to close these gaps.

The Head of Internal Audit opinion also concluded that "we do not consider that within these areas there are any issues that need to be flagged as significant control issues."

Assurances as to the effectiveness of internal controls

Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control also provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by

* Internal Audit Reports and the Head of Internal Audit's opinion
* External Audit
* Care Quality Commission (CQC) registration requirements and outcomes
* CQC inspection reports
* The Trust's monthly, Integrated Business Performance Report
* Business Unit Performance Reports
* Minutes and papers of the Trust Board, Board Committees and Sub-Committees. (Including reports from executive directors as standing items)
* Reports from the Local Counter-Fraud Specialist
* Submissions to, and feedback from, NHS Improvement (NHSI)
* Quality and contract review meetings with commissioners
* Board and Executive site visits and "deep dives" into services
* Assurance Reports from the Chairs of Groups which report to the Executive Team
* NHS "Information Governance Toolkit" compliance.
* Board self-certification of compliance with NHS Provider Licence conditions GC (6) and FT (4)

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Audit Committee, Healthcare Governance Committee, Strategy & Resources Committee and the Executive Team.

The following have a role in maintaining and reviewing the effectiveness of the system of internal control:

* The Board

The Board has been actively involved in developing and reviewing the Trust's risk management processes including receiving and reviewing minutes and Chair's observations from all committees which report to the Board. The Board also reviews the Board Assurance Framework, High Level Risk Register, Integrated Performance reports and Quality reports.

* The Audit Committee

The Audit Committee has been a directing force in relation to reviewing the framework of internal control particularly with regard to corporate risk, the Assurance Framework, the High Level Risk Register and counter fraud.

* The Healthcare Governance Committee

The Healthcare Governance Committee is responsible for the governance and management of clinical risk, including ensuring compliance with regulatory standards and requirements, adoption of clinical policies and review of clinical aspects of performance, including incidents and complaints. The Committee also (i) provides assurance to the Board in respect of patient safety, quality of services and patient experience and (ii) seeks assurance as to the assessment of the quality impacts of cost improvement schemes.

* The Strategy and Resources Committee

The Strategy and Resources Committee is made up of the majority of the members of the Board and meets monthly. The remit of the Committee is to scrutinise current financial performance and future financial plans; review financial, workforce and business risks; monitor that decisions involving finance, resources and assets are properly made to promote good financial practice throughout the Trust and to receive assurances that an integrated and holistic approach is taken to the use of all the Trust's resources for the delivery of Trust strategy.

* The Information Governance Group

The Information Governance Group reports to the Executive Team and is responsible for the governance and management of information associated risk and compliance with the "NHS Information Governance Toolkit".

* The Executive Team

The Executive Team meets weekly and operationally manages all areas of risk, including the risk and control framework. The Executive also populates and reviews the Board Assurance Framework and reviews the High Level Risk Register.

Executive Directors ensure that key risks have been highlighted and monitored within their directorates and the necessary action has been taken to address them.

* Internal Audit

  Internal Audit has reviewed and reported upon control, governance and risk management processes, based on an audit plan approved by the Audit Committee and endorsed by the Board. Where scope for improvement was found, recommendations were made and appropriate action plans agreed with management.

* Clinical Audit

  Clinical Audit is overseen by the Trust's Clinical Effectiveness Group, which reports to the Executive team and gives assurance to the Healthcare Governance Committee. The Clinical Effectiveness programme is also reported to the Trust's Audit Committee. Lessons learned from clinical audits are fed back to services and lessons of general application are disseminated through the Trust's "Clinical Matters" publication.

My review confirms that Hertfordshire Community NHS Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

Conclusion

No significant internal control issues have been identified for 2017/18.

Clare Hawkins
(Acting) Chief Executive

24th May 2018

Remuneration Report

Remuneration and the Remuneration Committee

HCT has a Remuneration Committee which makes decisions to recommend to the HCT Board on the remuneration, terms and performance related pay of the Chief Executive and executive directors on Very Senior Manager (VSM) terms and conditions.

The Remuneration Committee also reviews all severance payments as required by the NHS Improvement (NHSI) Accountability Framework. This relates to all employees at Executive Director level and below.

Membership of the Committee consists of:

- Anne McPherson Non-Executive Director and Chair of the Remuneration Committee
- Declan O'Farrell – Chair of HCT
- Jeff Phillips – Non-executive Director and Chair of the Audit Committee

The following may also be in attendance:

- Chief Executive
- Director of Human Resources & Organisational Development
- Executive Directors (except when their remuneration or terms and conditions of service are discussed).

During 2017/2018 the Committee met on 6 occasions and the main items addressed were:

- Consideration of national guidance on remuneration for executive directors
- Salary, terms and conditions for new executive directors (substantive or interim)
- Changes to executive director roles
- Completion of executive director appraisals
- Redundancy payments

The Chair and Non-Executive Directors are remunerated at rates prescribed by the Secretary of State for Health. Executive Directors are remunerated as set out in the NHS Very Senior Managers Pay Framework (VSM) and senior managers are paid in accordance with NHS Agenda for Change pay scales.

Executive Directors are appointed on substantive, permanent contracts, on a notice period of three months, with remuneration overseen by NHS Improvement. Where there is a temporary vacancy, however, an interim Director may be appointed. In the event of termination by the Trust, any payment due is paid in accordance with the reason for termination and the contract of employment.

During 2017/18, the Trust made no new substantive appointments. However, some acting up arrangements were put in place to cover the secondment of the Director of Finance to another NHS Trust and the absence of the CEO.

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 Hertfordshire Community NHS Trust in the financial year 2017/18 was £143,727 (2016/17, £142,500). This was 4.99 times (2016/17, 4.77 times) the median remuneration of the workforce, which was £28,746 (2016/17, £29,885). *(This paragraph was subject to audit and is referred to in the auditor's opinion).*

In 2017/18, no employees received remuneration in excess of the highest-paid director (2016/17, none). Remuneration ranged from £6,157 to £143,727 (2016/17 £6,157 - £142,543).

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.

Compensation on early retirement or for loss of office and Payments to past directors

The Trust made no payments in the way of exit packages or severance payments to directors in 2017/18 and no payments were made to past directors. *(This paragraph was subject to audit and is referred to in the Auditor's Opinion).*

Exit Packages

12 exit packages were agreed in 2017/18 as per the table below. These relate to contractually obligated payments in respect of redundancy.

Exit package cost band (including any special payments)	Number of compulsory redundancies (Whole numbers only)	Cost of compulsory redundancies £s	Number of other departures	Cost of other departures Agreed £s	Total number of exit packages (Whole numbers only)	Total cost of exit packages £s	Number of departures where special payments have been made	Cost of special payment element included in exit packages £s
Less than £10,000	2	8876.20	0	0	2	8,876.20	0	0
£10,000 - £25,000	6	89955.34	0	0	6	89,955.34	0	0
£25,001 - £50,000	3	107333.39	0	0	3	107,333.39	0	0
£50,001 - £100,000	1	50596.00	0	0	1	50,596.00	0	0
£100,001 - £150,000	0	0	0	0	0	£0	0	0
£150,001 - £200,000	0	0	0	0	0	£0	0	0
› £200,000	0	0	0	0	0	£0	0	0
Total	12	256,760.93	0	0	12	256,760.93	0	0

Non-Contractual Exit Payments

The Trust has not made any non-contractual exit payments in 2017/18. Non-contractual payments are those made without contractual or legal obligation, including those from judicial mediation.

Board Salaries and Pensions

(This section was subject to audit and is referred to in the Auditor's Opinion).

Board Salaries and Allowances 2017/18

2017/18			(a)	(b)	(c)	(d)	(e)	(f)
Name	**Title**	**Dates**	**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)**
			£000	**£000**	**£000**	**£000**	**£000**	**£000**
Declan O'Farrell	Chair	1/4/2017 - 31/3/2018	20 - 25	0	0	0	0	20 -25
Alan Russell	Non-Executive Director	1/4/2017 - 31/3/2018	5 - 10	0	0	0	0	5 - 10
Anne McPherson	Non-Executive Director	1/4/2017- 31/3/2018	5 - 10	0	0	0	0	5 - 10
Jeff Phillips	Non-Executive Director	1/4/2017 - 31/3/2018	5 - 10	0	0	0	0	5 - 10
Dr Linda Sheridan	Non-Executive Director	1/4/2017- 31/3/2018	5 - 10	0	0	0	0	5 - 10
Brenda Griffiths	Non-Executive Director (Designate)	1/4/2017 - 31/3/2018	5 - 10	0	0	0	0	5 - 10
David Law	Chief Executive	1/4/2017 - 31/3/2018	140 - 145	0	0	0	7.5 – 10	150 - 155
Clare Hawkins	Acting Chief Executive Officer	17/09/2017- 31/03/2018	115 - 120	0	0	0	127.5 - 130	245 - 250
Clare Hawkins	Director of Quality & Governance	1/4/2017- 16/09/2017						
Marion Dunstone	Director of Operations	1/4/2017- 31/3/2018	95 - 100	0	0	0	50 - 52.5	150 - 155
Julie Hoare	Director of Service Development & Partnerships Director of Finance	1/4/2017 - 31/3/2018	105 - 110	0	0	0	10 – 12.5	115 - 120
Debbie Eyitayo	Director of Human Resources & Organisation Development	2/5/2017 - 31/3/2018	95 - 100	0	0	0	82.5 - 85	180 - 185
* Dr John Omany	Medical Director	31/1/2017 - 31/3/2018	110 - 115	0	0	0	0	85 - 90
Phil Bradley	Acting Deputy CEO	1/4/2017- 30/11/17	80 - 85	0	0	0	40 – 42.5	125 - 130

Phil Bradley	Director of Finance	1/4/2017-30/11/2017						
Kevin Curnow	Acting Director of Finance	1/12/2017-31/3/2018	30 - 35	0	0	0	10 – 12.5	40 - 45
Antonia Robson	Acting Director of Business Services	1/12/2017-31/3/2018	25 - 30	0	0	0	17.5 - 20	45 - 50
Patricia Wren	Acting Director Quality & Governance	28/9/2017 - 31/3/2018	55 - 60	0	0	0	40 – 42.5	95 - 100

Board Salaries and Allowances 2016/17

2016/17			(a)	(b)	(c)	(d)	(e)	(f)
Name	**Title**	**Dates**	**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)**
			£000	**£000**	**£000**	**£000**	**£000**	**£000**
Declan O'Farrell	Chair	1/4/2016 - 31/3/2017	20 - 25	0	0	0	0	20 -25
Alan Russell	Non-Executive Director	1/4/2016 - 31/3/2017	5 - 10	0	0	0	0	5 - 10
Anne McPherson	Non-Executive Director	1/4/2016 - 31/3/2017	5 - 10	0	0	0	0	5 - 10
Jeff Phillips	Non-Executive Director	1/4/2016 - 31/3/2017	5 - 10	0	0	0	0	5 - 10
Brenda Griffiths	Non-Executive Director	1/4/2016 - 31/3/2017	5 - 10	0	0	0	0	5 - 10
Dr Linda Sheridan	Non-Executive Director	1/4/2016 - 31/3/2017	5 - 10	0	0	0	0	5 - 10
David Law	Chief Executive	1/4/2016 - 31/3/2017	140 - 145	0	0	0	32.5 - 35	175 - 180
Phil Bradley	Director of Finance	1/4/2016 - 31/3/2017	115 - 120	0	0	0	52.5 - 55	170 - 175
Julie Hoare	Director of Operations	1/4/2016 - 1/5/2016						
	Director of Service Development & Partnerships	2/5/2016 - 31/3/2017	105 - 110	0	0	0	110 - 112.5	215 - 220
Marion Dunstone	Interim Director of Operations	2/5/2016- 30/1/2017						
	Director of Operations	31/1/2017 - 31/3/2017	85 - 90	0	0	0	45 - 47.5	135 - 140
Clare Hawkins	Director of Quality & Governance	1/4/2016- 31/3/2017	105 - 110	0	0	0	55 - 57.5	160 - 165
Alison Shelley	Director of Human Resources & Organisational Development	1/4/2016- 25/11/2016	65 - 70	0	0	0	15 - 17.5	80 - 85
Debbie Eyitayo	Interim Director of Human Resources & Organisational Development	1/3/2017 - 31/3/2017	5 - 10	0	0	0	55 - 57.5	60 - 65
Dr John Omany	Medical Director	14/11/2016 - 31/3/2017	45 - 50	0	0	0	27.5 - 30	75 - 80

Pension Benefits 2017/18 (and 2016/17)

(This section was subject to audit and is referred to in the Auditor's Opinion).

Pension Benefits 2017/18

Name & Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31st March 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31st March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 31st March 2017	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31st March 2018	Employers contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£00
David Law Chief Executive	0 - 2.5	2.5 - 5	50 - 55	160 - 165	1090	83	1184	
Clare Hawkins - Acting Chief Executive and Director of Quality & Governance	5 - 7.5	17.5 - 20	45 - 50	145 - 150	789	173	970	
Phil Bradley Acting Deputy CEO and Director of Finance	0 – 2.5	5 – 7.5	50 - 55	150 - 155	923	83	1056	
Julie Hoare Director of Service Development & Partnerships	0 - 2.5	0	40 - 45	115 - 120	740	54	801	
Marion Dunstone Director of Operations	2.5 - 5	2.5 - 5	35 - 40	90 - 95	533	75	613	
Debbie Eyitayo Director of Human Resources & Organisational Development	2.5 – 5	7.5 -10	30 - 35	80 - 85	445	103	552	
Dr John Omany Medical Director	0	0	35 - 40	115 - 120	0	0	0	
Kevin Curnow Acting Director of Finance	0 - 2.5	0	12.5 - 15	0	94	6	113	
Antonia Robson Acting Director of Business Services	0 - 2.5	0	10 - 12.5	0	79	11	114	
Patricia Wren Acting Director Quality and Governance	0 - 2.5	5 – 7.5	25 - 30	80 - 85	534	57	651	

Pension Benefits 2016/17

Name & Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31st March 2016 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31st March 2017 (bands of £5,000)	Cash Equivalent Transfer Value at 31st March 2016	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31st March 2017	Employers contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£00
David Law *Chief Executive*	0 - 2.5	5 - 7.5	50 - 55	155 - 160	1011	79	1090	
Phil Bradley Director of Finance	2.5 - 5	7.5 - 10	45 - 50	140 - 145	837	86	923	
Julie Hoare Director of Operations - Director of Service Development & Partnerships	5 - 7.5	15 - 17.5	35 - 40	115 - 120	622	118	740	
Marion Dunstone Interim Director of Operations - Associate Director of Operations	2.5 - 5	2.5 - 5	30 - 35	85 - 90	489	40	533	
Alison Shelley Director of Human Resources & Organisational Development	0 - 2.5	0	5 - 10	0	75	10	90	
Clare Hawkins Director of Quality & Governance	2.5 - 5	7.5 - 10	40 - 45	125 - 130	712	77	789	
Debbie Eyitayo Director of Human Resources & Organisational Development	0 - 2.5	0 - 2.5	25 - 30	70 - 75	394	4	445	
Dr John Omany Medical Director	0 - 2.5	0 - 2.5	35 - 40	115 - 120	0	0	0	

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 (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include 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.

Pension liabilities

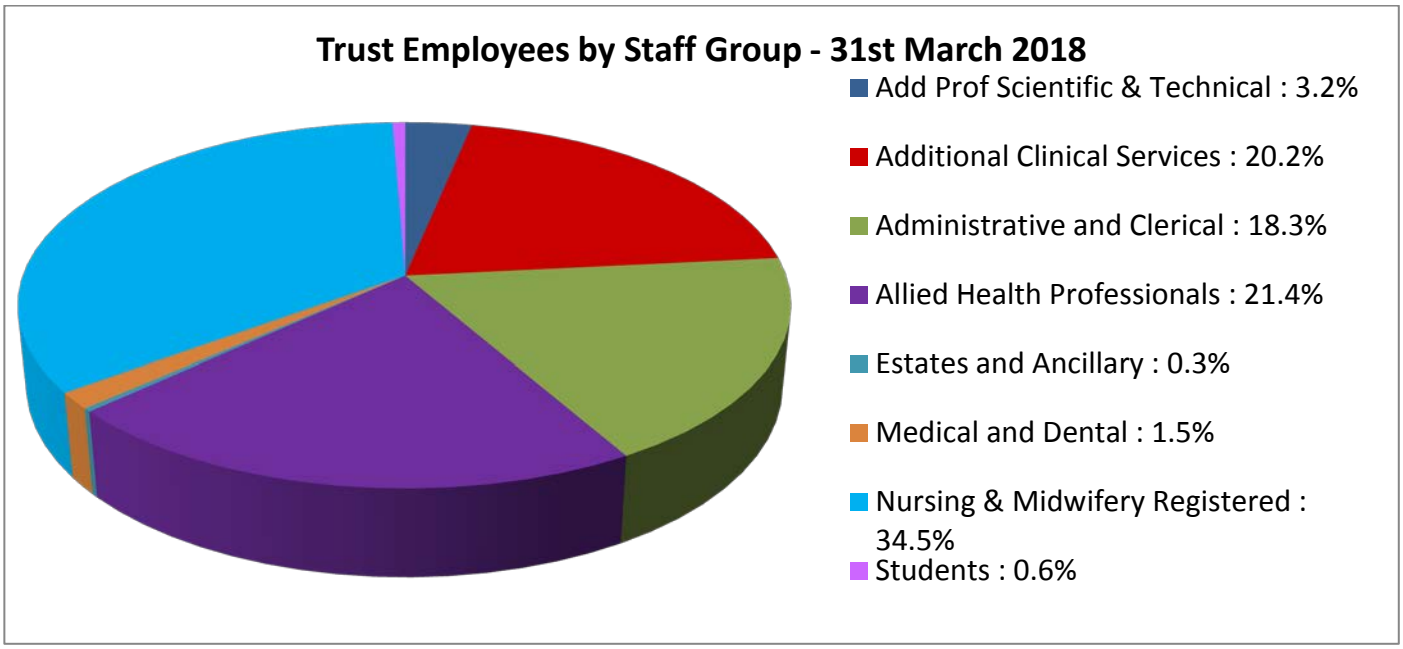
Pension liabilities are treated as payables in the accounts. The accounting policy 1.8 refers to the treatment of pensions within the Trust's accounts.

Staff Report

The Trust had 2,749 (2,253.89 FTE) positions filled as at 31st March 2018. (Compared to 2958 (2419.08 FTE) in 2016/17 and 3032 (2499.52 FTE) in 2015/16. *(This paragraph was subject to audit and is referred to in the Auditor's Opinion).*

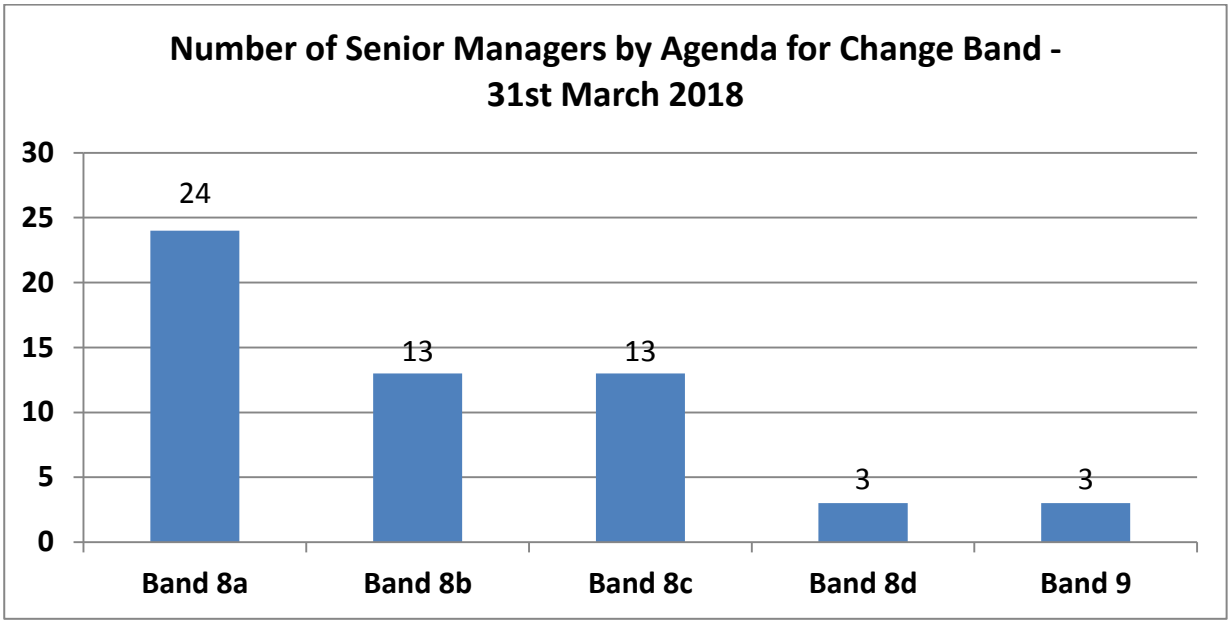
The profile of the staff is as follows:

Staff Groups

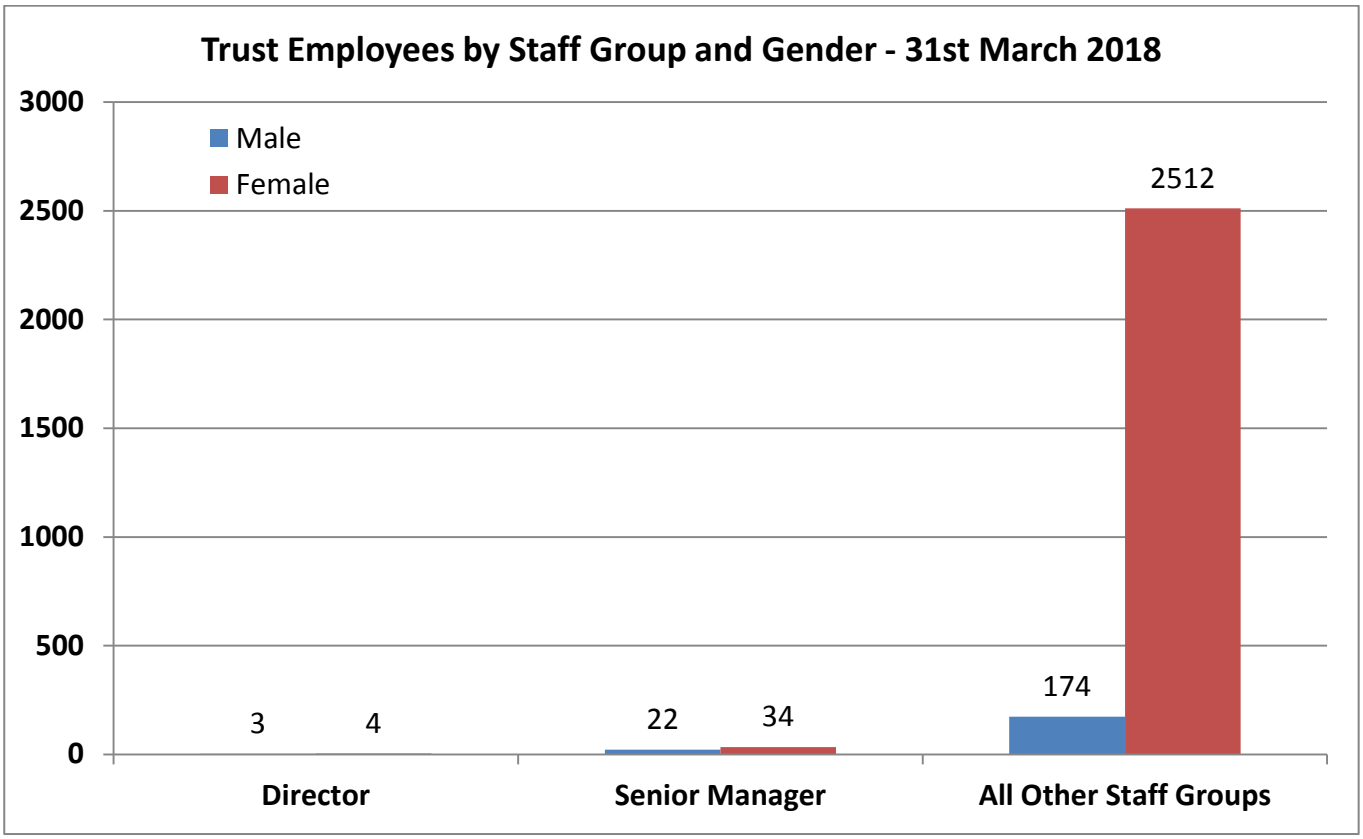


Senior Managers

For the purposes of the graph below, a senior manager has been classed as a non-clinical member of staff in Agenda for Change Band 8a or above.



Staff by Gender



Trust Total: Female 92.8% Male 7.2% (2016/17 = Female 93.2% Male 6.8%)

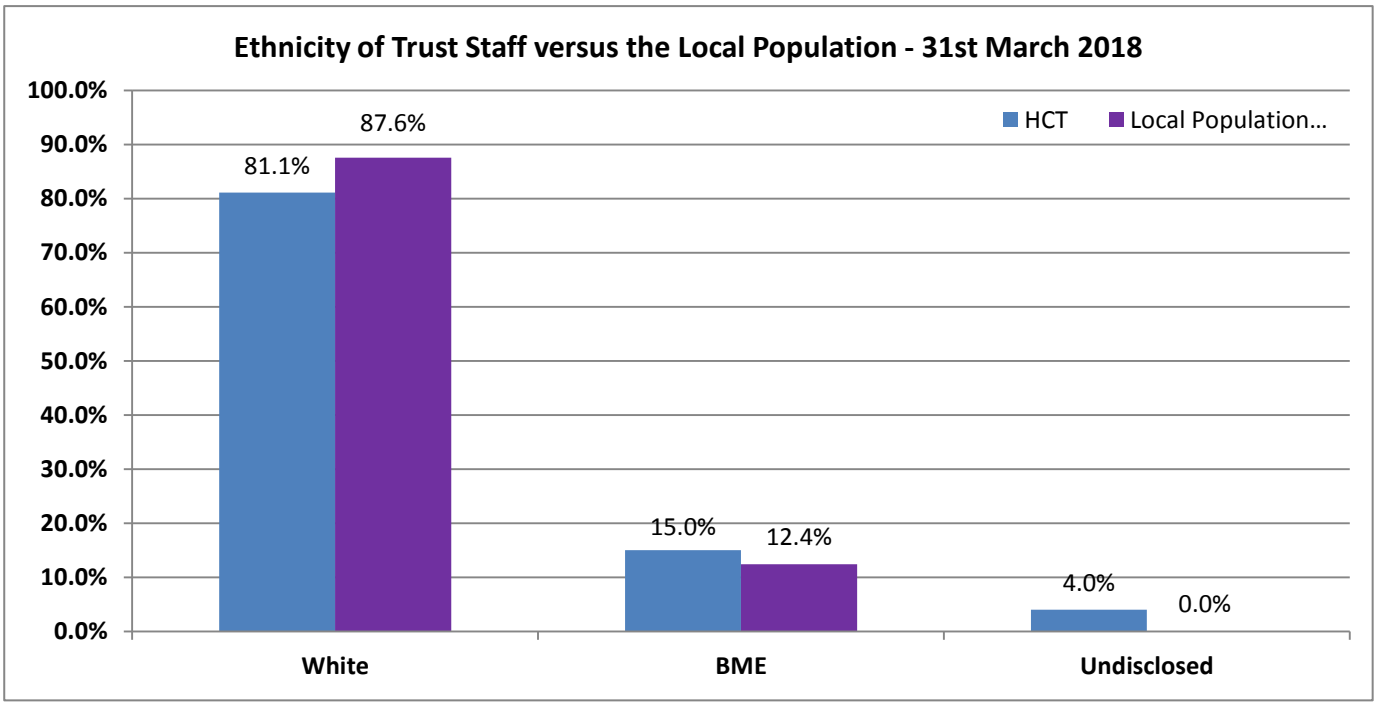
The Trust Board and Executive Directors by Gender

The mix of gender on the Board of Directors as at 31st March 2018 was as follows (*):

		No.	%
Chair and Non-Executive Directors:	Female	3	50%
	Male	3	50%
Executive Directors:	Female	5	71%
	Male	2	29%
Combined:	Female	8	62%
	Male	5	38%

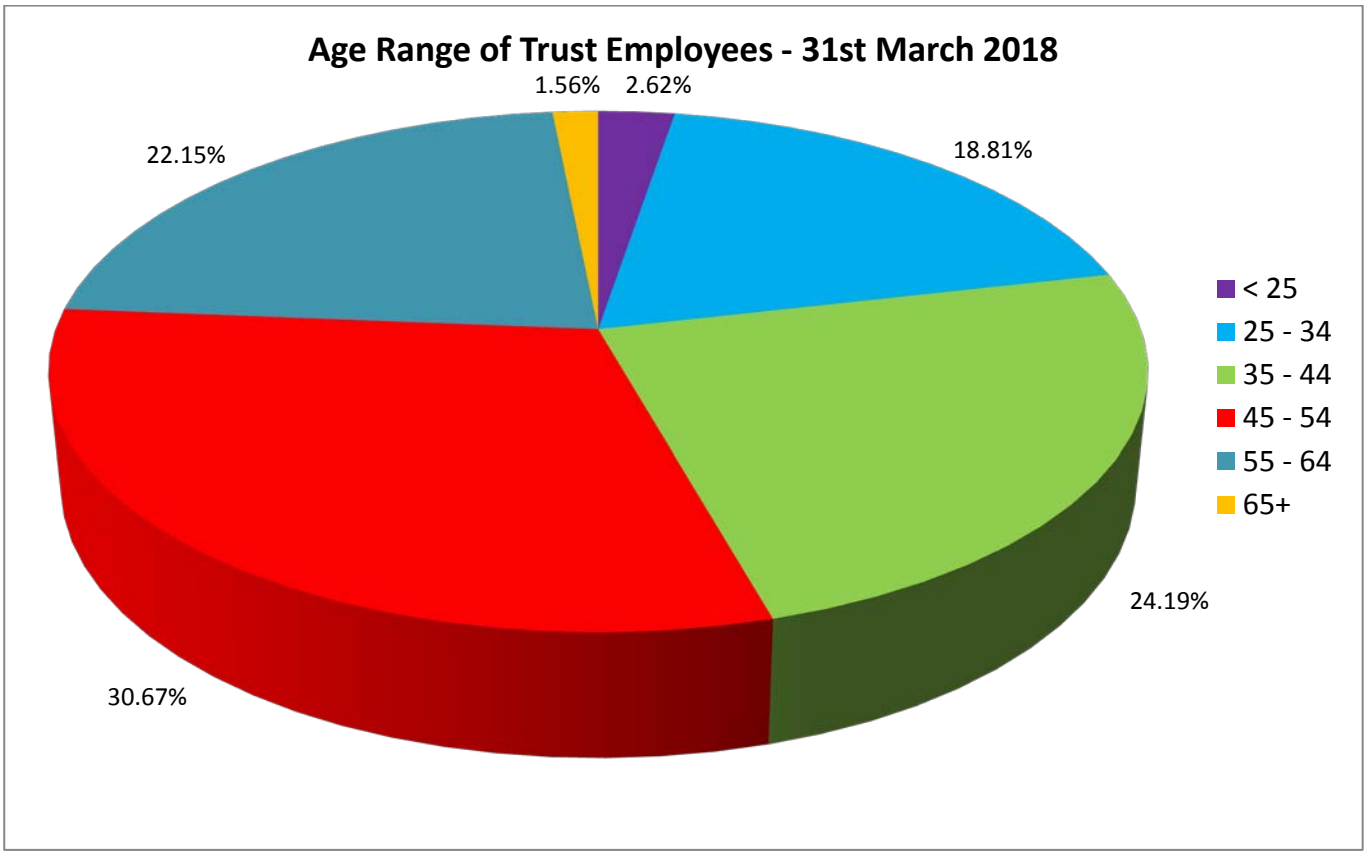
(*) Includes voting, non-voting and interim members.

Staff by Ethnic Background



BME = Black and Minority Ethnic

Staff by Age Band



Staffing Cost Analysis

The tables below show the average number of staff throughout the year and the total costs of staff to the Trust as employer.

Average Staff Numbers (*) / Total Costs	Total Staff Average Number	Total Staff Costs £ 000s	Permanently Employed Staff Average Number	Total Staff Costs Permanent £ 000s	Other Staff Average Number	Total Staff Costs Other £ 000s
Medical and dental	29	6,457	28	5,835	1	622
Ambulance staff	10	249	9	249	1	
Administration and estates	434	19,396	412	17,627	22	1,769
Healthcare assistants and other support staff	462	11,819	458	8,832	4	2,987
Nursing, midwifery and health visiting staff	815	38,823	795	34,906	20	3,917
Nursing, midwifery and health visiting learners	0	0	0		0	
Scientific, therapeutic and technical staff	554	28,604	544	26,041	10	2,563
Social Care Staff	0	0	0		0	
Healthcare Science Staff	0	0	0		0	
Other	0	0	0	351	0	
TOTAL	**2,304**	**£105,348**	**2,246**	**£93,490**	**58**	**£11,858**
Staff engaged on capital projects (included above)		139				139

(*) The average number of employees is calculated as the whole time equivalent number of employees under contract of service in each week in the financial year, divided by the number of weeks in the financial year.

Employee Expenses - Gross Expenditure	2017/18			2016/17		
	Total	Permanently employed	Other	Total	Permanently employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	**77,621**	76,136	1,485	**78,029**	77,786	243
Social security costs	**6,323**	6,323	0	**7,204**	7,204	0
Pension cost - NHS pension scheme	**9,685**	9,685	0	**9,980**	9,980	0
Pension cost - other	**0**	0	0	**7**	7	0
Termination benefits	**0**	0	0	**91**	91	0
Temporary staff - external bank	**3,085**	0	3,085	**2,543**	0	2,543
Temporary staff - agency/contract staff	**8,634**	0	8,634	**9,915**	0	9,915
Total Employee Benefits Including Capitalised Costs	**105,348**	**92,495**	**13,204**	**107,769**	**95,068**	**12,701**
Less:						
Costs capitalised as part of assets	**139**	139	0	**804**	215	589
Total Employee Benefits Excluding Capitalised Costs	**105,209**	**92,356**	**13,204**	**106,965**	**94,853**	**12,112**

Expenditure on Consultancy

In 2017/18, the Trust spent £681,911 on consultancy. Consultancy for this purposes is spend on external specialists whose service have been procured because necessary expertise or capacity is no available within the Trust. The bulk of consultancy spent was on supporting the Trust with business developments, tender submissions and transformation projects.

Off-payroll engagements

Following the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012, departments and their arms- length bodies, of which the NHS is considered to be an arms-length body of the Department of Health, are required to publish information on their highly paid and senior off-payroll engagements.

The disclosure is required for all engagements in place at 31 March 2018 that are more than six months and for more than £220 per day or those new in the year that meet these criteria. The tables below show the necessary information.

	Number
Number of existing engagements as of 31 March 2018	4 plus 15 doctors
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	2 plus 3 doctors
for between 2 and 3 years at the time of reporting	0 plus 11 doctors
for between 3 and 4 years at the time of reporting	1
for 4 or more years at the time of reporting	1 plus 1 doctor

The Trust policy is to require all contractors who are self-employed or paid through a personal services limited company to sign a Contract for Consultancy Services. This contract is also be signed by contractors who earn more than £220 a day and who are paid through a third party or agency.

Where the contractor is self-employed, they must provide evidence to demonstrate that they are registered to pay tax prior to commencing work (for example by supplying their business accounts and filed tax return or, if they are newly self-employed, their form SA250).

If the contractor fails to provide evidence when requested or if this evidence does not provide assurance that the contractor is complying with HMT requirements, then the

contractor's engagement will be terminated in accordance with the terms of the Contract for Consultancy Services.

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	0
Number of new engagements which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	0
Number for whom assurance has been requested	18
Of which:	
assurance has been received	7
assurance has not been received	11
engagements terminated as a result of assurance not being received	0

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	0
Number of individuals that have been deemed "board members, and/or senior officers with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements	16

Workforce Vision

Our workforce vision is ‘to have a workforce with the right skills and values, organised and supported in the right way, working together to maintain and improve the health and wellbeing of the people we serve’.

This is delivered through the strategic objectives set out in our five year Workforce and OD Strategy and supporting delivery plan. The strategy defines our commitment to staff in a range of key areas, including staff engagement, leadership, training & development, equality & diversity and staff health & wellbeing.

Staff Engagement

Staff engagement has continued to be a strong focus over the past year, with particular emphasis on involving our staff in the further development of our services, including our Customer Services Transformation programme and other innovative service developments to meet the needs of our patients and service users.

Our new Chief Executive Video updates and revised team brief process supplement our wide range of on-going communication mechanisms, including our programme of Board visits to services, the Director of HR’s Listening Events, Clinical Matters, local Business Unit Bulletins, HCT Facebook and Twitter accounts and staff e-newsletter ‘Noticeboard’.

The Trust has a well-established Joint Negotiating Committee and Medical Local Negotiating Committee, and engages regularly with union and professional association representatives on issues such as policy development, staff health and wellbeing and equalities, as well as in relation to organisational change and individual case management.

Staff Recognition

In addition to nominating our staff for external awards, staff achievements are recognised internally through our monthly local service schemes and annual Trust Leading Lights Awards, presented at our celebration event in July 2017. These awards include individual and team nominations under a range of categories, with all nominees being recognised for their achievements and certificates and vouchers being presented to the winners and runners up. Long Service Awards were also presented at this event, recognising 25, 30 and 40 years NHS service, along with recognition for our long serving retirees.

National Annual Staff Survey

The Trust runs its Annual Staff Survey as a full on-line census. The percentage response rate to the 2017 survey was 58.4% (compared to 54.5% in 2016), with over 1500 of our staff giving us their feedback, demonstrating a high level of engagement.

The results of the survey overall showed a positive picture. Whilst the responses to the latest survey were statistically considered the same as the 2016 survey, there were improved scores in several areas, including:

- More staff would recommend the Trust as a place to work
- Appraisals helped more staff to improve how they do their jobs

- The Trust took more action on staff health and wellbeing
- Fewer staff experienced harassment, bullying or abuse from colleagues
- Fewer experiences of violence have gone unreported

In terms of how we compared to other Community Trusts, there were 12 areas where we scored statistically above the average:

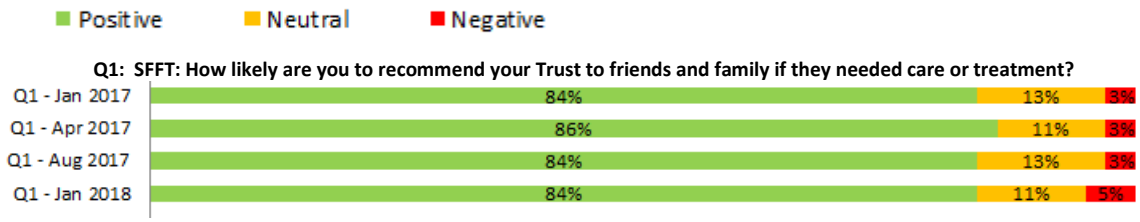
- Staff reporting good communication between senior management and staff
- Staff able to contribute towards improvements at work
- Staff recommending the trust as a place to work or receive treatment
- Quality of appraisals (Trust was top scorer for Community Trusts)
- Quality of non-mandatory training, learning or development
- Staff confidence and security in reporting unsafe clinical practice
- Effective use of patient / service user feedback
- Recognition and value of staff by managers and the organisation
- Staff receiving support from their immediate managers
- Staff belief the trust provides equal opportunities for career progression or promotion
- Staff experiencing harassment, bullying or abuse from staff in the last 12 months
- Staff experiencing physical violence from staff in the last 12 months

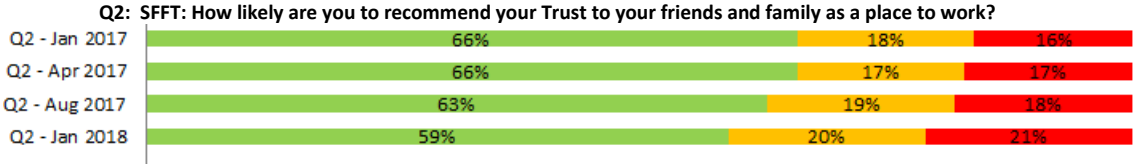
The Trust takes the staff survey results very seriously and is working to develop local action plans to address the areas requiring further development.

Pulse Surveys

In addition to the annual National Staff Survey, the Trust undertakes its own quarterly Pulse surveys. These comprise a number of core questions, plus some 'hot topic' questions on areas of particularly interest to the Trust. Response rates are high for this type of survey, at between 23-29% of the workforce each quarter. After a prolonged period of improvement, responses to the Pulse survey in 2017/18 showed a plateauing or slight dropping back of scores.

The Pulse survey also includes the staff Friend and Family Test questions, with stable results for staff recommending the Trust as a place to receive treatment, but a reduction in the score on the Trust as a place to work reflecting the current wider environment.





Leadership Development

Leadership development continues to be a key priority for the Trust and over the last year we have implemented the Effective Leadership project, a component of the Effective Teams transformation project. There are 3 strands of the project: identifying capability, developing our leaders and talent management. As part of the project plan the HCLM 360° tool has been used in all senior management teams and has supported team and organisational development requirements.

There remains continued development of our leaders at all levels through training and induction programmes, action learning sets, secondments, project work, coaching and access to regional strategic leadership programmes. .

These development opportunities have been supported by a range of engagement events and forums where leaders have come together to network, celebrate good practice, learn and influence. This includes our quarterly Senior Leaders and Leaders Forums, various clinical forums and an Administration Conference and development group. In June 2017, 200 leaders attended our annual Leadership conference to share information on our strategy and gain inspiration on Embracing the Pace of Change from our fun and dynamic keynote speaker.

Staff Development

Over the last year, we have continued to build on our training programme with other Trusts and the University of Hertfordshire to develop the skills and competencies of our staff, enabling them to deliver new models of care and to support patients as partners in their own health. Training in user self-management is being rolled out across the Trust.

Increasing the uptake of mandatory training has continued to be a key priority to ensure staff are confident to treat patients safely. 94% of staff completed this essential refresher training in the last year. The Trust will now accept training that has been completed with other NHS employers to enable new recruits to start work more quickly, and this has also reduced the time needed for corporate induction.

A 3 year Apprenticeship Plan has been developed to support the implementation of the new Apprenticeship Levy, and the Trust has been working closely with local partners to procure training providers to enable us to provide a wide variety of career pathways for staff. 32 of our current staff started apprenticeships this year, including 3 going through the Assistant Practitioner programme, 2 Nursing Associate Trainees and 3 on the Flexible Nursing Pathway. We are also recruiting 5 apprentice roles to work within our corporate structure. In this way the Trust is making good use of the apprenticeship levy to upskill our workforce.

In addition, we have reviewed our appraisal reporting system and continued to train appraisers to improve the quality of our appraisals. 92% of our staff received appraisals in the year and the 2017 national annual staff survey showed that we were the top rated Community Trust for the quality of our appraisals.

Staff recruitment and retention

The Trust recognises the vital importance of being able to recruit sufficient numbers of high quality staff to deliver safe and effective services to our patients and service users, along with retaining the experienced staff we already have working in our teams.

To address this important area, the Trust has a Workforce Resourcing Plan and is implementing a wide range of initiatives to attract new staff. During 2017/18 this has included training managers in fair and effective recruitment processes, improving our use of social media, and running innovative advertising campaigns on petrol pumps, at shopping centres and at the local cinema.

We have also focused on retention, working as part of a national collaborative to improve nursing retention. Alongside ongoing work on staff engagement, health and wellbeing and flexible working to improve our staff's working lives, we have further developed our retention action planning processes, held focus groups to ask staff what is important to them, improved preceptorship by providing increased support/buddying, and introduced career clinics for nurses looking for a change.

Equal opportunities in employment

HCT is committed to being an equal opportunities employer and our Equality and Diversity Policy sets out our aim to ensure that all employees, irrespective of their background, are supported to develop their full potential. An equal opportunity statement is included in all job descriptions to ensure staff are aware of their responsibilities.

We are committed to leading and embedding fairness in the culture and behaviours of our staff by:

- providing an environment where staff can thrive, are confident to be themselves, feel valued and treat each other with fairness, dignity and respect
- helping and supporting staff to understand the importance of personalisation, fairness and diversity in the planning and delivery of services
- showing zero tolerance towards bullying, harassment, inappropriate language and behaviour, and encouraging the reporting of all cases of discrimination.

We review and report on the profile of our workforce through our Public Sector Equality Duty (PSED) report, NHS Workforce Race Equality Standard (WRES) report and, for the first time this year, the Gender Pay Gap Report.

We train managers and staff in equality and diversity and are committed to implementing our equality and diversity objectives, which include further analysis of our equalities data to address any unconscious bias.

Disability

The Trust has achieved Level 2 Disability Confident Employer status under the Disability Confident scheme. This supports employers to make the most of the talents disabled people can bring to the workplace, by helping them to successfully recruit and retain disabled people and those with health conditions.

We currently employ 72 staff with a declared disability (2.6% of the workforce). Over the last year we have recruited 18 new staff with a disability to work in our services. We recognise the need to do more, however, and have introduced an application process to make it easier for people with learning difficulties to apply for posts.

Health and Wellbeing and Sickness Absence

One of our workforce priorities is to sustain positive initiatives for staff health and wellbeing in recognition of the significant transformational change we are expecting from our staff and the pressure they are working under.

Over the last year, we have worked towards national quality targets on staff health and wellbeing, and delivered a significant work programme on the priorities of muscular skeletal issues, mental health, healthy eating and staff flu vaccination uptake.

Working with our extended Staff Health and Wellbeing Network, we participated in the national Workplace Challenge, supported our staff through our comprehensive Employee Assistance Programme, piloted staff cholesterol and blood sugar tests and embedded our fast track physiotherapy service for staff.

This programme of work will continue over the coming year, working with partners across the health economy to respond to further national quality targets.

Staff sickness continues to be managed with support of our Health at Work (Occupational Health) Service. For the 12 month period to March 2018, our cumulative absence rate (Full Time Equivalent) was 3.81%. This equates to 13.91 calendar days per employee and this shows a decrease compared with the previous year's rate of 4.06% (14.82 calendar days per employee).

Sickness absence as reported back to the Trust from NHS Digital, based on data from the Electronic Staff Record (ESR) Data Warehouse shows that for January to December 2017:

	Number
Total Days Lost	21,215
Total Staff Years	2,314.5
Average working Days Lost	9.2

This is derived from the following data:

'Staff Years' 2017	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE-Days Available	FTE-Days Lost Sickness Absence
2,314.5	21,215	9.2	856,259	34,415

NB:

- The above sickness absence figures are reported on a calendar year and not a financial year basis and cover the period January to December 2016.

- ESR (The Electronic Staff Record) does not hold details of normal number of days worked by each employee. Data on days available and days recorded sick are based on a 365 – day year.

- The number of FTE-days available has been taken directly from ESR. This has been converted to FTE years in the first column by dividing by 365 (with a further adjustment where the figures are based on less than 12 months' data).

- The number of FTE-days lost to sickness absence has been taken directly from ESR. The adjusted FTE days lost has been calculated by multiplying by 225/365 to give the Cabinet Office measure (with a further adjustment where the figures are based on less than 12 months' data).

- Average Annual Sick Days per FTE has been estimated by dividing the estimated number of FTE – days sick by the average FTE, and multiplying by 225 (the typical number of working days per year).

The Trust's Health at Work Service is provided by East and North Herts Hospital Trust, which is accredited under the SEQOHS (Safe Effective Quality Occupational Health Service) scheme. In 2017/18:

- 588 pre-placement assessments were undertaken and 15 new employees attended for pre-placement health assessments
- 380 employees were referred to the Health at Work Service for advice
- 369 appointments were attended or telephoned for initial health at work assessments following referral
- 336 appointments were attended for occupational immunisations. During these appointments 1098 vaccines and blood tests were given for Hepatitis B, varicella (chickenpox), measles, mumps, rubella and TB (tuberculosis). This figure does not include flu vaccinations.
- 168 eye care vouchers were issued
- There were 26 sharps and body fluid injuries reported to the Health at Work Service

We also ran a very successful flu campaign, with Health at Work and our Flu Champions vaccinating 73.4% of eligible front-line staff to protect them and vulnerable patients.

Accountability report signed by the (Acting) Chief Executive

Clare Hawkins
(Acting) Chief Executive

24th May 2018

Proud to Care for you

Hertfordshire Community NHS Trust

Annual accounts for the year ended 31 March 2018

Contents:

Statement of directors' responsibilities in respect of the accounts

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

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

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

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

By order of the Board

24/5/18 Date ..... Chief Executive

24/05/18 Date ..... Finance Director

Independent auditor's report to the Directors of Hertfordshire Community NHS Trust

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Hertfordshire Community NHS Trust (the 'Trust') for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the National Health Service Act 2006.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Who we are reporting to

This report is made solely to the Directors of the 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 Trust's Directors 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 Trust and the Trust's Directors, as a body, for our audit work, for this report, or for the opinions we have formed.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Directors' use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The Directors are responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of our work including that gained through work in relation to the Trust's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resource or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS Improvement or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice we are required to report to you if:

- we have reported a matter in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we had reason to believe that the Trust, or an officer of the Trust, was about to make, or had made, a decision which involved or would involve the body incurring unlawful expenditure, or was about to take, or had 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 have made a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

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

Responsibilities of the Directors and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Director's Responsibilities, the Directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Directors determine is

necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Directors are responsible for 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 the Trust lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the Trust.

The Audit Committee is Those Charged with Governance.

Auditor's responsibilities for the audit of the financial statements

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 an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a 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 the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception - Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice we are required to report to you if, in our opinion we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

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

Responsibilities of the Accountable Officer

As explained in the Statement of the Chief Executive's Responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(3)(c) and 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 and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The

Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of Hertfordshire Community NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Paul Dossett

Paul Dossett
Partner
for and on behalf of Grant Thornton UK LLP

30 Finsbury Square
London
EC2A 1AG

24 May 2018

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	2	137,748	144,807
Other operating income	3	4,657	3,474
Operating expenses	4, 6	(137,486)	(144,200)
Operating surplus/(deficit) from continuing operations		**4,919**	**4,081**
Finance income	9	47	43
Finance expenses	10.1	(28)	(45)
PDC dividends payable		(1,587)	(1,555)
Net finance costs		**(1,568)**	**(1,557)**
Other gains / (losses)	11	(52)	(63)
Gains / (losses) arising from transfers by absorption	26	(1,206)	-
Surplus / (deficit) for the year from continuing operations		**2,093**	**2,461**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations		-	-
Surplus / (deficit) for the year		**2,093**	**2,461**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	5	(392)	-
Revaluations	14	3,293	720
Total comprehensive income / (expense) for the period		**4,994**	**3,181**

The retained surplus for the Trust for the year 2017-18 is £2,093m

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	12	384	595
Property, plant and equipment	13	62,998	60,087
Total non-current assets		**63,382**	**60,682**
Current assets			
Trade and other receivables	15	10,743	6,609
Cash and cash equivalents	16	18,734	18,773
Total current assets		**29,477**	**25,382**
Current liabilities			
Trade and other payables	17	(15,388)	(13,937)
Borrowings	19	(176)	(176)
Provisions	20	(91)	(144)
Other liabilities	18	(1,977)	(1,405)
Total current liabilities		**(17,632)**	**(15,662)**
Total assets less current liabilities		**75,227**	**70,402**
Non-current liabilities			
Borrowings	19	(2,356)	(2,532)
Provisions	20	(1,038)	(1,031)
Total non-current liabilities		**(3,394)**	**(3,563)**
Total assets employed		**71,833**	**66,839**
Financed by			
Public dividend capital		1,131	1,131
Revaluation reserve		19,602	17,221
Other reserves		4,946	4,946
Income and expenditure reserve		46,154	43,541
Total taxpayers' equity		**71,833**	**66,839**

The notes on pages 6 to 32 form part of these accounts.

The financial statements on pages 2 to 5 were approved by the Board on the 24th of May 2018 and signed on its behalf by:

Signature: 

Name: Clare Hawkins

Position: Chief Executive (Acting)

Date: **24 May 2018**

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

	Public Dividend Capital	Revaluation Reserve	Other Reserves	Income and Expenditure Reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**1,131**	**17,221**	**4,946**	**43,541**	**66,839**
At start of period for new FTs	**-**	**-**	**-**	**-**	**-**
Surplus/(deficit) for the year	-	-	-	2,093	**2,093**
Transfers by absorption: transfers between reserves	-	-	-	-	**-**
Transfer from revaluation reserve to income and expenditure reserve for impairr	-	-	-	-	**-**
Other transfers between reserves	-	(520)	-	520	**-**
Impairments	-	(392)	-	-	**(392)**
Revaluations	-	3,293	-	-	**3,293**
Transfer to retained earnings on disposal of assets	-	-	-	-	**-**
Taxpayers' equity at 31 March 2018	**1,131**	**19,602**	**4,946**	**46,154**	**71,833**

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

	Public Dividend Capital	Revaluation Reserve	Other Reserves	Income and Expenditure Reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**1,131**	**16,974**	**4,946**	**40,607**	**63,658**
Prior period adjustment	-	-	-	-	**-**
Taxpayers' equity at 1 April 2016 - restated	**1,131**	**16,974**	**4,946**	**40,607**	**63,658**
At start of period for new FTs	**-**	**-**	**-**	**-**	**-**
Surplus/(deficit) for the year	-	-	-	2,461	**2,461**
Transfers by absorption: transfers between reserves	-	-	-	-	**-**
Transfer from revaluation reserve to income and expenditure reserve for impairr	-	-	-	-	**-**
Other transfers between reserves	-	(473)	-	473	**-**
Impairments	-	-	-	-	**-**
Revaluations	-	720	-	-	**720**
Transfer to retained earnings on disposal of assets	-	-	-	-	**-**
Taxpayers' equity at 31 March 2017	**1,131**	**17,221**	**4,946**	**43,541**	**66,839**

Information on reserves

1 Public dividend capital

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

2 Income and expenditure reserve

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

3 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.

4 Other reserves

The balance of this reserve represents the opening balance of Hertfordshire Community NHS Trust at its establishment in November 2010; balances were transferred from Hertfordshire PCT.

Statement of Cash Flows for the Year ended 31 March 2018

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		4,919	4,081
Non-cash income and expense:			
Depreciation and amortisation	4	3,501	3,456
(Increase) / decrease in receivables and other assets		(4,134)	1,262
(Increase) / decrease in inventories		-	144
Increase / (decrease) in payables and other liabilties		206	1,434
Increase / (decrease) in provisions		(25)	269
Net cash generated from / (used in) operating activities		**4,467**	**10,646**
Cash flows from investing activities			
Interest received		47	43
Purchase of intangible assets		(16)	(15)
Purchase of property, plant, equipment and investment property		(2,815)	(4,581)
Sales of property, plant, equipment and investment property		84	-
Net cash generated from / (used in) investing activities		**(2,700)**	**(4,553)**
Cash flows from financing activities			
Movement on loans from the Department of Health and Social Care		(176)	(176)
Other interest paid		(49)	(53)
PDC dividend (paid) / refunded		(1,581)	(1,591)
Net cash generated from / (used in) financing activities		**(1,806)**	**(1,820)**
Increase / (decrease) in cash and cash equivalents		**(39)**	**4,273**
Cash and cash equivalents at 1 April - brought forward		**18,773**	**14,500**
Prior period adjustments		-	-
Cash and cash equivalents at 1 April - restated		**18,773**	**14,500**
Cash and cash equivalents transferred under absorption accounting		-	-
Cash and cash equivalents at 31 March	16	**18,734**	**18,773**

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Department of Health and Social Care has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

1.1 Accounting convention

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

Going Concern

These accounts have been prepared on a going concern basis. An assumption of going concern has been made as the Trust is a non-trading entity in the public sector with full expectation that the services it provides will continue in the future. This is in accordance with the GAM 2017/18 issued by the Department of Health and Social Care.

1.2 Acquisitions and discontinued operations

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

1.3 Movement of assets within the DH Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCI, and is disclosed separately from operating costs. Details of transfer by absorption are given in Note 26 to the accounts.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Charitable Funds

Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact.

For Hertfordshire Community NHS Trust the values of Charitable Funds are not material and are therefore not consolidated.

1.5 Critical accounting judgements and key sources of estimation uncertainty

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

1.5.1 Critical judgements in applying accounting policies

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

The Trust has considered its position with regard to financial, operational and other asociated risks and determined that it is a going concern. These accounts have been prepared on this basis.

1.5.2 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period. These present a significant risk of causing a material adjustment to the carrying amounts of financial assets and liabilities within the next financial year.

The Trust has estimated the life of assets capitalised as Plant, Property & Equipment based on advice from specialist staff and previous experience - Note 14.

The Trust continues to hold a provision for impairment of receivables. All non NHS debts over 30 days old are fully provided for (£27k) A number of other specific provisions have been made where there is a degree of uncertainty concerning the recovery of the debt; these sum to £248k in total and provision estimates range from 10% (£13k) to 100% (£168k).

The Trust is carrying a liability for provisions. In order to calculate the carrying amount the Trust has estimated the costs of dilapidation repairs required, its liability for potential litigation or claims during 2018-19 and beyond from issues arising in the current year, redundancy, the non achievement of CQUIN for 2017-18 which have been invoiced on an estimated basis.

The Trust has made a number of accruals for both income and expenditure; these have been estimated using the most appropriate information available for instance data provided by a counterparty organisation or the Trust's own internally generated information.
The Trust has used, wherever possible, advice from specialist providers or information from counterparty organisations to support estimated values within the accounts. If these were not available then the Trust's own data and experience has been used to calculate estimated amounts. This should reduce the risk of material errors arising in 2018-19 and future years from the estimated values included in these accounts.

1.6 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of income for the trust is from commissioners for healthcare services. Income relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay.

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

The NHS trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The NHS trust recognises the income only when it has been received.

1.7 Revenue government and other grant

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. The Trust has used the apprenticeship levy received to cover the costs of the graduate trainees engaged.

1.8 Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The Trust leave year runs from 1st April to 31st March. The Trust has a policy of not allowing any staff to carry forward untaken leave into the new financial year, however, the Trust acknowledges that those staff on maternity leave or long-term sick are entitled to annual leave that they will not have been able to take during the year and, therefore, an accrual has been made to take account of this.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The schemes 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, the schemes are accounted for as though they were defined contribution schemes: the cost to the NHS body of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.
Employer's pension cost contributions are charged to operating expenses as and when they become due.
Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.9 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.

1.10 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

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

- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. The Trust undertakes a full revaluation of all its properties every 5 years. In the intervening period an interim desk top valuation is carried out at 3 years with individual valuation exercises being performed on specific assets where significant building works have been undertaken. Current values in existing use are determined as follows:

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

The last full revaluation was undertaken at 31st March 2015.

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

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

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

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

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.

1.11 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5000.

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

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

Measurement

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

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.12 Depreciation, amortisation and impairments

Freehold land, assets under construction or development, and assets held for sale are not depreciated/amortised.

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

At each financial year-end, the NHS trust checks whether there is any indication that its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

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

1.13 Donated assets

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.14 Leases

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

The trust as lessee

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

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

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

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

1.15 Inventories

Inventories are valued at the lower of cost and net realisable value using an approximation of useful life and condition of the stock. It assumes stocks held in the community have no value as the NHS Trust is unable to confirm either their existence or condition therefore all the stocks handed out to the community are recognised as expenditure.

1.16 Cash and cash equivalents

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

1.17 Provisions

Provisions are recognised when the NHS trust has a present legal or constructive obligation as a result of a past event, it is probable that the NHS trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

- A short term rate of negative 2.42% (2016-17: negative 2.70%) for expected cash flows up to and including 5 years
- A medium term rate of negative 1.85% (2016-17: negative 1.95%) for expected cash flows over 5 years up to and including 10 years
- A long term rate of negative 1.56% (2016-17: negative 0.80%) for expected cash flows over 10 years.

All percentages are in real terms.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

1.18 Clinical negligence costs

The NHS Resolution (NHSR) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSR, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSR is administratively responsible for all clinical negligence cases the legal liability remains with the NHS trust. The total value of clinical negligence provisions carried by the NHSR on behalf of the trust is disclosed at Note 20.2

1.19 Audit negligence costs

The audit liability to the Trust on operational negligence is limited to £2 million.

1.20 Non-clinical risk pooling

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

1.21 Contingencies

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

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

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

1.22 Financial assets

Financial assets are recognised when the NHS trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the NHS trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

The Trust has reviewed its contracts and has determined they do not contain any embedded derivatives.

Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and where there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

The Trust does not hold any held to maturity investments.

Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

The Trust does not hold any available for sale financial assets.

Loans and receivables

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

The Trust holds current receivables which are held at book value and are expected to be recovered within one year.

1.23 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the NHS trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

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

1.24 Value Added Tax

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

1.25 Foreign currencies

The NHS trust's functional and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

The Trust did not have any foreign currency transactions during the financial year under review.

1.26 Public Dividend Capital (PDC) and PDC dividend

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

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

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

1.27 Losses and Special Payments

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

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

1.28 Research and Development

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

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

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

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

2. Operating Segments

The Trust engages in its activities as a single operating segment ie the provision of healthcare. The main source of revenue for the Trust is from commissioners of healthcare services which are principally CCGs and NHS England. The Department of Health has deemed that as CCGs and NHS England are under common control they are classed as a single customer for the purposes of segmental analysis.

Income from patient care activities received from:	**2017/18**	**2016/17**
	£000	**£000**
NHS England	7,600	6,954
Clinical commissioning groups	100,174	106,543
Department of Health and Social Care	74	32
Other NHS providers	6,222	5,534
NHS other	20	1
Local authorities	23,571	24,629
Non-NHS: private patients	28	25
NHS injury scheme	31	53
Non NHS: other	28	1,036
Total income from activities	**137,748**	**144,807**
Of which:		
Related to continuing operations	137,748	144,807
Related to discontinued operations	-	-

All the income from patient care activities received above is for community services.

The decrease of £7m income from Clinical Commissioning Groups is as a result of decommissioned services.

3. Other operating income

	2017/18	**2016/17**
	£000	**£000**
Research and development	173	142
Education and training	810	794
Charitable and other contributions to expenditure	-	57
Non-patient care services to other bodies	669	-
Sustainability and transformation fund income	2,215	1,676
Income in respect of staff costs where accounted on gross basis	9	-
Other income	781	805
Total other operating income	**4,657**	**3,474**
Of which:		
Related to continuing operations	4,657	3,474

Non patient care services to other bodies was previously coded under other income.

4. Operating expenses

	2017/18 £000	2016/17 £000
Purchase of healthcare from NHS and DHSC bodies	207	235
Purchase of healthcare from non-NHS and non-DHSC bodies	295	877
Purchase of social care	-	-
Staff and executive directors costs	105,300	106,965
Remuneration of non-executive directors	50	55
Supplies and services - clinical (excluding drugs costs)	6,376	8,011
Supplies and services - general	2,397	1,355
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	995	951
Consultancy costs	682	744
Establishment	4,816	4,335
Premises	9,021	12,809
Transport (including patient travel)	2,128	2,096
Depreciation on property, plant and equipment	3,282	3,200
Amortisation on intangible assets	219	256
Increase/(decrease) in provision for impairment of receivables	(396)	478
Increase/(decrease) in other provisions	18	-
Change in provisions discount rate(s)	-	33
Audit fees payable to the external auditor		
audit services- statutory audit	40	51
other auditor remuneration (external auditor only)	-	-
Internal audit costs	48	49
Clinical negligence	287	173
Legal fees	76	357
Insurance	6	101
Research and development	106	39
Education and training	441	502
Rentals under operating leases	749	471
Redundancy	260	-
Hospitality	-	10
Other	83	47
Total	**137,486**	**144,200**
Of which:		
Related to continuing operations	137,486	144,200

A number of expenses have decreased in 2017/18 because of the loss of services which were decommissioned during the year and end of 2016/17.

5. Impairment of assets

	2017/18	2016/17
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Total net impairments charged to operating surplus / deficit	-	-
Impairments charged to the revaluation reserve	392	-
Total net impairments	**392**	-

A desk-top revaluation was carried out by an Independent Professional Valuer which resulted in some of the land and buildings revalued less than the carrying book value and the resulting net negative impact of this exercise was £392k. See Note 16.1

6. Employee benefits

	2017/18	2016/17
	Total	Total
	£000	£000
Salaries and wages	77,621	78,029
Social security costs	6,323	7,204
Apprenticeship levy	351	-
Employer's contributions to NHS pensions	9,685	9,980
Pension cost - other	-	7
Termination benefits	-	91
Temporary staff (including agency)	11,719	12,458
Total gross staff costs	**105,699**	**107,769**
Recoveries in respect of seconded staff	-	-
Total staff costs	**105,699**	**107,769**
Of which		
Costs capitalised as part of assets	139	804

6.1 Retirements due to ill-health

During 2017/18 there was 1 early retirement from the trust agreed on the grounds of ill-health (2 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £23k (£95k in 2016/17).

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

7. Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

8. Operating leases

8.1 Hertfordshire Community NHS Trust as a lessor

Not relevant for the Trust

8.2 Hertfordshire Community NHS Trust as a lessee

The Trust is lessee under a number of operating leases, the main categories being estates and multi functional devices which are largely covered in consolidated leases with only a few individual leases remaining.

An additional two property leases commenced prior year which has increased overall commitments for operating leases.

	2017/18	2016/17
	£000	£000
Operating lease expense		
Minimum lease payments	683	388
Less sublease payments received	66	83
Total	**749**	**471**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease payments due:		
- not later than one year;	535	502
- later than one year and not later than five years;	1,704	1,619
- later than five years.	919	1,216
Total	**3,158**	**3,337**
Future minimum sublease payments to be received	-	-

9. Finance income

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

	2017/18	2016/17
	£000	£000
Interest on bank accounts	47	43
Total	**47**	**43**

10.1 Finance expenditure

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

	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	49	53
Total interest expense	**49**	**53**
Unwinding of discount on provisions	(21)	(8)
Other finance costs	-	-
Total finance costs	**28**	**45**

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

There was no payment made by the Trust under this legislation.

11. Other gains / (losses)

	2017/18	2016/17
	£000	£000
Losses on disposal of assets	(52)	(63)
Total gains / (losses) on disposal of assets	**(52)**	**(63)**

12.1 Intangible assets - 2017/18

	Software licences	Development expenditure	Other (purchased)	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**1,772**	**-**	**-**	**1,772**
Additions	16	-	-	**16**
Reclassifications	(8)	-	-	**(8)**
Gross cost at 31 March 2018	**1,780**	**-**	**-**	**1,780**
Amortisation at 1 April 2017 - brought forward	**1,177**	**-**	**-**	**1,177**
Provided during the year	219	-	-	**219**
Amortisation at 31 March 2018	**1,396**	**-**	**-**	**1,396**
Net book value at 31 March 2018	**384**	**-**	**-**	**384**
Net book value at 1 April 2017	**595**	**-**	**-**	**595**

12.2 Intangible assets - 2016/17

	Software licences	Development expenditure	Other (purchased)	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**1,757**	**-**	**-**	**1,757**
Prior period adjustments	**-**	**-**	**-**	**-**
Valuation / gross cost at 1 April 2016 - restated	**1,757**	**-**	**-**	**1,757**
Additions	15	-	-	**15**
Valuation / gross cost at 31 March 2017	**1,772**	**-**	**-**	**1,772**
Amortisation at 1 April 2016 - as previously stated	**921**	**-**	**-**	**921**
Prior period adjustments	**-**	**-**	**-**	**-**
Amortisation at 1 April 2016 - restated	**921**	**-**	**-**	**921**
Provided during the year	**256**	**-**	**-**	**256**
Amortisation at 31 March 2017	**1,177**	**-**	**-**	**1,177**
Net book value at 31 March 2017	**595**	**-**	**-**	**595**
Net book value at 1 April 2016	**836**	**-**	**-**	**836**

13.1 Property, plant and equipment - 2017/18

	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 2017 - brought forward	20,639	39,482	1,541	802	22	10,834	266	73,586
Transfers by absorption	(416)	(1,113)	-	-	-	-	-	(1,529)
Additions	-	14	3,069	327	-	1,216	-	4,626
Impairments	(25)	(367)	-	-	-	-	-	(392)
Revaluations	-	3,293	-	-	-	-	-	3,293
Reclassifications	-	-	-	-	-	8	-	8
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-
Disposals / derecognition	-	(60)	-	-	-	(76)	-	(136)
Valuation/gross cost at 31 March 2018	20,198	41,249	4,610	1,129	22	11,982	266	79,456
Accumulated depreciation at 1 April 2017 - brought forward	-	7,092	-	251	20	5,962	174	13,499
Transfers by absorption	-	(323)	-	-	-	-	-	(323)
Provided during the year	-	1,396	-	134	2	1,724	26	3,282
Accumulated depreciation at 31 March 2018	-	8,165	-	385	22	7,686	200	16,458
Net book value at 31 March 2018	20,198	33,084	4,610	744	-	4,296	66	62,998
Net book value at 1 April 2017	20,639	32,390	1,541	551	2	4,872	92	60,087

13.2 Property, plant and equipment - 2016/17

	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 2016 - as previously stated	20,639	37,590	749	575	22	9,465	264	69,304
Prior period adjustments	-	-	-	-	-	-	-	-
Valuation / gross cost at 1 April 2016 - restated	20,639	37,590	749	575	22	9,465	264	69,304
Transfers by absorption	-	-	-	-	-	-	-	-
Additions	-	883	1,025	232	-	1,369	2	3,511
Revaluations	-	849	-	-	-	-	-	849
Reclassifications	-	233	(233)	-	-	-	-	-
Disposals / derecognition	-	(73)	-	(5)	-	-	-	(78)
Valuation/gross cost at 31 March 2017	20,639	39,482	1,541	802	22	10,834	266	73,586
Accumulated depreciation at 1 April 2016 - as previously stated	-	5,629	-	137	15	4,257	148	10,186
Prior period adjustments	-	-	-	-	-	-	-	-
Accumulated depreciation at 1 April 2016 - restated	-	5,629	-	137	15	4,257	148	10,186
Transfers by absorption	-	-	-	-	-	-	-	-
Provided during the year	-	1,350	-	114	5	1,705	26	3,200
Revaluations	-	129	-	-	-	-	-	129
Disposals/ derecognition	-	(16)	-	-	-	-	-	(16)
Accumulated depreciation at 31 March 2017	-	7,092	-	251	20	5,962	174	13,499
Net book value at 31 March 2017	20,639	32,390	1,541	551	2	4,872	92	60,087
Net book value at 1 April 2016	20,639	31,961	749	438	7	5,208	116	59,118

13.3 Property, plant and equipment financing - 2017/18

	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 2018								
Owned - purchased	20,198	31,612	4,610	743	-	4,296	60	**61,519**
Owned - donated	-	1,472	-	1	-	-	6	**1,479**
NBV total at 31 March 2018	**20,198**	**33,084**	**4,610**	**744**	**-**	**4,296**	**66**	**62,998**

13.4 Property, plant and equipment financing - 2016/17

	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 2017								
Owned - purchased	20,639	30,931	1,541	549	-	4,872	86	**58,618**
Owned - donated	-	1,459	-	2	2	-	6	**1,469**
NBV total at 31 March 2017	**20,639**	**32,390**	**1,541**	**551**	**2**	**4,872**	**92**	**60,087**

14. Revaluations of property, plant and equipment

The Trust undertakes a full revaluation of all its properties every five years; the last full revaluation was undertaken at 31st March 2015, carried out by the Trust's qualified chartered surveyor. In the intervening period an interim desk top valuation is carried out at three years and in other years a review is undertaken, in consultation with the Trust's valuer, to ensure that the Trust's land and property is being held at current value in existing use.

The current interim desk top valuation was undertaken by Mr David Boshier Chartered Surveyor, an independent and experienced External Valuer of Boshier & Company, resulted in the values of the Trust's three specialised properties being increased by 5.8% in line with current forecasts for 2017/18. Forecast increases for both land and non specialised properties is negligible in the context of current property values, therefore, no adjustment has been made to these categories of non current asset.

The net increase in valuation for specialised properties was £2,901k (-£392k impairment and £3,293k increase in revaluations); more detail is provided in the Statement of Changes in Taxpayers' Equity and Note 13.1 Property, plant and equipment.

The Trust depreciates property, plant and equipment over their useful economic lives. The minimum and maximum lives of currently held non current assets are as follows:-

	Min Life Years	Max Life Years
Buildings	1	47
Plant and Machinery	1	15
Information Technology	1	10
Transport	1	1
Fixtures and Fittings	1	15

15.1 Trade receivables and other receivables

	31 March 2018	31 March 2017
	£000	£000
Current		
Trade receivables	8,621	3,474
Accrued income	526	2,286
Provision for impaired receivables	(248)	(644)
Prepayments (non-PFI)	1,402	685
PDC dividend receivable	168	168
VAT receivable	190	563
Other receivables	84	77
Total current trade and other receivables	**10,743**	**6,609**

The great majority of trade is with Clinical Commissioning Groups (CCGs). As CCGs are funded by Government to buy NHS patient care services no credit scoring of them is considered necessary.

15.2 Note 15.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	**644**	**491**
Prior period adjustments	-	-
At 1 April - restated	**644**	**491**
At start of period for new FTs	**-**	**-**
Increase in provision	152	478
Amounts utilised	-	(325)
Unused amounts reversed	(548)	-
At 31 March	**248**	**644**

15.3 Credit quality of financial assets

	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	£000	£000	£000	£000
0 - 30 days	-	-	2,968	-
30-60 Days	119	-	62	-
60-90 days	840	-	29	-
90- 180 days	711	-	415	-
Over 180 days	-	-	-	-
Total	**1,670**	**-**	**3,474**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	-	-	-	-
30-60 Days	57	-	-	-
60-90 days	651	-	35	-
90- 180 days	373	-	1	-
Over 180 days	-	-	61	-
Total	**1,081**	**-**	**97**	**-**

16 Cash and cash equivalents movements

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

	2017/18	2016/17
	£000	£000
At 1 April	**18,773**	**14,500**
Prior period adjustments	-	-
At 1 April (restated)	**18,773**	**14,500**
At start of period for new FTs	**-**	**-**
Net change in year	(39)	4,273
At 31 March	**18,734**	**18,773**
Broken down into:		
Cash at commercial banks and in hand	1	1
Cash with the Government Banking Service	18,733	1,772
Deposits with the National Loan Fund	-	17,000
Total cash and cash equivalents as in SoFP	**18,734**	**18,773**
Total cash and cash equivalents as in SoCF	**18,734**	**18,773**

17.1 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	1,947	2,979
Capital payables	2,147	336
Accruals	8,472	7,530
Receipts in advance (including payments on account)	-	-
Social security costs	1,038	1,081
VAT payables	2	22
Other taxes payable	647	635
PDC dividend payable	6	-
Accrued interest on loans	2	2
Other payables	1,127	1,352
Total current trade and other payables	**15,388**	**13,937**
Of which payables from NHS and DHSC group bodies:		
Current	3,624	4,063

17.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	2018 £000	2017 £000
- outstanding pension contributions	-	1,320

18. Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	1,977	1,405
Total other current liabilities	**1,977**	**1,405**

19. Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Loans from the Department of Health and Scoial Care	176	176
Total current borrowings	**176**	**176**
Non-current		
Loans from the Department of Health and Scoial Care	2,356	2,532
Total non-current borrowings	**-**	**-**

20.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Re-structuring	Continuing care	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000	£000
At 1 April 2017	-	25	-	-	24	1,126	1,175
Arising during the year	-	-	-	-	-	28	28
Utilised during the year	-	-	-	-	(24)	(19)	(43)
Reversed unused	-	(10)	-	-	-	-	(10)
Unwinding of discount	-	-	-	-	-	(21)	(21)
At 31 March 2018	-	15	-	-	-	1,114	1,129
Expected timing of cash flows:							
- not later than one year;	-	15	-	-	-	76	91
- later than one year and not later than five years;	-	-	-	-	-	-	-
- later than five years.	-	-	-	-	-	1,038	1,038
Total	-	15	-	-	-	1,114	1,129

Legal Claims:
These are provisions for Employer Liability and NHS Resolution member provision.

Other:
Other includes provisions for dilapidations in respect of leased buildings, the non achievement of improvement targets which have been invoiced on an estimated basis but may have to be part credited when actual activity becomes available, and the review of floor space utilisation with respect to specific rental income.

20.2 Clinical negligence liabilities

At 31 March 2018, £25k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Hertfordshire Community NHS Trust (31 March 2017: £162k).

21. Contingent assets and liabilities

	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities		
NHS Resolution legal claims	-	(12)
Employment tribunal and other employee related litigation	(4)	(483)
Redundancy	(15)	-
Other	-	-
Gross value of contingent liabilities	(19)	(495)
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	(19)	(495)
Net value of contingent assets	-	-

22. Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	2,147	1,904
Intangible assets	-	-
Total	2,147	1,904

23. Losses and special payments

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	4	1	11	3
Stores losses and damage to property	4	2	7	1
Total losses	8	3	18	4
Special payments				
Ex-gratia payments	2	5	1	1
Total special payments	2	5	1	1
Total losses and special payments	10	8	19	5
Compensation payments received		-		-

Losses and special payments are accounted for on accrual bases but exclude provision for future losses

24. Financial instruments

Not relevant for the Trust

24.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with its commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

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

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 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 commissioning organisations, 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.

24.2 Carrying values of financial assets

	Loans and receivables	Assets at fair value through the I&E	Held to maturity at	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2018					
Trade and other receivables excluding non financial assets;					
NHS Receivables	7,020	-	-	-	**7,020**
Non NHS Receivables	1,601	-	-	-	**1,601**
Cash and cash equivalents at bank and in hand	18,734	-	-	-	**18,734**
Total at 31 March 2018	**27,355**	**-**	**-**	**-**	**27,355**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2017					
Trade and other receivables excluding non financial assets;					
NHS receivables	3,118				**3,118**
Non NHS receivables	356				**356**
Cash and cash equivalents at bank and in hand	18,773	-	-	-	**18,773**
Total at 31 March 2017	**22,247**	**-**	**-**	**-**	**22,247**

24.3 Carrying value of financial liabilities

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018			
Borrowings excluding finance lease and PFI liabilities	2,532	-	**2,532**
Trade and other payables excluding non financial liabilities			
NHS payables	1,868	-	**1,868**
Non NHS payables	1,206		**1,206**
Total at 31 March 2018	**5,606**	**-**	**5,606**

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Borrowings excluding finance lease and PFI liabilities	2,708	-	**2,708**
Trade and other payables excluding non financial liabilities;			
NHS payable	1,735	-	**1,735**
Non NHS payable	2,933	-	**2,933**
Total at 31 March 2017	**7,376**	**-**	**7,376**

24.4 Carrying value of financial assets and liabilities

The carrying amount of the following financial assets and liabilities is considered a reasonable approximation of fair value;

- trade and other receivables
- cash and cash equivalents
- trade and other payables

25. Related parties

There have not been any related party transactions with individuals during 2017-18.

The Department of Health and Social Care is regarded as a related party. During the year Hertfordshire Community 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.

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies.

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	£000	£000	£000
Hertfordshire County Council	259	24,390	-	2,044

The Hertfordshire Community NHS Trust Board acts as a Corporate Trustee of Hertfordshire Health Charitable Funds (Registered Charity No 1061325).

During the year the Charity contributed £26k (unaudited) to the Trust (2016-17 £77k).

26. Transfers by absorption

During the year the Trust transferred an unused specified building including the land value to NHS Properties. The loss recognised in the SoCI resulting from of this transfer by absorption is £1,206k

27. Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	12,452	50,562	14,414	29,956
Total non-NHS trade invoices paid within target	11,284	44,913	13,346	28,393
Percentage of non-NHS trade invoices paid within target	90.62%	88.83%	92.59%	94.78%
NHS Payables				
Total NHS trade invoices paid in the year	913	14,333	1,134	24,301
Total NHS trade invoices paid within target	773	12,511	1,018	20,600
Percentage of NHS trade invoices paid within target	84.67%	87.29%	89.77%	84.77%

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.

28. External financing

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

	2017/18 £000	2016/17 £000
Cash flow financing	(137)	(4,449)
Finance leases taken out in year		-
Other capital receipts	(3,047)	-
External financing requirement	(3,184)	(4,449)
External financing limit (EFL)	(3,047)	25
Under / (over) spend against EFL	137	4,474

29. Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	4,642	3,527
Less: Disposals	(136)	(63)
Less: Donated and granted capital additions	-	-
Plus: Loss on disposal of donated/granted assets	-	-
Charge against Capital Resource Limit	4,506	3,464
Capital Resource Limit	4,769	3,464
Under / (over) spend against CRL	263	-

The Capital Resource Limit is £4,769 which includes £4,633 allocated plus £136 from disposals.

30. Breakeven duty financial performance

Cash Equivalent Transfer Value at 31st March 2018

	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000
Turnover	140,852	146,266	148,281	143,285
Breakeven duty financial performance surplus / (deficit)	2,129	2,419	2,512	3,350
Breakeven duty cumulative position	6,111	8,530	11,042	14,392
breakeven duty position as a percentage of operating income	1.5%	1.7%	1.7%	2.3%
Cumulative breakeven duty position as a percentage of operating income	4.3%	5.8%	7.4%	10.0%

31 Events after the reporting date

Since September 2017, negotiations have been going on between the Trust and St Albans City and District Council to dispose of a building including its land namely Principal St Albans Health Centre. The value of the asset (£1,202m) is included in the Property Plant and Equipment Note 13.1. The sale agreement for £2,003m was completed on the 27th of April 2018

Staff costs

	Permanent £000	Other £000	2017/18 Total £000	2016/17 Total £000
Salaries and wages	76,136	1,485	**77,621**	78,029
Social security costs	6,323	-	**6,323**	7,204
Apprenticeship levy	351	-	**351**	-
Employer's contributions to NHS pensions	9,685	-	**9,685**	9,980
Pension cost - other	-	-	**-**	7
Termination benefits	-	-	**-**	91
Temporary staff		11,719	**11,719**	12,458
Total gross staff costs	**92,495**	**13,204**	**105,699**	**107,769**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**92,495**	**13,204**	**105,699**	**107,769**
Of which				
Costs capitalised as part of assets	139	-	**139**	804

Average number of employees (WTE basis)

	Permanent Number	Other Number	2017/18 Total Number	2016/17 Total Number
Medical and dental	28	1	**29**	48
Ambulance staff	9	1	**10**	5
Administration and estates	412	22	**434**	495
Healthcare assistants and other support staff	458	4	**462**	562
Nursing, midwifery and health visiting staff	795	20	**815**	938
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	544	10	**554**	634
Other	-			
Total average numbers	**2,246**	**58**	**2,304**	**2,682**
Of which:				
Number of employees (WTE) engaged on capital projects	-	-	**-**	10

Reporting of compensation schemes - exit packages 2016/17

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	-	-	**-**
£10,001 - £25,000	1	-	**1**
£25,001 - 50,000	-	-	**-**
£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 (£)	£91,361	£0	**£91,361**

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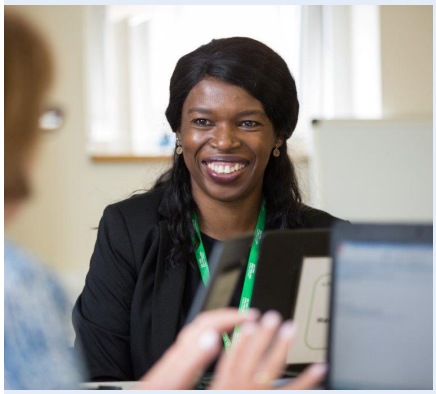

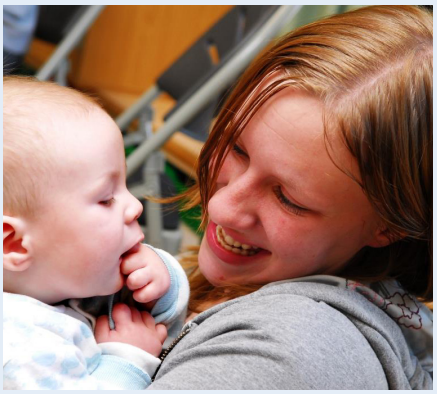

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