Annual report and accounts 2021/2022

Contents

WELCOME

Welcome to the 2021/22 Annual Report and Accounts for Portsmouth Hospitals University NHS Trust (PHU). We would like to start this report by sharing our thanks with the amazing staff that make up PHU. These last few years have tested our services like no other, and yet they have continued to innovate and implement changes to provide the best possible care to our patients and their carers. We cannot provide enough praise and heartfelt thanks for the incredible work they have, and continue to, carry out every single day.

The pressure on our services has remained high, with a strong community Covid prevalence meaning large numbers of staff sickness and higher numbers of patients with greater acuity being cared for in our wards. We have implemented a range of initiatives to help relieve this pressure alongside our system partners. This includes the establishment of our Medical Village bringing together our acute medical unit (AMU), short stay unit and same day emergency care service (SDEC), opening of the Emergency Care Centre and the 'My next patient' scheme. We have focused on improving the flow of patients through the hospital and discharging patients to the most appropriate place when they are fit enough to do.

Due to effective planning, maximising theatre utilisation and dedicated clinical engagement across our divisions, the Trust has maintained its elective programme throughout the pandemic. A dedicated green elective surgical pathway, and two ring fenced elective wards enabled teams to support surgical demand while investment in an additional surgical robot, in September 2021, contributed to increased productivity and created greater capacity for those clinically urgent cases requiring robotic surgery.

As part of care for people undergoing complex Orthopaedic procedures, the Enhanced Care Unit (ECU) for Elective Orthopaedics was set up in June 2021 to treat those who require more care than a general ward but less dependency than the critical care provided in ITU. The Trust also expanded Ophthalmology diagnostics into the community in 2021, thereby helping to tackle the backlog, as well as enabling those most urgent patients to be treated in an acute setting when required.

We have made great strides in improving technology to provide patients with the latest treatments. Patients with liver cancer can expect better outcomes and enhanced care with the implementation of microwave ablation (a new treatment for early-stage lung cancer) - a treatment called Stereotactic Ablative Body Radiotherapy (SABR). And our Breast Screening Department has invested in three new mammography units, which will have a significant impact on the ability to find new cancers at an early stage.

Our new pharmacy for outpatients, run by Lloyds Pharmacy, opened on the QA site. Located near the north entrance it also includes a retail outlet for patients, visitors, and colleagues. The new facility is in response to the high demand on our previous outpatient pharmacy and we hope it will reduce the length of time patients have to wait for their prescriptions.

In October 2021, we were announced as one of the successful locations to receive funding to create additional community diagnostic services. The aim is to provide earlier diagnostic tests for people closer to home and reduce the length of time patients are waiting to receive them. Fareham Community Hospital has also opened a new ten-station chemotherapy unit offering up to 375 hours of treatment time per year, which also provides care closer to people's homes.

In December 2021 we opened two new wards (D10 and E10) to care for patients requiring rehabilitation from head injuries or stroke. The beds have also given us extra capacity to help with pressures across the hospital. The wards are based on the old North carpark site and as a modular build they could be completed in just a few months. A new car park is now under construction and should be ready to open in Summer 2022. We also received the fantastic news that Portsmouth City Council granted full planning permission for our new Emergency Department

which is due to start building works in Autumn 2022 (subject to final national approvals). This will provide a range of new and improved facilities including double the current resus capacity, two further paediatric resus bays for children and faster access to our radiology team for scans and tests.

Looking forward to 2022/23 we will be focusing on providing timely discharges from our services so patients receive care in the most appropriate place for them, improving the flow of patients through our services to reduce delays and we are seeking to restore our elective capacity to ensure patients are treated as quickly as possible. We will also be working with our teams to ensure we can support them and make PHU the best place to work and where improvements are made by all staff at any point in time.

We are incredibly proud of our staff and services and we look forward to continuing to work for our populations in 2022/23.

Melloney Poole OBE
Chairman

Penny Emerit
Chief Executive Officer (Interim)

1. PERFORMANCE REPORT

The purpose and activities of the organisation

1.1 Statement from Chief Executive Officer on organisational performance

This year has again been dominated by the Covid pandemic. In the latter part of the year, we have seen the Government implement a relaxation of the Plan B rules in their plan 'Living with Covid'. Community prevalence of Covid has remained high in Portsmouth and the wider Hampshire area, leading to high numbers of Covid patients in our hospitals, increased acuity of patients and large numbers of staff sickness or staff isolating. Whilst the severity of the Omicron BA.2 variant was less, the transmissibility was higher which led to ongoing infection, prevention and control requirements with a significant impact on our bed occupancy levels and patient flow through our hospital.

We stepped back up command arrangements in PHU and with system partners in Portsmouth & South East Hampshire and wider Hampshire and Isle of Wight to support delivery of a capacity plan. We reopened our vaccination hub to the public and operated a COVID Medicine Delivery Unit (CMDU), to provide access to COVID treatments for our most vulnerable, non-hospitalised patients who are believed to be at greatest risk of disease progression, hospitalisation or death. This service is helping to reduce hospital admissions in that group.

As part of that plan, a number of key schemes were delivered by PHU, including our new emergency care centre, the new medical model, including acute medical unit and medical same day emergency care (SDEC), additional acute bed capacity with the opening of the modular ward and an increase in SDEC capacity for acute oncology. All of these schemes were delivered on time and are in place and operational

Despite these significant steps forward both handover delays and our occupancy remain high and we have been operating at Opel 4 level for the majority of the year. This means a continued focus on this into 2022/23, including our continued participation in the national discharge taskforce. We are one of 14 trusts working with the national team to give feedback on processes such as Criteria to Reside as well as share our plans and best practice.

We perform well in terms of reducing the number of patients with a very long length of stay and we were able to share our improvement work on shifting the profile of our discharges to earlier in the day as well as reducing variation in discharges across the seven day period.
The Care Quality Commission's Urgent and Emergency Care Survey was published in September and showed that, despite the challenges we faced and continue to face, 87 per cent of Emergency Department patients rating their overall experience as seven out of ten or higher. Similarly, 96 per cent of patients said they were treated with respect and dignity and 95 per cent had confidence and trust in the doctors and nurses treating them.

The Trust Elective Care Delivery Board has been established and monitors all aspects of the elective recovery programme for PHU. The waiting list has risen throughout the year, however there has been a reduction in the number of patients waiting more than 52 weeks for treatment and no patients are waiting more than 104 weeks.

Our performance against the delivery access standards in cancer services has remained consistent with us achieving eight out of the nine standards.

Moving into 2022/23 we will continue to work alongside our health and social care partners in Hampshire and the Isle of Wight to restore our services and recover our performance as quickly and efficiently as possible. I am very proud to be part of PHU and work alongside incredibly committed and hardworking colleagues, and look forward to facing the year together.

1.2 About the Trust

Who we are and what we do

Portsmouth Hospitals University NHS Trust provides secondary care and specialist services to a local population of 675,000 people across Portsmouth and south east Hampshire. In addition, we offer certain tertiary services to a wider catchment area in excess of two million people such as:

- a designated cancer centre serving a population of 800,000 within the south of Hampshire. We are also part of the Central and South Coast Cancer Network.
- We are home to the Wessex Kidney Centre which is the third largest renal unit in England providing renal services to 2.4million adults across Hampshire and the south of England.

Our population

The local population is characterised by its diversity. The rural and urban areas of wealth are contrasted with pockets of deprivation and a variation in life expectancy. Stroke, heart attacks, Chronic Obstructive Pulmonary Disease (COPD), diabetes and liver disease have a high prevalence within the local communities, and the Trust works strategically with both public health and local commissioners to provide high quality services to combat and treat these conditions.

Our sites

Most of the Trust's services are provided at the Queen Alexandra Hospital (QA) in Cosham, but with a range of outpatient and diagnostic facilities closer to patients' homes in local communities. These include:

- St Mary's Hospital in Portsmouth, which provides midwifery, dermatology and enablement services
- Gosport War Memorial Hospital, where a range of services, including the Blake Maternity Unit, Minor Injuries Unit (Urgent Treatment Centre) and diagnostics, are provided
- Petersfield Community Hospital, where the Grange Maternity Unit is based.
- Fareham Community Hospital, where a chemotherapy unit was opened in March 2022.

Education links

The Trust is a major provider of under-graduate and post-graduate education, working with three universities - Southampton, Bournemouth, and particularly with the School of Health and other faculties at the University of Portsmouth.

Research

The Trust has a significant reputation for research and innovation and is actively involved with the national agenda in these fields. In 2021/22 we recruited the highest number of patients to clinical trials since in 2008. More than 14,240 patients have taken part in 127 studies across 26 departments in the Trust, with more than 7500 of those involved in COVID-19 studies to help advance global understanding of the virus. The Trust is ranked as the highest recruiting large acute trust across the country and 11th of all Trusts. PHU is also ranked 11th nationally for COVID trial recruitment, with 5,410 patients into the Clinical Characterisation Protocol study, 2,492 into a home grown Stop-Covid19 study and 317 into the SIREN study.

Private Finance Initiative

The Trust awarded a £256m contract to The Hospital Company under the Private Finance Initiative (PFI) in December 2005. The concession term is 35 years until 2040.

As well as being responsible for the building works, The Hospital Company entered into a long-term agreement to provide facilities management services to the hospital. Portsmouth Hospitals University NHS Trust makes annual payments for the PFI facility to cover loan and interest

payments as well as payments for the provision of the Trust's facilities management and services including estates management, portering, cleaning, security, catering and car parking. All of these services, apart from estates management, are subject to value testing through benchmarking and/or market testing every five years throughout the operational concession, which ends in 2040.

Our history

Queen Alexandra Hospital started life more than a century ago as a military hospital. The current hospital was opened by Princess Alexandra in 1980 and subsequently went through a major redevelopment to create a modern and 'fit for purpose' hospital, which was completed in 2009. In July 2020, the Trust changed its Establishment Order and name to "Portsmouth Hospitals University NHS Trust" (PHU).

Developments in 2021/22

June 2021 - Microwave ablation was introduced within Diagnostic Imaging treating liver tumours, providing better outcomes and enhanced care for patients with liver cancer.

July 2021 - Diagnostic Imaging officially unveiled a new state-of-the-art room following a million-pound equipment and room replacement, allowing the interventional team to deliver a more timely and high-quality service.

September 2021 - We successfully treated our first patient with new Stereotactic Ablative Body Radiotherapy (SABR) radiation treatment for early-stage lung cancer. This new treatment minimises damage to surrounding organs and has been found to reduce side effects.

October 2021 - A third Da Vinci surgical robot arrived and is being used to perform the UK's first robotic assisted emergency surgery. The Breast Screening Department invested in three new mammography units.

November 2021 - We created a Medical Village on D level which contains our acute medical unit (AMU), short stay unit and same day emergency care service.

December 2021 - Work began in March 2021 to create a new two storey ward block in what was previously the North Car Park. This opened in December 2021 and now we have two wards to care for patients requiring rehabilitation from head injuries or stroke as well as much needed core capacity.

March 2022 - We have received full planning permission for our new and expanded Emergency Department (ED) from Portsmouth City Council. The new ED will provide a range of new and improved facilities, including double the current resus capacity from four adult bays to eight for patients needing treatment for critical conditions; two further paediatric resus bays for children, and faster access to our radiology team for scans and tests.

March 2022 - We opened our new chemotherapy unit at Fareham Community Hospital (FCH), bringing vital cancer services to local people.

Our statistics for 2021/22

- The Emergency Department saw 113,191 patients
- The Trust dealt with over 66,400 emergency admissions (excluding maternity)
- Over 617,000 outpatient consultations and more than 72,500 day-case admissions were completed
- 5,056 babies were delivered at Trust hospital sites or at home with the support of the Trust's midwifery team - a decrease of 47 on the previous year
- Services were delivered by over 8,280 employees and around 570 volunteers. More than 190 military personnel also worked alongside NHS colleagues at Queen Alexandra Hospital.

1.3 Working alongside military personnel

Under Commander Karen McCullough, the longstanding relationship with the military has continued to develop over the past year. This is as part of Joint Hospital Group (South), with the majority of the medical personnel involved providing a capable and flexible workforce at the Trust. This relationship was adapted to the requirements of the pandemic, with many of the innovations introduced in this period that are likely to remain in place on a permanent basis.

The stated objective of the Group is the provision of capable secondary healthcare personnel for operational deployments and exercises. The fulfilment of this has been evident in the military medicine provided during campaigns such as that undertaken in Afghanistan during 2021. In addition, the support provided by the Trust through measures such as the provision of Covid testing for the crew of the Queen Elizabeth has proved invaluable. Reciprocal benefits had been experienced through the work of the Group alongside Trust staff at the vaccination hub.

The staff includes consultant doctors, specialist and generalist nurses, and allied healthcare professionals. Their work has been reviewed to ensure that it reflects the current threats to national security, with those involved commended for their flexibility in providing this. Further to this, military and Trust staff have been aligned to facilitate workforce planning, emergency resilience and business continuity. The example of the Tiger Teams, which have been deployed to support wards, has demonstrated the impact of this and was recognised as team of the month in 2022. The Group's work is also acknowledged at national level and often quoted as an example of best practice.

During the last year, military personnel have maintained key leadership roles within the Trust, including Commander Barrie Dekker as Divisional Director for the Surgery and Outpatients Division. This further ensures the flow of best practice between the NHS and Ministry of Defence. This work has allowed for the Joint Hospital Group (South) to be in a position to be the first such body to complete its contract with the military. As part of this, a clinical pathway for nurses was being established whilst 43 staff were being deployed on exercises in March 2022. The success of the partnership lies in the quality of the personnel involved and the quality of the placements available to them, with the Institute of Health and Social Care Management having commended these efforts.

In terms of 2022 – 23, the military will build on their recent integration into the Trust's emergency planning, resilience and response arrangements. An exercise in this area was planned to be held earlier in the financial year, which will act as the platform for closer collaboration over coming months. The Commanding Officer attends operational meetings to support this and build on the co-operation which had been offered to resolve the water leak experienced at Queen Alexandra Hospital in January 2022. The military partnership will also provide an update to Trust Board meetings throughout the coming year.

The Armed Forces Covenant Lead Nurse (AFCLN) role has gone from strength to strength. Providing support for patients who are serving and retired military personnel and their families, as well as providing training to PHU staff and local primary care colleagues, this postholder also builds partnerships with relevant stakeholder groups. The role has been recognised nationally and the Trust is sharing its experience across the NHS to develop the same positive impact elsewhere.

Working with military personnel, the AFCLN has helped deliver on a number of initiatives over the past year. In line with a long-standing tradition in military history, the 'Challenge Coin' is given in recognition of individuals who have gone 'above and beyond' when performing their duties in relation to the military community. Receiving the coin, as a reward for excellent performance, builds pride and morale. The coin also provides a natural link between the military and the emergency services, which also have a history of using challenge coins to honour service or special accomplishments in the line of duty.

Receiving the coin is a great honour and team members work hard to get them. The PHU Veteran coin is given to recognise an individual accomplishment on the part of Trust, Engie (estates and facilities teams) and volunteer staff who have:

- Demonstrated care for the military community outside of their normal duties
- Demonstrated being a strong ambassador for the Armed Forces Covenant
- Proactively encouraged understanding of the military culture
- Gone 'above and beyond' in caring for the military community

1.4 Research and innovation

Working with our patients, universities, industry, and partner organisations we continue to strive to adopt the latest innovations from cutting-edge science and technology, to create real-life tests and treatments that benefit our patients. As a Trust, we recognise that research active environments improve outcomes and remain fully committed to ensure every patient within our care has an ability to participate in clinical research.

The effects of the global pandemic have been felt by all within the Trust. Despite seeing patient enrolment into most research studies paused, research and innovation has strived to continue to enable patients to access clinical research. However, this has not been achieved alone, we have worked as one Team across the Trust, providing specialised support to our clinical teams in secondments to ITU, Covid-19 dashboard, HR, Family Liaison Officers (FLOs), Swabbing and medical care through the Specialist Registrar on-call Rota.

Fast tracking and supporting Urgent Public Health (UPH) studies within Portsmouth Hospitals University NHS Trust (PHU) has seen research play an integral role in providing vital new evidence. Whether we have guided SAGE through findings from the CCP study, made changes to practice through the SIREN study, delivered novel treatments through RECOVERY & REMAP-CAP, we have continued to improve patient outcomes within our care. Working together with clinical departments across the Trust we have provided treatment options to patients with suspected or confirmed Covid-19 through access to our UPH portfolio of studies. The Trust is currently ranked 3rd nationally for our UPH recruitment into these complex portfolio studies, 2nd for delivery of the CCP study and 10th for RECOVERY study recruitment.

Despite continuing to work under the current Covid-19 restrictions the Trust has continued to support participants gain access to research studies and in the year recruited 14,240 participants, which positions us top of all large acute NHS Trusts and 11th nationally. In addition, we have continued to deliver the NIHR CRN high level objectives, restarting 81% of our pre Covid- 19 portfolio studies.

The Trust, in collaboration with the Wessex Clinical Research Network (CRN) successfully launched the Portsmouth Research Hub within the John Pounds Community Centre. The Hub officially launched in 2021

and has already seen the successful delivery of four Covid-19 vaccination studies recruiting 288 participants into both commercial and non-commercial studies. Initial results from the COV-BOOST vaccination study delivered at the Portsmouth Research Hub has helped to inform national policy and guide the booster vaccination programme. The team were also the first in the UK to recruit into the COV-BOOST study. The collaborative model with University of Southampton, CRN and local organisations will continue to support a community research hub within the heart of the City

1.5 Charity support

Over the last year Portsmouth Hospitals Charity continued to play a role in supporting patients and staff through the Covid-19 pandemic.

The Charity supported much needed staff 'boosts', including an ice cream van onsite in the height of summer and a Santa sleigh of treats in the winter. The Charity is also in the process of upgrading a number of staff rest and work areas to help the longer-term wellbeing of staff.

Throughout 2021/22 the Charity supported the purchase of items and equipment to enhance patient care. Sometimes it's the simple things which can really help patient experience, such as a new mammography chair which gives patients with mobility problems the option of sitting down during their examination. The Charity was also successful in obtaining a grant to purchase over 100 slippers for vulnerable patients to help prevent slips and falls in the hospital.

The Charity continues to be the grateful recipient of funding from NHS Charities Together. The Charity received a 'recovery grant' which has been used to upgrade the equipment in the onsite gym and start a 'Healthy You' scheme, aimed at improving the health of staff. The Charity also received funding to work with the British Red Cross on a 'settling at home' project. Through this project, selected patients are visited at home following discharge to help reintegrate them back into the community, prevent isolation and ultimately readmission to hospital. The project is a great example of how Portsmouth Hospitals Charity has worked in collaboration to support patients while in hospital, but also upon their return home.

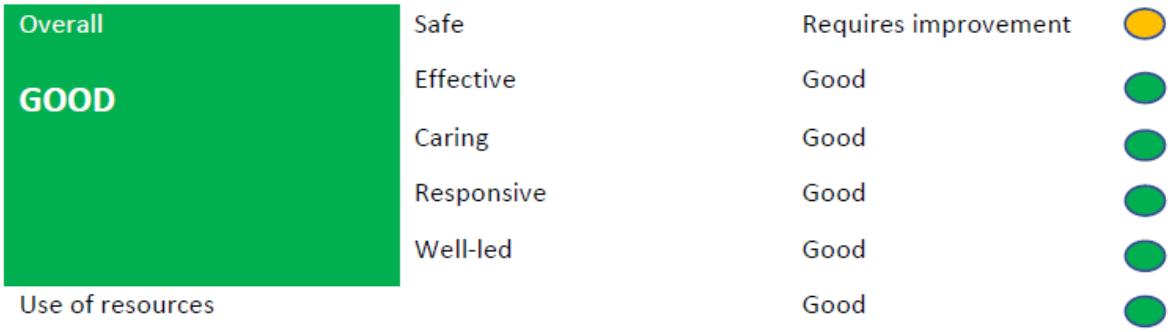
Although the ongoing pandemic continued to affect the Charities ability to fundraise through events, we still received a high level of support from our community. We are constantly moved, particularly by the high levels of 'in memory of' gifts we receive as well as gifts in wills from patients. It is a great pleasure to read the many notes and messages that accompany donations, often citing thanks for the high level of care received.

Portsmouth Hospitals Charity is continually grateful for the support of patients, their loved ones, staff, volunteers and the local community. The Trust also receives generous support from QA Hospital's League of Friends.

1.6 Care Quality Commission

The Trust is fully registered with the Care Quality Commission (CQC) to carry out a wide range of regulated activities. The principal location is Queen Alexandra Hospital, with other registrations in place for the other key sites at which the Trust provides services.

As outlined in more detail in section 3.14, the Trust was last subject to a comprehensive CQC inspection in October 2019 and a well-led inspection in November 2019, following which the Trust was rated as 'Good' overall:



The Trust continues to work on improving quality throughout all its services, but particularly in the CQC's 'safe' domain and across the urgent and emergency care pathway, both of which remain rated as 'requires improvement'. Like most CQC registered bodies, during the pandemic the Trust has not undergone the comprehensive inspection which would normally have taken place and allowed for a review and revision of its ratings.

The CQC conducted a brief focused inspection of Maternity Services in July 2021. The service was not rated following the inspection; therefore the previous rating of 'requires improvement' remains. The inspection had a broadly positive outcome; with the CQC recognising the progress which had been made since the 2019 full inspection. However, one 'must do' recommendation regarding policies and procedures (Regulation 12) was received. The Maternity Service is working to achieve compliance with the recommendation.

1.7 Organisational structure

The Board of Directors is accountable for setting strategic direction, monitoring performance against agreed objectives, and promoting links between the Trust and our local communities. Our Board committees, all chaired by a Non-Executive Director and reporting to the Board, provide strengthened oversight and management of planning, performance and risk. More details about our Board and committees can be found on page 38.

The Trust Leadership Team, which includes both executive directors and divisional directors, ensures good governance across the organisation.

Clinical services in the Trust are provided by four divisions;

- Clinical Delivery
  - Clinical engineering
  - Critical care
  - Theatres
  - Anaesthetics
  - Hospital Sterilisation and Disinfection Unit (HSDU)
- Medicine and Urgent Care
  - Urgent care
  - Medicine
  - Older peoples' medicine

- Networked Services
  - Women and Child services
  - Renal and transplant
  - Regional cancer care
- Surgery and Outpatient
  - Surgery
  - Outpatients
  - Medical records
  - Musculoskeletal MSK
  - Head and neck

We are a clinically-led organisation. Each division is led by a clinician as divisional director, with overall responsibility for their division. They are supported by a leadership team including an operations director, a nursing/allied health professions director and a Finance Business Partner. Each Division has an operational HR team for day to day work and specialist HR support is provided by the Corporate HR Team.

Each leadership team is accountable for the quality, performance and financial sustainability of their division and responsible for working together across the other divisions to ensure our strategy is delivered and that we sustain further improvements for our patients.

1.8 Strategic direction

What drives us
For PHU to provide the best possible healthcare to our population, we must have:

- A clear aim and vision
- A set of values that underpin everything we do
- An agreed strategy that sets out what we need to do to deliver our vision.

Our Vision
Working together to drive excellence in care for our patients and communities.

Our Values
We have four core values that outline how we expect each of us to "work together" to care for our patients. Our values were refreshed with input from patients and staff, to coincide with the launch of our Trust Strategy, *Working Together.*

- Working together for patients
  - Prioritise safety
  - Focus on the quality of patient care
  - Deliver great customer care and experiences
  - Act with professionalism
  - Pursue the best outcome
  - Take personal responsibility and make no excuses
- Working together with compassion
  - Compassionate and kind
  - Friendly and courteous
  - Attentive and helpful
  - Protective of patient dignity
- Working together as one team
  - Listen and hear
  - Break down silos and work in partnership internally and externally
  - Explain and involve patients and staff decisions
  - Respect everyone's time
- Working together, always improving
  - Seek and give feedback
  - Identify and make improvements to how we do things, however big or small
  - Work efficiently, and keep things simple
  - Live within our means
  - Develop through learning
  - Engage, innovate and improve

Our Strategy

Despite the COVID-19 pandemic, the Trust has continued to deliver its five-year strategy launched in July 2018 entitled 'Working Together'. There are five strategic aims, each of which is supported by a number of objectives as outlined below:

- **Fulfil our role for the communities we serve**
  - No delays – valuing our patients' time
  - 85% of patients arriving by ambulance will handed over within 15 minutes
  - No patient to spend longer than 240 minutes in the ED
  - No patient to wait loner than 52 weeks for elective treatment
  - All national cancer standards will be achieved
  - 40% of patients to be discharged before midday
  - Reduce the number of patients waiting over 18 weeks for outpatient appointments

- **Support safe, high-quality patient-focused care**
  - Provide the best possible patient experience and eliminate avoidable harm
  - No avoidable harm (Moderate or above)
  - Top acute trust for inpatients recommending care
  - Reduce hospital acquired pressure ulcers by 50 per cent
  - Reduce the number of complaint responses waiting longer than 25 days by 50 per cent.

- **Take responsibility for the delivery of care now and in the future**
  - Live within our means and eliminate waste
  - Achieve financial balance

- **Invest in the capability of our people to deliver on our vision**
  - Be the best place to work
  - Top acute trust in the staff survey for staff reporting as best place to work
  - At least 85 per cent of staff to have an annual appraisal with their line manager
  - Improve recruitment to keep our vacancies below 7.5 per cent

- **Build the foundations on which our team can best deliver care**
  - Continuously learn, supporting our people and teams to improve everyday
  - All staff report they feel able to contribute to improvement

These priorities inform the Trust's business objectives. The Board Assurance Framework records risks to the delivery of any of the priorities, and set out details of how these risks will be managed and mitigated. More information on our risk framework can be found on page 33.

1.9 Key issues and risks

The following table lists the most significant risks contained within the Board Risk Register (operational risks):

Board Risk Register	
Title	**Additional actions planned**
Compromised care of patients with primary mental illness due to lack of specialist knowledge, provision, and training.	• Review of banding to encourage recruitment to two RMN vacancies which have been created to support the mental health agenda across the Trust • A dedicated Task and Finish group will continue work on plans regarding ligature risk reduction across the site • Ligature has been added as a standard agenda item to the Health and Safety committee • Further Ligature risk assessment training planned to be delivered by the Mental Health Matron
Mismanagement of patient care and experience in urgent care pathway due to high occupancy & poor flow within & beyond the Trust	• Pilot projects continue to be developed and trialed to improve the patient journey for care that does not require an acute response via ED • System working continues to review the patient pathway to look to areas of intervention both relating to admission avoidance and the pathway when a patient is conformed as medically optimized for discharge
Potential risk of Covid-19 transmission to patients and visitors	• Review of national guidance and local update of Trust policies and procedures relating to Covid-19 both in relation to onsite management and visiting restrictions. In addition to this: • Consideration of future use of PPE/ face mask wearing • Further review of management of patients identified as Covid-19 positive on admission and contacts

The Board Assurance Framework also includes the following high-scoring strategic risks:

Board Assurance Framework	
Risk	**Risk overview**
System-wide pressure on the urgent care pathway with risk to quality and experience	This risk was updated in May 2021 to reflect the impact of system pressures on the Trust. The previous entry had an internal focus and was reducing given the lifting of a Section 29a notice from the Care Quality Commission. However, the additional consideration of the wider local context led to a significant escalation in the risk profile associated with the urgent care pathway. This remains the case given the extended period of operational pressures experienced by health service providers across the region.
Demand for mental health services in the Trust exceeds mental health resource available	Demand for mental health services has continued to increase locally, regionally and nationally since the start of the pandemic. Coupled with standard demand which could not be met by existing services during the pandemic for a variety of reasons (e.g. staff sickness absence, social distancing requirements), this means that the Trust has seen an increase in crisis presentations at its Emergency Department (ED). A mental health strategy is under development, whilst specialist staffing (e.g. Consultant Paediatrician) is being sought. An interim training strategy is being introduced at the Trust to provide staff with education on urgent care and paediatrics.

Governance systems across the Trust are ineffective in the delivery and monitoring of improvements and high standards of care, treatment and performance	An external review has reported with an action plan being finalized to support improved governance processes. As part of this, the Trust's risk management framework will be revised in 2022 – 23 to provide greater ward to board insight. Data systems are being established with a view to providing the robust systems required to interrogate data and triangulate information sources. The Trust-wide Delivering Excellent quality programme and Maternity Improvement Plan will also support this work.
There is inconsistency in the application of basic, compassionate care in some parts of the Trust.	Monitoring of quality and safety metrics continues as an integral part of the Delivering Excellence approach. There is oversight of quality and safety at our board committee. This will also be supported by the roll out of accreditation process and methodology. These all will impact over time on inconsistencies, however the current operating context of responding to the pandemic, its effects on staffing, the high activity and occupancy within the Trust results in an increase in this risk.
Pressure on system partners may compromise their ability to prioritise work streams and actions which support delivery of Trust objectives	It is acknowledged that the focus on delivery plans means that organisations will primarily concentrate work on their own priorities. As a result, the potential for this to hinder collaborative working is recognised. To mitigate this, the use of bodies such as the Integrated Care Board to emphasise communality in provision will be explored to its fullest extent. In addition, the Trust's continued efforts in its direct partnership working with bodies such as University of Portsmouth should bolster this.

1.10 Adoption of going concern

The Trust prepares its accounts on a going concern basis, in accordance with the definition as set out in section 4 of the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM). The GAM outlines the interpretation of IAS1 'Presentation of Financial Statements' as 'anticipated continuation of the provision of a service in the future, as evidenced by the inclusion of financial provision for that service in published documents'. The 2022/23 financial framework planning guidance, issued in January 2022 by NHS England & Improvement confirmed the financial framework arrangements for 2022/23 will continue to support a system-based approach to funding and planning.

This year, 2021/22, the Trust has reported an operational surplus of £206k income over expendituire (£609k surplus after technical adjustments). Income from NHS Commissioners was largely based on the simplified fixed block income basis introduced in response to the Covid-19 pandemic.

Whilst the Trust now carries no loans from DHSC, the historic cumulative deficit as at 31st March 2022 remains at £106.9m and, as a result, the External Auditor is obliged to issue a referral to the Secretary of State for Health and Social Care under Section 30(1)(b) of the Local Audit & Accountability Act 2014 reporting that the Trust has technically breached its statutory duty to breakeven over the rolling period.

For the year ahead, 2022/23, the Trust is aiming to 'live within its means' for a fourth consecutive year. However, at the time of writing, the financial plan for the Trust reflects an ongoing financial risk of £9.7m, which continues to be assessed with the Hampshire & Isle of Wight (HIOW) integrated care system on how this may be mitigated. The Trust's financial risk is broadly consistent with other providers across HIoW. The financial plan is supported by a cost improvement plan of £19.4m (representing 2.6% of planned turnover), and the plan reflects many of the changes in pathway and services funded during 2021/22 (e.g. medical village, additional bed capacity, emergency care centre).

The Trust has prepared a cash forecast for the going concern period to June 2023 which shows sufficient liquidity for the Trust to continue to operate. The minimum forecast month end cash balance during the going concern period is £3.2m, with an average of £15m.

In conclusion, these factors, together with the anticipated future provision of services in the public sector, support the Trust's adoption of the going concern basis for the preparation of the accounts.

1.11 Performance summary

Details of the Trust's performance against its constitutional and statutory obligations can be found in reports in the Trust Board papers section of the Trust website.

Performance against the Trust standards for quality of care is reported in the Trust's Quality Account found also on the Trust website at 'Trust publications'. The publication for 2021/2022 will be on 30th June 2022.

1.12 Performance analysis

Details of the Trust's performance against its constitutional and statutory obligations can be found in reports in the Trust Board papers section of the Trust website.

Performance against the Trust standards for quality of care is reported in the Trust's Quality Account found also on the Trust website at Trust publications.

The Trust is monitored by NHS Improvement and the CQC against a range of targets and thresholds as published in the Operating Framework by these bodies. The Trust Board is provided with integrated performance reports summarising quality, operational, finance and human resources performance which is reviewed at public board meetings.

A summary of performance against the key indicators and constitutional standards, by month, is set out below.

Table 1: Operational Performance Dashboard

Operational Dashboard	Target	20/21	21/22 (Cancer Data is National Published Position where final,RTT, Diagnostic and Cancer data is provisonal for latest month)											
		M	A	M	J	J	A	S	O	N	D	J	F	M
% Incomplete Pathways < 18 wks	>=92%													
No of Incomplete pathways	32808	36670	37155	37566	39095	40364	41893	43816	44845	45248	45416	45317	45559	**46667**
Incomplete Patients waiting >104 wks	0	0	0	0	2	2	1	3	0	3	2	3	3	**2**
Incomplete Patients waiting >52 wks	0	✗ 3104	✗ 2667	✗ 2063	✗ 1585	✗ 1430	✗ 1389	✗ 1419	✗ 1533	✗ 1356	✗ 1255	✗ 1019	✗ 877	✗ **873**
Incomplete Patients waiting >40 wks	0	4208	✗ 4008	3667	3517	3702	✗ 3871	4002	3637	3204	3402	✗ 2960	2746	**2840**
Diagnostic waits < 6 wks	>=99%	! 94.2%	! 96.3%	✓ 96.3%	✓ 96.3%	✓ 95.3%	✗ 87.6%	✗ 85.9%	✗ 79.8%	✗ 77.9%	✗ 70.1%	✗ 63.5%	✗ 68.6%	✗ **61.8%**
12 hr Trolley waits	0	0	✓ 0	0	0	0	✓ 0	0	0	0	0	✓ 0	0	**0**
All 2-week wait referrals	>=93%	✓ 97.3%	✓ 95.7%	✓ 95.9%	✓ 94.9%	✓ 94.9%	✓ 93.3%	✓ 96.1%	✓ 95.2%	✓ 94.6%	✓ 93.1%	✓ 93.3%	✓ 95.6%	✓ **93.9%**
Breast symptomatic 2-week wait referrals	>=93%	98.2%	98.0%	98.9%	94.6%	94.2%	✓ 93.1%	95%	90.5%	93.1%	93.9%	✗ 88.9%	96.6%	**93.5%**
31-day diagnosis to treatment	>=96%	✓ 99.1%	✓ 98.8%	✓ 99.6%	✓ 100%	✓ 98.6%	✓ 98.8%	✓ 98.1%	✓ 99.3%	✓ 98.0%	✓ 98.5%	✓ 98.7%	✓ 98.6%	✓ **97.6%**
31-day subsequent cancers to treatment	>=94%	100%	✓ 100%	100%	100%	98%	✓ 100%	96%	97%	100%	95%	✓ 100%	100%	**98%**
31-day subsequent anti-cancer drugs	>=98%	✓ 100%	✓ 100%	✓ 100%	✓ 100%	✓ 100%	✓ 100%	✓ 100%	✓ 100%	✓ 100%	✓ 98%	✓ 100%	✓ 100%	✓ **100%**
31-day subsequent radiotherapy	>=94%	100%	✓ 99%	99.2%	98.8%	98%	✓ 100%	99.1%	100%	95%	75%	! 89.2%	96.5%	**97.7%**
62-day referral to treatment	>=85%	✗ 82.1%	✓ 86.1%	✓ 86.6%	✓ 87.5%	✗ 82.5%	✓ 85.5%	✗ 75.4%	✗ 82.1%	✗ 76.5%	✗ 80.3%	✗ 73.3%	✗ 73.9%	✗ **65.9%**
62-day screening to treatment	>=90%	95.7%	95.7%	88%	96%	93%	✓ 92%	86%	94%	90%	96%	✗ 86%	95%	**93%**
Cancer maximum wait to treatment 104 days	0	✗ 7.0	✗ 3	✗ 2	✗ 2.5	✗ 4.5	✗ 5.5	✗ 4.5	✗ 2.0	✗ 3.0	✗ 4.0	✗ 14.0	✗ 8.0	✗ **11.5**
28 days to cancer diagnosis **(reported in arrears)**	>=75%	85.0%	85.5%	89.0%	86.9%	85.3%	✓ 84.6%	84.5%	86.4%	86.8%	83.2%	✓ 78.0%	86.7%	**83.6%**
Cancelled urgent operations	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ **0**
Urgent Operations cancelled for a 2nd time	0	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Total bed days blocked	<1000	✓ 267	✓ 269	✓ 366	✓ 322	✓ 265	✓ 382	✓ 338	✓ 342	✓ 332	✓ 314	✓		
Ambulance delays > 30 mins (PHT validated)	0	102	117	346	508	535	566	442	530	442	560	✗ 533	✗ 491	✗ **467**
Ambulance delays > 60 mins (PHT validated)	0	✗ 8	✗ 78	✗ 279	✗ 599	✗ 818	✗ 674	✗ 908	✗ 1315	✗ 816	✗ 1097	✗		
Arrival to DTA <2.5 hrs	>=45%	39.8%	38.5%	34.3%	30.5%	30.8%	33.3%	28.8%	21.6%	25.7%	25.9%	! 23.4%	! 24.9%	! **30.1%**

1.13 Emergency preparedness, resilience and response

The Trust is a Category One Responder under the Civil Contingencies Act 2004 and is required to:

- Assess the risk of emergencies occurring and use this assessment to inform contingency planning
- Put in place emergency plans
- Put in place business continuity arrangements
- Put in place arrangements to warn, inform, and advise the public in the event of an emergency
- Share information with local responders to enhance coordination
- Cooperate with other local responders to enhance coordination

Other encompassing legislation includes:

- The NHS Act 2006
- Section 46 of the Health and Social Care Act 2012
- NHS England Emergency Preparedness, Resilience and Response Framework November 2015
- NHS Core Standards for Emergency Preparedness, Resilience, and response July 2018
- NHS England Business Continuity Management Framework
- National Occupational Standards for Civil Contingencies
- BS ISO 22301 Societal Security – Business Continuity Management Systems

The Trust is required to work and engage closely with other Category One Responders such as health partners, blue light emergency services, and Local Authorities. In addition, the Trust works and engages closely with category two responders such as communications, energy and transport providers and the voluntary sector to enable effective response to a wide range of incidents.

Such work is carried out through the Hampshire and Isle of Wight Local Resilience Forum (HIOWLRF) and the Local Health Resilience Partnership (LHRP). This is attended by the Trust's Accountable Emergency Officer (AEO) and Emergency Preparedness, Resilience and Response (EPRR) Officer.

As well as generic incident response plans, the Trust has plans in place specifically designed to manage different types of incident such as adverse weather, pandemic flu, and lockdown. Ensuring the readiness of these plans is essential, and the Trust tests those plans internally and with partners by conducting desk-top exercises alongside other simulations. The Trust is required every three years and is currently involved with a National Health Major Incident for the Pandemic which came to the UK in January 2020 and until this incident is stood down, it counts towards the three-yearly requirement. The EPRR team have agreed to participate in a Mass Casualty exercise with the Isle of Wight NHS Trust to understand how we would support them with large numbers of casualties, and this is planned for the beginning of April. All other exercises that were planned for 2021 were cancelled, both internal events and those involving other agencies.

The Covid-19 Pandemic has tested the Trust in its response to managing a long-term Major Incident through good Command & Control processes laid out in the Trust's Incident Response Plan. This has also pushed the boundaries for supporting large numbers of patients who have been infected with Covid-19 and included identification of escalation areas for Critical Care and Acute Admissions. This incident has given Operational, Tactical and Strategic Commanders a chance to put their training into practice. This will prove invaluable in supporting the Trust in future should similar contingencies be required for other situations.

The Trust has managed two Critical Incidents in October and December 2021 due to extreme site flow pressures and these were called to manage high levels of patient attendances, high acuity and complex discharges which had prevent the flow of patients around the hospital. In addition, there was a Major Incident declared in January 2022 due to a burst mains water pipe which

resulted in 60% of the QA site being without a water supply for several hours and required support from partner agencies. These events were on top of the Covid response but were well managed and successfully stepped down with debriefing undertaken with learning adapted.
Each year NHS England (NHSE) assesses the Trust for assurance against the EPRR Core Standards, which set out the minimum levels of preparedness the Trust should have in place. This year the process was changed to having a peer review by the Acute Trusts in Hampshire and the CCG which supported the best practice between us and identified what could be improved. No others in the Country did the standards this way and it has been acknowledged at national level that this process would be taken forward in the future.

After presenting evidence of delivery against the above criteria, the Trust was given a rating of 'substantial assurance'. This acknowledged the amount of work carried out to meet this as well as the ongoing management of the Covid-19 response.

1.14 Financial performance

The Trust's financial statements for the year ended 31st March 2022 are shown in full from page 66 of this report onwards.

The Trust reported an operational surplus of £205k for the year ended 31st March 2022 (£609k after technical adjustments). This is after having provided for the financial impact of annual leave unable to be taken by staff during year two of the incident response (that is, £0.8m increase in pay provision beyond the £6.7m pay provision created at the end of March 2021).

2021/22 represented the third consecutive year whereby the Trust had reported a balanced position and thereby it 'lived within its means'. It is recognised that the Trust still has an underlying run-rate deficit of expenditure over income (with pre-pandemic 2019/20 financial balance having been underpinned by £17.5m planned national income from the Provider Sustainability and Financial Recovery Fund); nonetheless, the track record for delivery against planning assumptions will continue to serve the Trust well.

Key points to note in relation to 2021/22 financial performance include:

- Cost improvement plan (CIP): The Trust reported delivered operational savings and efficiencies totaling £4.6m during 2021/22 (£6.1m in 2020/21 compared with pre-pandemic levels of £21.6m in 2019/20, £23.9m in 2018/19). This second year of lower level of savings reflected the pandemic and is in line with comparable NHS organisations. Operational savings and efficiencies are required to return to 'near normal' levels from 2022/23 as NHS providers adjust to 'living with Covid-19'. The relative focus on financial grip and control will therefore intensify, with an enhanced focus on divisional financial performance.

- Agency staff expenditure: pre-pandemic and during the financial year 2019/20 the Trust was already able to significantly reduce its reliance on temporary agency staff as a direct result of successfully implementing its workforce investment strategy. Total agency staff expenditure had already therefore reduced to £15.4m in 2019/20 compared with £21.1m and £22.1m for 2018/19 and 2017/18 respectively. These actions served the Trust well during the pandemic response, with the Trust agency expenditure being £8.9m and £7.4m in each of the financial years 2021/22 and 2020/21 respectively. For 2021/22 this expenditure comprised of (with prior year 2020/21 comparator):
    - Nursing £2m (£1.3m)
    - Medical 5.4m (£4.7m)
    - Other Clinical £1.2m (£1.1m)
    - Administration and Clerical £0.3m (£0.3m)

- Capital Resource Limit (CRL): The Trust has continued to manage its annual capital programme of investments within its delegated CRL. Total capital investment in the Trust was £42.2m in 2021/22 (£34.2m in 2020/21, £22.5m in 2019/20, £22.1m 2018/19) summarised by funding source below:
    - Internally generated CRL £10.1m
    - PFI lifecycle expenditure £5.6m
    - Charitable donations £1.1m
    - Externally funded public dividend capital £25.4m (includes £9.4m additional D10/E10 ward block, £1.7m community diagnostic and £1m emergency care centre)

- Cash balance: The Trust ended the financial year with a cash balance of £37.5m at 31st March 2022 (£37.3m at 31st March 2021, £3.9m as at 31 March 2020, £4.6m as at 31st March 2019). Increased cash balances over the last two years reflect the pandemic financial framework and is expected to reduce in 2022/23.

- How we are supporting our suppliers: The Trust is committed to eliminating payment delays to all business critical suppliers. During 2021/22, 97.5% of non-NHS supplier invoices were paid within terms. This builds on sustained progress improvements made in 2020/21 where the Trust achieved 89.7% (a step increase from 41.5% during 2019/20 and 46.9% in 2018/19).

Signed:

Penny Emerit, Chief Executive (Interim)
Date: 13th June 2022

2. ACCOUNTABILITY REPORT

2.1 Corporate Governance Report and Directors' Accountability Report

The Trust's Board of Directors is responsible for the leadership, management and governance of the organisation, and in particular for

- Setting the strategic direction;
- Monitoring performance;
- Ensuring high standards of performance are maintained; and
- Promoting links between the Trust and the local community.

The Trust Board comprises a Chairman, five voting Non-Executive Directors (with one representing University of Portsmouth) and five voting Executive Directors (including, as required by statute, the Chief Executive, the Chief Financial Officer, a medical practitioner and a registered nurse). The voting membership of the Board is supplemented by a number of non-voting Associate Non-Executive Directors and non-voting Executive Directors who bring complementary and additional skills, experience and expertise to the unitary board of directors.

2.2 Portsmouth Hospitals University NHS Trust Board of Directors

Non-Executive Directors

All of the Trust's Non-Executive Directors, including the Chairman, are appointed to the Trust by NHS Improvement for a fixed term, following open invitation to members of the local community. The Trust Board's formal membership is supplemented, where appropriate, by the local appointment of non-voting associate Non-Executive Directors, who bring skills and experience particularly sought by the Trust Board to enhance its range and depth of expertise.

Melloney Poole OBE – Trust Board Chairman

Melloney Poole joined the Trust Board in May 2017 and was appointed as Chairman on 1st November 2017. She was the Chief Executive Officer of the Armed Forces Covenant Fund Trust until 31st December 2021. She is a corporate, charity and public administrative law solicitor and previously developed the combined legal service department which now supports all the legal and governance matters for the Arts Council England, the Heritage Lottery Fund, the Millennium Commission and the Community Fund.

In addition, she has been a Non- Executive Director in the NHS since 1993, serving on the boards of three NHS Trusts including leading one Trust through the Monitor process, and sat on the Board of the Health Foundation until 31st December 2021. She has also been a volunteer and fundraiser for various charities and a magistrate on the Preston bench. She was appointed to the Most Excellent Order of the British Empire as an Officer in the 2010 New Year Honours list in recognition of her contribution to legal and governance services.

Graham Galbraith CBE

Graham Galbraith has been Vice-Chancellor of the University of Portsmouth since September 2013. He has responsibility for the strategic direction of the university, working with the Board of Governors and senior management team.

He is passionate about higher education and its power to transform the life choices of individuals from a wide variety of backgrounds. He is also committed to leading the university to provide the very best student experience underpinned by internationally excellent research and world class business engagement.

David Parfitt

David Parfitt joined the Trust Board in May 2017. He is a chartered accountant, with broad commercial experience in a number of complex customer orientated businesses undergoing significant change, including the Granada Group, TSB Group and Lloyds Banking Group where he was the Risk, Control and Accounting Director of its retail banking business. In addition, he has direct experience of the NHS, firstly as a Non-Executive Director of NHS Luton and NHS Bedfordshire Primary Care Trusts as well as a Lay Member (audit and governance) of NHS Luton Clinical Commissioning Group.

David Parfitt is also a Non-Executive Director of Sussex Community NHS Foundation Trust, Chairman of Chichester Greyfriars Housing Association, a Board member/Trustee of The Brendoncare Foundation and and. a co-opted, independent non-voting member of the Regulation, Audit and Accounts Committee of West Sussex County Council.

Martin Rolfe

Martin Rolfe is Chief Executive Officer of NATS, the UK's leading provider of air traffic management services. Previously, he was the Managing Director of Operations at NATS responsible for delivering NATS' regulated UK air traffic business. Prior to joining NATS, he worked for the Lockheed Martin Corporation where he was Managing Director.

Martin Rolfe holds a Master's Degree in Aerospace Systems Engineering from the University of Southampton. His career started with the European Space Agency, working in orbital mechanics. Since then, he has worked in the aviation domain for more than 20 years across a number of companies leading large multinational teams across Europe, the US, and Asia with customers that include central government departments, military organisations and air navigation service providers.

Christine Slaymaker CBE

Christine Slaymaker joined the Trust Board in May 2017. Prior to this she was Chief Executive of Farnborough College of Technology, rated 'Outstanding' for Quality and Financial Health. She is a business graduate and has held non-executive positions for a number of organisations including Farnborough Aerospace Consortium, Treloar School and College, a Royal Engineers' charity and the Enterprise M3 Local Enterprise Partnership.

Christine Slaymaker was appointed to the most Excellent Order of the British Empire, as a Commander, in the Queen's Birthday Honours List in June 2014. She is from the Portsmouth area and still lives locally.

Vivek Srivastava

Vivek Srivastava is a consultant in Acute Medicine at Guy's & St Thomas' Hospital and Fellow of the Royal College of Physicians and Surgeons of Glasgow. He leads the development and implementation of new roles (e.g. advanced nurse practitioners and physician associates) to help his department provide high quality clinical services.

As a Clinical Coordinator at the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) he has contributed to reports on the quality of care of conditions like sepsis, pulmonary embolism, peri-operative diabetes care and mental healthcare in acute hospitals.

In his academic role, Vivek Srivastava is passionate about education and training for medical students and leads Acute Care teaching at King's College London School of Medicine. He has also published his work on mental health services, mental health education and predicting re-admissions in elderly patients.

The following Associate Non-Executive Directors are non-voting members of the Board

Roger Burke-Hamilton

Roger Burke-Hamilton is an ex Senior Civil Servant, with over 25 years in public sector and director level roles in the private sector. He has a technology background with considerable expertise in sourcing and managing supply chains for large critical national infrastructure, business to business logistics, and workforce transformation. He has a strong commitment to bring technology innovation into practical daily use for social advancement. He is a Fellow at the Royal Society of Arts and Manufacturing (FRSA) and mentors an entrepreneur who is building a philanthropy platform. Roger Burke-Hamilton sits on the Board at University of Portsmouth as an externally appointed Governor as well as serving as an associate director at this Trust.

His skill set includes setting leadership strategies, technical operations and commercial teams. His capabilities cover developing intellectual property in software using different technology stacks and cloud abstractions, cost modelling, asset valuation techniques, eco-system deployment involving complex cross-category and multi-channel delivery.

Gary Hay

Gary Hay has been a solicitor for more than 25 years, most of which was spent acting for public sector bodies including the NHS, police, fire and local government. He has acted as trusted legal adviser to many NHS trusts across the country, advising on employment law issues at a senior level. He is a recognised public speaker and is particularly known for his work around equality and diversity. During his time in private practice, he has sat on the boards of two firms for a combined total of 14 years, prior to serving as an associate director at this Trust. At Capsticks solicitors, as well as helping to shape and deliver an ambitious strategy for growth, he was responsible for a number of key initiatives, including expansion into new geographies, developing new markets and establishing an HR consultancy service.

Gary Hay recently set up his own consultancy focused on training and coaching for lawyers. He is also Chairman of the Helen Arkell Dyslexia Charity.

Inga J Kennedy CBE QHNS QARNNS

Inga Kennedy was the Head of the Royal Navy Medical Services, based at Navy Command Headquarters on Whale Island, Portsmouth. She is a Registered Nurse, Midwife and Nurse Lecturer, has undertaken post- graduate studies in education and has had the opportunity to attend the Ashridge Leadership and Management Centre, as well as the Royal College of Defence Studies as an associate. She also serves as an associate director at this Trust.

With a keen interest in the governance and assurance of healthcare, Inga Kennedy was most recently the Inspector General for the Defence Medical Services, a body which fulfills a role similar to that carried out by the CQC across England. With extensive experience in this area, she further developed systems and processes that deliver credible research-based evidence, providing an assurance of the standard of healthcare delivered across defence services. She was also appiointed as a Non-Executive Director at the Isle of Wight NHS Trust.

She was appointed to the Military Division of the Most Excellent Order of the British Empire, as a Commander, in the 2017 New Year's Honours.

Aswinkumar Vasireddy

Aswinkumar Vasireddy is an Orthopaedic Trauma Surgeon based at King's College Hospital in London, specialising in complex fractures. Prior to this, he has extensive experience in the area, having completed fellowships in both the UK and the United States of America. He also works as a Pre-Hospital Care Doctor and operates as a Consultant in this field with his regional Air Ambulance Service. This expertise led to his appointment as an associate director of this Trust.

He is committed to academia, holding two lecturer posts (Pre-hospital Care and Trauma Sciences). As the only full-time Orthopaedic Trauma Surgeon at King's College Hospital, he is highly involved in training junior doctors and also undertakes significant research in his professional duties.

Executive Directors

The Executive Directors are employees of the Trust. NHS and Trust recruitment guidance and policies are followed in the selection and recruitment of executive directors, including open competition and the involvement of an independent external assessor. The Chief Executive is appointed by the Chairman and Non-Executive Directors. The Executive Directors are recruited by a panel led by the Chief Executive.

As with Non-Executive Directors, the Executive Directors on the Board are supplemented by a small number of non-voting Executive Directors who bring additional expertise and experience to the Board. The first part of this section includes those executives with voting rights.

Penny Emerit – Chief Executive Officer (Interim)
Penny Emerit joined the Trust in January 2018 from NHSI having held senior leadership roles across the wider health system in London and the South. Her role as Delivery and Improvement Director for NHS Improvement involved oversight of the provider organisations across Hampshire and Isle of Wight and Dorset. Before joining NHS Improvement (formerly NHS Trust Development Authority) she was the Area Director for South London at NHS England, Director of Delivery at the South East London PCT Cluster and held a number of roles at NHS London Strategic Health Authority, latterly supporting the implementation of the Healthcare for London programme. Penny Emerit joined the NHS as a Management Trainee and holds an Economics degree and Post Graduate Diploma in Healthcare Management.

John Knighton – Medical Director
John Knighton spent three years gaining general medicine experience before training in intensive care medicine and anaesthesia in the south west and Wessex. He spent a year as a Visiting Instructor at the University of Michigan Hospital before taking a post in intensive care medicine & anaesthesia at Portsmouth Hospitals Trust at the start of 2000. He led the design of the state-of-the-art Critical Care facilities and was one of the clinical team leading on design for the whole hospital.

John Knighton was Clinical Director for the Department of Critical Care from 2010 – 2016 (during which time it was rated as "Outstanding" by the CQC), Chief of Service for Critical Care, Hospital Sterilisation, Anaesthetics & Theatres (CHAT), and Associate Medical Director. He has been a CQC Specialist Advisor for Acute Hospital inspections and has a long held passion for improving patient safety and quality of services, championing an open, learning culture of strong multi- disciplinary team working. He began as Medical Director at PHU in July 2017.

Liz Rix – Chief Nurse
Liz Rix has previously held a number of Director-level nursing positions in large, integrated Trusts, most recently at University Hospitals of North Midlands NHS Trust where she had been Chief Nurse since 2009. She is passionate about delivering quality care for patients through clinical leadership at all levels. She has the experience needed to develop strong nursing teams who manage workforce, patient experience and environment effectively, while also living the Trust values: working together for patients, with compassion, as one team and always improving. Liz Rix is one of the few nurses to graduate from the NHS Management Training Scheme after working in the health service for a number of years.

Chris Evans – Chief Operating Officer
Chris Evans joined the Trust in October 2020 from Warrington and Halton Teaching Hospitals NHS where he served in the same role. Prior to that, he was Managing Director at Salford Health and Social Care and manager for the Women's and Children's Division at the University Hospital for South Manchester. He commenced his NHS career in 2002 undertaking a range of administrative posts in Salford Primary Care Trust.

Subsequently, he developed his managerial career and gained experience working throughout the region at both Central Manchester University Hospitals and The Christie. He has managed a variety of acute, community and social care services.

Mark Orchard – Chief Financial Officer
Mark Orchard joined the Trust in October 2019 from Poole Hospital NHS Foundation Trust, where for five years he held the post of Executive Director of Finance at one of four NHS providers working together with the Dorset Clinical Commissioning Group as a part of a wave one integrated care system.

He has also held the Wessex system Finance Director post at NHS England, the Commissioning Finance Director role at Bristol, North Somerset and South Gloucestershire and more latterly, at NHS Bournemouth and Poole. Mark Orchard was national president of the Healthcare Financial Management Association (HFMA) during 2016/17 and served the maximum of three terms as Trustee on their national Board between 2009 to 2019. He is currently national chair of the NHS Providers' Finance and Commercial Directors' Network and also chairs the University Hospital Association finance directors' group at national level.

The following members of the board are all non-voting directors:

Nicole Cornelius – Chief People Officer
Nicole Cornelius joined the Trust as Chief People Officer in October 2018. She is a Fellow of the Chartered Institute of Personnel and Development, has a M.St from Cambridge University and is a member of the Independent Advisory Panel to the Military. She has over 30 years' public sector experience including Director roles in the Police, the Probation Service and Local Government. Nicole Cornelius is passionate about creating an environment of support and wellbeing for staff, particularly in relation to keeping staff safe at work and addressing the issue of violence against staff.

Anoop Chauhan MBE – Director of Research
Anoop Chauhan joined the Trust Leadership Team in July 2020. He had previously been Director of Research at the Trust since 2009 and is also a practicing physician in respiratory and general medicine. He has developed opportunities for patients throughout the region to participate in high quality research trials, introduced innovations in clinical pathways, developed new models of care, and helped set up a nationally recognised severe asthma centre in Portsmouth. His research has resulted in a positive impact on disease control, quality of life, healthcare usage and health economic benefits in patients with respiratory conditions.

He has also set up the Portsmouth Technology Trials Unit to allow more health technology companies to work with patients and the NHS. He was awarded an MBE in the Queens Birthday Honours in 2021 for services to respiratory medicine.

Graham Terry – Director of Strategy and Performance
Graham Terry joined the Trust in February 2018 as deputy director of planning and strategy, from Great Ormond Street Hospital for Children NHS Foundation Trust where he served as head of planning and performance. Before his move to London, he held a number of senior roles in provider, and more extensively in commissioning organisations within Hampshire and Isle of Wight. Many of these roles have allowed him to work between primary, secondary and tertiary care, in leading commissioning, planning and contracting functions.

His career in the NHS commenced directly from University in 1998. Over this time Mr Terry has developed his managerial career and has a master's degree in Business Administration (MBA), from the University of Portsmouth.

Lisa Ward – Director of Communications and Engagement (from 21st June 2021)
Lisa Ward is a communications and engagement professional with more than 25 years of experience. This has involved a range of roles and environments, incorporating the public, charity and private sector. Over this time, she has been involved with the delivery of comprehensive internal and external communications, engagement and media relations strategies at a national, regional and local level. She has provided leadership in communications for numerous healthcare organisations, including NHS Providers, the Department of Health & Social Care and other NHS trusts such as Kingston Hospital NHS Foundation Trust.

Lois Howell – Director of Governance and Risk (until 1st July 2021)
Lois Howell joined the Trust in January 2018. She is a solicitor by background with an MBA in public sector management and many years' experience in governance and regulatory roles. Lois Howell worked in local government before joining the NHS in 2007, and has also spent time as a consultant in governance and regulation, supporting clients across the public and private sectors. She has held director level roles in a number of NHS and local government bodies. Since July 2021 Lois Howell has been seconded to the Board of the Isle of Wight NHS Trust as Director of Governance and Risk.

Alison Fox-St Marthe – Interim Director of Governance and Risk (from 1st August 2021 to 28th January 2022)
Alison Fox-St Marthe has 30 years of business and legal experience in a range of public and private sector organisations. Having qualified as a barrister in 2005, she has subsequently gained qualification as a Chartered Secretary. She took the role at the Trust on secondment from East Kent Hospitals University NHS Foundation Trust. Her experience and involvement in setting up the Research Council Shared Services Centre involved negotiations with the Department of Business, Enterprise and Regulatory Reform.

Kevin Street – Interim Director of Governance and Risk (from 7th February 2022)
Kevin Street has a doctorate in governance and a Masters degree in risk, crisis and disaster management. He has extensive experience in commissioning, acute, specialist and primary care in the NHS.
As well as this NHS work, he has been involved internationally in governance work with board, ministerial authorities, regulators, staff and stakeholders. This has enabled him to work within the context of a range of perspective on risk and governance. He is also committed to ensuring that practitioners have the required skills to facilitate good practice in the public sector.

2.3 Executive Director pay

The NHS Very Senior Manager Pay Framework has been adopted by the Remuneration Committee as guidance regarding pay for the executive team. Full details can be found in the Remuneration Report on pages 53 and 54 of this report.

2.4 Board Effectiveness

All Executive Directors and Non-Executive Directors have annual appraisals and performance development plans. The appraisal includes a self-assessment in line with both the fit and proper persons requirement (FPPR) and the NHS Improvement quality governance framework. No issues or concerns have been raised in connection with these appraisals or self-assessments.

As outlined above, the Trust underwent a 'Well-Led' inspection by the CQC in November 2019. During the second and third quarters of 2019/20, the Board also undertook a Well-Led review, which comprised of a self-assessment followed by external scrutiny by Deloitte. The CQC rated the Trust as 'Good' for being well-led, and the report of the externally assessed well-led review was also broadly positive.

The Trust has maintained a range of board development activities during the 2021/22 financial year. These have reviewed a wide range of strategic priorities for the Trust, including the recovery of elective services following the pandemic, the Board's risk appetite, the Delivering Excellence quality improvement programme and the development of the local Integrated Care System. It has also taken presentations from the Culture Change programme and considered the strategic partnerships which will form the basis for collaborative working across the region over coming years.

In response to the variable demand for services relating to Covid, the Trust Board has been flexible in its governance arrangements as required by the situation. Where possible, governance arrangements have been maintained with the Board and all assurance committees maintaining their regular meeting patterns throughout the year. However, business and agendas have on occasion been streamlined to provide essential assurance activity but reduce the workload for clinical teams during the periods of peak activity. In particular, this applied to the period at the turn of 2021 – 22 following the issuing of national guidance on reducing the burden of reporting and releasing capacity to manage the Covid-19 pandemic.

2.5 Audit Committee

The Board Committee structure is set out in the Annual Governance Statement on page 38 of this report, but for the purposes of the Corporate Governance Report section of the Annual Report and Accounts, it is confirmed that the Board has established an Audit Committee, comprised of the following Board members:

- David Parfitt (Committee Chair)
- Gary Hay
- Martin Rolfe
- Christine Slaymaker

A number of Executive Directors also attend and participate in the Audit Committee's meetings, as well as representatives of the Trust's internal and external auditors and its Counter Fraud Service. The Non-Executive Director members of the Committee have regular opportunities to meet with the auditors in the absence of the Executive Directors.

2.6 Counter-Fraud

During 2021/22 the Counter Fraud Service was provided by the Fraud and Security Management Service (F&SMS), which provides a specialist service for a fixed cost, underpinned by a risk sharing agreement with the Trust. The appropriate level of resource was made available to meet the fluctuating demands of the Trust. The Trust has an accredited, nominated Local Counter Fraud Specialist (LCFS) who reports directly to the Chief Financial Officer and Audit Committee. The LCFS provides a risk assessed plan of work to meet the Government Functional Standard (GovS 013: Counter Fraud) and NHS Counter Fraud Authority requirements.

The Fraud, Bribery and Corruption Work Plan was agreed at the beginning of the year and was regularly reviewed. The reviews resulted in the inclusion of additional activities which were designed to address emerging trends, system weakness arising from planned activity and reactive criminal investigations. The additional work included the development of a Local Fraud, Bribery and Corruption Strategy for 2021 – 2024 and proactive exercise reviews of salary overpayments, conflicts of interest and sponsorship.

This year saw the introduction of the Counter Fraud Functional Standard Return which replace the NHS Counter Fraud Authority Self Review Tool. The organisation achieved an overall green rating across the 12 Functional Standard Components; the return was approved by the Chief Financial Officer and Audit Committee. The Audit Committee received an annual report and quarterly update reports and during the year approved the Fraud, Bribery and Corruption Work Plan. In addition, the policy and strategy for the next three years also received approval.

A continued programme of fraud awareness work was undertaken, including the development and maintenance of a website and delivery of e-learning. The Trust has responded to high numbers of local and national fraud alerts and prevention notices which were subject to an NHS Counter Fraud Authority Prevention Guidance Impact Assessment. This year the Trust established a Policy Steering Group to scrutinize and consider all Trust Policies, with the LCFS as an invited member as well as acting in the same capacity for the Human Resources Policy Group. During the year the LCFS received 33 reports of suspected fraud. These were investigated where appropriate and resulted in 11 disciplinary sanctions. All investigation work is conducted in accordance with relevant legislation and closure reports included recommendations to address system weaknesses where appropriate. The amount of fraud losses prevented from reactive work during the year was £31,539.61.

2.7 Cost allocation / setting of charges for information

The Trust certifies that it has complied with HM Treasury's guidance on cost allocation and the setting of charges for information.

2.8 Information Governance

The confidentiality and security of information regarding patients, staff and the Trust are maintained through governance and control policies, all of which underwent extensive review in 2018 in readiness for the implementation of the General Data Protection Regulation 2016/679. Personal information is, increasingly, held electronically within secure IT systems. It is inevitable that in a complex NHS organisation a small number of data security incidents occur. The Trust is diligent in its reporting and investigation of such incidents, in line with statutory, regulatory and best practice obligations.

Any incident involving a breach of personal data is graded and the more serious incidents are reported to the Department of Health & Social Care and the Information Commissioner's Office (ICO) where appropriate.

As reported in the more detailed description of information governance arrangements set out in the Annual Governance Statement (page 45), the Trust experienced four externally reportable serious incidents in 2021/22 and these were reported using the Data Protection and Security Toolkit.

2.9 Directors' confirmation concerning audit information

The Trust's Directors participated in the governance arrangements described in the Annual Governance Statement throughout 2021/22.

Each individual Trust Director, at the time the Directors' Report is approved, confirms:

- So far as the Director is aware, that there is no relevant audit information of which the Trust's external auditor is unaware; and
- That the Director has taken all the steps that they ought to have taken in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.

Signed: Penny Emerit, Chief Executive (Interim)
Date: 13th June 2022

3. ANNUAL GOVERNANCE STATEMENT

3.1 Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the 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 Portsmouth Hospitals University 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.

3.2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable, and not absolute, assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- identify and prioritise risks to the achievement of the policies, aims and objectives of the Trust,
- evaluate the likelihood of those risks being realised,
- assess the impact of those risks, should they be realised, and,
- manage the risks efficiently, effectively and economically.

The system of internal control has been in place in the Trust for the year ended 31st March 2022 and up to the date of the approval of the Annual Report and Accounts.

3.3 Capacity to handle risk

During 2021/22, the Board Assurance Framework was updated to ensure enhanced oversight of risks to the delivery of the Trust's annual plan priorities for the delivery of the organisational objectives set out in the Trust strategy, Working Together (adopted in July 2018).

The Board Assurance Framework has been presented to the Board of Directors throughout 2021/22 and is effectively used in the day to day operational management of the Trust - for example, it is regularly reviewed and taken into account by the Trust Leadership Team.
Throughout 2021/22 all meetings of the Trust Board and its committees have concluded with a consideration of whether any of the matters discussed during the meeting should be added to the Board Assurance Framework. The Board Assurance Framework has also been used during 2021/22 to plan for 2022/23.

Continuous update and improvement on the Trust risk management approach has continued through the year. The clinical Divisions' and corporate risks registers have all been reviewed and updated throughout the year.

The Board Risk Register is comprised of Trust wide risks which link to the Board Assurance Framework, in addition to risks from Divisional risk registers which require further support as the risk cannot be mitigated sufficiently by the Division. The Board risk register is presented on a quarterly basis to the Trust Board for review, having been scrutinised in advance by the Quality & Performance Committee.

Executive leadership for both operational and strategic risk was in the portfolio of the Director of Governance & Risk. Risk management training is delivered to all staff on induction and on request.

3.4 The Risk and Control Framework

Operational risk management

The organisation's Risk Management Strategy is based on an on-going process designed to:

- identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives;
- evaluate the likelihood of those risks being realised, and the impact should they be realised; and
- manage them effectively.

Risks were identified in 2021/22 from a variety of sources, including:

- internal and external reviews and inspections
- internal and external audit activities
- counter fraud activities
- risk assessments
- Care Quality Commission enquiries and observations
- complaints, safety learning events and claims
- alerts received from the Central Alert System
- consultation with staff and patients
- mandatory/statutory targets
- service and quality reviews

All risks across the Trust are evaluated according to a standard scoring matrix, which maps the likelihood of the risk occurring against the impact/consequence of its occurrence. The outcome is then recorded on a standardised risk assessment form. This standardised approach ensures consistency of appraisal across the Trust and permits the prioritisation of risks on an on-going basis. This process is clearly outlined in the Trust's Risk Management Policy. The risk profile covers wide ranging themes emerging from financial, operational, clinical and reputational issues.

The Governance and Risk team support Divisions and Corporate teams to review risks, quality check and to ensure that risk management is undertaken as per the policy. Any risks requiring additional support are presented to the Executive team for consideration of inclusion on the Board risk register. The Quality & Performance Committee review the Board risk register, before proposing the latter to the Trust Board for review and approval. This process ensures that there is Board oversight of the quality of risk management activity.

During the year 2021/22 a number of risks rated 15 and above were identified. Action plans to mitigate these risks through addressing gaps in control and/or assurance were reported and reviewed as part of the on-going scrutiny through the key committees/groups responsible for the oversight of risk management.

In that period, the highest scoring risks continued to reflect the impact of the pandemic on patients, staff and services and the increased demand on the hospital with regard to capacity and demand, especially as community restrictions have been relaxed regarding Covid-19. These areas have been the subject of detailed internal and external scrutiny, with extensive action plans in place to mitigate the risks to the Trust.

The Trust Board will continue to monitor closely the actual and potential impact upon the operational and strategic objectives of the Trust of work with system partners

3.5 Risk management in practice

Risk management is embedded within the Trust in a variety of ways, including policies which require staff to report incidents through a web-based reporting system (Datix). The Trust provides annual mandatory and statutory training for staff, which includes risk awareness training.

Risk registers are recorded and held centrally on the Datix-web reporting management system allowing for staff to view risks.

Strategic risk management

The Board uses the Board Assurance Framework (BAF) to record and manage risks to the delivery of the Trust strategic objectives, as set out in the Trust Strategy, Working Together. Risks are allocated to designated Executive Directors so that management of risks can be overseen effectively, and progress reported to the Board through quarterly reports.

The highest risk on the BAF throughout 2021/22 has been that posed to the delivery of all of the Trust's objectives by the diversion of resources necessary to react appropriately to the pandemic. The rating for that risk is likely to reduce as the latest acute phase of the pandemic abates but may increase again if further waves occur. Risk associated with the recovery programme, as outlined above, may well replace that risk in 2022/23. The BAF will be reviewed in the new financial year to ensure that it reflects the Trust's risk profile following the Covid-19 pandemic and the need to recover delivery of elective services and business as usual functions.

3.6 Risk management responsibility

Risk management is a corporate responsibility, and therefore the Trust Board has the ultimate responsibility for ensuring that effective processes are in place. The Board is committed to the continuous development of a framework that manages risks in a structured and focused way to protect the Trust from loss, damage to its reputation or harm to its patients, staff and the public.

Whilst I, as Chief Executive, retain overall accountability for the management of risk, I have delegated oversight to the Director of Governance & Risk. However, elements of responsibility also lie with other employees and the structure of the organisation ensures there is adequate capacity to fulfil these responsibilities.

3.7 Risk registers

All identified risks that cannot be addressed immediately are placed on a risk register and held and managed at the appropriate level within the Trust: specialty, care group, division or corporate department. Risk registers are recorded on the Datix web management system and reviewed according to the level of risk to support monitoring of the implementation of action plans necessary for mitigation and escalation indicated.

Any risk that cannot be managed at the appropriate organisational level or has the potential to affect the whole of the care group, is escalated to the relevant care group's governance committee for consideration and potential inclusion on the care group risk register. A similar process applies to care group risks with escalation to the divisional risk register. It is the responsibility of the divisional governance committees to escalate any risk that cannot be managed at divisional level, or which may have a Trust-wide impact, for consideration and possible inclusion on the Board Risk Register.

3.8 Risk appetite

The Trust's risk appetite is expressed in two ways. Firstly, through the score attributed to particular risk impacts, and secondly through the approach to risks which have specific overall risk scores.

The Trust uses a risk matrix, which is common across the NHS, and is a globally recognised standard for risk measurement and management. Details of significant risks are included in Section 1.9 of this report.

3.9 Risks to compliance with condition 4 of the Trust's NHS provider licence

The Board is required to identify and articulate any risks it has identified to its compliance with condition 4 of its NHS Provider Licence, under the following headings.

Risk	Risk rating	Mitigation
Effectiveness of governance structures		
The Trust keeps its governance arrangements under continual review and has identified a need to strengthen quality and operational governance arrangements. In particular, the Trust seeks confirmation that governance activity leads to appropriate action.	Medium	• An external review of current quality governance arrangements was completed in May 2021, with its recommendations having been implemented throughout the remainder of 2021 – 22.
The Trust also streamlined performance and accountability activity during the pandemic, and there is a need to re- introduce appropriate and proportionate levels of oversight, monitoring and challenge in order to deliver the challenging operational and strategic objectives of the coming year	Medium	• The Trust re-introduced performance and accountability activity in April 2021 • The impact and effectiveness of the reviews has been monitored, with practices aligned with the findings of the governance review mentioned above.
The responsibilities of directors and subcommittees		
Reporting lines and accountabilities between the board, its subcommittees and the executive team		
Risk	**Risk rating**	**Mitigation**
The Trust has identified that some of the quality governance arrangements which feed into the Board's Quality & Performance Committee are not as effective as they need to be.	Low	• Quality Safety and Patient Experience Group introduced in July 2021 to provide cross-organisational overview of these areas • This then reported directly to Quality and Performance Committee to provide Board-level oversight of emerging issues • Ongoing review of Trust practices and provision of three lines of assurance being undertaken
The submission of timely and accurate information to assess risks to compliance with the conditions of the licence		
The degree and rigour of oversight the Board has over the Trust's performance		
There will be further work on the collection, collation, use and analysis of data and information during 2021/22, but no material risks in this regard have been identified	Low	• Datix platform at Trust updated • Use of information from Datix being reviewed to align with provision of assurance as mentioned against previous risk

In addition to the matters above, the Trust has received notice from NHS England and NHS Improvement that its undertakings will be revised. This is in relation to ambulance handover performance, waiting times experienced by patients on the urgent and emergency care pathway and the risks associated with these areas. The details of these are currently being finalised, with reporting on the matter to Board and external organisations to be carried out as appropriate.

3.10 Quality governance arrangements

During 2021/22 the Chief Nurse had delegated responsibility for quality and safety, supported by the Medical Director. In addition, the Trust Leadership Team (executive directors and divisional directors) had responsibility for the general management of business, including the delivery of relevant quality and performance standards, on behalf of the Trust Board.

Since their establishment in July 2018, the divisional management teams attend monthly performance and accountability reviews with the Trust Executive team. These reviews monitored the delivery of quality, safety and performance standards in line with the Trust's strategy and operating plan. The Performance reviews were re-instated in April 2021, following suspension due to the Covid pandemic on 30th September 2020.

The Trust Board continues to receive quality and safety metrics as part of the Integrated Performance Report. This provides the Board with assurance in respect of all aspects of the Trust's performance against national priorities, set by NHS Improvement (NHSI) and NHS England (NHSE), and local priorities. Quality, safety and performance elements were reviewed in detail, monthly by the Quality and Performance Committee, with key issues being escalated to the Board as required. The Trust continues to strive to reach sustainable improvement in its performance against its priorities.

In July 2021, the Trust established the Quality, Safety and Patient Experience Group (QSPE) to provide monthly oversight, and monitoring of all areas of quality, safety and patient experience; holding Divisional Nurse Directors and their Governance Leads to account for quality recovery and improvement. Each Division provides a monthly report to QSPE, which includes an 'alert', 'advise' and 'assure' summary detailing the issues to highlight. The report also includes the sharing of learning from incidents, complaints etc.

In October 2021, a Policy Steering Group was established as a multidisciplinary group to oversee the management of Trust policies. The group are responsible for considering new and reviewed policies to ensure there has been appropriate regard to risks, legislative changes, consultation and corporate matters.

The annual clinical audit plan is linked to the Trust's priorities and risks and is monitored by the Clinical Effectiveness Committee, which reports to the Quality and Performance Committee. The Audit Committee also has oversight of the delivery of the plan.

The strengthened process for the management of all serious incidents continues, with weekly executive and senior patient safety team review and early investigation planning, with an enhanced focus on learning.

3.11 Equality, diversity and human rights

The Trust is committed to embedding equality, diversity, and inclusion (EDI) in everything it does, with the aim of working towards Intentional Inclusion and ensuring our workforce at every level is inclusive and representative of the community we serve.

Appreciating diversity is important to the Trust and helps all staff understand that treating people in the same way does not deliver equality for all. The Trust acknowledges and celebrates individual differences whilst recognising that having a diverse workforce drives innovation, enhances creativity and can increase recruitment and retention.

Equality is about fair treatment, and we believe that employment and our services should be accessible to all. Everyone has individual needs and the right to have those needs respected.

Diversity is about respecting difference and can include individuals and groups with varying backgrounds, experiences, perceptions, values, and beliefs. It is important that we understand, value, and respect those differences.

Inclusion is about recognising and valuing the differences we each bring and creating an environment where everyone can be their true selves and has equal access to services, opportunities, resources and can contribute to the organisation's success.

In 2020 the Covid-19 pandemic shifted the landscape globally and influenced every aspect of our lives and the way we operate as a Trust. The disproportionate impact of Covid-19 on many of our communities brought into focus the enormity of the task and the importance of taking focused and deliberate action on creating a truly inclusive environment here at Portsmouth Hospitals University Trust.

This year has been an opportunity to reflect, listen and take our first steps towards creating a vision for equality diversity and inclusion that reflects the needs of the people we work with and care for. Our key focus was to develop this vision by creating an equality diversity and inclusion strategy that was codesigned by our colleagues, community, and patients. Our commitment is to develop and sustain an inclusive and compassionate workplace and to ensure our service will be accessible and truly inclusive to all.

The Trust employs a diverse workforce; proportionately greater than the population and communities it serves. The following tables provide a high-level summary of the Trust's workforce by protected characteristic and staff group:

Division	Disability (%)			Age (%)	Ethnicity (%)		
	Yes	No	Not Stated	Largest Age Group	White	BME	Not Stated
Charitable Funded Division	0.0%	100.0%	0.0%	36-40, 33.3%	100.0%	0.0%	0.0%
Clinical Delivery Division	8.0%	71.1%	20.9%	31-35, 16.1%	80.5%	17.9%	1.7%
Corporate Services	10.0%	71.6%	18.4%	51-55, 15.8%	91.0%	7.7%	1.4%
Medicine and Urgent Care Division	8.7%	78.0%	13.3%	31-35, 20.9%	60.3%	36.8%	3.0%
Networked Services Division	8.5%	73.0%	18.5%	31-35, 16.2%	79.9%	18.7%	1.3%
Overheads/Commercial	10.7%	72.8%	16.5%	26-30, 22.8%	63.1%	30.1%	6.8%
Surgical and Outpatients Division	8.0%	72.6%	19.4%	26-30, 14.4%	75.7%	22.5%	1.7%
Trust	**8.5%**	**73.7%**	**17.8%**	**31-35, 16.7%**	**74.7%**	**23.3%**	**2.1%**

Division	Sexual Orientation (%)				Maternity & Adoption Leave (%)	Marital Status (%)		
	LGBTQ+	Heterosexual	Undecided	Not Stated		Married/Civil Partnership	Single	Not Stated
Charitable Funded Division	0.0%	100.0%	0.0%	0.0%	0.0%	50.0%	50.0%	0.0%
Clinical Delivery Division	2.9%	74.4%	0.0%	22.6%	2.7%	51.2%	45.9%	2.9%
Corporate Services	3.1%	78.4%	0.3%	18.2%	1.8%	49.7%	47.7%	2.6%
Medicine and Urgent Care Division	3.0%	78.6%	0.2%	18.2%	3.6%	50.9%	45.1%	4.1%
Networked Services Division	2.6%	73.8%	0.3%	23.3%	3.9%	57.5%	39.1%	3.4%
Overheads/Commercial	2.9%	78.6%	0.5%	18.0%	5.8%	46.6%	47.1%	6.3%
Surgical and Outpatients Division	2.1%	73.7%	0.3%	24.0%	3.5%	54.4%	41.7%	4.0%
Trust	**2.8%**	**75.8%**	**0.2%**	**21.2%**	**3.3%**	**52.6%**	**43.9%**	**3.5%**

Division	Top 5 Religion/Beliefs (%)					Religion/Belief not stated (%)	Gender	
	1	2	3	4	5		Male	Female
	Christianity	Atheism	Other	Islam	Hinduism			
Charitable Funded Division	66.7%	16.7%	16.7%	0.0%	0.0%	0.0%	0.0%	100.0%
Clinical Delivery Division	43.6%	16.1%	7.0%	2.2%	2.3%	0.0%	25.4%	74.6%
Corporate Services	44.0%	19.3%	10.2%	1.0%	1.0%	0.0%	33.7%	66.3%
Medicine and Urgent Care Division	52.3%	11.3%	7.5%	4.4%	2.3%	0.0%	22.0%	78.0%
Networked Services Division	46.3%	13.0%	7.8%	1.9%	1.7%	0.0%	11.4%	88.6%
Overheads/Commercial	42.2%	14.1%	6.3%	10.7%	4.4%	0.0%	22.8%	77.2%
Surgical and Outpatients Division	44.1%	12.6%	7.6%	2.8%	1.8%	0.0%	22.5%	77.5%
Trust	**46.6%**	**13.9%**	**7.7%**	**2.9%**	**2.0%**	**0.0%**	**22.0%**	**78.0%**

In April 2022, the Trust published its first EDI strategy which reflected the voice of our people and service users. The EDI Strategy 2022-2025 builds upon what we have already achieved and pledges to address inequalities with real purpose and action. It was developed using feedback from 'Every Voice Matters', data from our NHS Staff Survey, staff quarterly survey, Workforce Race Equality Standard, Workforce Disability Equality Standard, Gender Pay Gap, Model Employer targets and listening to our staff, patients, partners and members of our local communities.

The strategy was approved and supported by our Trust Leadership Team, Workforce and Organisational Development Committee in February 2022 and Trust Board the following month. It sets out our aims, objectives, and principles for inclusion with a detailed action plan. Our strategy is our commitment to addressing inequalities for our people, patients and our community with real purpose and action. We value the diversity of our people and commit to developing and sustaining an inclusive and compassionate workplace. For our patients and community, we want to ensure our services will be accessible and truly inclusive to all.

The NHS People promise "to work together to improve the experience of working in the NHS for everyone" reminds us that our business as a Trust is about people and our people provide our services to our patients and communities. We want all our staff to feel and work as part of one team that bring out the very best in each other. In doing this, we will be working towards fulfilling our Trust vision, "Working together to drive excellence in care for our patients and communities" which will be achieved through our strategic aims and supported by our values which underpin everything we do.

3.12 Developing workforce safeguards

The Trust monitors its compliance with the "developing workforce safeguards" recommendations by a number of measures. Nursing establishments are reviewed regularly and safer staffing reports, based on the National Quality Board model, are regularly received by Board. The Workforce and Organisational Development Committee, chaired by a non-executive director, has been in operation throughout the year and regularly considers all aspects of staffing for all groups of staff. It has a specific focus on role development, hard to recruit roles, culture, and leadership.

The Committee and the Trust Board approved the annual workforce plan which includes a significant investment in recruiting Band 5 nurses to ensure vacancies are minimised in this group where recruitment can often prove challenging. The Trust has an active Bank Partner; this has achieved a high level of bank fill. Agency staff are employed, as necessary, to ensure critical gaps are filled and services maintained for all staff groups.

3.13 Trust Board

Board committee structure

The Trust has developed governance structures to deliver an integrated governance agenda. Integrated governance is the combination of systems, processes and behaviours which the Trust uses to lead, direct and control its functions in order to achieve its organisational objectives. The Trust recognises the importance of responsible, accountable, open and effective governance.

The Trust Board approves an annual schedule of business to which it will add additional items as required. Exception reports to the Trust Board ensure that it considers key issues and makes effective use of its time. The Trust Board met, on a formal basis, a total of six times during the year and Board papers are published on the Trust website.

The Trust's Standing Orders, Standing Financial Instructions and Reservation and Delegation of Powers were reviewed and revised in January 2022. These essentially retained the changes made arising from the Well-led Review conducted in February 2020 and have facilitated decision making outside of Board meetings. This has supported the reduction of these meetings to six per year, thus maintaining governance and oversight whilst ensuring that the workload for clinical teams arising from reporting requirements was at a reasonable level.

Board performance

As of 31st March 2022, the Trust Board comprised the Chairman, five independent Non-Executive Directors (plus four independent Associate Non-Executive Directors) and ten Executive Directors. Five of the Executive Directors are non-voting (Director of Communications & Engagement, Director of Strategy & Performance, Director of Governance & Risk, Director of Research and the Chief People Officer).

The Trust Board has been relatively stable throughout the year, with the most recent Well-led Review noting the strength of leadership provided by the Trust Board's members. The Board has been assessed as providing a positive and supportive environment for challenge and debate which supports the vision and strategy being implemented across the Trust. This continuity has allowed the improvements made to culture across the organisation (referenced in the Care Quality Commission inspection discussed on page 42) to embed.

As part of this, the operation of the Trust Board and its constituent Committees has been consistent throughout the year. As originally planned, the Trust Board met six times in the financial year as is appropriate for its strategic, rather than operational, focus. The Board has benefitted from its membership being experienced and established, with their operation as a corporate whole supporting the Trust's accountability framework in an appropriate manner. As a central element of this, the Integrated Performance Report has continued to evolve. This is further enhanced by the work of the newly-formed Quality, Safety and Patient Experience Group which held its inaugural meeting in July 2021. This Group reports to the Quality & Performance Committee and provides divisional oversight of the areas under its remit at corporate level.

As a result, the Quality and Performance Committee has been able to receive and consider input which has moved from information towards genuine analysis. Therefore, the information currently presented to the Trust Board is based on metrics which are appropriate, triangulated with external sources and provides rigorous analysis. Further support has been provided through the revised presentational format used to consider patient safety and patient experience; in 2022/23, it is intended that the structure for providing quality governance will be a focus for continued improvement.

The Board has also been supported in its work on financial planning and oversight by the Finance and Infrastructure Committee. The Committee has maintained its focus on sustainability and securing value for money. A series of established tests (e.g. management oversight and scrutiny, quality and safety, benefits realisation) are used to assess business cases, and these have supported the production of proposals in a suitable format for presentation to Trust Board. The reporting of a version of the contracts register which is tailored to the Committee's interests and remit has augmented this. Meanwhile, the formulation of the Operational Plan 2022/23 has continued, with the Committee having an interest in assessing the impact on this from commitments made regarding future expenditure.

As a result, 2021/22 built on the positive developments of previous years and saw the Trust Board and its committees continue to evolve and support the Trust's ambitions for improvement. Whilst the pandemic has had an inevitable impact on the priorities for the year, there has been a move towards a more streamlined and strategic work programme. The reporting process adopted in 2020/21, with a substantially higher number of items reported through committees after receiving prior scrutiny, has continued to support the efficient use of time in Board meetings. This has supported a higher-level focus in discussions which will support the wider health and social care system's aims. The healthy number of stakeholders and members of the public at the Annual General Meeting was also indicative of the prominence of the work of the Trust Board.

Processes to ensure that the Trust Board undertakes its duties appropriately are in place. As outlined in other parts of this report, the Chairman of the Trust Board conducts annual appraisals of the Non-Executive Directors and the Chief Executive. The Chief Executive reviews the performance of the Executive Directors. As part of this latter process, the expressed views of Non- Executive Directors are taken into account.

A record of attendance at meetings of the Trust Board is set out below:

	26-May-21	28-Jul-21	29-Sep-21	24-Nov-21	26-Jan-22	30-Mar-22
Executive Directors						
Penny Emerit	✓	✓	✓	✓	✓	✓
Anoop Chauhan	✓	✓	✓	✓	✓	✓
Nicole Cornelius	✓	✓	✓	✓	X	✓
Chris Evans	✓	✓	✓	✓	✓	✓
Lois Howell	✓					
John Knighton	✓	✓	✓	✓	✓	✓
Mark Orchard	✓	✓	✓	✓	✓	✓
Liz Rix	✓	✓	✓	✓	✓	✓
Graham Terry	✓	✓	✓	✓	✓	X
Lisa Ward		✓	✓	✓	✓	✓
Alison Fox-St Marthe			✓	✓	✓	
Non-Executive Directors						
Melloney Poole	✓	✓	✓	✓	✓	✓
Christine Slaymaker	✓	✓	✓	✓	✓	✓
David Parfitt	✓	✓	✓	✓	✓	✓
Gary Hay	✓	✓	✓	✓	✓	✓
Inga Kennedy	X	✓	✓	✓	✓	✓
Martin Rolfe	✓	✓	✓	✓	X	✓
Roger Burke-Hamilton	✓	✓	✓	✓	✓	✓
Graham Galbraith	✓	✓	✓	✓	✓	✓
Vivek Srivastara	✓	✓	✓	✓	✓	✓
Aswinkumar Vasireddy	✓	✓	✓	✓	✓	✓

Attended	✓
Apologies given	X

All members of the Trust Board fully accept the principles contained in the September 2014 Corporate Governance Code relating to accountability, transparency, probity and focus on sustainable success, and the Nolan principles. Each Director of the Trust has passed the 'fit & proper person' test. A register setting out details of company directorships and other significant interests held by members of the Trust board which may conflict with their Board responsibilities is available on the Trust's web-site at https://www.porthosp.nhs.uk/about-us/key-documents.htm

Board committees

The following committees have reported to the Trust Board throughout 2021/22 (all with Non-Executive Directors as Chairs):

- Audit Committee (mandatory):
  The Audit Committee is the senior Board committee responsible for oversight and scrutiny of the Trust's systems of internal control and risk management. It ensures that there are effective internal audit arrangements in place that meet mandatory NHS Internal Audit Standards and provides independent assurance to the Board. In addition, the Committee reviews the work and findings of External Audit and maintains oversight of the Trust's Counter Fraud arrangements. Membership was in line with the Terms of Reference. The Audit Committee met six times during 2021/22.

- Quality and Performance Committee:
  This committee reviews the delivery of key national, local and internal performance targets. It also oversees clinical quality and effectiveness to drive continuous improvement. As part of this, the Committee scrutinises specific issues it has identified, or others have referred to it to seek assurance on their management and resolution. It met 12 times during 2021/22.

- Finance and Infrastructure Committee:
  The committee reviews financial reporting and management, identifying and monitoring progress against risks related to these areas. It also provides assurance to the Board on all significant performance aspects relating to finance and infrastructure as well as reviewing the financial aspects of investment proposals. The committee met 12 times during 2021/22.

- Workforce and Organisational Development Committee:
  This committee reviews all aspects of workforce and organisational development, including monitoring the implementation of the Trust's Workforce and Organisational Development Strategy and compliance with relevant national standards, regulations and local requirements pertaining to staffing. This is with particular focus upon safe staffing of the hospital to provide safe, high quality, patient-centred care and the delivery of the Trust's strategic priorities and ambitions in an affordable manner. This committee met on a quarterly basis during 2021/22.

  The Board has overall responsibility for the effectiveness of the governance framework and requires that each of its committees has terms of reference, approved by the Board, which describe its duties, responsibilities and accountabilities, and the process for assessing and monitoring effectiveness. The committees are charged with providing assurance on the matters in their remits, as discussed above.

In addition, the Remuneration Committee (chaired by the Trust Board Chaiman) has overseen the following areas under delegated authority from the Trust Board:

- The broad remuneration policy and performance management framework
- The setting of individual remuneration arrangements for the Trust's Executive Directors.

Operation during the pandemic

In response to national guidance on safe management of the Covid-19 pandemic, all Board and Committee meetings have been held virtually throughout 2021/22. However, the scheduled calendar of events was maintained. When required by a peak in Covid-19 related activity, such meetings have had an appropriate focus on providing direction and seeking assurance in respect of the Trust's handling of the challenges presented by the pandemic. However, wherever possible business as usual has been maintained, with Trust Board undertaking its planned work for the year. Where appropriate, items relating to the pandemic (e.g. recovery planning for elective services, infection prevention and control) have been added to the agenda, whilst discussions have considered Covid-19 as appropriate. Despite the conditions outlined above, the Finance & Infrastructure Committee and Trust Board undertook their consideration of business cases.

3.14 Care Quality Commission

All NHS healthcare providers are required by law (Health and Social Care Act 2008 (Regulated Activity) Regulations 2009 and the Care Quality Commission (Registration) Regulations 2009) to register with the Care Quality Commission (CQC) and to deliver compliance with its 28 regulations, 16 of which relate to the quality and safety of care received by patients. The CQC periodically inspects healthcare providers to assess compliance with these regulations and, if necessary, places conditions on a Trust's registration when non-compliance is identified.

As noted in section 3.14, the Trust was subject to a full CQC inspection in October and November 2019, following which the Trust rating improved from 'Requires Improvement' to 'Good'. In September 2019, the Trust was also inspected under the 'Use of Resources' framework, resulting in a 'Good' rating.

Overall **GOOD**	Safe	Requires improvement
	Effective	Good
	Caring	Good
	Responsive	Good
	Well-led	Good
Use of resources		Good

The Trust continues to work on improving quality throughout all its services, but particularly in the CQC's 'safe' domain and across the urgent and emergency care pathway, both of which remain rated as 'requires improvement'.

The CQC conducted a brief focused inspection on Maternity Services in July 2021. The service was not rated following the inspection and consequently the previous rating of 'requires improvement' remains. The inspection had a broadly positive outcome, with the CQC recognising the progress which had been made since the 2019 full inspection.

There is regular communication with the CQC regarding delivery of improvements, including weekly briefing calls, and quarterly engagement events.

The Trust continues to work on a range of projects to ensure that the improvements delivered during 2021/22 are sustained. The revised approach to quality governance, developed in partnership with the CCGs, continued in 2021/22. This continues to promote an open and transparent governance structure.

The Trust is fully compliant with the registration requirements of the Care Quality Commission. Following the last CQC inspection in October and November 2019, the Trust was rated overall as 'Good'.

3.15 Quality Account

The directors are required, under the Health Act 2009 and subsequent Health and Social Care Act 2012, to produce a Quality Account each financial year.

The deadline for publishing the Quality Account was removed in 2020 due to the Covid-19 pandemic. The requirement to be published by 30th June, has been reinstated for 2021/2022.

The processes for producing the Quality Account has reverted back to the same as previous years; however, there is now no national requirement for NHS trusts to obtain the external auditor's assurance. Approval from within the Trust's own governance procedures is sufficient.

The Trust Quality Account sets out the priorities for 2022/23 and reflects on achievements during 2021/22.

The majority of quality metrics are reported monthly or quarterly to the Trust Board and the Quality and Performance Committee. The Quality Account for 2021/22 will be published by 30th June 2022 and will include the priorities for 2022/23.

To provide assurance on the accuracy and data quality of the Quality Account, data submissions must be accompanied by a data validation form signed by both the data owner and their line manager.

3.16 NHS Pension Scheme governance

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 members' Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations. The Trust provides the NHS Pensions Agency with an annual assurance statement.

3.17 Carbon reduction

The Trust is committed to sustainability. It will be publishing its Travel Plan in the spring of 2022 and the Green Plan in the summer of 2022.

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

The main mechanisms through which the Trust monitors its economy, efficiency and the effectiveness of its use of resources are its corporate governance and financial governance arrangements.

The Trust also underwent its first Use of Resources inspection in September 2019, conducted by NHS Improvement. The report acknowledged improvements in governance and delivering against the year's financial plan, and a low cost per weighted activity unit, which places the Trust in the lowest cost quartile nationally. The overall rating for the use of resources is "Good".

Areas highlighted as outstanding practice include the bed management system (Bedview) and the Outpatient transformation programme. Areas identified for improvement include:

- a need to continue to reduce agency spend below the ceiling specified by NHS England and NHS Improvement
- acceleration of Cost improvement Plan (CIP) opportunities to improve underlying deficit
- pursue further reduction of costs in prescribing, waste management, medical staffing, job planning, microbiology
- embed SLR to drive productivity and efficiency
- improve operational performance (although it is of note that the Trust is not commissioned to achieve RTT constitutional standards).

3.19 Corporate governance

Through its governance arrangements, the reviews undertaken by the Trust's Internal Auditors, and the preparation of the Board Governance Memorandum, assurance is provided that the Trust complies with the HM Treasury/Cabinet Office Corporate Governance Code and there are no significant departures from the Code.

The Audit Committee specifically considers matters of probity, propriety and regularity of public finances and value for money. These discussions are based on the work of the external auditors, the Trust's local counter fraud specialist and internal auditors.

3.20 Financial governance

The main formal document setting out the Trust's financial governance and processes are the Standing Financial Instructions (SFIs). Compliance with SFIs is regularly reported to the Audit Committee, which requires explanations of the reasons for which a breach occurred, action to prevent reoccurrence, and details of sanctions applied where appropriate. The Trust continues to review its arrangements for devolved accountability and delegated limits.

The duties and responsibilities of the Finance and Infrastructure Committee include the review of the Trust's financial position and to scrutinise and approve, under delegated limits, the investment appraisal of business cases and wider business development opportunities.

3.21 Information governance

The position of nominated Senior Information Risk Officer (SIRO) was held by the following officers in 2021/22:

- Lois Howell - 1st April to 30th June 2021
- Graham Terry - 1st July to 31st July 2021
- Alison Fox-St Marthe - 1st August 2021 to 28th January 2022
- Lisa Ward - 29th January 2022 onwards

This post holder is responsible (alongside the Medical Director as Caldicott Guardian and the Trust's Data Protection Officer) for ensuring there is a control system in place to maintain the security and confidentiality of personal information.

The Trust has a Data Protection and Data Quality Committee, chaired by the Director of Governance and Risk with representatives from across the Trust, including the Head of Information Governance / Data Protection Officer and all clinical divisions and corporate departments. The Group takes responsibility for overseeing compliance with information governance requirements, including the review of all relevant serious incidents and risks, and gathering evidence and assurance across the ten standards within the Data Security and Protection Toolkit (DSPT).

At the time of writing this report, the submission of evidence for the 2021/22 DSPT has been moved by NHS Digital until 30th June 2022. It is likely that the Trust will be unable to submit DSPT as 'standards met' due to the Trust's ability to supply assurance for the following standards:

Standard 6.2.11 –You have implemented on your email Domain-based Message Authentication Reporting and Conformance (DMARC), Domain Keys Identified Mail (DKIM) and Sender Policy Framework (SPF) for your organisation's domains to make email spoofing difficult
Standard 8.3.2 – How often in days is automatic patching typically being pushed out to remote endpoints?
Standard 6.2.12 – You have implemented spam and malware filtering, and enforce DMARC on inbound email.
Standard 8.4.2– All infrastructure is running operating systems and software packages that are patched regularly and as a minimum in vendor support

Action plans for all the above assertions have been completed and agreed by NHS Digital.

Risks to information security are managed through the Trust's incident reporting system and Risk Registers. The top three information governance risks reported on the 2021/22 DSPT, are:

348	Support for Microsoft XP, Office 2003 & Exchange 2003 ended in April 2014, there are still Trust devices using some of these products. Devices using the affected products are no longer be supplied with security updates and the IT Department does not have access to Microsoft's technical support service (to assist with the identification & resolution of problems). As time progresses these devices become more vulnerable to cyber-attack. This could mean that the data held on them is compromised (including PID), or that they could be taken over by a malicious attacker and used to gain access other parts of the Trust's network. There is no reliable way of being able to quantify the probability of this happening or consequences if it does.
737	Inadequate cyber security defences lead to the inability to deliver safe patient care due to: 1. the prevention of authorised access to, 2. malicious alteration of, or 3. theft of clinical or other sensitive information from the Trust's IT systems. Such attack could result in: 1. Harm to patients through maliciously altered data leading to incorrect diagnosis or treatment. 2. Loss of ability to provide patient care due to IT systems and the information within them not being available to clinicians or for clinical care (e.g. clinics and operations cancelled, ambulances diverted, etc.). 3. Unauthorised disclosure of the Trust's information (including personal identifiable information). 4. The Trust finding that access to its systems and the data contained within them may be held subject to ransom. 5. Reputational damage, litigation and substantial fines from the Information Commissioners Office.
1435	Support for Microsoft XP, Office 2003 & Exchange 2003 ended in April 2014, there are still Trust devices using some of these products. Devices using the affected products are no longer be supplied with security updates and the IT Department does not have access to Microsoft's technical support service (to assist with the identification & resolution of problems). As time progresses these devices become more vulnerable to cyber-attack. This could mean that the data held on them is compromised (including PID), or that they could be taken over by a malicious attacker and used to gain access other parts of the Trust's network. There is no reliable way of being able to quantify the probability of this happening or consequences if it does.

Actions are in place to address each of these risks. Delivery of the actions is monitored by the Data Protection and Data Quality Committee, which reports to the Quality and Performance Committee.

3.22 Information governance incidents

As reported in the Annual Governance Statement (from page 32) the Trust experienced four reportable serious incidents in 2021/22 which were reported using the Data Security and Protection Toolkit. In addition, the Trust was the subject of seven complaints made to the Information Commissioner's Office. Of these, one resulted in the issuing of a decision notice with four being closed after the decision was made to take no further action. The remaining two are still pending.

Data quality and governance

The Trust has a Data Quality Policy to guide and instruct employees involved in the collection, use and management of data, on how to achieve and maintain high levels of data quality to support high quality patient care. The Data Quality Policy emphasises that data quality is the responsibility of the whole Trust, with all employees holding responsibility for the quality of the information they collect and provide. Overall, responsibility for data quality sits with the Trust Board, with delegated responsibility to the Data Protection and Data Quality Committee (DPDQ) and executive leadership through the Director of Governance & Risk. Compliance with the Data Quality Policy and standards is monitored by the DPDQ committee. The DPDQ Committee also has responsibility for setting the Trust's strategy for maintaining and improving data quality. It is responsible for providing assurance on data quality to the Board and identifying risks posed by poor data quality.

Divisional Management Teams hold devolved responsibility for the quality of data recorded within their Division. The PAS Data Quality Team is responsible for improving the quality of the demographic data and the Analytics Department is responsible for running final data quality checks. Information Asset Owners are accountable for the quality of data held in the information assets that they 'own', Information Asset Administrators are responsible for ensuring that data quality procedures, standards and checks are implemented for their assets and team/ward managers and administrative managers hold responsibility for ensuring their staff comply with data quality procedures.

In applying the Trust's Data Quality Policy, there has been an emphasis on 'getting data right first time'. The Trust, therefore, has a formal and on-going programme of training on data quality including induction training, PAS training, system-specific training, remedial and refresher training. In addition, there is an established approach to data quality monitoring activities within the Trust involving:

- Routine data quality checks – routinely published information and reports involving information either missing or likely to be incorrect or put in the system late. These comprise of routine reporting to Divisions, Care Groups, Executives and the Outpatient Booking Centre on data quality issues as appropriate. Examples include outpatient appointments with missing information, issues with coding details, issues with patient details, issues with activity validation including 52 week referral to treatment (RTT) breaches, 18 week RTT breaches and six week breaches on diagnostic waiting times.

- Ad hoc data quality checks – as and when deemed required, detailed quality checks are performed on data to determine its accuracy. These are not regular checks, but only carried out when data seems irregular or unexpected. Examples of some ad hoc checks and fixes include audiology fit appointments have been entered onto PAS as telephone appointments, invalid GP Practice codes, incorrect manual entry of referral dates and 12 hour trolley waits in the Emergency Department.

- Spot checks on data quality – throughout the year, there are spot checks performed on the quality of the data recorded on the hospital's systems. These are randomised spot checks undertaken to check the accuracy of the data and any improvements or reductions in this quality. For example, the Data Quality team with IT, every week, selects a randomised number of active patients on our system to run against the digital central point for NHS online services. Many patient details are compared against the information the GP has recorded for this patient. Validations and quality checks are also performed on the full RTT Patient Tracking List.

Benchmarking review of the Trust against other providers within Hampshire and the Isle of Wight health system, as well as national averages, shows the Trust was consistently above its peers for some data quality indicators including:

- The percentage of valid NHS numbers in data held

	PHU	Region	National
Inpatient	99.9%	99.7%	99.7%
Outpatient	100%	99.9%	99.8%
A&E	99.7%	98.5%	96.1%

- When looking into inpatient activity in data quality reports, the Trust is above the national average for 10 out of 13 KPIs.

The overall quality of the Trust's data is high, and this is apparent when benchmarked against other Trusts. However, opportunities for data quality improvement identified as part of the Trust's benchmarking review include:

- Commissioner details (Registered Commissioner and Commissioner of residence). There have been issues since the merge of our local CCGs and the introduction of the ANANA codes. This is a project that has been worked on throughout this financial year and final adjustments are in place to see this compliance increase throughout 2022/23

- Ethnicity coding recorded across the different systems and the correct use of Z and 99 (patient asked and did not answer compared to unknown).

- Outpatient recording of outcome and associated referrals details, such as referral source and priority.

The Trust re-established a Data Quality Steering Group in 2021/22 to ensure monitoring of data quality and potential improvements are actioned. Areas discussed included;

- Ethnicity
- CCG codes
- First attendance code vs Appointment type (i.e. one being F2F the other being telephone on the same appointment)
- Specialty activity all under one consultant code
- Site code of treatment
- Missing activity in SUS
- Missing contracts in PAS
- PHU activity under IOW consultants

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare a Quality Account for each financial year. The publication of this document is usually aligned to the publication of the Annual Report and Accounts, but has been delayed nationally this year in response to the Covid-19 pandemic. The Quality Account for 2020/21 was published in June 2021 and the Quality Account 2021/22 is to be published on 30th June 2022.

3.23 Freedom of information

The Trust received 667 Freedom of Information (FoI) requests in 2021/22, a increase of 4% on the 641 requests received in 2020/21. The Trust continues to embrace its duty of openness and transparency, and has made a full or partial disclosure of information in approximately 72% of requests. The reasons for non- disclosure in the remainder of cases include legal exemption (13.5%) or the cancellation of the request (5.9%), information not held (3.3%). Compliance with issuing a response within 20 working days is currently at 78.4%, up from 77% in 2020/21. Measures to address compliance have been put into place, including the appointment of a permanent FOI Administrator, stability within the team and a robust validation process.

Two complaints were made to the Information Commissioner's Office with regard to delays in responding to specific requests or failure to release information.

3.24 Review of effectiveness of risk management and internal control

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 Directors and senior managers within the organisation who have responsibility for the development and maintenance of the system of internal control. 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 Trust Board, Audit Committee, Finance and Infrastructure Committee, Quality & Performance Committee and Trust Leadership Team.

The Trust Board has received assurance on the effectiveness of the controls within the organisation through the following means:

Independent sources:

- Internal Audit, which carries out a continuous review of the system of internal control and reports the results of audits and any associated recommendations for improvement to the Audit Committee and to the relevant senior managers
- External Audit work which is reported to Audit Committee
- The work of the Local Counter Fraud Specialist (LCFS), which is regularly reported to the Audit Committee
- Announced and unannounced visits by the Care Quality Commission and other Regulators

Internal sources:

- Quarterly review of the Board Assurance Framework and Board Risk Register
- Preparation and publication of the 2020/21 Quality Account, and quarterly reporting against delivery of the Quality Account objectives to the Quality and Performance Committee
- Quarterly quality reports to the Quality & Performance Committee, which provide more detail about patient safety, patient experience and clinical effectiveness
- Quarterly Health and Safety reports to the Health and Safety Committee and Quality and Performance Committee
- Monthly reports of serious incidents to the Trust Board
- Monthly quality exception reports to the Quality & Performance Committee and Trust Board
- Monthly reports from key directors, including Chief Finance Officer, Chief Nurse and the Chief Operating Officer
- The review of all Internal Audit reports by the Audit Committee and Trust Leadership Team. This process provides assurance that any risks identified by Internal Audit are discussed for potential inclusion on the Board Risk Register and/or Board Assurance Framework.

An Internal Audit programme, designed to ensure that adequate and effective controls over the Risk Management and Assurance Framework process are in place, is carried out each year. This provides the Trust with an objective opinion of the effectiveness of its risk management and internal controls and any agreed actions will be implemented.

The Head of Internal Audit Opinion is that the Trust has reasonable and effective risk management, control and governance processes in place. The Covid-19 pandemic has not impacted on the Head of Internal Audit's overall assessment.

3.25 Significant internal control issues

The table below sets out details of the areas where the Trust's internal auditors have identified concerns rated as Priority 1 (fundamental control issues on which action should be taken immediately) and the Trust's response to the issues raised.

Audit	Key concerns identified	Trust response
Patients' property	• A high proportion of patient moves within the hospital did not see a record of property transferred with the individual concerned • In those cases where a note was provided, these could lack the required level of detail • Signatures of representatives from both the ward transferring the patient and the ward receiving them were required on official property records	• The Patient Property Policy was updated and ratified by Policy Steering Group in January 2022 • Property listing form reviewed and amended • Process for patients with diminished responsibility has distinct actions to reflect their needs • Posters outlining patient and Trust responsibilities relating to property published and placed around hospital • Property listing form placed on electronic nursing record
Deprivation of Liberty Safeguarding and Mental Capacity Assessment documentation procedures	• The documentation of mental capacity assessments was not consistently available for review • The level of information included in the available records was not consistent	• A new system to ensure that assessments were recorded and produced in sufficient depth was introduced • Safeguarding team to review policy and training in line with recommendation • Above matters to be applied as appropriate once Liberty Protection Safeguards are introduced to replace existing legislation

3.26 Conclusion

The Trust has identified the internal control issues identified at paragraph 3.25 above and addressed them in a timely way to ensure that the statement of internal control for2021/22 is unqualified.

Accountable Officer:	Penny Emerit
Organisation:	Portsmouth Hospitals University NHS Trust
Signature:	

Date: **13th June 2022**

4. REMUNERATION AND STAFF REPORT

4.1 Investing in staff and workforce

The Trust believes that a highly skilled, motivated, and engaged workforce is essential to ensuring the delivery of quality integrated care for the population it serves. The Trust has a track record of promoting workforce diversity and engagement, shared values and behaviours and continuous development and learning among its workforce. The Trust employs around 8,300 staff and is the largest employer in Portsmouth.

4.2 Remuneration Committee

NHS trusts' constitutions statutorily require that a Remuneration Committee is established as a committee of the Trust Board to consider the employment terms of the Chief Executive Officer and Executive Directors.

The Trust has a Remuneration Committee which has delegated authority from the Trust Board to:

- Agree the remuneration and terms of service for each executive director, including performance related pay;
- Agree overall remuneration in terms of service for senior managers not on National contracts;
- Agree any termination arrangements required for executive directors;
- Monitor the performance of executive directors; and
- Agree special/exceptional payments covering any individual member of staff or staff group.

The Committee membership is comprised of all Non-Executive members of the Board and is chaired by the Board Chairman. The Chief Executive and other executive directors may be invited to attend meetings of the Committee but must withdraw for any issue that personally relates to them.

4.3 Remuneration policy

Remuneration for staff is set through nationally agreed terms and conditions as detailed in Agenda for Change and the national contracts for Consultants and Junior Doctors. The Trust is compliant in its application of these policies. Remuneration for Executive Directors is overseen by the Remuneration Committee.

4.4 Remuneration tables(audited)

Salary and pension entitlements of senior managers are shown on the following tables (pages 53 and 54).

Salary and Pension entitlements of senior managers 2021/22

Name	Title	Voting Board Member	Start date/leaving date (where not in post for full year)	2021/22							2020/21						
				Salary (bands of £5,000) £000	Expenses Payments (Taxable) (total to nearest £100)	Performance Pay and Bonuses (bands of £5,000)	Long Term Performance Pay and Bonuses (bands of £5,000)	Total Salary (bands of £5,000)	All Pension Related Benefits**** (bands of £2,500)	Total Salary and Pension Benefits (bands of £5,000)	Salary (Restated) ****** (bands of £5,000) £000	Expenses Payments (Taxable) (total to nearest £100)	Performance Pay and Bonuses (bands of £5,000)	Long Term Performance Pay and Bonuses (bands of £5,000)	Total Salary (bands of £5,000)	All Pension Related Benefits (Restated) ***** (bands of £2,500)	Total Salary and Pension Benefits (Restated) ***** (bands of £5,000)
Executive Directors in post at 31st March 2022																	
Penny Emerit	Chief Executive from 24/03/2021, Director of Strategy and Performance until 23/03/2021	Y	See Title for Dates	200-205	-	-	-	200-205	217.5-220	415-420	155-160	-	-	-	155-160	2.5-5	160-165
John Knighton	Medical Director	Y		230-235 *	-	-	-	230-235 *	102.5-105	335-340	230-235 *	-	-	-	230-235 *	42.5-45	275-280
Mark Orchard	Chief Financial Officer	Y		160-165	-	-	-	160-165	20-22.5	180-185	145-150	-	-	-	145-150	32.5-35	180-185
Chris Evans	Chief Operating Officer	Y	From 01/10/2020	165-170	-	-	-	165-170	82.5-85	250-252.5	75-80	-	-	-	75-80	42.5-45	120-125
Liz Rix	Chief Nurse	Y		145-150	-	-	-	145-150	-	145-150	145-150	-	-	-	145-150	0	145-150
Nicole Cornelius	Chief People Officer	N		135-140	-	-	-	135-140	30-32.5	165-170	135-140	-	-	-	135-140	175-177.5	315-320
Graham Terry	Director of Strategy and Performance	N	From 24/03/2021	115-120	-	-	-	115-120	122.5-125	235-240	0-5	-	-	-	0-5	0 ***	0-5
Lisa Ward	Director of Communications and Engagement	N	From 21/06/2021	75-80				75-80	52.5-55	130-135	-	-	-	-	-	-	-
Anoop Chauhan	Executive Director of Research	N	From 27/07/2020	215-220 **	-	-	-	215-220 **	107.5-110	325-330	145-150 **	-	-	-	145-150 **	82.5-85	225-230
Executive Directors who left during the year ending 31st March 2022																	
Lois Howell	Director of Governance & Risk		Until 01/07/2021	30-35	-	-	-	30-35	5-7.5	35-40	130-135	-	-	-	130-135	57.5-60	190-195
Alison Fox-St Marthe	Interim Director of Governance & Risk		From 01/08/2021 to 28/01/2022	60-65	-	-	-	60-65	-	60-65	-	-	-	-	-	-	-
Kevin Street	Interim Director of Governance & Risk		From 07/02/2022	35-40	2,100	-	-	35-40	-	35-40	-	-	-	-	-	-	-
Executive Directors who left during the year ending 31st March 2021																	
Mark Cubbon	Chief Executive		Until 23/03/2021	-	-	-	-	-	-	-	220-225	-	-	-	220-225	77.5-80	295-300
Nigel Kee	Interim Chief Operating Officer		Until 30/09/2020	-	-	-	-	-	-	-	95-100	-	-	-	95-100	32.5-35	130-135
Helen Bray	Director of Communications and Engagement		From 20/04/2020 to 26/10/2020	-	-	-	-	-	-	-	105-110	-	-	-	105-110	5-7.5	110-115
Non- Executive Directors in post at 31st March 2022																	
Melloney Poole	Chair	Y		35-40	-	-	-	35-40	0	35-40	35-40	-	-	-	35-40	-	35-40
Christine Slaymaker	Non-Executive Director	Y		10-15	-	-	-	10-15	0	10-15	10-15	-	-	-	10-15	-	10-15
David Parfitt	Non-Executive Director	Y		10-15	-	-	-	10-15	0	10-15	10-15	-	-	-	10-15	-	10-15
Graham Galbraith	Non-Executive Director	Y	From 24/06/2020	10-15	-	-	-	10-15	0	10-15	5-10	-	-	-	5-10	-	5-10
Martin Rolfe	Non-Executive Director	Y		10-15	-	-	-	10-15	0	10-15	10-15	-	-	-	10-15	-	10-15
Vivek Srivastava	Non-Executive Director	Y	From 28/10/2020	10-15	-	-	-	10-15	0	10-15	0-5	-	-	-	0-5	-	0-5
Aswinkumar Vasireddy	Associate Non-Executive Director	N	From 28/10/2020	10-15	-	-	-	10-15	0	10-15	0-5	-	-	-	0-5	-	0-5
Gary Hay	Associate Non-Executive Director	N		10-15	-	-	-	10-15	0	10-15	10-15	-	-	-	10-15	-	10-15
Inga Kennedy	Associate Non-Executive Director	N		-	-	-	-	-	-	-	-	-	-	-	-	-	-
Roger Burke-Hamilton	Associate Non-Executive Director	N		10-15	-	-	-	10-15	0	10-15	10-15	-	-	-	10-15	-	10-15

* Medical Director salary and pension entitlements includes remuneration for clinical responsibilities rather than management responsibilities of £45k-£50k (£45k-£50k in 2020/21)

** Executive Director of Research salary includes remuneration for research work rather than management responsibilities of £190k-£195k (£125k-£130k in 2020/21 - for the period from taking up the post of Executive Director of research in July 2021)

*** 2020/21 Pension information not available due to timing of taking up post

**** The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. **This value does not represent an amount that will be received by the individual.** It is an indicative calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

***** The prior year comparators have been restated as the incorrect Consumer Prices Index was used in the calculation of total pension benefits

****** The prior year comparators have been restated for the Medical Director and Executive Director of Research to include all remuneration received (including Clinical Excellence Awards and Additional Programmed Activity)

Signed: Chief Executive

Date:13th June 2022

Salary and Pension entitlements of senior managers

B) Pension Benefits

Name	Title		Real increase in pension at retirement age (bands of £2,500) £000	Real increase in pension lump sum at retirement age (bands of £2,500) £000	Total accrued pension at 31/03/2022 (bands of £5,000) £000	Lump sum at pension age related to accrued pension 31/03/2022 (bands of £5,000) £000	Cash equivalent transfer value 31/03/2022 £000		Cash equivalent transfer value 31/03/2021 £000	Real increase in cash equivalent transfer value £000	Employers Contribution to Stakeholder Pension* To nearest £100
Penny Emerit	Chief Executive from 24/03/2021, Director of Strategy and Performance until 23/03/2021		10-12.5	10-12.5	40-45	60-65	537		392	122	0
John Knighton	Medical Director		5-7.5	5-7.5	85-90	195-200	1,834		1,675	123	0
Mark Orchard	Chief Financial Officer		0-2.5	0 - 2.5	45-50	85-90	727		691	26	0
Chris Evans	Chief Operating Officer		5-7.5	5-7.5	35-40	65-70	529		455	49	0
Liz Rix	Chief Nurse		0	0	0	0	0		0	0	0
Nicole Cornelius	Chief People Officer		2.5-5	0	15-20	0**	230		186	23	0
Graham Terry	Director of Strategy and Performance		5-7.5	10-12.5	30-35	65-70	535		425	92	0
Lisa Ward	Director of Communications and Engagement		2.5-5	2.5-5	10-15	25-30	228		168	36	0
Anoop Chauhan	Executive Director of Research		5-7.5	7.5-10	80-85	215-220	1,909		1,738	136	0

* The Trust has not made contributions to stakeholder pensions
** No lump sum is shown for employees who only have membership in the 2008 Section of the NHS Pension Scheme.

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

CASH EQUIVALENT TRANSFER VALUES
A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital va;ue of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the members accrued benefits and any contingent spouse's pension payable from the scheme. CETV's 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 takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Signed: Chief Executive

Date: 13th June 2022

4.5 Pension liabilities

The majority of the Trust's employees are entitled to membership of the NHS Pension Scheme. The scheme is an unfunded defined benefit scheme that covers NHS employers, General Practices, and other bodies, allowed under the direction of the Secretary of State, in England and Wales.

The scheme is accounted for as if it were a defined contribution scheme; further details can be found in the Trust's accounting policy at note 9 in the Trust's Annual Accounts.

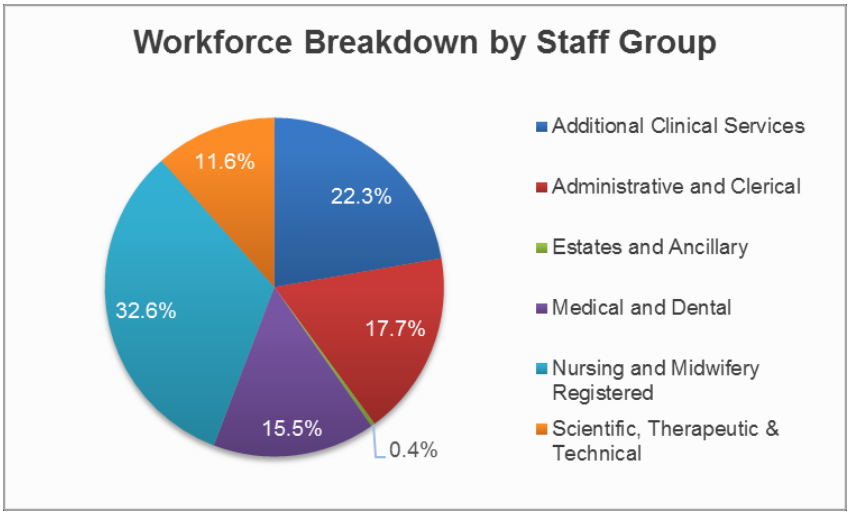
The alternative pension scheme is NEST, a government scheme for auto enrolment run as a trust. NEST is run by its Trustee, NEST Corporation.

4.6 Resourcing

Recruiting and maintaining an effective workforce is a major priority and the Trust's strong partnerships with Bank Partners, which provides the Trust's temporary workforce, Equans and the Ministry of Defence helps the Trust to achieve the goal of maintaining safe services for all patients.

The table below details the Trust's total workforce capacity which is made up of the following staff groups.

- Registered Nursing and Midwifery workforce
- Additional Clinical Services workforce - support to nursing and AHP workforce
- Professional, Technical and Scientific workforce
- Allied Health Professional workforce
- Healthcare Science workforce
- Administrative and clerical workforce
- Medical and dental workforce - including consultants and junior doctors.



In addition to the substantive workforce, temporary staffing accounts for 7.5% of the total workforce establishment.

4.7 Volunteers

The Trust is privileged to have a large community of volunteers who are an integral part of the hospital. They provide valuable support to patients, families, carers and staff. As a result of Covid-19, volunteering was paused in many areas and some volunteers were unable to offer their services. However, we continued to have many new recruits join us either on a temporary or permanent basis.

Volunteers contribute across a wide range of roles. They support staff in delivering high-quality care that goes above and beyond core services, improving the satisfaction and wellbeing for patients and staff. Volunteers have been responsive to the requirements of the Trust, in particular the Patient Belonging Drop Off Service. This service came about due to the restrictions on visiting and has delivered over 50,000 bags of patient belongings and messages to loved ones. Other examples of volunteering include:

- Providing support and companionship to patients on the wards living with dementia
- Supporting the Family Liaison Team by keeping patients in touch with loved ones
- Helping the pharmacy team with the delivery of medicines to the wards
- Guiding patients and visitors around the hospital
- Helping at mask and cleaning stations at the hospital entrances
- Assisting with administration and patient wellbeing in the Emergency Department
- Helping us to understand what matters most to our patients through surveys
- Helping the hospital charity team, delivering and packing boost boxes to our staff with fundraising team and delivering boxes of toiletries to each ward from donations from the community

The post Covid-19 environment has provided an opportunity to begin to redesign the volunteer workforce to support the Trust priorities, enhancing patient experience. A recruitment drive is in place to rebuild and restore our volunteer numbers to what we had prior to the pandemic prioritising the following roles:

- Dementia Volunteers
- Ward Response Volunteers
- Dining Companions
- Patient Experience and Feedback Volunteers
- Patient Representatives
- Pharmacy Runners

Volunteers are celebrated and recognised at the Trust Annual Pride of Portsmouth Awards and by special recognition awards from the Trust Chairman, Melloney Poole OBE. The Trust Chairman presents a 'Kindness of your Heart' award to volunteer teams or individuals to thank them and show her appreciation for all that they do. The award recognises the dedication and commitment that they have made in their volunteering role in making an immeasurable contribution to the quality of care received by patients.

4.8 Health, safety and wellbeing

The Trust is committed to protecting all our staff through the continuing effects of the Covid-19 pandemic, supporting their health and wellbeing as a top priority. This has been another challenging year for staff working through Covid-19 conditions.

Covid-19 risk assessments have been provided for staff throughout this year, and support and assessments completed for staff who were shielding to enable them to safely return to the workplace. Occupational Health have provided supportive conversations with staff around Covid- 19 vaccination concerns and administered Covid-19 vaccinations, with 97.1% of staff now having received their 1st and 2nd Covid-19 vaccination. Booster Covid vaccines were given to 87.1% of staff. We also successfully achieved 80.9% of staff having received their flu vaccinations this year.

CISM (Critical Incident Stress Management) is a confidential and voluntary service designed for all staff working at PHU (teams and individuals) following critical or traumatic incidents and is delivered by colleagues who have undergone specific training. It was designed to piece things together by defusing the situation, debriefing the incident, and offering follow up peer support. It has been established during 2021.

REACT Mental Health Training for Managers has continued for front line leaders to enable them to recognise when staff may be experiencing mental health issues and provide them with the tools to have a psychologically informed conversation with their staff and identify if they are at risk of harm.

Oasis has provided use of the onsite gym and the indoor heated pool free to all staff throughout Covid- 19 to support staff wellbeing and mental health. The "Healthy You" scheme launched in January 2022 has been set up to support staff with their physical health and wellbeing.

Staff can access a nurse wellbeing consultation appointment, access to a 12-week personalised physical activities program facilitated by the Oasis team, dedicated 1:1 exercise support and guidance, advice on healthy lifestyle choices and regular weight monitoring/dietician referrals. The take up of this service has been well received with 96 staff having signed up to the scheme and been assessed. Funding for this has been provided by Portsmouth Hospitals charity.

Following on from another challenging year for staff, access to the Hampshire and the Isle of Wight Staff Support Hub, has been set up for all health and care staff to access free, safe, and confidential support for individuals or teams. The hub is separate and confidential.

The Wellbeing team have offered several Health and Wellbeing events which coincide with specific days throughout the calendar in line with Government and NHS Employers' guidance. Some of the events that were hosted include World Health Day, On Your Feet Britain, Time-to-talk Day, Mental Health Awareness Day.

Managing staff sickness

There are associated Human Resources (HR) policies and procedures which support staff and managers within the Trust.

The average staff sickness level for the year increased, from 4.5% 2020/21 to 4.7% for 2021/22 largely due to Covid-19 isolation rules and lateral flow testing isolation periods.
Our innovative Staff Support Line continued to run for most of last year being staffed by occupational health staff, enabling employees to ring a central number to report sickness and provide them with absence advice and mental health and wellbeing support in a timely manner if necessary. There are a range of measures in place to ensure that absence is managed appropriately and that employees who are unable to fulfil their contractual duties due to ill health or disability are managed fairly and sensitively.

4.9 Raising staff concerns

To ensure that the Trust's vision and values are at the forefront of everything it does, openness, transparency and dealing with any issues that may arise in a confidential, timely, consistent, fair and appropriate manner is fundamental. It is a right of employees in the Trust, if they have any concerns about wrong-doing at work, to be able to raise these concerns through the Trust's Raising Concerns (Whistle Blowing) Policy. Any disclosure, or 'whistle-blow', is handled in a confidential manner, taken seriously and investigated appropriately.

The Trust's Freedom to Speak Up (FTSU) Guardian continues to help staff raise concerns in a confidential, supporting and anonymised manner, signposting appropriately. The Guardian is available to be contacted by all staff for advice and support in raising and managing concerns about their working life, including concerns surrounding patient safety and quality and bullying and harassment. This is a key role in promoting an open and honest culture of listening, learning and not blaming, so that concerns raised are welcomed, acted upon in a fair manner and addressed. The Guardian has access to anyone in the Trust, including the Chief Executive, and can, if necessary, seek further support from outside of the Trust.

The Guardian is supported by a number of FTSU Advocates across the organisation who champion the FTSU agenda and provide a direct link between individuals, departments and the FTSU Guardian. The Trust has ensured that the team of Advocates is representative of a broad sector of the workforce.

Staff can raise concerns to the Guardian through a number of routes, including, but not limited to:

- A dedicated phone line for the Guardian
- A confidential email address
- An online reporting portal via the DATIX system -that will go directly to the Guardian and allows concerns to be raised anonymously as required
- A network of FTSU Advocates

Alongside these routes to access the FTSU service the Trust is also committed to ensuring alternative avenues are available for staff with the provision of a 'whistleblowing' line, a 'respect me' service and staff network groups. All of which the FTSU Guardian has formed strong links. There is an intranet page for Freedom to Speak Up and posters containing contact details of the Guardian are well distributed throughout the organisation.

Whilst 2021/22 has been challenging for many aspects of the organization, with a number of staff being redeployed and others facing the challenges of Covid pressures the FTSUG was able to continue availability to ensure the service was maintained and available to all staff groups. During this period, we saw an increase in the number of anonymous concerns that were raised via the online portal. Whilst anonymous concerns have their own challenges the FTSU Guardian has continued to see positive responses and engaging from the management teams of areas concerned.

4.10 Fair pay policy (audited)

On pages 53 and 54 of this report are tables relating to the details of salary, allowances and pension benefits of the executive directors of the Trust.

Reporting bodies are required to disclose the percentage change from the previous financial year in respect of the highest paid director and the average percentage change from the previous financial year in respect of employees of the Trust, taken as a whole. This is a new disclosure for 2021/22.

Percentage change from the previous year in respect of the highest paid director.	+0.00%
Percentage change from the previous year in respect of employees of the Trust, taken as a whole (excluding the highest paid director).	+3.90%

Reporting bodies are also required to disclose the relationship between the remuneration of the highest paid director in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce.Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director in the Trust in the financial year 2021/22 was £230-£235k, which was the Medical Director and his salary was comparable with 2020/21. The relationship to the remuneration of the organisation's workforce is disclosed in the table below.

2021/22	**25th percentile**	**Median**	**75th percentile**
Total remuneration (£)	21,777	31,534	40,057
Salary component of total remuneration (£)	21,777	31,534	40,057
Pay ratio information	10.7	7.4	5.8
2020/21*			
Total remuneration (£)		27,417	
Salary component of total remuneration (£)		27,417	
Pay ratio information		8.5	

* For 2020/21 only the median salary was disclosed

The median remuneration of the workforce which was £31,534 (2020/21, £27,417) the majority of these relate to Band 6 staff members. In 2021/22, no employees received remuneration in excess of the highest-paid director (2020/21, none).

Total remuneration includes salary, non-consolidate performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. The figures disclosed relate solely to the period of time the executive post was held during the financial year.

			2021/22	2020/21
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	291,019	2,083	293,102	284,183
Social security costs	30,335	-	30,335	28,553
Apprenticeship levy	1,524	-	1,524	1,436
Employer's contributions to NHS pensions	52,261	-	52,261	49,136
Temporary staff (external bank)		42,217	42,217	36,091
Temporary staff (agency)		9,283	9,283	8,332
Total gross staff costs	**375,139**	**53,583**	**428,722**	**407,731**
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	**375,139**	**53,583**	**428,722**	**407,731**
Of which				
Permanent staff costs capitalised as part of assets	2,055	-	2,055	1,283
Agency staff costs capitalised as part of assets	349	-	349	992
Average number of employees (WTE basis)				
	Permanent Number	Other Number	2021/22 Total number	2020/21 Total number
Medical and dental	1,152	92	1,244	1,089
Administration and estates	1,310	41	1,351	1,301
Healthcare assistants and other support staff	0	147	147	149
Nursing, midwifery and health visiting staff	4,006	194	4,200	4,171
Scientific, therapeutic and technical staff	695	19	714	719
Healthcare science staff	178	6	184	182
Total average numbers	7,341	499	7,840	7,611
Of which:				
Number of employees (WTE) engaged on capital projects	44	6	50	21

4.11 Staff engagement and consultation

Research has shown a clear relationship between staff engagement and individual and organisational outcome measures, such as staff absenteeism and turnover, patient satisfaction and mortality; and safety measures, including infection rates. The more engaged staff members are, the better the outcomes for patients and the organisation generally. It is, therefore, important that the Trust strengthens the staff voice, as well as the patient voice. The Trust Strategy 'Working Together' and the Workforce and Organisational Development strategy 'Working Together to Invest in our People' both have developing compassionate inclusive leadership for cultures of safe, high quality, compassionate patient care as a fundamental thread running through them. This is set out within the objective 'to embed a culture that supports the achievement of our vision'

Effective two-way communication between the Trust, its staff, patients, and the wider community is crucial. There are in place a variety of methods to achieve this, which include a weekly 'all staff message' from the Chief Executive, a monthly Team Brief, staff bulletin, staff surveys and various other initiatives, including the Proud To Be PHU strategic initative.

The Trust Board committed to an evidence based 3-year culture change programme in March 2018 following a Well-led inspection in May 2017. In Phase 1 'Discover', a team of 15 Change Agents were recruited who undertook a cultural audit and identified 3 themes for improvement – Valuing staff, Improvement and Leadership. These themes informed the work led through Phase 2 'Design' with a new team of 15 Change Agents, which included a number of quick wins and longer programmes of work such as:

- Thank You cards
- A Staff Benefits brochure
- Leadership Journey May
- Team Based Development
- A Leadership Behaviours framework
- Standardised Local Induction
- A review of the management and leadership development offer

Phase 3 'Deliver' began in November 2019, with 15 new change Agents and 3 from previous phases, with the focus of work quickly adapting to respond to the Covid-19 pandemic. In particular to support the increasing priority of staff health and wellbeing the following initiatives were undertaken:

- Introduction of the Manager and Staff Support lines
- Developing the role of the Wellbeing Champion
- Rest areas and engaging with staff about rest breaks Delivery of the original workstreams
- Agreeing and implementing a Leadership Behaviours model
- Developing a standard Local Induction
- Re-launched employee recognition schemes

The work supported by the Board and led by change agents has contributed to a number of measurable improvements such as:

- +5% of staff recommended as a place to work and receive treatment
- Improvements in staff feeling valued and support for health and wellbeing
- A decrease in staff turnover
- The number of formal complaints has reduced
- Biggest improvement in the 2020 staff survey was within the Safety Culture theme.

Change agents presented feedback to the Board in October 2021 and identified the next steps for improving culture and how any future work needs to continue to align to organisational priorities and in particular our improvement approach.

Having received the feedback, and subsequently the results of the 2021 National Staff Survey, the Board have launched the Proud to be PHU Initiative, which is one of the six strategic initiatives of our new operational model 'Delivering Excellence'. This will focus on using a robust staff engagement approach to ensure that all staff would recommend PHU as a place to work and to have care and treatment. As part of this strategic initiative, we will be progressing work on improving our culture of kindness, civility, and respect, and developing an approach to calling out poor or unprofessional behaviours.

In support of the Trust's vision to have a compassionate and inclusive leadership culture and in response to the pandemic, leadership development has been focused on health and wellbeing of leaders and their teams, enabling managers to hold effective conversations with staff about their physical and mental health and general leadership skills workshops. Work has commenced to align leadership development and behaviours to the delivering excellence agenda, to ensure that all leaders have the skills they need to create the conditions for improvement.

Increased provision has been put in place for coaching and mentoring of leaders and the use of action learning sets. This has also involved training several of our staff as coaches, mentors, and action learning facilitators to encourage ownership and provide peer support to colleagues.

Performance appraisal has continued to be a challenge during 2021/22, and the staff appraisal compliance rate has remained below the target of 85% throughout the year, most recently being 71.4% in March 2022.This will be a focus over the coming months, has been raised as a local risk, is a watch metric for the divisions and a process of staff engagement has commenced to understand how we can improve compliance and quality of appraisals...

Compliance with the Trust's essential skills training and currently stands at 89.2%, remaining above the target of 85%.

4.12 The NHS National Staff Survey 2021

The NHS Staff Survey is an official process conducted to the highest standards of quality and accuracy. It is one of the world's largest workforce surveys. In line with the commitment in the 2021 People Plan, the survey has been redeveloped to align with the People Promise which sets out what we can expect from our leaders and from each other to make the NHS the workplace where people want to stay, to stay well, and where others want to join us. The results have been aligned to the seven new People Promise themes and the two existing themes. Results from this survey are used to improve care for patients and working conditions for staff. The results of the 2021 NSS conducted in the Trust were presented to the Trust Board in March 2022 and can be found below.

The survey ran from September to November 2021 with 3,998 members of staff taking part, this is a 49% response rate but is 5% lower than the previous year although is above average when compared with similar organisations.

The survey showed staff in the service continue to be under extreme pressure which mirrors the national picture of the cumulative impact of Covid-19, rising demand, and the move back to business as usual in 2021 which has clearly taken its toll on staff. Although most themes have been adversely affected by the disruptive impact of Covid-19 there were positive improvements in reductions in staff experiencing physical violence, harassment, bullying or abuse and increases in staff reporting these incidents which demonstrates the continued focus on the Prevention of Violence at Work initiatives.

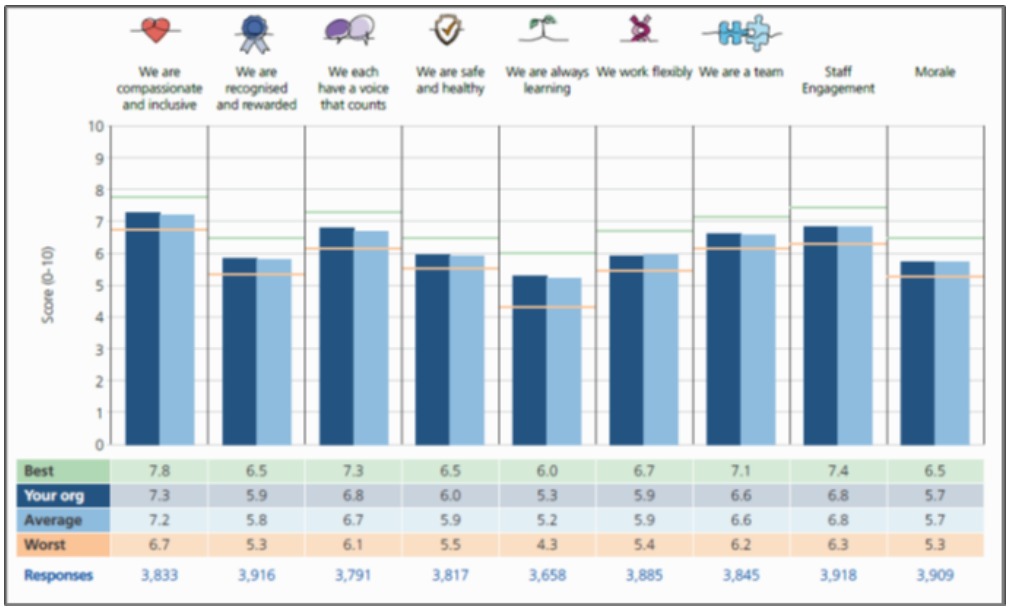
When comparing PHU against the benchmark group - Acute and Acute and Community Trusts, as displayed in the table below; five are above average:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice than counts
- We are safe and healthy
- We are always learning

Four are the same:

- We work flexibly
- We are a team
- Staff engagement
- Morale

Only two themes can be compared to the previous year (Staff Engagement and Morale), both show a decline.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.3	5.9	6.8	6.0	5.3	5.9	6.6	6.8	5.7
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	3,833	3,916	3,791	3,817	3,658	3,885	3,845	3,918	3,909

Proud to be PHU is one of PHU's strategic initiatives for 2022 to support staff to be at their best to provide the best care, to build a culture at PHU that not only listens and learns from colleagues but works in partnership to invest in and support the development of each other. The main things that will take place as a Trust in response to the survey results are:

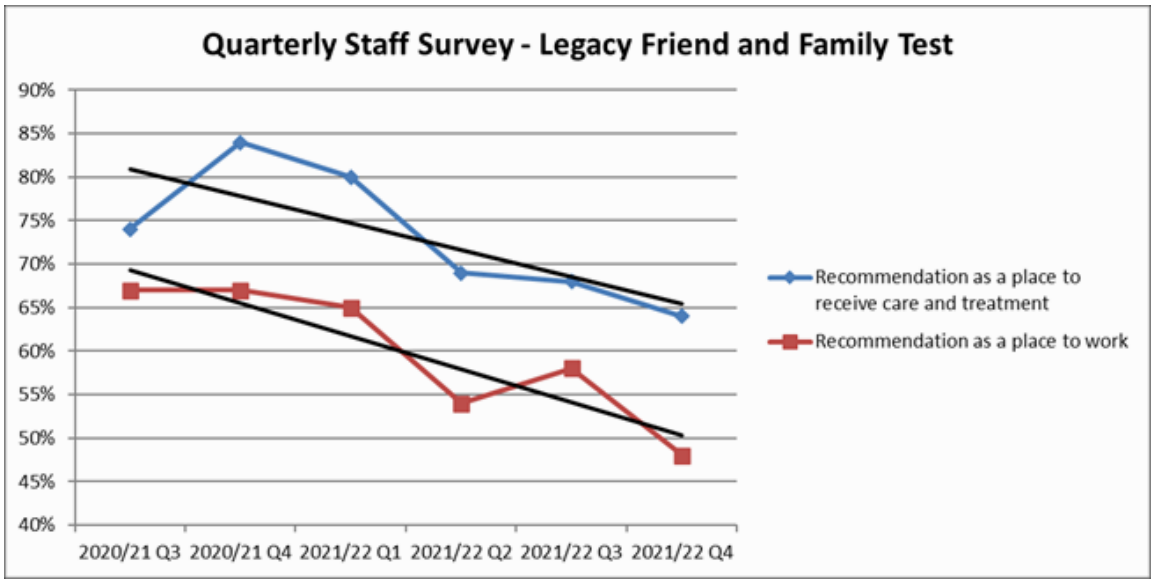
- Ensuring staff have an appraisal as this and having regular 1:1s are important opportunities for staff to speak with their line manager about their development needs and ambitions.
- Enabling staff to have more opportunities to feedback and share ideas and views with line managers, care group leaders and divisional leadership teams.
- Establishing a staff engagement forum to help deliver key projects as part of Proud to be PHU and the ambition for the trust to be the best place to work.
- Improving how staff are recognised and rewarded for the work they do
- Supporting staff to make changes or improvements to their work in the easiest way possible using the Delivering Excellence improvement methods, allowing staff to link day to day work with PHU's wider commitments to improving patient care now and in the future.
- Focusing on values and behaviours to create a kinder and safer organisation and working environment for everyone.

4.13 Quarterly Staff Friends and Family Survey

NHS England resumed central data collection in July 2021 with a new Staff Survey. The Quarterly Staff Survey (QSS) is the national survey which replaces the Staff Friends and Family Test (Pulse) arising from the NHS People Plan and includes the nine questions within the annual national survey 'engagement' theme and five additional local questions on health and wellbeing.

The responses and data are primarily for action at a local level which will build on the yearly, granular level data available from the National Staff Survey.

The Trust has been through unprecedented times with substantial and sustained pressure resulting from the Covid-19 pandemic, the return to normal activity, elective recovery, and high demand in the Emergency Department. This has continuing to have a negative impact on staff morale as demonstrated in this table, and the aforementioned actions arising from the National Staff Survey should have a positive impact on these scores.



4.14 Workforce Race Equality Standard (WRES)

The WRES is a requirement for all NHS organisations to publish data and action plans against nine indicators of workforce race equality. Research and evidence strongly suggest that black and minority ethnic staff in the NHS have a poorer experience or opportunities than White staff and this has a significant impact on the efficient and effective running of the NHS and impacts the quality of care received by all patients. WRES aims to ensure employees from black and minority ethnic backgrounds have equal access to career opportunities and receive fair treatment in the workplace and support NHS organisations make the necessary structural and cultural changes needed to advance workforce race equality.

In 2019, the WRES published the Model Employer paper which sets out an ambition to increase black and minority ethnic representation at all levels of workforce by 2028. This ambition has been expedited by the NHS People Plan 2020 to increase senior leader representation by 2025 to equate to either the organisational or community percentage, whichever is highest. The Trust has set year on year targets to increase black and ethnic minority representation in bands 7 to VSM and developed actions to achieve this.

4.15 Workforce Disability Equality Standard (WDES)

The WDES is a set of 10 measures that enables NHS organisations to compare the work experience of Disabled and Non-Disabled staff. The data gathered is used to develop and publish action plans that aim to improve the work experience of Disabled staff. Every year comparisons are made to enable us to demonstrate progress against the indicators of disability equality. The WDES is important because we know that an included and valued workforce helps to deliver high quality patient care and improved patient safety. It also allows us to better understand the experiences of our Disabled employees and supports positive change for all by creating a more inclusive environment.

4.16 Gender Pay Gap report

The Trust's Gender Pay Gap Report 2021 has been produced and is published on the Trust's external facing website in line with national requirements. In summary, the report shows that:

- Females make up the majority of the workforce
- The mean pay for males was 28.4% higher than that of females
- The median pay for males was 20.3% higher than that of females
- The mean bonus pay for males was 44.7% higher than that of females
- The median bonus pay for males was 33.6% higher than that of females
- 8.5% of male relevant employees received a bonus payment and 1.4% of female relevant employees received a bonus payment

All female staff and all male staff are ranked separately according to their pay (ordinary and bonus pay combined). They are then put in to four quartiles, with quartile 1 being the lowest paid and quartile 4 in receipt of the highest wages. Males are under-represented in Quartile 1, 2 and 3, while Quartile 4 shows a higher proportion of males. Quartile 4 has a higher number of male, Medical and Dental workforce who receive a large number of bonus payments.

The yearly comparison data highlights that the mean and median hourly rate pay gap has decreased in 2021, whereas the mean bonus pay gap has increased in and the median bonus pay gap has decreased in 2021.

A number of improvement actions have been identified to address the gap, which are included in the Trust's Gender Pay Gap 2021 Report.

4.17 Off-payroll engagements

Off-payroll engagements over six months and over £245 per day as at 31st March 2022

Number of existing arrangements as at 31st March 2022	3
Of which the number that have existed:	
For less than one year at the time of reporting	

New off-payroll Engagements over six months and over £245 per day

Number of new engagements, or those that reached six months in duration between 1st April 2021 and 31st March 2022	1
Of which:	
Number assessed as being covered by IR35	0
Number assessed as not being covered by IR35	3
Number engaged directly (through PSC contracted to department) and are on the departmental payroll	0
Number of engagements re-assessed for consistency/assurance purposes during the year.	0
Number of engagements that saw a change to IR35 status following the consistency review	0

4.18 Exit packages (audited)

Reporting of compensation schemes - exit packages

Exit Packages 2021/22	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special element)			
<£10,000	-	12	12
£10,001-£25,000	-	-	-
£25,001-£50,000	-	-	-
Total number of exit packages by type	-	-	-
Total cost (£)	£0	**£45,000**	**£45,000**

Exit Packages 2020/21	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special element)			
<£10,000	-	25	25
£10,000-£25,000	-	3	3
Total number of exit packages by type	-	1	1
Total cost (£)	£0	**£140,000**	**£140,000**

Exit packages: other (non-compulsory) departure payments				
	2021/22		2020/21	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Contractual payments in lieu of notice	12	45	29	140
Total	12	45	29	140
Non-contractual payments requiring HMT approval made to individuals where the payment value was	0	0	0	0

4.19 Expenditure on consultancy

The Trust spent a total of £2.7m on external consultancy in the year (£1.9 million in 2020/21).

5. FINANCIALSTATEMENTS

ANNUAL ACCOUNTS 2021/22

The accounts of Portsmouth Hospitals University NHS Trust for the year ended 31st March 2022 have been prepared in accordance with the financial records maintained by the Trust and the accounting standards and policies for the NHS laid down by the Secretary of State with the approval of the Treasury.

The accounts were approved by the Audit Committee, with delegated authority from the Board, at a meeting on the 13th June 2022 and have been audited. The auditor's report is unqualified and is incorporated in the annual report.

EXTERNAL AUDITOR

The Trust's external auditor is Ernst & Young LLP, based at Grosvenor House, Grosvenor Square, Southampton, SO15 2BE.

The audit fee for the 2021/22 annual accounts for statutory work carried out by external audit was £111,787 exclusive of non-recoverable VAT. Of this sum, £83,840 has been charged to 2021/22 and the balance, £27,947 will be charged in 2022/23

Statement of the Chief Executive's responsibilities as the accountable officer of the trust

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

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

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

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

Signed: Penny Emerit, Chief Executive (Interim)

Date: 13th June 2022

Statement of directors' responsibilities in respect of the accounts

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

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

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

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

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

By order of the Board

Penny Emerit, Chief Executive (Interim)

13th June 2022

Mark Orchard, Chief Financial Officer

13th June 2022

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF PORTSMOUTH HOSPITALS UNIVERSITY NHS TRUST

Opinion

We have audited the financial statements of Portsmouth Hospitals University NHS Trust for the year ended 31 March 2022 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 36.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted International Financial Reporting Standards as interpreted and adapted by the 2021/22 HM Treasury's Financial Reporting Manual (the 2021/22 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2021/22 and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England.

In our opinion the financial statements:

- give a true and fair view of the financial position of Portsmouth Hospitals University NHS Trust as at 31 March 2022 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2021 to 2022; and
- have been prepared properly in accordance with the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

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 the Comptroller and Auditor General's AGN01 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.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of 12 months to 30 June 2023 from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report. However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Trust's ability to continue as a going concern.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information contained within the annual report.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

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 the audit 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 themselves. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with the National Health Service Act 2006 and the Accounts Directions issued thereunder.

Matters on which we are required to report by exception

The Code of Audit Practice requires us to report to you if:

- in our opinion the governance statement does not comply with the NHS Improvement's guidance; or
- we issue a report in the public interest under section 24 and schedule 7of the Local Audit and Accountability Act 2014 (as amended); or
- we make a written recommendation to the Trust under section 24 and schedule 7of the Local Audit and Accountability Act 2014 (as amended); or
- we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

We have nothing to report in these respects.

In respect of the following, we have matters to report by exception

Referral to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014

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

At 31 March 2022, Portsmouth Hospitals University NHS Trust has reported a surplus against its incoming resources for the financial year of £1.68 million in its accounts, but has failed to meet the break-even duty over a rolling 3-year period, with a cumulative deficit at 31 March 2022 of £106.9 million.

Under Paragraph 2 (1) of Schedule 5 of the 2006 Act, an NHS Trust shall ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to its revenue account.

Responsibilities of the Directors and Accountable Officer

As explained more fully in the Statement of directors' responsibilities in respect of the accounts, set out on page 67, the directors are responsible for the preparation of the financial statements and 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 they either intend to cease operations, or have no realistic alternative but to do so.

As explained in the statement of the chief executive's responsibilities, as the Accountable Officer of the Trust, the Chief Executive is responsible for ensuring that the financial statements are prepared in a format directed by the Secretary of State and for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibility 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.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect irregularities, including fraud. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below. However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the entity and management.

We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant are the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), as well as relevant employment laws of the United Kingdom. In addition, the Trust has to comply with laws and regulations in the areas of anti-bribery and corruption, data protection and health & safety.

We understood how Portsmouth Hospitals University NHS Trust is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of management, the head of internal audit and those charged with governance and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance. We corroborated this through our review of the Trust's board minutes, and through the inspection of other information. Based on this understanding we designed our audit procedures to identify non-compliance with such laws and regulations. Our procedures had a focus on compliance with the accounting framework through obtaining sufficient audit evidence in line with the level of risk identified and with relevant legislation.

We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur by understanding the potential incentives and pressures for management to manipulate the financial statements, and performed procedures to understand the areas in which this would most likely arise. Based on our risk assessment procedures, we identified manipulation of reported financial performance (through improper recognition of revenue and expenditure), inappropriate capitalisation of revenue expenditure and management override of controls to be our fraud risks.

To address our fraud risk around the manipulation of reported financial performance through improper recognition of revenue, we reviewed the Trust's manual year end receivable and payable accruals, challenging assumptions and corroborating the income and expenditure to appropriate evidence. We tested year-end cut-off arrangements by selecting samples of income and expenditure from either side of the 31 March 2022 balance sheet date and reviewing to supporting evidence to ensure these were recorded in the appropriate financial year.

To address our fraud risk of inappropriate capitalisation of revenue expenditure we tested the Trust's capitalised expenditure to ensure the capitalisation criteria were properly met and the expenditure was genuine. We also tested that the expenditure was recognised in the correct financial year.

To address our fraud risk of management override of controls, we implemented a journal entry testing strategy, assessed accounting estimates for evidence of management bias and evaluated the business rationale for significant unusual transactions. This included testing specific journal entries identified by applying risk criteria to the entire population of journals. For each journal selected, we tested specific transactions back to source documentation to confirm that the journals were authorised and accounted for appropriately.

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

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice 2020, having regard to the guidance on the specified reporting criteria issued by the Comptroller and Auditor General in December 2021, as to whether the Trust had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria 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 2022.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 (as amended) to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 (as amended) requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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.

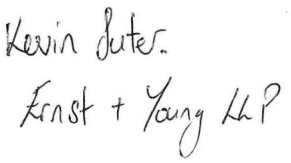
Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have issued our Auditor's Annual Report for the year ended 31 March 2022. We have completed our work on the value for money arrangements and will report the outcome of our work in our commentary on those arrangements within the Auditor's Annual Report.

Until we have completed these procedures, we are unable to certify that we have completed the audit of the accounts in accordance with the requirements of the Local Audit and Accountability Act 2014 (as amended) and the Code of Audit Practice issued by the National Audit Office.

Use of our report

This report is made solely to the Board of Directors of Portsmouth Hospitals University NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014 (as amended) and for no other purpose. Our audit work has been undertaken so that we might state to the Directors of the Trust 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 Directors, for our audit work, for this report, or for the opinions we have formed.



Kevin Suter (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Southampton
21 June 2022

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF PORTSMOUTH HOSPITALS UNIVERSITY NHS TRUST

Issue of audit opinion on the financial statements

In our audit report for the year ended 31 March 2022 issued on 21 June 2022 we reported that, in our opinion, the financial statements:

- gave a true and fair view of the financial position of Portsmouth Hospitals University NHS Trust as at 31 March 2022 and of its expenditure and income for the year then ended;
- had been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2021 to 2022; and
- had been prepared properly in accordance with the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

Certificate

In our report dated 21 June 2022, we explained that we could not formally conclude the audit on that date until we had issued our Auditor's Annual Report for the year ended 31 March 2022. We have now completed our procedures and no matters have come to our attention that would have resulted in a different opinion on the financial statements or additional exception reporting on significant weaknesses in the Trust's value for money arrangements.

We certify that we have completed the audit of the accounts of Portsmouth Hospitals University NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 (as amended) and the Code of Audit Practice.

Kevin Suter.
Ernst + Young LLP

Kevin Suter (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Southampton
12 July 2022

Statement of Comprehensive Income

	Note	2021/22 £000	2020/21 £000
Operating income from patient care activities	3	695,350	607,334
Other operating income	4	80,584	106,707
Operating expenses	5, 7	(753,022)	(689,759)
Operating surplus/(deficit) from continuing operations		**22,912**	**24,282**
Finance income	10	34	8
Finance expenses	11	(18,131)	(17,851)
PDC dividends payable		(5,113)	(3,469)
Net finance costs		**(23,210)**	**(21,312)**
Other gains / (losses)	12	(43)	14
Surplus / (deficit) for the year		**(341)**	**2,984**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	(547)	(5,236)
Revaluations	16	10,266	1,898
Total comprehensive income / (expense) for the period		**9,378**	**(354)**
Adjusted financial performance:			
Surplus / (deficit) for the period		(341)	2,984
Remove net impairments not scoring to the Departmental expenditure limit		547	407
Operational Surplus / (deficit) before technical adjustments		**206**	**3,391**
Remove I&E impact of capital grants and donations		(239)	(2,223)
Remove net impact of inventories received from DHSC group bodies for COVID response		642	(950)
Adjusted financial performance surplus / (deficit)		**609**	**218**

Statement of Financial Position

	Note	31 March 2022 £000	31 March 2021 £000
Non-current assets			
Intangible assets	13	7,165	6,031
Property, plant and equipment	14	409,770	379,927
Receivables	19	1,899	2,586
Total non-current assets		**418,834**	**388,544**
Current assets			
Inventories	18	18,006	17,200
Receivables	19	32,028	25,960
Cash and cash equivalents	20	37,552	37,358
Total current assets		**87,586**	**80,518**
Current liabilities			
Trade and other payables	21	(90,925)	(79,134)
Borrowings	23	(9,259)	(7,620)
Provisions	25	(1,689)	(266)
Other liabilities	22	(3,471)	(1,904)
Total current liabilities		**(105,344)**	**(88,924)**
Total assets less current liabilities		**401,076**	**380,138**
Non-current liabilities			
Borrowings	23	(192,583)	(201,841)
Provisions	25	(5,439)	(4,214)
Total non-current liabilities		**(198,022)**	**(206,055)**
Total assets employed		**203,054**	**174,083**
Financed by			
Public dividend capital		231,346	211,753
Revaluation reserve		131,686	122,590
Income and expenditure reserve		(159,978)	(160,260)
Total taxpayers' equity		**203,054**	**174,083**

The notes on pages 77 to 125 form part of these accounts.

Signed:

Name Penny Emerit
Position Chief Executive (Interim)
Date 13 June 2022

Statement of Changes in Equity for the year ended 31 March 2022

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2021 - brought forward	**211,753**	**122,590**	**(160,260)**	**174,083**
Surplus/(deficit) for the year	-	-	(341)	**(341)**
Impairments	-	(547)	-	**(547)**
Revaluations	-	10,266	-	**10,266**
Transfer to retained earnings on disposal of assets	-	(623)	623	**-**
Public dividend capital received	26,593	-	-	**26,593**
Public dividend capital repaid	(7,000)	-	-	**(7,000)**
Taxpayers' and others' equity at 31 March 2022	**231,346**	**131,686**	**(159,978)**	**203,054**

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020	67,376	126,383	(163,699)	30,060
Surplus/(deficit) for the year	-	-	2,984	**2,984**
Impairments	-	(5,236)	-	**(5,236)**
Revaluations	-	1,898	-	**1,898**
Transfer to retained earnings on disposal of assets	-	(482)	482	-
Public dividend capital received	144,377	-	-	**144,377**
Other reserve movements	-	27	(27)	-
Taxpayers' and others' equity at 31 March 2021	**211,753**	**122,590**	**(160,260)**	**174,083**

Information on reserves

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

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

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

Statement of Cash Flows

	Note	2021/22 £000	2020/21 £000
Cash flows from operating activities			
Operating surplus / (deficit)		22,912	24,282
Non-cash income and expense:			
Depreciation and amortisation	5.1	20,373	17,865
Net impairments	6	547	407
Income recognised in respect of capital donations	4	(1,083)	(2,841)
(Increase) / decrease in receivables and other assets		(7,258)	32,392
(Increase) / decrease in inventories		(806)	(2,108)
Increase / (decrease) in payables and other liabilities		13,614	3,552
Increase / (decrease) in provisions		2,688	407
Net cash flows from / (used in) operating activities		**50,987**	**73,956**
Cash flows from investing activities			
Interest received		34	8
Purchase of intangible assets		(3,592)	(3,888)
Purchase of PPE and investment property		(36,429)	(28,164)
Sales of PPE and investment property		64	158
Receipt of cash donations to purchase assets		521	-
Net cash flows from / (used in) investing activities		**(39,402)**	**(31,886)**
Cash flows from financing activities			
Public dividend capital received		26,593	144,377
Public dividend capital repaid		(7,000)	-
Movement on loans from DHSC		-	(125,165)
Capital element of finance lease rental payments		(353)	(354)
Capital element of PFI, LIFT and other service concession payments		(7,267)	(6,140)
Interest on loans		-	(369)
Other interest		(5)	(1)
Interest paid on PFI, LIFT and other service concession obligations		(18,167)	(17,837)
PDC dividend (paid) / refunded		(5,192)	(3,125)
Net cash flows from / (used in) financing activities		**(11,391)**	**(8,614)**
Increase / (decrease) in cash and cash equivalents		**194**	**33,456**
Cash and cash equivalents at 1 April - brought forward		**37,358**	**3,902**
Cash and cash equivalents at 31 March	20.1	**37,552**	**37,358**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2021/22 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Note 1.2 Going concern

The Trust prepares its accounts on a going concern basis, in accordance with the definition as set out in section 4 of the DHSC Group Accounting Manual (GAM). The GAM outlines the interpretation of IAS1 'Presentation of Financial Statements' as 'anticipated continuation of the provision of a service in the future, as evidenced by the inclusion of financial provision for that service in published documents'. The 2021/22 priorities and operational planning guidance issued in March 2021 by NHS England & Improvement confirmed the financial framework arrangements for 2021/22 will continue to support a system-based approach to funding and planning.

This year, 2021/22, the Trust has reported an operational surplus of £206k income over expenditure (£609k surplus after technical adjustments). Income from Commissioners was largely based on a simplified fixed block income basis introduced in response to the COVID-19 pandemic.

Whilst the Trust now carries no loans with DHSC, the historic cumulative deficit as at 31st March 2021 remains at £106.9m and as a result the External Auditor is obliged to issue a referral to the Secretary of State for Health and Social Care under Section 30(1)(b) of the Local Audit & Accountability Act 2014 reporting that the Trust has technically breached its statutory duty to breakeven over a rolling period.

For the year ahead, 2022/23, the Trust is aiming to 'live within its means' for a fourth consecutive year. However, at the time of writing, the financial plan for the Trust reflects an ongoing financial risk of £9.7m, which continues to be assessed with the Hampshire and Isle of Wight (HIOW) Integrated Care System on how this may be mitigated. The Trust's financial risk is broadly consistent with other providers across HIOW. The financial plan is supported by a cost improvement plan of £19.4m (representing 2.6% of planned turnover), and the plan reflects many of the changes in pathway and services funded during 2021/22 (e.g. medical village, additional bed capacity, emergency care centre).

The Trust has prepared a cash forecast for the going concern period to June 2023 which shows sufficient liquidity for the Trust to continue to operate. The minimum forecast month end cash balance during the going concern period is £3.2m with an average of £15m.

In conclusion, these factors, together with the anticipated future provision of services in the public sector, support the Trust's adoption of the going concern basis for the preparation of the accounts.

Note 1.3 Revenue from contracts with customers

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

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

Revenue from NHS contracts

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

The main source of income for the Trust is contracts with commissioners for health care services. In 2021/22 and 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. The Trust receives block funding from its commissioners, where funding envelopes are set at a Integrated Care System and Sustainability & Transformation Partnership level. For the first half of the 2020/21 comparative year these blocks were set for individual NHS providers directly, but the revenue recognition principles are the same. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust also receives additional income outside of the block payments to reimburse specific costs incurred and, in 2020/21, other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

In 2021/22, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as variable consideration.

Revenue from research contracts

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

NHS injury cost recovery scheme

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

Note 1.4 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits

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

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

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

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Discontinued operations

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

Note 1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

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

Subsequent expenditure

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

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

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

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

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

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

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

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

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use. The Trust uses the GDP deflator to calculate indexation on equipment assets with a life of more than 5 years (medium and long term assets).

Depreciation

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

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

Revaluation gains and losses

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

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

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

Impairments

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

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

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

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

Donated and grant funded assets

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

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

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

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

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

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively.

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

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	10	75
Dwellings	25	26
Plant & machinery	5	15
Transport equipment	7	7
Information technology	5	10
Furniture & fittings	15	15

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

Note 1.9 Intangible assets

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

Internally generated intangible assets

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

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

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

Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

Amortisation

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

Useful lives of intangible assets

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

	Min life Years	**Max life Years**
Software licences	2	5

Note 1.10 Inventories

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

In 2020/21 and 2021/22, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.11 Cash and cash equivalents

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

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

Note 1.12 Financial assets and financial liabilities

Recognition

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

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

Classification and measurement

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

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

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

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

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

Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

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

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

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

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

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

Note 1.13 Leases

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

The trust as a lessee

Finance leases

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

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

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

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

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

The trust as a lessor

Finance leases

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

Operating leases

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

Note 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2022:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	0.47%	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.70%	0.18%
Long-term	After 10 years up to 40 years	0.95%	1.99%
Very long-term	Exceeding 40 years	0.66%	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2022:

	Inflation rate	Prior year rate
Year 1	4.00%	1.20%
Year 2	2.60%	1.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 1.30% in real terms (prior year: minus 0.95%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 25.2 but is not recognised in the Trust’s accounts.

Non-clinical risk pooling

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

Note 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity’s control) are not recognised as assets, but are disclosed in note 26 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 26, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

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

Note 1.16 Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

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

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

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

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

Note 1.17 Value added tax

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

Note 1.18 Climate change levy
Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.19 Foreign exchange

The functional and presentational currency of the Trust is sterling.

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

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

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

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

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

Note 1.20 Third party assets

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

Note 1.21 Losses and special payments

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

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

Note 1.22 Gifts

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

Note 1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2021/22.

Note 1.24 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

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

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

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be defined by HM Treasury. For 2022 this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

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

The trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

Estimated impact on 1 April 2022 statement of financial position	**£000**
Additional right of use assets recognised for existing operating leases	8,290
Additional lease obligations recognised for existing operating leases	(8,290)
Net impact on net assets on 1 April 2022	**0**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(1,510)
Additional finance costs on lease liabilities	(98)
Lease rentals no longer charged to operating expenditure	1,571
Estimated impact on surplus / deficit in 2022/23	**(37)**
Estimated increase in capital additions for new leases commencing in 2022/23	**2,043**

From 1 April 2022, the principles of IFRS 16 will also be applied to the Trust's PFI liabilities where future payments are linked to a price index representing the rate of inflation. The PFI imputed lease liability will be remeasured when a change in the index causes a change in future imputed lease payments and that change has taken effect in the cash flow. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred. This is expected to increase the PFI liability on the statement of financial position upon transition to IFRS 16. The effect of this has not yet been quantified.

Other standards, amendments and interpretations

IFRS 14 Regulatory Deferral Accounts -Not EU-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.

IFRS 16 Leases - Standard is effective at 1 April 2022 per the FReM.

IFRS 17 Insurance Contracts - Application required for accounting periods beginning on or after 1 January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted.

Note 1.25 Critical judgements in applying accounting policies

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

Classification of Leases. Under IAS 17 a finance lease is one that transfers to the lessee 'substantially all the risks and rewards incidental to ownership of an asset'. This requires the consideration of a number of factors for each lease. The Trust considers that where the net present value of lease payments amount to more than 85% of the fair value of the asset and the lease term is more than 80% of the economic life of the asset there is a strong presumption that a lease is a finance lease unless there is other evidence to the contrary.

For leases entered into prior to 2009/10 the Trust has applied a "deminimis" value of £25,000 before recognising finance leases for photocopiers and lease arrangements under IFRIC 4. From 2009/10 the Trust has assessed all leases and lease arrangements with a value of more than £5,000 against the finance lease criteria contained within IAS17 and IFRIC 4.

Asset Lives and Residual Values. Property, plant and equipment is depreciated over its useful life taking into account residual values, where appropriate. The actual lives of the assets and residual values are assessed annually and may vary depending on a number of factors. In reassessing asset lives, factors such as technological innovation and maintenance programmes are taken into account. Residual value assessments consider issues such as the remaining life of the asset and projected disposal values.

PFI Life Cycle Costs. An element of the PFI contract payment relates to the replacement of asset components by the Operator. The Operator has provided a schedule of asset replacements and the Trust capitalise life cycle replacements where appropriate. Life cycle replacements are capitalised when the Operator's invoices are received (approximately one quarter in arrears) with depreciation commencing in the following quarter.

Land & Property Valuation. The Trust is required to show its land and property at fair value in its statement of financial position (see notes 1.7 and 1.8). This includes the valuation of peripheral buildings on the QA site at depreciated replacement cost on a modern equivalent basis. As part of the valuation the Valuer conducts a site inspection at least every five years and assesses the impact of any construction or improvement work that has been conducted on the buildings.

Impairment of Assets. At each statement of financial position date, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is any indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

Recoverability of Receivables. Provision for non-payment is made against non-NHS receivables that are greater than 360 days old unless recoverability is certain. Provision is made against more recent receivables where there is some doubt concerning recoverability.

Provisions. The Trust regularly monitors the position regarding provisions, including legal claims and restructuring, to ensure that it accurately reflects at each balance sheet date the current position in providing for potential future costs from past events, including board resolutions.

Note 1.26 Sources of estimation uncertainty

Other than the valuation of land and buildings, there are no key assumptions for 2021/22 concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Although the assumptions behind the valuations of land and building has been developed by a senior member of the Trust's estates team and the Valuation Office Agency, there is inherent uncertainty in the assumptions, which could give rise to a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Note 2 Operating Segments

The Trust has identified two operating segments relating to the provision of healthcare and pharmacy trading. The vast majority of the Trust's income (£699.5m, 98%) is derived from 'non-trading' healthcare. Of the total income, 2% (£14.5m) is generated from the sale of drugs externally to the NHS and private sector. In addition to selling drugs externally, Pharmacy Trading sell drugs internally on a full cost basis.

	Healthcare		Pharmacy Trading		Total	
	2021-22	2020-21	**2021-22**	2020-21	**2021-22**	2020-21
	£000's	£000's	**£000's**	£000's	**£000's**	£000's
Income						
External	**751,195**	699,538	**24,739**	14,503	**775,934**	714,041
Internal	**0**	0	**55,104**	47,186	**55,104**	47,186
Total Income	**751,195**	699,538	**79,843**	61,689	**831,038**	761,227
Expenditure						
Segment costs	**698,287**	650,662	**77,094**	59,458	**775,381**	710,120
Common costs	**55,104**	47,186	**894**	937	**55,998**	48,123
Total Expenditure	**753,391**	697,848	**77,988**	60,395	**831,379**	758,243
Retained surplus/(deficit) for the year	(2,196)	1,690	1,855	1,294	(341)	2,984

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3

Note 3.1 Income from patient care activities (by nature)	2021/22 £000	2020/21 £000
Acute services		
Block contract / system envelope income	594,494	519,321
High cost drugs income from commissioners (excluding pass-through costs)	65,492	57,473
Other NHS clinical income	6,391	7,295
Other services		
Private patient income	599	274
Elective recovery fund	10,113	-
Additional pension contribution central funding*	16,388	15,384
Other clinical income	1,873	7,587
Total income from activities	**695,350**	**607,334**

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

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2021/22 £000	2020/21 £000
NHS England	170,197	149,030
Clinical commissioning groups	516,290	450,443
Department of Health and Social Care	47	-
Other NHS providers	6,391	5,982
Non-NHS: private patients	599	274
Non-NHS: overseas patients (chargeable to patient)	407	322
Injury cost recovery scheme	759	816
Non NHS: other	660	467
Total income from activities	**695,350**	**607,334**

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

	2021/22	2020/21
	£000	£000
Income recognised this year	407	322
Cash payments received in-year	108	115
Amounts added to provision for impairment of receivables	429	310
Amounts written off in-year	100	40

Note 4 Other operating income

	2021/22			2020/21		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	5,206	-	**5,206**	4,361	-	**4,361**
Education and training	23,098	-	**23,098**	21,860	-	**21,860**
Non-patient care services to other bodies	7,781		**7,781**	5,311		**5,311**
Reimbursement and top up funding	3,010		**3,010**	36,394		**36,394**
Income in respect of employee benefits accounted on a gross basis	-		**-**	-		**-**
Receipt of capital grants and donations		1,083	**1,083**		2,841	**2,841**
Charitable and other contributions to expenditure *		2,068	**2,068**		13,083	**13,083**
Support from the Department of Health and Social Care for mergers		-	**-**		-	**-**
Rental revenue from finance leases		-	**-**		-	**-**
Rental revenue from operating leases		1,550	**1,550**		1,568	**1,568**
Amortisation of PFI deferred income / credits		-	**-**		-	**-**
Other income **	36,788	-	**36,788**	21,289	-	**21,289**
Total other operating income	**75,883**	**4,701**	**80,584**	**89,215**	**17,492**	**106,707**
Of which:						
Related to continuing operations			80,584			106,707
Related to discontinued operations			-			-

* includes £1.8m Personal Protective Equipment consumables purchased by DHSC (£12.3m in 2020/21)

** other contract income includes £24.7m Pharmacy Sales and £0.8m Income Generation (£14.5m and £1.5m respectively in 2020/21)

Note 5.1 Operating expenses

	2021/22	2020/21
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	3,117	2,586
Purchase of healthcare from non-NHS and non-DHSC bodies	17,177	11,641
Staff and executive directors costs	421,348	400,837
Remuneration of non-executive directors	162	121
Supplies and services - clinical (excluding drugs costs)	67,905	63,134
Supplies and services - general	2,313	1,968
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	103,958	84,941
Inventories written down	17	282
Consultancy costs	2,718	1,895
Establishment	6,065	6,021
Premises	20,637	18,630
Transport (including patient travel)	1,945	1,656
Depreciation on property, plant and equipment	17,915	16,357
Amortisation on intangible assets	2,458	1,508
Net impairments	547	407
Movement in credit loss allowance: contract receivables / contract assets	(128)	3
Movement in credit loss allowance: all other receivables and investments	156	325
Change in provisions discount rate(s)	1,531	243
Fees payable to the external auditor		
audit services- statutory audit	139	141
Internal audit costs	67	67
Clinical negligence	21,908	21,488
Legal fees	914	2,041
Insurance	347	338
Research and development	4,970	4,619
Education and training	2,054	1,282
Rentals under operating leases	2,692	2,597
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	45,958	41,049
Hospitality	51	2
Other	4,081	3,580
Total	**753,022**	**689,759**

Note 5.2 Other auditor remuneration

	2021/22	2020/21
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**-**	**-**

Note 5.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2 million (2020/21: £2 million).

Note 6 Impairment of assets

	2021/22	2020/21
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	(6)	407
Other	553	-
Total net impairments charged to operating surplus / deficit	**547**	**407**
Impairments charged to the revaluation reserve	547	5,236
Total net impairments	**1,094**	**5,643**

Note 7 Employee benefits

	2021/22 Total £000	2020/21 Total £000
Salaries and wages	293,102	284,183
Social security costs	30,335	28,553
Apprenticeship levy	1,524	1,436
Employer's contributions to NHS pensions	52,261	49,136
Pension cost - other	-	-
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	-	-
Temporary staff (including agency)	51,500	44,423
Total gross staff costs	**428,722**	**407,731**
Recoveries in respect of seconded staff	-	-
Total staff costs	**428,722**	**407,731**
Of which		
Costs capitalised as part of assets	2,404	2,275

Note 7.1 Retirements due to ill-health

During 2021/22 there were 3 early retirements from the trust agreed on the grounds of ill-health (2 in the year ended 31 March 2021). The estimated additional pension liabilities of these ill-health retirements is £229k (£49k in 2020/21).

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

Note 8 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 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

Note 9 Operating leases

Note 9.1 Portsmouth Hospitals University NHS Trust as a lessor

This note discloses income generated in operating lease agreements where Portsmouth Hospitals University NHS Trust is the lessor.

This mainly relates to the sub-leases of the Rehab Building to Solent NHS Trust, the Gym Building and Fort Southwick Building 3 to NHS Property Services Ltd and the PET Scanner Unit to Alliance.

	2021/22 £000	2020/21 £000
Operating lease revenue		
Minimum lease receipts	1,550	1,568
Total	**1,550**	**1,568**

	31 March 2022 £000	31 March 2021 £000
Future minimum lease receipts due:		
- not later than one year;	2,049	1,568
- later than one year and not later than five years;	1,302	999
- later than five years.	399	156
Total	**3,750**	**2,723**

Note 9.2 Portsmouth Hospitals University NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Portsmouth Hospitals University NHS Trust is the lessee.
Operating leases mostly relate to property and the most significant are:

- Railway Triangle lease - used for Pharmacy Manufacture, the lease period is for 30 years (expires 2036) and has an annual lease value of £90,000.

- Matrix Park - used for Pharmacy Regional Distribution Centre, the lease period is for 10 years (expires 2029) and has an annual value of £245,000.

- Mitchell Way lease - used for the health records storage and office buildings, the lease period is for 17 years (expires 2027) and has an annual value of £195,000.

- Fort Southwick office buildings and car parks - used for off site car parking and administration, the lease period is for 10 years (expires 2029) and has an annual value of £572,000.

- Manor Court - office buildings used for Procurement - the lease period is for 5 years (expires 2025) and has an annual value of £73,000

	2021/22 £000	2020/21 £000
Operating lease expense		
Minimum lease payments	2,692	2,597
Total	**2,692**	**2,597**

	31 March 2022 £000	31 March 2021 £000
Future minimum lease payments due:		
- not later than one year;	2,844	2,844
- later than one year and not later than five years;	6,957	7,840
- later than five years.	2,888	3,767
Total	**12,689**	**14,451**
Future minimum sublease payments to be received	-	-

Note 10 Finance income

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

	2021/22	2020/21
	£000	£000
Interest on bank accounts	34	8
Total finance income	**34**	**8**

Note 11.1 Finance expenditure

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

	2021/22	2020/21
	£000	£000
Interest expense:		
Interest on late payment of commercial debt	5	2
Main finance costs on PFI and LIFT schemes obligations	10,897	11,218
Contingent finance costs on PFI and LIFT scheme obligations	7,269	6,618
Total interest expense	**18,171**	**17,838**
Unwinding of discount on provisions	(40)	13
Total finance costs	**18,131**	**17,851**

Note 11.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2021/22	2020/21
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	5	2

Note 12 Other gains / (losses)

	2021/22	2020/21
	£000	£000
Gains on disposal of assets	64	158
Losses on disposal of assets	(107)	(144)
Total gains / (losses) on disposal of assets	**(43)**	**14**
Other gains / (losses)	-	-
Total other gains / (losses)	**(43)**	**14**

Note 13.1 Intangible assets - 2021/22

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2021 - brought forward	**12,134**	**12,134**
Additions	3,592	**3,592**
Disposals / derecognition	(2,848)	**(2,848)**
Valuation / gross cost at 31 March 2022	**12,878**	**12,878**
Amortisation at 1 April 2021 - brought forward	**6,103**	**6,103**
Provided during the year	2,458	**2,458**
Disposals / derecognition	(2,848)	**(2,848)**
Amortisation at 31 March 2022	**5,713**	**5,713**
Net book value at 31 March 2022	**7,165**	**7,165**
Net book value at 1 April 2021	**6,031**	**6,031**

Note 13.2 Intangible assets - 2020/21

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2020 - as previously stated	**9,674**	**9,674**
Valuation / gross cost at 1 April 2020 - restated	**9,674**	**9,674**
Additions	3,888	**3,888**
Disposals / derecognition	(1,428)	**(1,428)**
Valuation / gross cost at 31 March 2021	**12,134**	**12,134**
Amortisation at 1 April 2020 - as previously stated	**6,023**	**6,023**
Amortisation at 1 April 2020 - restated	**6,023**	**6,023**
Provided during the year	1,508	**1,508**
Disposals / derecognition	(1,428)	**(1,428)**
Amortisation at 31 March 2021	**6,103**	**6,103**
Net book value at 31 March 2021	**6,031**	**6,031**
Net book value at 1 April 2020	**3,651**	**3,651**

Note 14.1 Property, plant and equipment - 2021/22

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2021 - brought forward	**26,736**	**314,237**	**3,416**	**7,390**	**86,633**	**41**	**23,689**	**3,022**	**465,164**
Additions	-	8,685	124	19,616	5,080	-	4,973	215	**38,693**
Impairments	-	(206)	-	(407)	(1,315)	-	-	(49)	**(1,977)**
Revaluations	1,200	9,042	24	-	-	-	-	-	**10,266**
Reclassifications	-	11,082	-	(11,082)	-	-	-	-	
Disposals / derecognition	-	-	-	-	(7,768)	(41)	(5,502)	-	**(13,311)**
Valuation/gross cost at 31 March 2022	**27,936**	**342,840**	**3,564**	**15,517**	**82,630**	**-**	**23,160**	**3,188**	**498,835**
Accumulated depreciation at 1 April 2021 - brought forward	**-**	**17,414**	**293**	**-**	**52,913**	**41**	**12,285**	**2,291**	**85,237**
Provided during the year	-	8,462	148	-	5,690	-	3,416	199	**17,915**
Impairments	-	146	-	-	(786)	-	-	(37)	**(677)**
Reversals of impairments	-	(206)	-	-	-	-	-	-	**(206)**
Disposals / derecognition	-	-	-	-	(7,661)	(41)	(5,502)	-	**(13,204)**
Accumulated depreciation at 31 March 2022	**-**	**25,816**	**441**	**-**	**50,156**	**-**	**10,199**	**2,453**	**89,065**
Net book value at 31 March 2022	**27,936**	**317,024**	**3,123**	**15,517**	**32,474**	**-**	**12,961**	**735**	**409,770**
Net book value at 1 April 2021	**26,736**	**296,823**	**3,123**	**7,390**	**33,720**	**-**	**11,404**	**731**	**379,927**

Note 14.2 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 brought forward	**26,613**	**312,458**	**3,484**	**2,933**	**79,469**	**40**	**20,301**	**2,959**	**448,257**
Additions	-	5,876	197	6,589	11,402	-	6,317	5	**30,386**
Impairments	-	(5,378)	(265)	-	-	-	-	-	**(5,643)**
Revaluations	123	1,281	-	-	1,441	1	-	58	**2,904**
Reclassifications	-	-	-	(2,132)	2,132	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(7,811)	-	(2,929)	-	**(10,740)**
Valuation/gross cost at 31 March 2021	**26,736**	**314,237**	**3,416**	**7,390**	**86,633**	**41**	**23,689**	**3,022**	**465,164**
Accumulated depreciation at 1 April 2020 brought forward	**-**	**9,099**	**139**	**-**	**54,860**	**40**	**12,282**	**2,050**	**78,470**
Provided during the year	-	8,315	154	-	4,755	-	2,932	201	**16,357**
Revaluations	-	-	-	-	965	1	-	40	**1,006**
Disposals / derecognition	-	-	-	-	(7,667)	-	(2,929)	-	**(10,596)**
Accumulated depreciation at 31 March 2021	**-**	**17,414**	**293**	**-**	**52,913**	**41**	**12,285**	**2,291**	**85,237**
Net book value at 31 March 2021	**26,736**	**296,823**	**3,123**	**7,390**	**33,720**	**-**	**11,404**	**731**	**379,927**
Net book value at 1 April 2020	**26,613**	**303,359**	**3,345**	**2,933**	**24,609**	**-**	**8,019**	**909**	**369,787**

Note 14.3 Property, plant and equipment financing - 2021/22

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2022								
Owned - purchased	27,936	5,245	3,123	15,517	27,756	12,949	735	**93,261**
Finance leased	-	-	-	-	867	-	-	**867**
On-SoFP PFI contracts and other service concession arrangements	-	307,507	-	-	-	-	-	**307,507**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	**-**
Owned - donated/granted	-	4,272	-	-	3,851	12	-	**8,135**
NBV total at 31 March 2022	**27,936**	**317,024**	**3,123**	**15,517**	**32,474**	**12,961**	**735**	**409,770**

Note 14.4 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021								
Owned - purchased	26,736	5,344	3,123	7,390	28,828	11,388	731	**83,540**
Finance leased	-	-	-	-	1,265	-	-	**1,265**
On-SoFP PFI contracts and other service concession arrangements	-	287,282	-	-	-	-	-	**287,282**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	**-**
Owned - donated/granted	-	4,197	-	-	3,627	16	-	**7,840**
NBV total at 31 March 2021	**26,736**	**296,823**	**3,123**	**7,390**	**33,720**	**11,404**	**731**	**379,927**

Note 15 Donations of property, plant and equipment

£1.1m of the donated assets were received from the Portsmouth Hospitals Charity (registered charity number 1047986).

Note 16 Revaluations of property, plant and equipment

All land and buildings, with the exception of new buildings, have been restated to modern equivalent asset value based on a formal valuation carried out in March 2019, refreshed by a desktop valuation at 31st March 2022 by the District Valuer from the HM Revenue and Customs Valuation Office Agency. The next formal valuation is due in 2023/24, when accumulated depreciation will be reset according to the requirements of the DHSC GAM.

New buildings are formally valued when they are bought into operational use.

Equipment is valued at historic cost where the estimated life is less than 5 years (short term) and equipment with an estimated life of more than 5 years (medium and long term) has been valued using the GDP deflator.

Assets are depreciated using the asset lives as set out at note 1.7.6.

Gross carrying amount of fully depreciated assets still in use is £34.7m

Note 17 Disclosure of interests in other entities

Material entities over which the Trust has the power to exercise control are classified as subsidiaries and are consolidated. The Trust has control when it is exposed to or has rights to variable returns through its power over another entity. The income and expenses; gains and losses; assets, liabilities and reserves; and cash flows of the subsidiary are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust or where the subsidiary's accounting date is not co-terminus.

Following HM Treasury's agreement to apply IAS27 to NHS Charities from 1 April 2013, the Trust has established that as the corporate trustee of the linked NHS Charity 'Portsmouth Hospitals Charity', it effectively has the power to exercise control so as to obtain economic benefits. However the transactions are immaterial in the context of the group and transactions have not been consolidated.

Due to the materiality of the transactions the Trust concluded that consolidation would not add to the quality of the accounts. The Trustees Annual Report and Annual Accounts are published on the Charity Commission website.

Note 18 Inventories

	31 March 2022 £000	31 March 2021 £000
Drugs	8,883	8,999
Consumables	9,123	8,201
Total inventories	**18,006**	**17,200**

Inventories recognised in expenses for the year were £130,604k (2020/21: £133,010k). Write-down of inventories recognised as expenses for the year were £17k (2020/21: £282k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2021/22 the Trust received £1,780k of items purchased by DHSC (2020/21: £12,336k).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 19.1 Receivables

	31 March 2022 £000	31 March 2021 £000
Current		
Contract receivables	17,926	12,158
Allowance for impaired contract receivables / assets	(74)	(210)
Allowance for other impaired receivables	(1,362)	(1,295)
Prepayments (non-PFI)	6,585	5,050
PFI lifecycle prepayments	2,992	4,894
PDC dividend receivable	255	176
VAT receivable	4,463	3,815
Other receivables	1,243	1,372
Total current receivables	**32,028**	**25,960**
Non-current		
Contract receivables	628	843
PFI lifecycle prepayments	-	54
Other receivables	1,271	1,689
Total non-current receivables	**1,899**	**2,586**
Of which receivable from NHS and DHSC group bodies:		
Current	10,392	8,088
Non-current	1,271	1,689

Note 19.2 Allowances for credit losses

	2021/22		2020/21	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**210**	**1,295**	**207**	**1,005**
Prior period adjustments			-	-
Allowances as at 1 April - restated	**210**	**1,295**	**207**	**1,005**
Transfers by absorption	-	-	-	-
New allowances arising	3	223	3	428
Changes in existing allowances	-	-	-	-
Reversals of allowances	(131)	(67)	-	(103)
Utilisation of allowances (write offs)	(8)	(89)	-	(35)
Changes arising following modification of contractual cash flows	-	-	-	-
Foreign exchange and other changes	-	-	-	-
Allowances as at 31 Mar 2022	**74**	**1,362**	**210**	**1,295**

Note 19.3 Exposure to credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has relatively low inherent exposure to credit risk.

Note 20.1 Cash and cash equivalents movements

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

	2021/22	2020/21
	£000	£000
At 1 April	**37,358**	**3,902**
Net change in year	194	33,456
At 31 March	**37,552**	**37,358**
Broken down into:		
Cash at commercial banks and in hand	9	9
Cash with the Government Banking Service	37,543	37,349
Total cash and cash equivalents as in SoCF	**37,552**	**37,358**

Note 20.2 Third party assets held by the Trust

The Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

Note 21.1 Trade and other payables

	31 March 2022 £000	31 March 2021 £000
Current		
Trade payables	10,114	14,417
Capital payables	4,906	5,160
Accruals	12,236	12,920
Social security costs	4,377	4,181
Other taxes payable	4,042	3,912
Other payables	55,250	38,544
Total current trade and other payables	**90,925**	**79,134**
Non-current		
Other payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	3,300	5,851
Non-current	-	-

Note 21.2 Early retirements in NHS payables above

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

	31 March 2022 £000	31 March 2022 Number	31 March 2021 £000	31 March 2021 Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-

Note 22 Other liabilities

	31 March 2022 £000	31 March 2021 £000
Current		
Deferred income: contract liabilities	3,471	1,904
Total other current liabilities	**3,471**	**1,904**
Non-current		
Other non-current liabilities	-	-
Total other non-current liabilities	**-**	**-**

Note 23.1 Borrowings

	31 March 2022 £000	31 March 2021 £000
Current		
Obligations under finance leases	189	353
Obligations under PFI, LIFT or other service concession contracts	9,070	7,267
Total current borrowings	**9,259**	**7,620**
Non-current		
Obligations under finance leases	455	644
Obligations under PFI, LIFT or other service concession contracts	192,128	201,197
Total non-current borrowings	**192,583**	**201,841**

Note 23.2 Reconciliation of liabilities arising from financing activities - 2021/22

	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2021	**-**	**997**	**208,464**	**209,461**
Cash movements:				
Financing cash flows - payments and receipts of principal	-	(353)	(7,267)	**(7,620)**
Financing cash flows - payments of interest	-	-	(10,896)	**(10,896)**
Non-cash movements:				
Application of effective interest rate	-	-	10,897	**10,897**
Carrying value at 31 March 2022	**-**	**644**	**201,198**	**201,842**

Note 23.3 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2020	**125,534**	**1,351**	**214,604**	**341,489**
Cash movements:				
Financing cash flows - payments and receipts of principal	(125,165)	(354)	(6,140)	**(131,659)**
Financing cash flows - payments of interest	(369)	-	(11,218)	**(11,587)**
Non-cash movements:				
Application of effective interest rate	-	-	11,218	**11,218**
Carrying value at 31 March 2021	**-**	**997**	**208,464**	**209,461**

Note 24 Finance leases

Note 24.1 Portsmouth Hospitals University NHS Trust as a lessor

The Trust does not hold any finance leases as a lessor.

Note 24.2 Portsmouth Hospitals University NHS Trust as a lessee

Obligations under finance leases where the trust is the lessee.

	31 March 2022 £000	31 March 2021 £000
Gross lease liabilities	**644**	**997**
of which liabilities are due:		
- not later than one year;	189	354
- later than one year and not later than five years;	455	643
- later than five years.	-	-
Net lease liabilities	**644**	**997**
of which payable:		
- not later than one year;	189	353
- later than one year and not later than five years;	455	644
- later than five years.	-	-

Note 25.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims *	Other **	Total
	£000	£000	£000	£000	£000
At 1 April 2021	**332**	**2,273**	**186**	**1,689**	**4,480**
Change in the discount rate	(5)	1,536	-	-	**1,531**
Arising during the year	-	292	1,434	-	**1,726**
Utilised during the year	(21)	(73)	(26)	-	**(120)**
Reversed unused	(14)	-	(17)	(418)	**(449)**
Unwinding of discount	12	(52)	-	-	**(40)**
At 31 March 2022	**304**	**3,976**	**1,577**	**1,271**	**7,128**
Expected timing of cash flows:					
- not later than one year;	39	73	1,577	-	**1,689**
- later than one year and not later than five years;	156	292	-	-	**448**
- later than five years.	109	3,611	-	1,271	**4,991**
Total	**304**	**3,976**	**1,577**	**1,271**	**7,128**

* Covers the cost to the Trust of claims from staff and third parties - costs shown are based on an assessed probability of payment.

** Relates to Clinicians Pension Tax Reimbursement.

Note 25.2 Clinical negligence liabilities

At 31 March 2022, £623,909k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Portsmouth Hospitals University NHS Trust (31 March 2021: £440,007k).

Note 26 Contingent assets and liabilities

	31 March 2022 £000	31 March 2021 £000
Value of contingent liabilities		
NHS Resolution legal claims *	(26)	(26)
Employment tribunal and other employee related litigation	(214)	(132)
Gross value of contingent liabilities	**(240)**	**(158)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(240)**	**(158)**
Net value of contingent assets	**-**	**-**

* The contingent liabilities for NHS Resolution legal claims are based on an assessment of probability of the claim succeeding made by NHS Resolution.

** Employment tribunal and other employee related litigation claims are based on a 50% chance of the claim succeeding where judgement has not already been made.

Note 27 On-SoFP PFI, LIFT or other service concession arrangements

Note 27.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

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

	31 March 2022 £000	31 March 2021 £000
Gross PFI, LIFT or other service concession liabilities	**315,373**	**333,537**
Of which liabilities are due		
- not later than one year;	19,588	18,164
- later than one year and not later than five years;	70,674	72,893
- later than five years.	225,111	242,480
Finance charges allocated to future periods	(114,175)	(125,073)
Net PFI, LIFT or other service concession arrangement obligation	**201,198**	**208,464**
- not later than one year;	9,070	7,267
- later than one year and not later than five years;	33,111	33,575
- later than five years.	159,017	167,622

Note 27.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

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

	31 March 2022 £000	31 March 2021 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**1,453,101**	**1,315,390**
Of which payments are due:		
- not later than one year;	77,499	66,602
- later than one year and not later than five years;	309,995	266,408
- later than five years.	1,065,607	982,380

Note 27.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2021/22 £000	2020/21 £000
Unitary payment payable to service concession operator	**74,933**	**70,074**
Consisting of:		
- Interest charge	10,897	11,218
- Repayment of balance sheet obligation	7,267	6,140
- Service element and other charges to operating expenditure	44,580	40,177
- Capital lifecycle maintenance	3,542	5,049
- Revenue lifecycle maintenance	1,378	872
- Contingent rent	7,269	6,618
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	-	-
Total amount paid to service concession operator	**74,933**	**70,074**

Note 28 Financial instruments

Note 28.1 Financial risk management

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

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

Any loans received are from the Department of Health and Social Care and as such the Trust is not exposed to significant interest rate risk.

Whilst the Trust does conduct some foreign currency transactions, these are not of sufficient value or volume to present a risk from currency exchange rate variations.

Note 28.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2022	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	19,632	-	-	**19,632**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents	37,552	-	-	**37,552**
Total at 31 March 2022	**57,184**	**-**	**-**	**57,184**

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	12,727	-	-	**12,727**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents	37,358	-	-	**37,358**
Total at 31 March 2021	**50,085**	**-**	**-**	**50,085**

Note 28.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	-	-	**-**
Obligations under finance leases	644	-	**644**
Obligations under PFI, LIFT and other service concession contracts	201,198	-	**201,198**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	82,506	-	**82,506**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2022	**284,348**	**-**	**284,348**

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	-	-	**-**
Obligations under finance leases	997	-	**997**
Obligations under PFI, LIFT and other service concession contracts	208,464	-	**208,464**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	70,925	-	**70,925**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2021	**280,386**	**-**	**280,386**

Note 28.4 Maturity of financial liabilities

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

	31 March 2022 £000	31 March 2021 £000
In one year or less	103,446	89,443
In more than one year but not more than five years	71,129	73,536
In more than five years	225,111	242,480
Total	**399,686**	**405,459**

Note 28.5 Fair values of financial assets and liabilities

Financial assets and liabilities are carried at book value as a reasonable approximation of fair value.

Note 29 Losses and special payments

	2021/22		2020/21	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	39	14	28	7
Bad debts and claims abandoned	267	119	170	51
Stores losses and damage to property	1	160	1	121
Total losses	**307**	**293**	**199**	**179**
Special payments				
Ex-gratia payments	118	548	100	97
Total special payments	**118**	**548**	**100**	**97**
Total losses and special payments	**425**	**841**	**299**	**276**
Compensation payments received		-		-

Note 30 Related parties

Portsmouth Hospitals University NHS Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Department of Health and Social Care Ministers, Portsmouth Hospitals University NHS Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the Trust.

The Department of Health and Social Care is regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as parent Department. Entities are listed below where the cumulative value of transactions exceed £5 million. Total Expenditure and Income for the year is shown, together with amounts payable to and amounts receivable from the related party as at 31st March 2022.

	Receipts from Related Party £'000	Payments to Related Party £'000	Amounts due from Related Party £'000	Amounts owed to Related Party £'000
Health Education England	23,514	2	391	1
NHS England	159,278	30	1,679	1,432
NHS Hampshire, Southampton and Isle of Wight CCG	368,040	0	493	338
NHS Portsmouth CCG	140,328	0	48	12
NHS Resolution	0	22,219	0	0
NHS West Sussex CCG	8,123	0	0	0
Isle of Wight NHS Trust	10,887	341	746	217
University Hospital Southampton NHS Foundation Trust	12,561	2,189	2,862	792

The Trust has also received revenue and capital payments from a number of charitable funds, including Portsmouth Hospitals Charity and the League of Friends. The Trust is the corporate trustee of the Portsmouth Hospitals Charity. The total value of grants made to the Trust by the Charity was £0.7m.

Note 31 Events after the reporting date

There have been no events after the reporting date to report.

Note 32 Better Payment Practice code

Non-NHS Payables	2021/22 Number	2021/22 £000	2020/21 Number	2020/21 £000
Total non-NHS trade invoices paid in the year	113,885	374,705	112,195	325,006
Total non-NHS trade invoices paid within target	111,005	367,221	100,618	308,822
Percentage of non-NHS trade invoices paid within target	97.5%	98.0%	89.7%	95.0%
NHS Payables				
Total NHS trade invoices paid in the year	2,567	24,480	2,439	15,835
Total NHS trade invoices paid within target	1,950	22,610	1,861	13,622
Percentage of NHS trade invoices paid within target	76.0%	92.4%	76.3%	86.0%

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.

The Trust is committed to eliminating payment delays to all business critical suppliers. Achieving 97.5% compliance builds on sustained process improvements made in 2020/21 where the Trust achieved 89.7% (a step increase from 41.5% during 2019/20 and 46.9% in 2018/19).

Note 33 External financing limit

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

	2021/22 £000	2020/21 £000
Cash flow financing	11,779	(20,738)
Finance leases taken out in year	-	-
Other capital receipts	-	-
External financing requirement	**11,779**	(20,738)
External financing limit (EFL)	11,779	16,231
Under / (over) spend against EFL	**-**	**36,969**

Note 34 Capital Resource Limit

	2021/22 £000	2020/21 £000
Gross capital expenditure	42,285	34,274
Less: Disposals	(107)	(144)
Less: Donated and granted capital additions	(1,083)	(2,841)
Plus: Loss on disposal from capital grants in kind	-	-
Charge against Capital Resource Limit	**41,095**	**31,289**
Capital Resource Limit	42,295	31,360
Under / (over) spend against CRL *	**1,200**	**71**

* £1.2m of the underspend relates to Public Dividend Capital for a multi-year project that is being reprofiled to 2022/23

Note 35 Breakeven duty financial performance

	2021/22 £000
Adjusted financial performance surplus / (deficit) (control total basis)	609
Remove impairments scoring to Departmental Expenditure Limit	-
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	1,071
Breakeven duty financial performance surplus / (deficit)	**1,680**

Note 36 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		(14,877)	159	148	4,293	830	(2,912)
Breakeven duty cumulative position	9,479	(5,398)	(5,239)	(5,091)	(798)	32	(2,880)
Operating income		432,167	446,161	440,231	451,906	469,094	484,463
Cumulative breakeven position as a percentage of operating income		(1.2%)	(1.2%)	(1.2%)	(0.2%)	0.0%	(0.6%)

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(23,477)	(17,645)	(30,701)	(35,826)	1,708	255	1,680
Breakeven duty cumulative position	(26,357)	(44,002)	(74,703)	(110,529)	(108,821)	(108,566)	(106,886)
Operating income	504,572	530,382	543,069	558,702	638,962	714,041	775,934
Cumulative breakeven position as a percentage of operating income	(5.2%)	(8.3%)	(13.8%)	(19.8%)	(17.0%)	(15.2%)	(13.8%)

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year. This adjustment is shown at Note 35 and does not count in the performance against the control total for the year.