Portsmouth Hospitals NHS
NHS Trust

Annual report and accounts 2019 – 2020

Contents

WELCOME

The last year was notable for two different reasons. We continued to build a solid foundation and achieved several milestones that demonstrated good progress, while also facing the significant challenge of COVID-19 in the last months of the year.

In January, the Care Quality Commission (CQC) improved its overall rating of the Trust to good, following an Autumn inspection that focused on the Trust's leadership, use of resources and five core services. Our ratings improved or were maintained across all five core services inspected – maternity, medicine and older people's care, surgery, outpatients and emergency and urgent care. This reflects the effort and dedication of teams throughout the Trust. Our improved rating demonstrates good progress; however, we recognise there is still more to do. We are absolutely committed to driving further improvements in the areas highlighted by the CQC around safety, with plans and progress reporting firmly established.

We have worked hard to recover our financial performance in recent years, and in 2019/20 we achieved the significant milestone of balancing expenditure and income. We delivered cost improvement of 3.6% of operating expenditure (£21.6m), with a significant contribution from a reduction in expenditure on agency staff largely due to the success of our innovative overseas recruitment initiative. Our rating of good in the use of resources by the CQC provides external validation of our progress.

These building blocks of improvement are a testament to the hard work and commitment of our staff in all areas of the Trust as we implement the second year of our five-year strategy 'Working Together' with the support of our culture change agents from across the Trust. In the 2019/20 NHS Staff Engagement Survey we saw encouraging improvements in many areas including morale, engagement and team working. We have continued to invest in developing the leadership capability that will support further transformation through our senior leadership and management development programmes.

Our 'Working Together' strategy focuses not only on how we work within the Trust but also on our broader partnerships across the health system. In February we announced a partnership with the Isle of Wight NHS Trust. This agreement allows us to strengthen our joint working in a planned way so that we can manage demand better for services at both Trusts in the future for the benefit of all our patients.

Much changed in the last two months of the year as we began to prepare and implement plans to manage the operational demands of the COVID-19 outbreak. Working to national guidance and with true commitment to our patients, our staff have risen to the challenge, supported strongly by the community, our military colleagues and health system partners. Our plans to deal with the expected surge in demand were built around expanding capacity by repurposing and equipping additional parts of the hospital to provide enhanced respiratory support. We recognise the very difficult times our patients, their loved ones and our staff have faced and will continue to face for an uncertain period.

Looking forward, our focus will remain on our long-term vision to work together to drive excellence in care for our patients and communities. As we start to re-build our activities, we must balance the needs of patients with COVID-19 and other patients who require our care, while learning from the innovative, collaborative approaches that have supported our response.

We would not have been able to deliver the improvements we have made, or to coordinate the response required for the COVID-19 situation without the contribution of all who work at the Trust, our volunteers and the support of our communities. We are deeply grateful to them all.

Melloney Poole OBE
Chairman

Mark Cubbon
Chief Executive

CHAPTER 1 – PERFORMANCE REPORT

OVERVIEW

About the Trust

Queen Alexandra Hospital started life more than a century ago as a military hospital. Today it is one of the largest, most modern hospitals in the region, with 1,200 beds housed in light, bright and infection resistant en-suite wards.

The current hospital was opened by Princess Alexandra in 1980 and then went through a major redevelopment to create a modern and 'fit for purpose' hospital, which was completed in 2009. The Trust awarded the £256m contract to The Hospital Company, a 50:50 joint venture between Carillion and The Royal Bank of Scotland under the Private Finance Initiative (PFI) although Carillion subsequently disposed of its interest.

As well as being responsible for the building works, The Hospital Company also entered into a long-term agreement to provide facilities management services to the hospital. Portsmouth Hospitals 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, portering, cleaning, security, catering and car parking.

All of these services, apart from estates, are subject to value testing through benchmarking and/or market testing every five years throughout the operational concession, which ends in 2040.

We are 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. We anticipate that the Trust will be able to reflect this close relationship by changing its Establishment Order and name (to include "University") in 2020. We have a significant reputation for our research and innovation and are actively involved with the national agenda in these fields. Some of our patients are regularly the first in the world to have the opportunity to trial new treatments, and even more are first in the UK.

We provide comprehensive secondary care and specialist services to a local population of 675,000 people across Portsmouth and South East Hampshire. We also offer certain tertiary services to a wider catchment area in excess of two million people.

Our population is characterised by its diversity. The rural and urban areas of wealth are contrasted with pockets of deprivation, and variation in life expectancy. Stroke, heart attacks, diabetes and liver disease have a high prevalence within our local communities, and we work, strategically, with public health and local commissioners to provide high quality services to combat and treat these conditions.

Most of our services are provided at Queen Alexandra Hospital ("QA") in Cosham, but we also offer a range of outpatient and diagnostic facilities closer to patients' homes in community hospital sites and at local treatment centres throughout Portsmouth and South East Hampshire. These include:

- St Mary's Hospital - midwifery, dermatology and enablement services.
- Gosport War Memorial Hospital - a range of services including the Blake Maternity Unit, Minor Injuries Unit and diagnostics.
- Petersfield Community Hospital - the Grange Maternity Unit.

Working alongside our military personnel

The mutual relationship between the Ministry of Defence (MoD), in the form of Joint Hospital Group (South) and the Trust remains as important as ever.

Under the command of Wing Commander Emma Redman, and subsequently Commanding Officer Alister Witt, the military medical personnel, which include Consultant Doctors, Specialist and Generalist Nurses and Allied Healthcare Professionals, provide a capable and flexible workforce which works to support the priorities of the Trust. In doing this, the MoD clinicians maintain and develop their clinical skills that will be used to provide medical support to the Royal Navy, Army and Royal Air Force wherever they may be deployed world-wide.

During the last year military personnel have also taken up leadership roles within the Trust, including the appointment of Colonel Neil Mackenzie as Divisional Director for the Surgery and Outpatients Division and Commander Barrie Dekker who has since succeeded him in this role. This further ensures the flow of best practice between the NHS and MoD. The success of the partnership lies in the quality of the personnel and the quality of the placements available to them and we look forward to the relationship continuing for the foreseeable future.

During the year we were immensely proud that the Trust was one of 24 NHS bodies to be awarded Veteran Aware status, having been accredited by the Veterans Covenant Hospital Alliance. This means that our staff caring for those who have served in the armed forces will have receive training and education on their specific needs, both physical and mental health, and will be able signpost them to local support services. It is a huge honour for us to be among the first organisations in the country to be recognised with Veteran Aware status.

Private Patients

All the income generated from the Harbour Suite goes into our general finances to help support improvements in services which benefit our NHS patients.

The Trust's Harbour Suite provides services for patients with private medical insurance, and works with all of the major healthcare insurance companies. Patients without insurance, who choose to pay for their own treatment and care, are also welcome. NHS patients can also choose the benefits of a private amenity bedroom, paying a daily charge. The Trust is able to offer 'the best of both' experience of private health care within the safety of an NHS facility.

This service is increasingly attractive to patients from a wide geography, choosing our hospital for its clinical excellence, the wide range of specialist skilled staff and the equipment not available elsewhere, for example our laparoscopic Da Vinci robots.

A caring and charitable hospital

Portsmouth Hospitals Charity aims to support the vision of the Trust by raising charitable funds and providing charitable grants to the Trust. The Charity plays an integral part in providing extra funding for equipment and facilities, research and innovation, the development of services and education for patients and staff – all enabling excellence in care provision for the patient and communities served by the Trust.

Portsmouth Hospitals Charity is very grateful for the ongoing support from patients, their loved ones, staff and the local community choosing to support a ward or department close to their heart.

Throughout the year, the Charity has received incredible support from the local community, from local golf clubs and community groups to businesses and networking groups. Local supermarkets have also continued to provide fresh flowers to Hospital reception areas and match funding where possible. The Charity was also chosen as the main recipient from a corporate Dodgeball event which will fund a Cinegym within our Paediatric Department.

Portsmouth Hospitals Charity held its first Wing Walking event in 2019 raising over £20,000 to support Portsmouth Hospitals NHS Trust. The Charity is very grateful to the volunteers who continuously give up their time to support the Charity shop onsite and other fundraising events throughout the year.

Our staff and departments also receive generous support from QA Hospital's League of Friends.

Research and innovation

We believe that every patient who enters our hospital should have the opportunity to participate in a clinical trial. We are continually working hard with patients, universities, industry and others to take the best new innovations from cutting-edge science and technology and use them to create real-life tests and treatments that benefit patients more quickly.

Year-on-year, we aim to increase our research portfolio to be able to offer our patients the very best treatments, medicines and services available, because we know that patients cared for in a research-active environment have better outcomes.

At the end of 2019/20, 5,996 patients were enrolled into clinical research studies and trials and the Trust was ranked third in the league of Large Acute Trusts; when this was weighted for study complexity, the Trust was ranked first.

Several of our clinical specialties are also consistently in the national top three rankings for recruitment, with further specialties consistently ranking in the top ten. The respiratory specialty is a national exemplar: in the last 4 years across 742 Trusts in England, the majority of recruitment to respiratory trials nationally has come from PHT.

Organisational structure

The clinical services in the Trust are spread across four Clinical Divisions; Clinical Delivery, Medicine and Urgent Care, Networked Services, and Surgery and Outpatients.

Each Division is led by a team consisting of a consultant, a nurse or allied health professional and a manager. Each leadership team is accountable for the quality, performance and financial sustainability of their Division as well as being responsible for working together across the other Divisions to ensure our patients receive a seamless pathway of care. The Divisions also lead the implementation of our strategy across their clinical areas and seek to forge strong relationships with our partners outside the organisation.

Did you know?

- Our Emergency Department saw 120,967 patients.
- We dealt with over 60,000 emergency admissions (excluding maternity).
- We saw over 632,000 outpatients and carried out over 62,000 day-case admissions.
- 5,454 babies were delivered at our hospital sites or at home with our midwifery team - an increase of 140 on the previous year.
- Our services were delivered by over 7,800 employees and over 700 volunteers.
- More than 200 military personnel also work alongside NHS colleagues at QA.

Our strategic direction

The Trust continues to work to deliver its five-year strategy for the Trust, launched in July 2018 and entitled 'Working Together'. The Trust's vision is 'Working together to drive excellence in care for our patients and communities.' The vision will be achieved through five strategic aims which each have a number of objectives. These are:

- Fulfil our role for the communities we serve
    - Fulfil our role as a provider of timely, accessible care to the Portsmouth and South East Hampshire communities
    - Work with partners, leading in the provision of the right specialist services in the region
    - Strengthen our relationship with Defence Medical Services
- Support safe, high quality patient-focused care
    - Get the basics right- deliver high quality care across all clinical services
    - Build an environment and culture where patients, families and carers can take the lead in meaningful care
    - Utilise research, development and academic opportunities to support our core purpose
- Take responsibility for the delivery of care now and in the future
    - Be financially sustainable, identifying opportunities for non-clinical income where appropriate
    - Empower staff to be responsible for service sustainability
- Invest in the capability of our people to deliver on our vision
    - Embed a culture that supports the achievement of our vision
    - Adopt workforce models that reflect new models of care and service needs
    - Support the development and capability of our people and value our staff

- Build the foundations on which our team can best deliver care
    - ➢ Optimise our estate portfolio and equipment
    - ➢ Enhance IT and information systems
    - ➢ Embed improvement in how we work

Delivery of our strategic aims is underpinned by our refreshed Trust values:

- Working together for patients
- Working together with compassion
- Working together as One Team
- Working together Always Improving

These priorities inform the Trust's business objectives. The Board Assurance Framework then identifies where there are risks to the delivery of any of the priorities and provides assurance on how these risks will be managed.

Care Quality Commission

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

As outlined in more detail at section 2.7, the Trust was subject to a comprehensive CQC inspection in October 2019 and a specific well-led inspection in November 2019, following which the Trust was rated as follows:

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement	**Good**	**Good**	**Good**	**Good**	**Good**

These rating are an improvement on the 2018 inspection outcome, which rated all areas and domains as 'Requires improvement'. The Trust had previously been served with a number of Warning Notices issued under s 29A of the Health & Social Care Act 2008. The Trust worked to address the findings and requirements set out in the 2018 inspection report and notices, and is pleased to confirm that all of the conditions previously applied to the Trust's registration as a result inspections in earlier years have been lifted.

The Trust has, however, been served with a new Notice under section 29A concerning practice in the Emergency Department (ED), focussed principally on:

- Reducing delays to the handover to the Trust of patients brought to the ED by ambulance
- Improving the oversight of self-presenting patients in the ED waiting areas

The report of the 2019 inspection also included 17 'must-do' requirements. A detailed action plan to address these matters, and the areas of concern identified in the Warning Notice, has been developed and has been monitored by the Quality & Performance Committee monthly starting from February 2020.

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 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 Trust's use of resources was Good.

Areas highlighted as outstanding practice include a system to monitor bed usage across the hospital (Bedview) and the outpatient transformation programme.

Areas identified for improvement include:

- A need to continue to reduce agency spend below the ceiling set by NHS England and NHS Improvement
- Acceleration of Cost improvement Plan (CIP) opportunities to improve the underlying deficit
- Pursue further reduction of costs in prescribing, waste management, medical staffing, job planning, microbiology
- Embed service level reporting (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).

Key issues and risks

Please refer to the Annual Governance Statement 2019/20 from page 34 of this document.

Adoption of going concern

The Trust prepares it's accounts on a going concern basis, in accordance with the definition as set out in section 4 of the GAM which 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'.

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow their repayment. The affected loans totalling £122.7m are classified as current liabilities within these financial statements. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the Trust.

The Trust will therefore no longer be required to generate surpluses to eliminate its historic debt, and the total net assets will increase by £122.7m during financial year 2020/21 thereby strengthening the value of the balance sheet.

Whilst the Trust has an underlying deficit and is currently reliant on additional support funding during the going concern period, NHS England and Improvement have issued the Trust with a financial improvement trajectory and indicative financial recovery funds which will continue on reducing basis for the remaining four years of the Long Term Plan up to 2023/24.

The Trust has refreshed its financial plan consistent with the trajectory and this has been reviewed by Board members. The Trust and NHS Improvement have a clear understanding of the financial position of the Trust.

DHSC have also previously confirmed the availability of ongoing interim support (where required) to ensure that NHS providers remain operationally viable.

In March 2020 NHS England and Improvement announced revised arrangements for NHS contracting and payment to apply for the first four months of the 2020/21 year due to the Covid-19 pandemic. The contracting arrangements for the rest of 2020/21 and beyond have not yet been definitively announced but it remains the case that the Government has issued a mandate to NHS England for the continued provision of services in England in 2020/21 and CCG allocations have been set for the remainder of the financial year to 31 March 2021. The Trust can therefore continue to expect NHS funding to flow at similar levels to that previously provided where services are reasonably still expected to be commissioned.

The Trust has prepared a cash forecast for the going concern period modelled on the expectation that the revised contracting and payment arrangements will remain in place until October 2020. The cash forecast shows sufficient liquidity for the Trust to continue to operate but interim support can be accessed if it were required.

These factors all support the adoption of the going concern concept. The underlying deficit, reliance on additional support from NHS England and Improvement and the lack of framework structure beyond July 2020 do, however, indicate the existence of material uncertainty which may cast significant doubt about the Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the Trust were unable to continue as a going concern.

Year at a glance

April 2019

- In April we shared news of our involvement in the national pilot for the new urgent and emergency care standards, which aligns with our long-term work to transform our urgent and emergency care for our patients in the communities we serve.
- We also introduced our #RespectandProtect campaign to raise awareness about violence and aggression against our staff.
- We took delivery of a sensory trolley to help adult patients with learning difficulties.

May 2019

- In May we celebrated being the top performing Trust in the UK during 2018/19 for complexity weighted recruitment to research studies for large acute NHS Trusts - a fantastic achievement for our Research and Innovation Team.
- The Nursing and Midwifery Awards were held in May in Portsmouth, with 148 nominations over 10 categories.
- We also saw the Junior Doctors Awards taking place.
- Our Medical Director, Dr John Knighton, hosted our second Patient Safety Conference, with powerful presentations from Dr Chris Turner of the Civility Saves Lives campaign and our Chief Nurse, Liz Rix, as well as poster presentations on safety initiatives and quality improvement projects from across the Trust.
- Our Digital Strategy was published to push forward investments in digital technology to improve patients' experience and the working lives of staff.
- We announced that we would be partnering with The Great South Run for the first time for the two events taking place in October as part of our focus on staff wellbeing
- Our Mental Health Conference was themed around body image and mental health. It included interactive presentations and Team GB Paralympian Aaron Phipps presented his inspirational story.
- Our Butterfly Suite was opened to provide families a quiet place to grieve.
- Jayne Longstaff, Lead Specialist Respiratory Research Nurse, won Outstanding Research Professional Award at the NIHR CRN Wessex Awards.

June 2019

- June saw the introduction of the NHS rainbow badge as we continued our work to support inclusion and diversity.
- We are very proud of our strong military links and we were honoured to mark the 75th anniversary of D-Day with a service at QA. Armed Forces Day was also marked in June.
- We came together to celebrate the amazing work our volunteers do as part of National Volunteers Week, with 75 volunteers attending a special tea party attended by Chief Executive, Mark Cubbon and Chairman, Melloney Poole.
- We also celebrated the tenth anniversary of our Neonatal Intensive Care Unit (NICU) moving to QA, marked by a tea party event for current and former NICU staff.
- Research and Innovation held its annual conference in partnership with the University of Portsmouth, themed 'Innovating for a Healthier Future'.

July 2019

- In July we launched a range of activities and initiatives to support the one-year anniversary of the launch of our five-year Trust Strategy and Trust Values so staff could play a part in showcasing how they have made a positive difference.
- We started the month looking at our 'Working Together' campaign including the launch of our Tree of Compassion, a simple way for staff and patients to share their stories of compassion throughout the Trust.
- We announced that knee and hip replacements were being offered to NHS patients using the Stryker Mako, a pioneering robotic arm to assist surgery.
- We welcomed Chris Pointon, co-founder of #HelloMyNameIs, who spoke to a packed lecture theatre about why the initiative is so important when it comes to building a culture of compassion and we used the occasion to help us relaunch #HelloMyNameIs across the Trust.

August 2019

- In August, Ruth May, Chief Nursing Officer (CNO) for England, visited QA to discuss her priorities and presented Matron, Colin Beevor, with a silver Chief Nursing Officer award.
- The winners of our first Consultant Awards were announced and over 100 nominations were received from Junior Doctors.
- We were also delighted to be named as one of the top 40 NHS Trusts in the UK by CHKS healthcare insight.
- Our Staff Benefits brochure was launched, bringing together all the benefits available to staff employed by the Trust.
- Our Workforce and Organisational Development Strategy was launched. This was developed with patients, staff and partners to strengthen our workforce and support their health and well-being.
- We also celebrated the end of the Research and Innovation team's Vision D study. The trial involved using an iPad camera and advanced software to detect the vital signs of patients by simply taking a photograph. This was the first study of its kind and is the largest ever digital physiological trial undertaken, with an incredible 8,585 people taking part.
- We were also shortlisted for 10 Health Service Journal (HSJ) awards in August.

September 2019

- Our Hospital Open Day took place in September, attended by around 700 members of the public, with 10 department tours and over 50 information stalls.
- Our annual general meeting took place in September, themed around our Trust Values and attracting more than 50 members of the public.
- We unveiled our Wonderwall as part of our Working Together campaign to invite staff and members of the public to share positive messages.
- We launched our LGBT+ Staff and Allies' network as well as our Disability Staff Network.
- In September and again in January, we shared progress with key stakeholders on the planning for our £58m initiative 'Building Better Emergency Care' which will include rebuilding our Emergency Department.

October 2019

- In October we hosted the Care Quality Commission (CQC) for a three-day inspection of our services.
- We held a tea party to celebrate staff who have had 40 years' of continuous service at the Trust as part of an ongoing programme of staff recognition.
- We also held our first ever diversity and inclusion conference as part of Black History Month.
- Over 125 team members joined the tens of thousands of other competitors to walk, jog or run the 5km or 10-mile Great South Run events.

November 2019

- The relationship between the Trust and the University of Portsmouth was strengthened further with the signing of a strategic partnership in November that outlines how we will work together over the next five years to improve outcomes for the local community.
- Professor Anoop Chauhan, Director of Research and Innovation, was named as Clinical Leader of the Year, and the Modern Innovative Solutions to Improve Outcomes in Asthma, Breathlessness and COPD project awarded winner of the Acute Sector Innovation of the Year category at the HSJ Awards
- We launched our long service board recognising individuals who have dedicated 30 years or more of service to the Trust.
- We celebrated colleagues at our annual Pride of Portsmouth Awards, with 364 nominations across 12 categories.
- A service of remembrance was held on 11 November with readings from our military colleagues and a two-minute silence.
- We took delivery of an additional CT scanner following a successful joint bid by the Imaging Department with colleagues from the Respiratory Department for central funds for the Early Detection of Lung Cancer.

December 2019

- In December we launched the SIGHT project, a European Regional Development funded business support programme which helps support SMEs who are developing healthcare technology products to get them market ready.
- The Trust was rated as one of the top ten performing NHS Trusts in the country in the National Hip Fracture Database (NHFD) Annual Report.
- We hosted a visit from Paula McGowan, who shared the story of her son Oliver who died tragically at the age of 18. Paula was here to raise awareness about the needs of those with learning disabilities and training for healthcare professionals.
- We began the roll out of DigiBoards across the wards to allow ward and patient level data to be displayed in one place, replacing handwritten whiteboards.
- We also got into the festive spirit and were delighted to host numerous visits including Portsmouth Football Club and local theatres. We are extremely grateful to have received thousands of gift donations from our local communities and a Christmas tree sponsored by Portsmouth Hospitals Charity and the League of Friends.

January 2020

- January 2020 marked the start of International Year of the Nurse celebrations.
- We announced a record low number of nursing vacancies alongside a much-improved retention rate with our international nurses and reduced turnover.
- We were delighted to announce an overall rating of good from the Care Quality Commission (CQC), following a comprehensive inspection.
- A new service was started to ensure that rough sleepers who come to hospital have a home to go to when their treatment is over.

February 2020

- We and the Isle of Wight NHS Trust announced a partnership to improve services for people living on the Isle of Wight. This strengthens our joint working so that we can better manage demand for services at both Trusts.
- We marked the annual National Apprenticeships Week in February.
- Our very own Anna Benton became the first Nurse Endoscopist accredited with the Bowel Cancer Screening Programme in the south coast region.
- Peter Brennan, Consultant Oral and Maxillofacial Surgeon, was awarded a Gold Clinical Excellence Award (CEA) for his outstanding work and going above and beyond for his patients.

March 2020

- March 2020 was dominated by the COVID-19 pandemic. However, we still had things to be proud of:
- The Trust signed the NHS Single Use Plastics Reduction Campaign Pledge. The pledge forms part of an environmental sustainability programme in the NHS, following the commitments made in the NHS Long Term Plan.
- The Eden Midwifery team began work in the community to provide women continuity of care throughout pregnancy, birth and into the postnatal period.
- Our staff worked tirelessly to plan and deliver care and support for patients with COVID-19, their carers and their families.

Statement from Chief Executive Officer on organisational performance

Although the Trust made significant improvements in a number of areas during 2019/20, the ongoing pressures related in urgent care flow and access remained a feature of the health and social care system in Portsmouth and South East Hampshire. We are proud that our delivery against key constitutional standards has contributed to our 'Good' CQC ratings for quality of care and use of resources, but we acknowledge that in other areas we did not deliver to the standards to which we aspire for ourselves and our patients.

Demand in the urgent care pathway increased in 2019/20 by comparison with 2018/19, and was coupled with continued high bed occupancy rates. During several periods of the year, our urgent care services experienced some very significant peaks in demand, and presented challenges in our ability to deliver key urgent care access standards. Of particular concern to the Trust at these times were delays to the handover of the care of some incoming patients from ambulance crews to the Trust's Emergency Department. Working with the support of partners, including particularly South Central Ambulance Service NHS Foundation Trust (SCAS), the Trust developed a multi-agency improvement plan, implementation of which will continue during 2020/21. Changes to the pathway for self-presenting patients in the Emergency Department were also an important part of our work to improve performance in urgent care during 2019/20.

Much of the work to address performance issues in urgent care has been conducted as part of our Building Better Emergency Care (BBEC) project. The project is aimed at reviewing, refining and improving all aspects of the pathway to ensure that urgent care services and facilities, on and off the Queen Alexandra site, work effectively to meet patients' needs. This includes working with partners in the local health and social care system to develop plans to correct the number of acute beds available, and expect to deliver these during 2020/21.

The Trust began participating in a pilot of revised urgent care indicators in May 2019, and learned a lot from this process, as well as contributing to the development of new national measures.

A key challenge throughout 2019/20 was the significant the number of patients who remained in our hospital after they have been identified as Medically Fit For Discharge. Although there have been some improvements in addressing the most prolonged of the delays, delivered through a system wide approach, we will continue to work with our partners during 2020/21 to ensure that as few patients as possible experience delays to their discharge from hospital. We are particularly grateful for the support of our partners in helping us to ensure the safe discharge of very many of our in-patients at the start of the pandemic period.

Our performance in respect of stroke services improved during 2019/20, leading to a Level B rating (Level C in 2018/19). This was the result of improvements throughout the pathway, including in diagnostics and increased speech & language therapy input for our patients.

The Trust worked towards the achievement of the national standard for diagnostic access throughout 2019/20, and made material improvements by the end of the year, delivering its best performance for several years. Successful recruitment activity contributed to this outcome, and a number of key items of diagnostic equipment were purchased including endoscopes, ultrasound systems and CT scanners. These factors have led to increased resilience and reliability in the service, and associated improvements in delivery of the access standard.

Delivery of access standards in cancer services was also a focus during 2019/20. The Trust met seven of the eight standards throughout the year, and all eight standards during the last quarter, thanks to improvements in the 62-day referral to first definitive treatment standard. The Trust also performed well in a pilot of a new cancer access standard – 28 days from referral to confirmed or excluded

diagnosis of cancer, and the Trust achieved this outcome in 85% to 93% of cases, prior to the advent of the pandemic period.

As referenced above, the Trust was rated as 'Good' in its first use of resources inspection, conducted in 2019/20. The rating recognised effective and efficient application of Trust resources to the delivery of operational and quality standards and our own objectives. The Trust's board of directors set a target of delivering a balanced financial position in 2019/20, taking into account £17.5 million of expected national income and, after many years of deficit, the Trust delivered a modest surplus of £525,000. This outturn was underpinned by delivery of a robust, but quality assessed, cost improvement programme of £21.6m (3.6% of operating expenditure). Another key saving during the year was a reduction in clinical staff agency expenditure to £15.4 million, from £21.2 million in 2018/19.

The Trust's commitment to high levels of engagement with our patients continued throughout 2019/20, and enabled us to ensure that our operational performance improvements also helped to meet our patients' needs. The 2019/20 Friends & Family Test scores were above the national average until the measure was nationally suspended as a result of re-focus on management of the COVID-19 pandemic. As Chief Executive Officer I am proud that our staff have maintained their commitment to improving patient experience while striving for improved performance, and I thank them for doing so.

The pandemic inevitably had a significant impact on our performance towards the end of 2019/20. As a Trust, and as part of the wider Health & Social Care system, in the coming year we will be dedicated to our efforts to mitigate those impacts and recover performance in respect of the standards that matter most to our patients and our community.

Performance summary

Details of the Trust's performance against its constitutional and statutory obligations can be found in the monthly Trust Board reports found at 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. However, the publication of these for 2019 – 20 have been suspended to allow priority to be given to the response to COVID-19.

Performance analysis

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

Performance

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	19/20 (March RTT, Diagnostics & Cancer is provisional)											
		A	M	J	J	A	S	O	N	D	J	F	M
% Incomplete Pathways < 18 wks	>=92%	82.0%	82.9%	82.7%	82.6%	82.0%	81.6%	80.8%	80.7%	79.5%	79.2%	79.1%	74.4%
No of Incomplete pathways	32808	33694	34669	35237	34785	35258	35636	36055	36198	35283	34829	34957	33893
Incomplete Patients waiting >52 wks	0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 4
Incomplete Patients waiting >40 wks	0	✗ 292	✗ 289	✗ 284	✗ 265	✗ 306	✗ 279	✗ 222	✗ 264	✗ 380	✗ 340	✗ 320	✗ 467
Diagnostic waits < 6 wks	>=99%	! 92.1%	! 93.7%	! 95.3%	! 93.5%	! 89.9%	! 97.2%	! 97.5%	✓ 99.0%	! 98.0%	! 98.6%	! 98.5%	! 97.5%
4 hr arrival to admission/transfer/discharge	>=95%	✗ 86.1%											
4 hr combined with Partners	>=95%	✗ 76.8%											
12 hr Trolley waits	0	✓ 0	✓ 0	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
All 2-week wait referrals	>=93%	✓ 96.5%	✓ 94.9%	✓ 96.2%	✓ 95.9%	✓ 95.9%	✓ 96.9%	✓ 96.1%	✓ 96.4%	✓ 96.1%	✓ 96.7%	✓ 98.6%	✓ 96.6%
Breast symptomatic 2-week wait referrals	>=93%	✓ 93.2%	✓ 93.2%	✓ 93.4%	✓ 97.4%	✓ 93.2%	✓ 98.2%	✓ 94.4%	✓ 94.8%	✓ 96.8%	✓ 96.7%	✓ 99.1%	✓ 99.1%
31-day diagnosis to treatment	>=96%	✓ 96.1%	✓ 97.6%	✓ 97.2%	✓ 98.6%	✓ 98.6%	✓ 98.7%	✓ 98.7%	✓ 98.4%	✓ 97.5%	✓ 97.6%	✓ 97.4%	! 93.9%
31-day subsequent cancers to treatment	>=94%	✓ 96.9%	✓ 94.7%	✓ 96.3%	✓ 96.7%	✓ 100%	✓ 97%	✓ 98%	! 94%	✓ 94%	✓ 97%	✓ 96%	✓ 98%
31-day subsequent anti-cancer drugs	>=98%	✓ 100%	✓ 100%	✓ 100%	✓ 100%	✓ 98.5%	✓ 99.0%	✓ 99.1%	✓ 99.2%	✓ 100%	✓ 98.3%	✓ 99.0%	✓ 100%
31-day subsequent radiotherapy	>=94%	✓ 96.4%	✓ 96.5%	✓ 95.7%	✓ 94.7%	✓ 94.0%	✓ 94.4%	✓ 96.8%	✓ 95.1%	✓ 98.6%	✓ 95.5%	✓ 97.4%	✓ 100%
62-day referral to treatment	>=85%	✗ 78.2%	✗ 80.5%	✗ 78.4%	✗ 78.3%	✗ 82.9%	✓ 85.3%	✗ 82.7%	✗ 81.3%	✓ 86.1%	✓ 87.5%	✓ 86.8%	✗ 78.0%
62-day screening to treatment	>=90%	✓ 92.9%	✓ 93.8%	✓ 94.4%	✓ 92.5%	✓ 92.3%	✓ 95.0%	✓ 94.7%	✓ 97.8%	✓ 90.7%	✓ 94.4%	✓ 98.9%	✓ 90.9%
Cancer maximum wait to treatment 104 days	0	✗ 8	✗ 9	✗ 9	✗ 16	✗ 5	✗ 4	✗ 8	✗ 7	✗ 8	✗ 9	✗ 8	✗ 14
28 days to cancer diagnosis	>=75%	✓ 82.0%	✓ 83.0%	✓ 81.2%	✓ 85.8%	✓ 84.5%	✓ 83.2%	✓ 81.7%	✓ 83.9%	✓ 84.1%	✓ 80.1%	✓ 88.0%	✓ 85.0%
Cancelled urgent operations	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
Urgent Operations cancelled for a 2nd time	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
Cancelled operations: 28-day guarantee	0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1
Total bed days blocked	<1000	✗ 1547	✗ 1843	✗ 1530	✗ 1737	✗ 1798	✗ 1969	✗ 1616	✗ 1422	✗ 1268	✗ 1301	✗ 1231	✗ 1568
Delayed Transfers of Care	<=3.5%	✓ 2.7%	✓ 2.4%	✓ 2.3%	✓ 3.3%	✓ 2.8%	✓ 2.6%	✓ 2.8%	✓ 1.5%	✓ 1.4%	✓ 2.0%	✓ 1.9%	✓ 1.2%
30 days emergency readmissions	N/A	8.2%	8.2%	8.2%	8.3%	8.3%	8.3%	7.8%	7.8%				
Ambulance delays > 30 mins (PHT validated)	0	✗ 799	✗ 638	✗ 388	✗ 481	✗ 646	✗ 728	✗ 835	✗ 757	✗ 315	✗ 519	✗ 560	✗ 152
Ambulance delays > 60 mins (PHT validated)	0	✗ 750	✗ 617	✗ 244	✗ 191	✗ 393	✗ 441	✗ 929	✗ 737	✗ 300	✗ 402	✗ 523	✗ 124
Arrival to DTA < 2.5 hrs	>=45%	! 24.1%	! 28.3%	! 34.2%	! 33.4%	! 29.8%	! 27.1%	! 25.8%	! 30.3%	! 32.4%	! 30.9%	! 26.9%	! 36.5%
Medically Fit for Discharge (average / mth)	<100	✗ 180	✗ 188	✗ 184	✗ 200	✗ 195	✗ 202	✗ 204	✗ 184	✗ 176	✗ 192	✗ 195	✗ 145
% of Medical take seen in AEC	>=33%	✗ 22%	✗ 23%	✗ 30%	✗ 24%	✗ 22%	✗ 22%	✗ 21%	✗ 21%	✗ 21%	✗ 20%	✗ 19%	✗ 19%
AMU Bed Occupancy		✓ 101%	✓ 100%	✓ 98%	✓ 97%	✓ 96%	✓ 100%	✓ 100%	✓ 100%	✓ 98%	✓ 102%	✓ 101%	✓ 74%
Number of patients on AMU over 24 hours LOS	<38.6%	✓ 30%	✓ 28%	✓ 26%	✓ 28%	✓ 28%	✓ 28%	✓ 27%	✓ 25%	✓ 23%	✓ 24%	✓ 24%	✓ 28%
FIT Reduction in conversion rate - >75yrs	<67%	✓ 64%	✓ 63%	✓ 66%	✓ 63%	✓ 65%	✓ 63%	✓ 66%	✗ 69%	✓ 67%	✓ 67%	✓ 66%	✓ 66%
% of Patients with EDD	>95%	✓ 97.6%	✓ 97.6%	✓ 97.3%	✓ 97.6%	✓ 97.6%	✓ 97.9%	✓ 97.5%	✓ 97.5%	✓ 97.0%	✓ 97.3%	✓ 97.0%	✓ 97.2%
% of discharges pre 12:00	>33%	✗ 16.8%	✗ 17.2%	✗ 16.2%	✗ 16.4%	✗ 15.8%	✗ 15.5%	✗ 17.7%	✗ 16.9%	✗ 17.3%	✗ 16.7%	✗ 17.6%	✗ 16.7%
Achievement of weekday discharge target	100%	✗ 76%	✗ 78%	✗ 81%	✗ 80%	✗ 77%	✗ 81%	✗ 83%	✗ 82%	✗ 82%	✗ 80%	✗ 82%	✗ 75%
Achievement of weekend discharge target	100%	✗ 67%	✗ 76%	✗ 77%	✗ 69%	✗ 66%	✗ 66%	✗ 70%	✗ 70%	✗ 72%	✗ 73%	✗ 71%	✗ 63%

A safe hospital – measuring our performance

The overwhelming feedback received by the Trust is that it is greatly valued by all as it provides safe, high quality, care in all of it services, even though there continue to be recognised challenges relating to our emergency care.

The Trust always aims to place the patient at the centre of everything, and is proud of its proven track record in safety. The Trust is, therefore, disappointed that nine 'Never Events' occurred in the last year. Six of the events resulted in no, or low, harm for the patient whilst three were categorised as moderate harm. Regardless of the level of harm, this is unacceptable, and all have been fully investigated, with action plans put in place to ensure that lessons are learned and such incidents do not recur. Five of these events involved surgical procedures and as a result the Trust has introduced a Theatre Safety team who will focus on implementing actions to improve procedural safety.

Date of incident	Nature of incident
April 2019	Wrong procedure, eye muscle resected instead of recessed. (moderate harm)
August 2019	Wrong site procedure, additional tooth extracted (moderate harm)
August 2019	Retained surgical equipment (no harm)
September 2019	Incorrect prosthesis used (hip surgery) (no harm)
October 2019	Retained surgical equipment (no harm)
November 2019	Medical air administered in place of oxygen (low harm).
January 2020	Wrong route medication (no harm)
February 2020	Wrong route medication (no harm)
March 2020	Misplaced Naso-gastric tube- feeding commenced (moderate harm).

The Hospital Standardised Mortality Ratio (HSMR) of 102.0 (December 2018 – November 2019) and SHMI (Summary Hospital-level Mortality Indicator) of 104.4 (October 2018 – September 2019) have remained stable over the last year and are within the expected ranges for the Trust, when benchmarked nationally.

The Trust has continued to work to improve the identification and treatment of deterioration in patients' condition, including sepsis. The Trust has further improved compliance with screening for hospital acquired sepsis, achieving the overall target. The Trust has further to do to deliver the standard of commencing treatment within one hour. However, Trust mortality from sepsis remains below the national average. The Trust has also seen a continued downward trend in inpatient cardiac arrests and unexpected admissions to critical care, both indicators that patients are receiving appropriate and timely clinical review and intervention.

The Trust has worked hard throughout the year to reduce avoidable harm to patients and has built on success achieved last year, reducing incidence of falls resulting in harm by a further 20%.

A safe hospital - infection prevention

Our aim is to provide our patients with safe and effective care in a clean and safe hospital. We continue to work closely with clinical colleagues, as well as with Engie facilities management staff, to ensure high standards of cleaning and disinfection across the Trust. This year, NHS Improvement made changes to the apportioning algorithm and attribution of cases of C.difficile. Therefore, a key focus this year was to maintain the Trust's low rate of these infections, in light of these changes. In 2019/20, the Trust successfully reduced the number of these infections further, and while the Trust did not meet the objective set by NHS Improvement, the rate of C.difficile infection remains below the national average.

In recent years, we have also had to focus our attention on newer infections, such as E.coli bloodstream infections. Following hard work by teams across the hospital, the Trust successfully achieved its lowest rate of these infections since surveillance began in 2011. The focus for next year will be to reduce the numbers of staphylococcus aureus infections, particularly MSSA. This will involve changes to skin suppression treatments and screening protocols, as well as additional emphasis on device care.

Following its introduction in 2018/19, the Trust extended the use of its rapid screening test for influenza. This meant that patients across the Trust could be tested and a result be available within 30 minutes. This allowed for prompt treatment and isolation of those who were positive and appropriate triage and management for those who tested negative. The Trust's IT colleagues also worked hard to successfully integrate the equipment with the Trust's interface, meaning that results were available electronically from anywhere in the Trust, as soon as the test was complete.

This year also saw unprecedented challenges across the NHS due to the COVID-19 pandemic. A number of significant changes were made across the Trust in response to this. However, throughout this difficult time, staff across the organisation continued to work together, showing dedication, kindness and compassion to those in their care, as well as their colleagues. Moving in to 2020/21, the importance of infection prevention has never been clearer, and will remain a key focus for the Trust.

Improved participation and engagement

The Patient, Family and Carer Collaborative

The Trust is working towards the development of an even more ambitious programme of engagement to support delivery of the Trust's Quality Improvement Strategy. The Trust is committed to listening, hearing and acting on feedback from people who use Trust services this is a patient led group which leads the Trust's engagement and involvement work. The group includes current and former patients, carers, primary care patient participation group members, representatives of Healthwatch Portsmouth and Hampshire and a number of special interest groups. They advise on the development of Trust Strategies and provide support and advice to the hospital. The group are trained to undertake quality monitoring and help with teaching and education across the Trust. They help the Trust think differently, acting as advisors and experts in care and are regularly involved in strategy development and improving the experience of our patients.

The collaborative are involved in a number of areas across the Trust, for example helping the Trust with the redesign of the out-patients service, a review of patient transport in Renal services and improving the signage for patients in the Emergency Department. The collaborative is at the beginning of a recruitment campaign to increase the number of members, recruiting a diverse and inclusive number of patient representatives who are experts by experience.

Patient Participation and Engagement

The Trust actively involves people in the running of their hospital and works in partnership with patients and community groups to design and develop services, engaging and involving people who use those services in quality monitoring. This includes:

- Care quality reviews – patients, community partners and third sector organisations join staff in the regular reviews of quality and standards throughout the hospital and observing care
- Experts by experience – learning and development programmes are increasingly including people who have experience of local hospital care, both good and not so good, an example of this is the training being developed around hidden disabilities and deaf awareness
- Recruitment – patients are involved in stakeholder groups and participate on interview panels to some posts within the Trust
- Patient Representation in Trust meetings – including the End of Life Committee and Patient Experience and Environment Group and Patient safety
- Patient Participation Groups – increased engagement with Patient Participation Groups in GP surgeries

Veteran Aware

The Trust is dedicated to supporting all parts of the Armed Forces community, from serving personnel to service families, and veterans. The Trust has been re-accredited as 'Veteran Aware' in 2019/20. During this year, the Trust has appointed to a new role of 'Armed Forces Covenant Lead Nurse', to ensure that those who serve or have served and are patients or staff are treated fairly and not disadvantaged. This role is the only one of its kind in the South East.

Each month the Trust hosts a 'Cake, Companionship and Camaraderie' social event for our patients and staff who serve or have served. The event encourages friendly conversation and mutual support for all involved. New opportunities to engage with the wider community will include monthly roadshows in the hospital atrium, and supporting national events like Armistice Day and the VE Day 75 celebrations.

NHS Choices and Care Opinion

Both the NHS Choices and Care Opinion websites afford an opportunity for patients, families and carers who have accessed Trust services to provide real time feedback about their experience. This is used, in combination with a wide range of other sources of patient experience feedback, to help the Trust improve the quality of services provide and act on any concerns or complaints expressed.

NHS Choices displays the Trust's CQC inspection rating and Friends and Family Test scores and by the end of 2019/20 the Trust had a score of 97% of inpatients who would recommend this hospital to others and 94% of outpatients recommending us.

Freedom of Information

The Trust received 641 Freedom of Information requests in 2019/20, a decrease of 11% on the 725 requests in 2018/19. The Trust continues to embrace its duty of openness and transparency, and has made a full or partial disclosure of information in approximately 90% of requests. The reasons for non-disclosure in the remainder of cases include legal exemption (0.5%), the cancellation of the request (5.5%), information not held (3.6%) or information already published (0.2%). Compliance with issuing a response within 20 working days is currently at 77.7%, up from 69.5% in 2018/19. Measures to address compliance have been put into place, including the appointment of a permanent FOI Administrator and stability within the team. No complaints were made to the Information Commissioner's Office with regard to delays in responding to specific requests or failure to release

information.

Patient experience

All Trust staff work hard every day to try to provide the best possible care for patients and to support relatives and visitors and we are always keen to listen to feedback and find new ways of seeking the views of patients and visitors. Patient feedback provides opportunities for us to identify where things may not be going as well as they should and to make improvements so that all patients, relatives and visitors have a positive experience when they come into hospital.

Despite staff's efforts, things may not always go as well as hoped and the Trust wants to make sure that people feel confident to raise any concerns and to be assured that this will not affect their future care in any way. For this reason, the Trust provides an effective support service (Patient Advice & Liaison Service - PALS) which is available Monday to Friday, from 9am to 5pm, and offers advice and support for people who have concerns about their own care or that of a family member or friend. PALS has an easy accessible 'drop in' office in the hospital, a free phone telephone number (0800 917 6039) and a dedicated e-mail address (PHT.PALS@porthosp.nhs.uk) so that support is easily available. PALS aim to resolve any difficulties as quickly as possible and to rebuild and maintain people's confidence in the Trust's services.

PALS Volunteers also do an excellent job of helping us to ensure that patients' voices are heard, particularly those who are vulnerable and who may not have family or friends to visit and raise issues on their behalf. It is important that patients have a smooth and safe transition from hospital back to the comfort of their home environment and the Trust's PALS volunteers have supported hundreds of patients and their relatives over the last year.

The majority of feedback gathered by the PALS Volunteers shows that people have had a positive experience of Trust services. This is reinforced by the large number of plaudits and messages of thanks that the Trust continues to receive from its patients and visitors. Each day staff receive cards and letters from patients and relatives/friends, and some of these are recorded on the Trust's database, which shows that during 2019/20 the Trust documented 4,741 plaudits - many more verbal plaudits are not recorded on the system so the total number is undoubtedly much higher.

For more serious complaints, the Trust has a policy in place for handling these which adheres to the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, as well as the guidance provided by the Parliamentary and Health Service Ombudsman, and a claims policy that adheres to NHS Resolution guidance.

Effective and timely investigations are carried out to enable decisions to be made about any claim, including allegations of clinical negligence, public liability or personal injury against the Trust. Learning from claims is disseminated within the organisation to help to reduce the occurrence of incidents and events which may give rise to future claims.

The number of formal complaints received in 2019/20 increased by 15% on the previous year to a total of 704. The increase may be a reflection of the increased pressure on Trust services and/or the accessibility of our complaints process.

The number of people seeking advice from PALS fell by 14% to 4,821 which may have been caused by the occasional closure of the PALS desk due to lack of resources. However, the majority of the

issues raised with PALS were resolved within 5 working days. The Trust has reviewed and revised the composition of its PALS and Complaints team in early 2020, and this has had a very positive impact, helping to address concerns informally and promptly before the need for patients and their families to make a formal complaint arises.

Ensuring a sustainable future

NHS England has set a national target of a 34% reduction in the NHS's carbon footprint by 2020 and a 50% reduction by 2025. This supports the Government's Climate Change Act target of an 80% reduction by 2050. The Trust supports this strategy and aspire to meet these targets. With the support of its partners, the Trust takes the opportunity to promote carbon reduction to staff, visitors and the general public.

The Lord Carter Report into Operational Productivity and Performance in the NHS, published in 2016, identified the potential for significant savings in energy related emissions and costs as well as recommending investment in energy saving technologies. The Trust is working with its new FM service provider to establish opportunities to improve efficiency in energy consumption, identifying potential invest to save schemes as well as operational improvements.

Waste segregation and recycling schemes continue to be extended throughout the organisation and these will contribute to a significant carbon saving as well as financial benefits.

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 to form 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

It 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), which 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 fuel shortage. Ensuring these plans' readiness is essential, and the Trust tests those plans internally and with partners by conducting desk-top and other exercises. The Trust held a full live play exercise in November 2019 of its Incident Response Plan; something required every 3 years and has 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.

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. In 2019, NHSE concluded that the EPRR assurance assessment was 'Partially Compliant' and acknowledged that the last year had been a challenging year due to changes in staff at Strategic level and not having a full time EPRR Officer however this has now been addressed so next year's assurance is expected to show improvement.

Financial performance

The Trust's financial statements for the year ended 31 March 2020 are shown in full from page 64 of this report.

The financial plan for 2019/20 set an ambitious target for the Trust to achieve a balanced expenditure over income position, for the first time in recent years, after taking into account £17.5m planned national income from the Provider Sustainability and Financial Recovery Funds.

The Trust has exceeded its planned financial target and is reporting a modest £525,000 surplus of income over expenditure for the year, represents less than 0.1% of its 2019/20 operating expenses (£618m). Within this, the planned £17.5m national income was achieved in full. This reported financial performance compares with a prior year financial deficit of £37.9m.

Key points to note:

- Cost improvement plan (CIP): The Trust delivered operational savings and efficiencies totaling £21.6m during 2019/20 (£23.9m during 2018/19) which represented 3.6% of operating expenditure. This level of further sustained savings benchmarks favourably with comparable NHS organisations.
- Agency staff expenditure: During 2019/20 the Trust was 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 during the twelve months to 31 March 2020 was £15.4m, compared with £21.1m and £22.1m for each of the two prior financial years 2018/19 and 2017/18 respectively.
- Capital Resource Limit (CRL): The Trust managed its annual capital programme of investments within its delegated CRL. For the twelve months ended 31 March 2020 the Trust underspent its CRL by £1,000. Total capital investment in the Trust was £22.5m in 2019/20 (£22.1m 2018/19).
- Cash balance: The Trust ended 31 March 2020 with a closing cash balance of £3.9m (£4.6m as at 31 March 2019).

Signed:

Mark Cubbon, Chief Executive
Date: 15 June 2020

CHAPTER 2 – ACCOUNTABILITY REPORT

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 Non-Executive Directors and five Executive Directors (including, as required by statute, the Chief Executive, the Chief Financial Officer, a medical practitioner and a registered nurse).

PORTSMOUTH HOSPITALS 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 NHSI 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

Ms Poole joined the Trust Board in May 2017 and was appointed as Chairman on 1st November 2017. Since June 2015, she has been the Head of the Armed Forces Covenant Fund and the other grant programmes funded by LIBOR fines which directly support the delivery of the Armed Forces Covenant across the UK. Ms Poole is a corporate, charity and public administrative law solicitor with 25 years of private sector commercial and corporate experience before becoming the Head of the Legal Department for the Big Lottery Fund in 2003.

Ms Poole developed the combined legal service department which now supports all the legal and governance matters for the Arts Council England, the Heritage Lottery Fund and the Big Lottery Fund. In addition, Ms Poole had a parallel career as a Non- Executive Director in the NHS, serving on the boards of three NHS Trusts including leading one Trust through the Monitor process, and is the Vice Chairman of the Health Foundation. She has also been a volunteer and fundraiser for various charities and a magistrate on the Preston bench. Ms Poole 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.

Roger Burke-Hamilton

Mr 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. Mr Burke-Hamilton 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. Mr Burke-Hamilton also sits on the Board at University of Portsmouth as an externally appointed Governor.

Mr Burke-Hamilton's 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. Mr Burke-Hamilton is a non-voting Associate Non-Executive Director of the Board.

Gary Hay

Mr 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 & Diversity. During his time in private practice, Mr Hay sat on the boards of two firms for a combined total of 14 years. 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.

Mr Hay recently set up his own consultancy, Law2Business, focused on training and coaching for lawyers. He is also Chairman of the Helen Arkell Dyslexia Charity.

Commodore Inga J Kennedy CBE QHNS QARNNS

Commodore Kennedy is currently the Head of the Royal Navy Medical Services and is based in 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.

With a keen interest in the governance and assurance of healthcare, Commodore Kennedy was most recently the Inspector General for the Defence Medical Services, 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.

Commodore Kennedy 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.

David Parfitt

Mr 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 and then as a Lay Member (audit and governance) of NHS Luton Clinical Commissioning Group.

Mr Parfitt is also a Non-Executive Director of Sussex Community NHS Foundation Trust; Chairman of Chichester Greyfriars Housing Association and a Board member/Trustee of The Brendoncare Foundation.

Martin Rolfe

Mr Rolfe is Chief Executive Officer of NATS, the UK's leading provider of Air Traffic Management services. Previously, Mr Rolfe 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 of its £350M UK Civil business.

Mr 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, Mr Rolfe 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

Ms 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.

Ms 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.

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.

Mark Cubbon – Chief Executive

Mr Cubbon first qualified as a nurse before moving into general and senior management roles within the NHS. He has worked at senior Director level at a number of high-profile London Hospital Trusts, including Deputy Chief Executive Officer at Moorfields Eye Hospital. He also held the role of Managing Director at Whipps Cross, and in the newly merged Barts Health NHS Trust he became their Executive Director for Delivery. Before taking up the post of Chief Executive at Portsmouth Hospitals NHS Trust Mr Cubbon held the role of Regional Chief Operating Officer for the Midlands and East at NHSI.

John Knighton – Medical Director

Dr 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.

Dr 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 CHAT, and an Associate Medical Director. He has been a CQC Specialist Advisor for Acute Hospital inspections, and has had a long held passion for improving patient safety and quality of services, championing an open and learning culture of strong multi-disciplinary team working. He took up his post as Medical Director at the Trust in July 2017.

Liz Rix – Chief Nurse (from 10th June 2019)

Ms 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. Liz is passionate about delivering quality care for patients through clinical leadership at all levels. She has the experience needed to development strong nursing teams who manage workforce, patient experience and environment while also living the Trust values: working together for patients, with compassion, as one team and always improving.

Ms 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.

Paul Bytheway – Chief Operating Officer (until 21st June 2019)

Mr Bytheway joined the Trust in October 2017 from Dudley Group NHS Foundation Trust where he was Chief Operating Officer. A registered nurse by background, Mr Bytheway is responsible for the day to day delivery of clinical services as well as delivering the organisation's strategy working alongside the Chief Nurse and Medical Director. Mr Bytheway believes passionately in the importance of staff engagement and sees it as a central part of his role to ensure that the views of the frontline (both clinical and corporate) are heard at the top of the organisation. He enjoys the challenge of working with teams from a range of disciplines to bring about better outcomes for all of our patients.

Steven Vaughan – Interim Chief Operating Officer (from 15th May until 22nd August 2019)

Mr Vaughan had held a range of interim operational positions prior to Portsmouth Hospitals NHS Trust. These include Chief Operating Officer positions at North Lincolnshire & Goole NHS Foundation Trust, Walsall Healthcare NHS Trust and Royal Cornwall Hospitals NHS Trust. He also specialises in change management, having overseen remedial activity for elective and non-elective pathways. In particular, his experience focuses on establishing improvement trajectories and ensuring that performance improves to the levels required for better patient experience and long-term outcomes.

Nigel Kee – Interim Chief Operating Officer (from 3rd September 2019)

Mr Kee trained as a nurse in New Zealand, and brings a wealth of experience having held both Chief Nurse and Chief Operating Officer roles in acute trusts in the NHS.

He had over 14 years of Board level experience as well as having previously served as an acting Strategic Health Authority Chief Nurse at two authorities. He also has commissioning experience in addition to his international roles.

Mr Kee is committed to improving health outcomes through development and engagement with the workforce, service redesign, effective healthcare planning and excellent governance. In particular he is passionate about excellence in leadership and operational management.

Chris Adcock – Chief Financial Officer (until 26th June 2019)

Mr Adcock has worked in the NHS since 1997. He was Chief Financial Officer at Brighton and Sussex University Hospitals from 2009 to 2013, and Director of Finance for University Hospitals of North Midlands from 2013 before joining the Trust in October 2015. He served almost four years prior to his departure in the summer.

Mark Orchard – Chief Financial Officer (from 30th September 2019)

Mr Orchard joined the Trust in October 2019 from Poole Hospital NHS Foundation Trust, where he held the post of Executive Director of Finance for five years 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 is currently national chair of the NHS Providers Finance and Commercial Directors Network. Mr Orchard 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. Mr 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.

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

Emma McKinney – Director of Communications and Engagement (until 21st June 2019)

Ms McKinney joined the Trust in December 2017 from Southern Health NHS Foundation Trust, where she was Associate Director of Communications. She has over 15 years' experience in communications and has particular expertise in media relations and stakeholder engagement. She brings with her experience from a range of sectors including the NHS, trade unions, private providers and the charity sector. In her role as Director of Communications and Engagement she has oversight of strategic communications for the Trust as well as responsibility for the Trust charity.

Penny Emerit – Director of Strategy and Performance

Ms Emerit joined the Trust in January 2018 from NHSI having held senior leadership roles across the wider health system in London and the South. Ms Emerit's 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 (and formerly NHS Trust Development Authority) Ms Emerit 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. Ms Emerit joined the NHS as a Management Trainee and holds an Economics degree and Post Graduate Diploma in Healthcare Management.

Lois Howell – Director of Governance and Risk

Ms 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. Ms 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. Ms Howell has held director level roles in a number of NHS and local government bodies.

Nicole Cornelius – Director of Workforce and Organisational Development

Ms Cornelius joined the Trust as Director of Workforce and Organisational Development in October 2018. She has over 30 years' public sector experience including Director roles in the Police, the Probation Service and Local Government. Ms 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. Ms Cornelius is a Fellow of the Chartered Institute of Personnel and Development and is also a member of the Independent Advisory Panel to the Military.

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 page 54 of this report.

Board Effectiveness

All Executive Directors and Non-Executive Directors have annual appraisals and performance development plans which includes a self-assessment in line with both the fit and proper persons requirement (FPPR) and the NHSI 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 quarter 2 and 3 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 CQC's rating and the Well-Led Review report have informed a number of revisions to the Trust's governance arrangements (implemented from December 2019 onwards) and the Board's regular structured development sessions. An associated programme of collective and individual development work has been in place throughout 2019/20, which will continue during 2020/21.

Audit Committee

The Board Committee structure is set out in the Annual Governance Statement on page 39 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 Chairman)
- 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.

Counter-Fraud

During 2019/20 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 budget was agreed at the start of the financial year and 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 provides a risk assessed plan of work to meet the NHS Counter Fraud Authority Standards.

The plan was agreed at the start of the year and reviewed throughout the year, with a number of additional off plan activities to address system weakness arising from trend analysis, planned activity and reactive criminal investigations. The additional work has included reviews of; salary overpayment; secondary employment, temporary staffing, cyber fraud, conflicts of interest, procurement, patient travel and participation in the Cabinet Office National Fraud Initiative. There is a programme of fraud awareness work, including a Fraud, Bribery and Corruption Policy, development of a new website and delivery of e-learning and face to face fraud training, including the Trust Leadership Team. The Trust receives all local and national fraud alerts and prevention notices and have been further risk assessed by the F&SMS in key areas, including procurement and invoicing. All investigation work is conducted in accordance with relevant legislation and an action plan to implement the recommendations follows each investigation and proactive exercise to address any system weaknesses. The annual Self Review Tool was rated as green in all four generic areas.

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.

Information Governance

The confidentiality and security of information regarding patients, staff and the Trust, is 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 organisations a level of data security incidents can occur which are subject to a full investigation.

Any incident involving a breach of personal data is graded and the more serious incidents are reported to the Department of Health 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 49), the Trust experienced six externally reportable serious incidents in 2019/20 and these were reported using the Data Protection and Security Toolkit.

Directors' confirmation concerning audit information

The Trust's Directors participated in the governance arrangements described in the Annual Governance Statement throughout 2019/20. In accordance with NHSE/I guidance issued as a result of the COVID-19 pandemic, the Trust temporarily revised its governance arrangements from 16th March 2020 onwards. The revised governance arrangements involved reduced reporting to the Trust Board and Committees (essential performance, financial and quality monitoring items only) and the conduct of meetings by virtual means. On 1st April 2020 the Trust also established an additional Board Committee, the Board Major Incident Response Committee (BMIRC) to support the Trust's Executive in management of the pandemic response.

The confirmation below is made in the context of those revised governance arrangements having been in operation from 1st April 2020 until the date of approval of this report and beyond.

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: Mark Cubbon,
Chief Executive

Date: 15 June 2020

ANNUAL GOVERNANCE STATEMENT

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 NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Trust Accountable Officer Memorandum*.

2. 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 31 March 2020 and up to the date of the approval of the annual report and accounts.

3. Capacity to handle risk

The Trust's risk management processes were assessed as part of both the CQC's well-Led inspection and the Well-Led review.

The CQC reported that "The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. They used a systematic approach to improve the quality of the service. Managers we spoke with at all levels understood the risks to the services and could describe action to reduce risks."

The report of the Well-Led Review included the following summary against Key Line of Enquiry 5: 'Are there clear and effective processes for managing risks, issues and performance?': "Risk management arrangements were widely described to have improved significantly over recent years and we observed a number of elements of good practice, including the Board Assurance Framework and the escalation process for risk between the divisions and the Executive."

During 2019/20, 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 2019/20, and is used more effectively in day to day operational management of the Trust - for example, it is regularly reviewed and taken into account by the Trust Leadership Team.

Throughout 2019/20 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 2019/20 to plan for 2020/21 - for example the Internal Audit plan has been closely aligned with the risks reported in the Board Assurance Framework.

Work required to improve the management of operational risk continues. The clinical divisions' risks registers have all been reviewed and updated throughout the year, and work on the corporate functions' risk registers has also been undertaken. Each clinical division presents its Divisional risk register for scrutiny and challenge at monthly performance and accountability meetings with the Executive Directors, and there has been further scrutiny of corporate function risk registers on a quarterly basis at the Quality & Performance Committee.

The Board Risk Register comprises of all risks which require corporate support for management and oversight, as well as those risks on divisional risk registers which score 15 or above, on a scale of 1 to 25, where 25 is the highest risk score. The Board risk register is also presented quarterly to the Trust Board for review, having been scrutinised in advance by the Quality & Performance Committee.

Executive leadership for both operational and strategic risk is in the portfolio of the Director of Governance & Risk.

Risk management training is delivered to all staff on induction and in specialised forms to those staff who need enhanced skills and expertise. These include clinical risk assessment training packages (e.g. falls risk assessment, venous thromboembolism risk assessment etc.) and non-clinical risk training (e.g. information governance risk assessment, health & safety risk assessment).

4. The Risk and Control Framework

4.1. 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 continued to be identified throughout 2019/20 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 CentralAlert 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 Assessment Policy. The risk profile covers wide ranging themes emerging from financial, operational, clinical and reputational issues.

The Executive team reviews all divisional risk registers at monthly Performance & Accountability meetings, to ensure effective oversight of the quality of risk management activity in the Trust, as well as the prevailing risk environment. The Quality & Performance Committee reviews the draft 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 2019/20, 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.

As at 31 March 2020, the highest scoring risks remain concentrated around meeting the demand for unscheduled care and the potential impact on the provision of scheduled care, financial sustainability, and staff welfare. This has been the subject of detailed internal and external scrutiny, with extensive action plans in place to mitigate the risks to the Trust.

Future major risks for the Trust relate to on-going compliance with the CQC's regulatory requirements, particularly in relation to safety of patients within the Unscheduled Care Pathway. This risk is being addressed through a revised Urgent Care Improvement Plan which is monitored through the Systems Resilience Group/A&E Delivery Board. 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. The Trust has also acknowledged a number of risks associated with managing the currently unknown scale and duration of the continuing COVID-19 pandemic while continuing to seek to meet the needs of non-COVID patients.

4.2. 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 now recorded and held centrally on the Datix-web reporting management system allowing for all staff to view risks affecting the organisation.

4.3. 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 the first three quarters of 2019/20 has been that posed by the inadequacy of the Trust's Information and Communications technology systems to provide

support for delivery of the strategic objectives. The rating for that risk has now reduced as a result of the delivery of a number of key upgrades and the confirmation of external support for further investment in IT systems. Most of the other risks on the BAF have moved up and down, indicating that the BAF is regularly reviewed, and reflects accurately both the changing challenges facing the Trust and the actions taken to mitigate the scale of those risks.

4.4. 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, in order to protect the Trust from loss, damage to its reputation or harm to its patients, staff and the public. To support the Trust's capacity to manage these risks, a clear Board approved Risk Management Strategy is in place.

Whilst I, as Chief Executive, retain overall accountability for the management of risk, I have delegated oversight of that management 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.

4.5. 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. All risk registers are recorded on the Datix web management system and reviewed at least quarterly, to aid monitoring of the implementation of action plans necessary for mitigation. The transfer of risk registers to the Datix web management system has allowed for further transparency and awareness of risks across the organisation.

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 which require 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, to the Director of Governance & Risk for consideration and possible inclusion on the Board Risk Register.

The Board Risk Register contains all of the Trust's identified corporate risks. This includes those which cannot be managed at a divisional level and/or have the potential to impair or affect the operational or financial ability of the Trust to deliver core services, affect the quality of service provision or which may adversely affect the Trust's profile or reputation. Each risk has a responsible lead charged with overseeing the management of the risk.

4.6. 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. The risks set out below were identified in an external review (conducted by Deloitte, report produced in January 2020) of the Well Led self-assessment conducted by the Trust Board in line with the NHSI Well-Led Review framework.

Risk	Risk rating	Mitigation
Effectiveness of governance structures		
External assessment of the Trust's governance structures and systems has indicated that they are effective, but may now be unnecessarily detailed and resource-intensive.	Low	• The Trust Board reviewed its governance arrangements in the last quarter of 2019/20 and determined a range of revisions which commenced in December 2019 and will take effect fully in April 2020 • An 'earned autonomy' model for the oversight of performance and application of accountability in the divisions is in development for introduction in 2020/21
The responsibilities of directors and subcommittees		
Reporting lines and accountabilities between the board, its subcommittees and the executive team		
In line with recommendations set out in the Well-led Review report, the Board has agreed a revised meetings schedule from April 2020 onwards which will be reliant on the continued effectiveness of its committees and associated reporting	Low	• The Board will review the effectiveness of the new committees in late 2020/21 after an appropriate interval following the introduction of the new Board meeting schedule and work plan • The Well-Led review report identified the form and function of the Committee as broadly very effective, but recommended a more strategic approach in some areas. This will be reflected in agenda planning and work programming
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		
• The Integrated Performance Report (IPR)has been refined a number of times during 2019/20. It was identified as a strong point in the Well-Led Review report: "…we would point to the Integrated Performance Report (IPR) as an excellent example which incorporates many areas of best practice we often recommend elsewhere. The use of 'balancing measures' within this is particularly innovative." • However, some further adjustment to ensure that the production and accessibility of the report remains manageable is required • The timeliness of some of the data presented to the Board is also a potential risk	Low	• The development of the IPR has been an iterative process, during which concerns about content, style and use have been addressed. • The development process has included review of the IPR by the Trust's internal auditors, whose recommendations were adopted. • Board members will be engaged in the development of the further refinement of the IPR. • The capacity and capability in the Information Service has been strengthened and will be the subject of further improvement during 2020/21.

5. Trust Board

5.1. 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 10 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 during 2019/20 to ensure that they reflect any changes to legislation and changes to the Trust's governance arrangements, including the revisions to the Board's committee structure and the re-organisation of clinical teams into divisions in July 2018.

5.2. Board performance

As at 31 March 2020, the Trust Board comprised the Chairman, four independent Non-Executive Directors (plus one independent Associate Non-Executive Director) and eight Executive Directors. Three of the Executive Directors are non-voting (Director of Workforce & Organisational Development, Director of Strategy & Performance and Director of Governance & Risk).

The Trust Board and its revised Committee structure, implemented in 2018 – 19, have now embedded. These have delivered a series of benefits in terms of oversight and management of planning, performance and risk. In particular, the Quality and Performance Committee has seen significant alterations to the quality governance arrangements underpinning its work. Heat Map meetings have been introduced and seen expert voices from across the Trust provide insight and evidence on emerging quality, safety and performance issues. In addition, the Quality Assurance Sub-Committee has been established to ensure that operational matters are considered appropriately, and the Quality & Performance Committee can undertake its remit with greater focus. The development of the Integrated Performance Report has continued, with much of the relevant input emerging from the Quality and Performance Committee; this has focused on ensuring that metrics are appropriate, triangulated and provide rigorous analysis that provides insight beyond the surface level data.

The Board has also been supported in its work on financial planning and oversight by the Finance and Infrastructure Committee which reviewed its reporting to ensure that themes emerging regarding budgetary decisions are anticipated and resolved in a timely manner. As part of this, a meeting of certain Committee chairs was held twice a year; once to consider the proposed Operating Plan for the coming financial year, and then mid-way through the year to review its implementation. This has assisted with the Trust's strategic considerations, and supported the greater level of adherence to the original forecasts for 2019/20 discussed elsewhere in this Annual Report. It has also given rise to the intended integration and cross-referencing of the different perspectives covered by the Board Committees.

The Trust Board was the central element of a recent well-led review, conducted by an external reviewer. This noted the strength of leadership provided by the Trust Board's members. The Board itself was noted as providing a positive and supportive environment for challenge and debate. This bolstered the vision and strategy being implemented across the Trust. The Trust has also been rated as 'Good' in the Well-led domain by the Care Quality Commission following a Well-Led inspection in November 2019. Items of outstanding practice noted in the inspection report include improvements made to culture across the organisation.

Given this promising level of development, 2020/21 will be a year in which Trust Board and its committees will continue to evolve and mirror the Trust's improvement trajectory. Whilst the intensive workload of 2019/20 may have been appropriate for the period of transition, it may be beneficial to move towards a more streamline and strategic work programme. This could allow for a higher level focus in discussions which would support the wider health and social care system's aims. Ensuring that the visibility of the Board increases, and its role as the strategic decision-making forum for the Trust is more prominent, will support the cohesive implementation of its objectives.

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 for 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:

	04-Apr-19	01-May-19	29-May-19	26-Jun-19	31-Jul-19	25-Sep-19	30-Oct-19	27-Nov-19	29-Jan-20	26-Feb-20	25-Mar-20
Executive Directors											
Mark Cubbon	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nicole Cornelius	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
John Knighton	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓
Chris Adcock	✓	✓	✓	✓							
Liz Rix				X	✓	X	✓	✓	✓	✓	✓
Paul Bytheway	✓	✓	X	✓							
Emma McKinney	✓	✓	✓	✓							
Lois Howell	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Penny Emerit	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓
Nigel Kee						✓	✓	x	✓	✓	✓
Mark Orchard							✓	✓	✓	✓	✓
Non-Executive Directors											
Melloney Poole	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Christine Slaymaker	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
David Parfitt	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Gary Hay	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	✓
Inga Kennedy	X	✓	✓	X	✓	X	✓	X	✓	X	✓
Martin Rolfe	✓	✓	X	✓	✓	✓	x	✓	✓	✓	✓
Roger Burke-Hamilton	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	✓

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 management responsibilities is available on the Trust's web-site at https://www.porthosp.nhs.uk/about-us/key-documents.htm

5.3. Board committees

The following committees have reported to the Trust Board throughout 2019/20 (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 2019/20. It was chaired by a Non-Executive Director, who submits a regular report to the Trust Board.

- Quality and Performance Committee:

This committee, chaired by a Non-Executive Director, 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 in order to seek assurance on their management and resolution.

- 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 is a chaired by a Non-Executive Director.

- Workforce and Organisational Development (OD) Committee:

This committee, chaired by a Non-Executive Director, 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.

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 has overseen the following areas under delegated authority from the Trust Board (chaired by the Trust Board Chairman):

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

5.4 Operation during the COVID-19 pandemic

In response to national guidance on safe management of the COVID-19 pandemic, on 16th March 2020 the Trust restricted significantly the number of visitors permitted on the Trust's site, including Non-Executive Directors. As a result, all planned Board and Committee meetings for the remainder of 2019/20 were held, but were conducted virtually.

Additionally, such meetings were predominantly focused on providing direction and seeking assurance in respect of the Trust's handling of the challenges presented by the pandemic. As a result, items 'to note' were removed from agendas, and all meetings took updates on activity relating to COVID-19.
Despite the conditions outlined above, the Finance & Infrastructure Committee and Trust Board undertook their planned consideration of business cases.

As indicated earlier in the report, the Trust also created an additional committee, the Board Major Incident Response Committee (BMIRC). The purpose of the BMIRC was to provide support to the Trust's Executives during the pandemic period. The BMIRC was not established until 01.04.20, and for this reason its activities will be described in the 2020/21 report.

6. Quality governance arrangements

During 2019/20 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) was responsible 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 have attended monthly performance and accountability reviews with the executive team to monitor the delivery of quality, safety and performance standards in line with the Trust's strategy and operating plan.

The Trust continues to report monthly to the Board on quality and safety metrics as part of the Integrated Performance Report, which provides the Board with assurance in respect 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.

To ensure the on-going provision of safe, high quality, care and compliance with relevant regulatory and contractual obligations, the Trust has implemented quarterly themed quality care reviews. This assurance is undertaken by a team of multi-disciplinary staff of all grades, with external stakeholders. These are supported by regular front-line peer reviews.

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 process for the management of all serious incidents has been strengthened with weekly executive and senior patient safety team review and early investigation planning, with an enhanced focus on learning. All action plans are reviewed by the Serious Incident Review Group to ensure closure and to identify key themes and shared learning for the organization.

The Trust revised its mortality review process in 2017/18 in line with the National Quality Board guidance; the impact of this process has continued to improve throughout 2019/20. The sustained focus on mortality has been associated with both the Trust Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-Level Mortality Indicator (SHMI) remaining 'as expected' levels with the lower confidence limit consistently below 100.

The Trust implemented review of deaths by Medical Examiners in line with national guidance on 1st November 2019, with additional Consultants to cover the roles in Quarter 4 2019/2020. A Medical Examiner's Officer commenced in March 2020. The mortality review panel continue to meet each weekday to review deaths that have occurred in the previous 48 hours. The panel undertakes a concise guided review of each death by clinicians independent of the specialty, identifying any areas of concern or opportunities for learning that may require further investigation. Processes and data are overseen by the Trust's mortality review group, chaired by the medical director.

7. 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 deliver compliance with 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 and if necessary places conditions on a Trust's registration when non-compliance is identified.

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.

Ratings	
Overall trust quality rating	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good
Are resources used productively?	Good
Combined quality and resource rating	Good

The CQC issued a Warning Notice to the Trust following the inspection, advising that improvements were required in connection with the safety and welfare of patients awaiting treatment in the Emergency department, and of those experiencing delays in the handover of their care from ambulance crews to the Emergency Department team. The Trust has revised its operating model in the Emergency Department waiting area, and implemented an ambulance handover recovery plan. There is regular liaison with the CQC about delivery of these improvements, and a further inspection to review them is awaited. Full details of the Warning Notice can be found on the CQC's website.

All conditions previously imposed upon the Trust have been removed from the Trust's registration.

The Trust continues to work on a range of projects to ensure that the improvements delivered during 2019/20 are sustained. The revised approach to quality governance, developed in partnership with the CCGs, continued during 2019/20. This helped to promote an open and transparent governance structure and to balance compliance activities with the pursuit of aspirational and ambitious improvement.

As a result of the Warning Notice in place, the Trust declares itself as not fully compliant with the registration requirements of the Care Quality Commission.

8. 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.

9. Equality, diversity and human rights

The Trust is committed to embedding equality, diversity and inclusion (EDI) in everything it does, with the aim of 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.

The Board has adopted a number of key priorities which focus on improving the work experience of employees with a protected characteristic. The Workforce and Organisational Development Committee maintains oversight and delivery of key actions for improvement, ensuring the Trust is compliant in meeting the statutory EDI requirements for public sector bodies.

By engaging with diverse groups, in particular Black Asian Minority Ethnic (BAME), Lesbian Gay Bisexual Transgender (LGBT+) and disabled employees, the Trust aims to develop and improve its understanding of the needs of all staff members, with a view to bettering their work experience at Portsmouth.

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

Staff Group	Disability			Age		Ethnicity		
	Yes (%)	No (%)	Not Stated (%)	Largest Age Group	(%)	White (%)	BAME (%)	Not Stated (%)
Additional Clinical Services	6.2%	67.0%	26.8%	-	-	86.4%	12.6%	1.1%
Administrative and Clerical	7.2%	58.8%	34.0%	56-60	16.2%	95.6%	3.8%	0.6%
Estates and Ancillary	20.0%	20.0%	60.0%	56-60	40.0%	100.0%	0.0%	0.0%
Medical and Dental	4.6%	76.0%	19.3%	26-30	20.8%	66.4%	31.1%	2.5%
Nursing and Midwifery Registered	4.5%	54.8%	40.7%	26-30	16.1%	77.6%	21.3%	1.0%
Scientific, Therapeutic & Technical	4.3%	63.8%	31.9%	31-35	19.1%	87.9%	10.3%	1.8%
Trust	**5.4%**	**62.6%**	**32.0%**	**26-30**	**14.6%**	**82.7%**	**16.0%**	**1.3%**

Staff Group	Sexual Orientation				Marital Status			Maternity
	LGBT+ (%)	Heterosexual (%)	Undecided (%)	Not Stated (%)	Married/Civil Partnership (%)	Single (%)	Not Stated (%)	Maternity Leave (%)
Additional Clinical Services	3.0%	74.6%	0.2%	22.1%	48.2%	49.8%	2.1%	22.1%
Administrative and Clerical	1.7%	74.7%	0.1%	23.5%	49.8%	47.7%	2.5%	8.7%
Estates and Ancillary	0.0%	20.0%	0.0%	80.0%	60.0%	40.0%	0.0%	0.0%
Medical and Dental	2.0%	74.9%	0.8%	22.3%	58.7%	37.5%	3.9%	16.4%
Nursing and Midwifery Registered	2.0%	67.9%	0.1%	30.0%	55.2%	42.0%	2.8%	36.9%
Scientific, Therapeutic & Technical	1.3%	73.6%	0.0%	25.1%	54.3%	43.1%	2.6%	15.9%
Trust	**2.1%**	**72.4%**	**0.2%**	**25.2%**	**52.9%**	**44.4%**	**2.7%**	**2.6%**

Staff Group	Top 5 Religion/Beliefs & the Percentage of Religion/Beliefs not disclosed						Gender	
	1. Christianity (%)	2. Atheism (%)	3. Other (%)	4. Islam (%)	5. Hinduism (%)	Not Stated (%)	Male (%)	Female (%)
Additional Clinical Services	45.1%	13.6%	9.1%	0.9%	0.8%	29.7%	15.6%	84.4%
Administrative and Clerical	44.2%	15.3%	9.7%	0.7%	0.4%	29.4%	20.9%	79.1%
Estates and Ancillary	20.0%	0.0%	20.0%	0.0%	0.0%	60.0%	60.0%	40.0%
Medical and Dental	37.9%	13.7%	4.3%	9.5%	5.5%	25.7%	51.0%	49.0%
Nursing and Midwifery Registered	50.0%	10.0%	7.6%	0.4%	0.4%	31.5%	10.0%	90.0%
Scientific, Therapeutic & Technical	46.1%	15.7%	5.4%	1.2%	1.5%	29.6%	22.5%	77.5%
Trust	**45.5%**	**13.1%**	**7.6%**	**2.0%**	**1.3%**	**29.6%**	**20.7%**	**79.3%**

In January 2019, an Equality Delivery System workshop was held where stakeholders came together to develop new equality objectives in a collaborative and inclusive way. Through a series of activities, the stakeholders identified and agreed four priorities to be taken forward as the Trust's equality objectives for 2019-2023. Focus continued on establishing networks for staff with a protected characteristic and as well as the robust BAME and LGBT+ networks, there is a newly formed DisAbility staff network with very active co-chairs. The network Chairs are vital members of the Equality, Diversity and Inclusion Group.

10. Developing workforce safeguards

The Trust achieves 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. A Workforce and Organisational Development Committee, chaired by a non-executive director, has been established and regularly considers all aspects of staffing for all groups of staff; with a specific interest in role development, hard to recruit roles, culture and leadership. The Committee and the Trust Board have approved the annual workforce plan which has a significant investment into the recruitment of Band 5 nurses to ensure vacancies are minimised in this hard to recruit group. Following successful overseas recruitment for international nursing in 2019/20, the plan for 2020/21 is to apply a similar scheme to overseas medical staff. 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.

11. Carbon reduction

The Climate Change Act 2008 targets were set for Carbon Reduction of 34% by 2020 and 51% by 2025. Government has now declared a climate emergency and updated the Climate Change Act, seeking to achieve zero carbon by 2050.

The NHS publishes regular updates on carbon reduction and achieving zero carbon for the health and care sector will require both delivery of the NHS Long Term Plan targets and wider action to reduce carbon emissions across the healthcare supply chain.

The Long Term Plan outlines the first steps required to achieve significant carbon reductions. This includes ensuring a Green estate by investing in projects such as LED lighting, switching to renewable energy and ensuring all trusts follow best practice efficiency standards. Further carbon efficiencies and continuous carbon improvement strategies are required including reducing waste, water and carbon energy usage. Adherence to best practice efficiency standards and adoption of new innovations are also essential. Key to this will be delivering improvements, including reductions in single use plastics, throughout the NHS supply chain. (NHS Sustainable Development Unit. www.sduhealth.org.uk/nhs)

In support of the NHS Long Term Plan, the Climate Change Act and the Climate Change Emergency, key carbon reduction work streams also under way, including the creation of a new post of Energy and Sustainability Lead. This additional post will help to develop the Trust's Carbon Reduction Delivery Plans and strategies.

Joint working with the Trust's PFI provider (The Hospital Company) and facilities management partner (Engie) to agree greater support for energy saving initiatives and management of energy use and carbon emissions at Queen Alexandra Hospital has commenced. A feasibility study for Solar PV at Queen Alexandra Hospital is underway, whilst the Trust has engaged with partners in the local healthcare system to collaborate on energy and regional carbon initiatives.

An action plan is being implemented to reduce the effects of traffic congestion and car parking pressure at Queen Alexandra Hospital. In addition, the Trust has a place on the new Portsmouth Climate Action Board and Strategy Sub-group in support of the local climate and carbon reduction initiatives.

12. 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 this 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).

13. Corporate governance

Through its governance arrangements, the reviews undertaken by the Trust's Internal Auditors, and the preparation of the Board Governance Memorandum, I am assured 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 gives specific consideration to matters of probity, propriety and regularity of public finances and value for money, which arise from the work of the external auditors, the Trust's "local counter fraud specialist" and internal auditors.

14. 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 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.

15. Information governance

The Director of Governance and Risk is the nominated Senior Information Risk Officer (SIRO), and responsible, along with 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 of 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).

The Trust's Data Security and Protection Toolkit (DSPT) 2019/20 was submitted on the 31st March 2020 with a status of **"standards not met"**. The following standards are those which the Trust has not met during 2019/20:

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
Standard 6.2.12 - You have implemented spam and malware filtering, and enforce DMARC on inbound email.
Standard 7.3.1 - On discovery of an incident, mitigating measures shall be assessed and applied at the earliest opportunity, drawing on expert advice where necessary.

NHS Digital has allowed trusts to delay their final toolkit submission until 30 September 2020 as a result of the pandemic. Action plans to deliver the achievement of all of the 'not met' standards have been produced and submitted to NHS Digital, but those for standards 6.2.11 and 6.2.12 will not be complete by 30 September 2020. As a result, the Trust's status will remain 'not met'.

In 2018/19 the Trust status for the DSPT was 'standards not met' due to:

- failure to ensure that 95% of Trust staff were trained in data protection
- inability to demonstrate that IG-related due diligence checks had been carried out in respect of all contracts

Both of these assurances were met in the 2019/20 DSPT.

Risks to information security are managed through the Trust's incident reporting mechanisms and Risk Registers. The top three risks, reported on the 2019/20 DSPT, are:

1435	The Trust's compliance figure for answering FOIs within 20 working days has gone down to 78%. Target is 90%. Risk of regulatory action/financial penalty from the Information Commissioner's Office.
348	Support for Microsoft XP, Office 2003 and 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 and 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: the prevention of authorised access to, malicious alteration of, or theft of clinical or other sensitive information from the Trust's IT systems. Such attack could result in: Harm to patients through maliciously altered data leading to incorrect diagnosis or treatment. 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). The Trust finding that access to its systems and the data contained within them may be held subject to ransom. Reputational damage, litigation and substantial fines from the Information Commissioners Office. The above impacts could be short term, long term or permanent.

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 & Performance Committee.

16. Information governance requests

The confidentiality and security of information regarding patients, staff and the Trust is maintained through governance and control policies. Personal information is increasingly held electronically within secure IT systems. It is inevitable that in a complex NHS organisation a certain level of data security risk arises, leading to incidents which are appropriately reported and always fully investigated.

Any incident involving a breach of personal data is graded and the more serious incidents must be reported to the Department of Health and Social Care and the Information Commissioner's Office (ICO). As reported in the Annual Governance Statement (from page 34) the Trust experienced six reportable serious incidents in 2019/20 which were reported using the Data Security and Protection Toolkit and are summarised below.

Externally Reportable Incidents

ICO Reference	Date Reported	What Happened	Reported to	Outcome
17048	26/09/2019	The Trust was unable to locate the paper health record of a deceased patient. The notes were required for an inquest.	ICO	Closed – no further action
17391	18/10/2019	Employee of the Trust was found to have accessed patient information to which she is not entitled.	ICO	Closed – no further action
17671	08/11/2019	Employee used her IT access to view confidential information about third parties	ICO	Closed – no further action
17900	27/11/2019	Patient was given a diagnosis related to another patient of a very similar name.	ICO	Closed – Further action recommended. Continue to raise staff awareness of appropriate ID procedures to be completed prior to disclosing personal data
18064	10/12/2019	Consultant left a folder containing approximately 30 patient letters on a train. Folder was not sealed and was not marked 'Private & Confidential' or have a return address if found. Folder subsequently returned by rail company.	DHSC/NHSE/ ICO	Closed – no further action

18785	07/02/2020	Phone call received from Public Health England (PHE) office in Fareham. Notification of infectious diseases forms sent to former address of PHE in Whiteley. Forms forwarded to PHE (Fareham) by current occupiers of premises	ICO	Closed – no further action.

17. 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 quality of information. 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. These involve:

- Routine data quality checks – this are accompanied with routine reporting to Divisions, Care Groups, Executives and the Outpatient Booking Centre on data quality issues as appropriate; for example; Outpatient appointments with missing information, issues with Coding details, issues with patient details, issues with activity Validation including 52 week RTT breaches, 18 week RTT breaches and 6 week DM01 breaches.
- Ad hoc data quality checks – as and when deemed required, detailed quality checks are performed on data determine its accuracy. These are not regular checks, but only carried out when data seems irregular or odd. Examples of some adhoc checks and fixes include

Audiology fit appointments have been entered onto PAS as telephone appointments, Invalid GP Practice codes to PAS, Incorrect referral dates manually entered onto PAS, A&E patients recorded as entered in error, and 12 hour trolley waits in A&E.

- 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 PAS to run against the Spine (the 'Spine' is the digital central point allowing key NHS online services and allowing the exchange of information across local and national NHS systems. The Spine connects pharmacy teams with GP practice staff, patients and others.) Many patient details are compared against the information the GP has recorded on the Spine for this patient. Validations and quality checks are also performed on the full Referral to Treatment (RTT) Patient Tracking List (PTL).

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 within our APC CDS data, especially noted in our A&E data, where we are on average 1.5% higher than our peers for the valid proportion of NHS numbers submitted with our A&E CDS data
- for Inpatient CDS data, PHT are above the national average for all metrics monitored, with the exception of the percentage of valid Registered GP Practice
- When Referral to Treatment (RTT) triangulation projects are performed on the RTT waiting list, the Trust was seeing improvements and maintaining a high standard in many areas.

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:

- quality of GP details on our PAS system; this is due to the age of our PAS system, and the IT department and the analytics team are working together to improve the accuracy of the data at source.
- ethnicity recording within our A&E data.
- outpatient recording of outcome and associated referrals details

The Trust is also in the process of re-establishing a Data Quality Steering Group to ensure ongoing data improvement in the overall data quality and provide a forum for further discussion and development of the current data quality exercises.

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 2019/20 will be published in December 2020.

18. 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. A plan to address weaknesses and ensure continuous improvement of the system is in place.

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
- 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

Internal sources:

- Quarterly review of the Board Assurance Framework and Board Risk Register
- Preparation and publication of the 2018/19 Quality Accounts, 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, 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 me with an objective opinion of the effectiveness of our 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. Not having completed all of the planned work due to the global Covid-19 pandemic has not impacted on the Head of Internal Audit's overall assessment.

19. Significant internal control issues

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

Audit	Key concerns identified	Trust response
Emergency Planning and Business Continuity	• Ensuring there is a named accountable officer for Business Continuity and Emergency Preparedness Resilience and Response (EPRR) Planning, and that the named member of staff responsible for Business Continuity Management is fully sighted on the role and responsibilities	• The Interim Chief Operating Officer is formally designated as the accountable officer, and has appropriate resources in place to ensure fulfilment of the role and responsibilities he holds in relation to Business Continuity and Emergency Planning
	• A requirement for a training needs analysis for staff expected to complete BCP and EPRR training, and to what level. Lack of records maintenance	• A training analysis has been completed, based on the 2019 requirements, and is available on the Trust's intranet
	• Lack of awareness of EPRR responsibilities. A requirement for procedures to be devised and promulgated to ensure all staff are aware. Annual review required	• Business continuity plans have been produced and made available on the Trust's intranet. They will be reviewed on a regular basis

Conclusion

The Trust has identified the internal control issues identified at paragraph 19 above, and has addressed them in a timely way to ensure that the statement of internal control for 2019/20 is unqualified.

Accountable Officer:	Mark Cubbon
Organisation:	Portsmouth Hospitals NHS Trust
Signature:	
Date:	**15 June 2020**

REMUNERATION AND STAFF REPORT

1. Investing in staff and workforce

The Trust believes that a highly-skilled, motivated and engaged workforce is essential to ensuring delivery of high 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 6,900 full time equivalents and is the largest employer in Portsmouth.

2. Remuneration Committee

NHS Trusts' constitution 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 relates to them personally.

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. Remuneration tables (audited)

Salary and pension entitlements of senior managers are shown in Appendix 1 to this report on pages 123 – 124.

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.

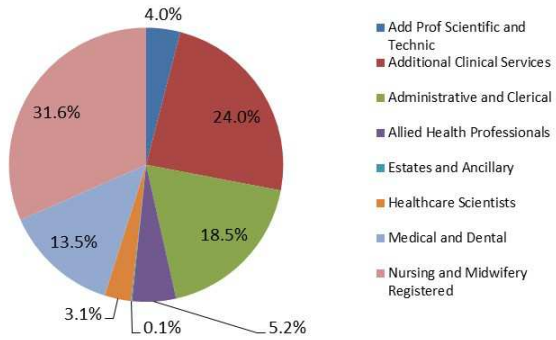
6. Resourcing

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, Engie and the Ministry of Defence helps the Trust to achieve the goal of maintaining safe services for all patients.

In addition to creating partnerships with other organisations, the Trust has continued to recruit from abroad to fill key vacancies and maintain workforce levels across all staff groups and departments.

Table one details the Trust's total workforce capacity which is made up of the following staff groups;

Table one: 2019/20 Workforce Capacity by Staff Group



- 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% of the total workforce establishment. This is a one percentage point decrease in comparison to this time last year.

Investment has been made in 2019/20 to increase substantive staffing levels across the Trust. The Trust's effort has targeted 'hard to recruit'/high-cost agency areas, with a specific focus on Band 5 nurses, aimed at reducing the Trust's reliance on the temporary workforce and bringing the total pay bill to more affordable levels. In addition, partnership with Bank Partners has given the Trust support in meeting staffing requirements for an increased patient demand.

The Trust continues to be highly successful in employing apprentices, and has achieved national recognition for this. This is proving to be a great source for future recruitment as the vast majority of Trust apprentices have gone into full time employment within the Trust.

7. Volunteers

There are currently more than 700 active volunteers across the Trust and at least 20 applications are received every month from a wide range of people including students and former and current patients.

Volunteers support the Trust in many different ways, and the Trust is actively developing new roles and increasing the volunteer community in the following areas:

- Mealtimes – Mealtime volunteers provide additional support on wards, encouraging patients to keep up fluid intakes and supporting them at mealtimes
- Befriending - Happy to Chat volunteers enrich and enhance the emotional health, wellbeing and overall hospital experience of patients, offering time to chat for patients who may feel lonely or isolated in the hospital
- End of Life – Butterfly volunteers help by providing non-medical services so as to enhance care in the final days of life and provide temporary respite to relatives and carers by being there to ensure that no one dies alone. This is a new role that been developed with the support of the Rowans.
- Supporting areas of high pressure - Response volunteers respond to direct calls for assistance from clinical staff and help improve patient experience, reduce waiting times for discharge and release time to care

Volunteers are an integral part of the Trust and are celebrated in a number of ways which include numerous thank you get-togethers. In addition, volunteers are recognised at the Trust Annual Pride of Portsmouth Awards and also monthly by a special recognition award from the Trust Chair. Melloney Poole, 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. The Trust is privileged to have an exceptional cohort of volunteers who provide valuable support to patients, families, carers and staff.

8. Health, safety and wellbeing

The Trust is fully committed to supporting and improving the health, safety and wellbeing of all employees throughout the organisation with a fully integrated Health, Safety and Wellbeing Service onsite and the provision of a bespoke Wellbeing Centre, providing a gym, swimming pool and a range of wellbeing support for staff.

Key health and safety activities over this year have included a further Trust-wide audit of sharps disposal, with improved results Trust wide due to increased awareness training and reporting. There has been an increase in mental health awareness training and resilience training. Improving awareness of menopause and the effects on staff has also been a focus this year.

75.6% of frontline staff were vaccinated against seasonal flu which was an improvement on uptake by two percentage points from last year.

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 about 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.

FTSU Advocates are in place from all Divisions / Care Groups and Corporate Functions to support the Guardian. During 2019/20 the Trust's FTSU service has seen marked improvement in the number of concerns that are being managed effectively at a local level with support and guidance without the need for escalation, this was evidenced within the recent CQC Well Led report where it was felt that the culture across the organisation had improved, Staff felt respected, supported and valued. Identifying an open culture where patients, their families and staff could raise concerns without fear.

10. Fair pay policy (audited)

On pages 123 – 124 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 relationship between the remuneration of the highest-paid director in the organisation and the median remuneration of the Trust's 'substantive' workforce.

The banded remuneration of the highest paid director in the Trust in the financial year 2019/20 was £205 – £215k, which was the Chief Executive and his salary was comparable with 2018/19. The salary was 7.77 times (2018/19, 7.42 times) the median remuneration of the workforce which was £27,260 (2018/19, £25,934) all of these relate to Band 5 staff members. In 2019/20, no employees received remuneration in excess of the highest-paid director (2018/19, none).

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

11. Managing staff sickness

The Trust is committed to protecting the on-going health and wellbeing of all staff and 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 was maintained at 3.9%. There is 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.

12. Staff numbers and costs (audited)

			2019/20	2018/19
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	250,659	1,549	**252,208**	237,773
Social security costs	25,290	-	**25,290**	23,381
Apprenticeship levy	1,282	-	**1,282**	1,194
Employer's contributions to NHS pensions	44,589	-	**44,589**	29,285
Temporary staff (external bank)		26,520		21,126
Temporary staff (agency)		16,221		21,376
Total gross staff costs	**321,820**	**44,290**	**366,110**	334,135
Recoveries in respect of seconded staff	-	-	**-**	**-**
Total staff costs	**321,820**	**44,290**	**366,110**	334,135
Of which				
Permanent staff costs capitalised as part of assets	1,831	-	**1,831**	1,093
Agency staff costs capitalised as part of assets	773	-	**773**	350
Average number of employees (WTE basis)				
	Permanent Number	**Other Number**	**2019/20 Total number**	**2018/19 Total number**
Medical and dental	1,000	92	**1,092**	1,038
Administration and estates	1,283	39	**1,322**	1,257
Healthcare assistants and other support staff	-	170	**170**	177
Nursing, midwifery and health visiting staff	3,782	263	**4,045**	3,978
Scientific, therapeutic and technical staff	679	28	707	692
Healthcare science staff	181	4	**185**	182
Total average numbers	**6,925**	**597**	**7,521**	**7,324**
Of which:				
Number of employees (WTE) engaged on capital projects	**43**	**10**	**53**	21

13. Staff engagement and consultation

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 regular 'all staff message' from the Chief Executive, a monthly Team Brief, staff magazine, staff surveys and various other initiatives.

The Trust's three-year Culture Change Programme was launched in March 2018. The programme has a three stage approach; Discover, Design, Deliver, and was developed by NHS Improvement working in partnership with The Kings Fund and the Centre for Creative Leadership. Its focus is on helping organisations to develop a culture, through staff fled change, that enables and sustains safe, high-quality, compassionate care.

Culture Change Agents, who are members of staff from all areas of the Trust and at all grades, were recruited via a selection process and worked together to undertake a cultural audit to identify the gaps between what the culture is now and what it needs to be in the future to deliver successfully the organisational priorities. During 2019, Phase 2 Change Agents considered all twenty six recommendations that emerged from Phase 1, and identified which best supported delivery of the organisational strategic priorities and key work streams. Phase 3 began in November 2019 with a newly recruited team of Change Agents who will engage and work with staff across the organisation to further shape, test and deliver the proposals agreed in Phase 2. The impacts from the programme to date are reflected in the Trust's most recent CQC report and the 2019 National NHS Staff Survey.

Details of the national support tool kit can be found here https://improvement.nhs.uk/improvement-hub/culture-and-leadership/

In recognition of the importance of effective inclusive and compassionate leadership, the Trust has invested significantly in 2019/20 in providing bespoke leadership development for 96 of its most senior leaders. This targeted approach to strengthening leadership is underpinned by an improved focus on a talent management process to support succession planning for the future. The model is being further developed and cascaded to the next level of leadership to ensure behaviours and practices are consistently aligned to organisational priorities and values.

The staff appraisal rate has been above the target of 85% since August 2019, dipping slightly to 84.8% in March 2020. The appraisal form was reviewed during 2019 following feedback from staff and has received a positive response whilst helping to maintain the compliance rate. Training for managers continues in both stand-alone appraisal training sessions and the Passport to Manage induction programme, with over 300 attendees at these sessions over the last 12 months.

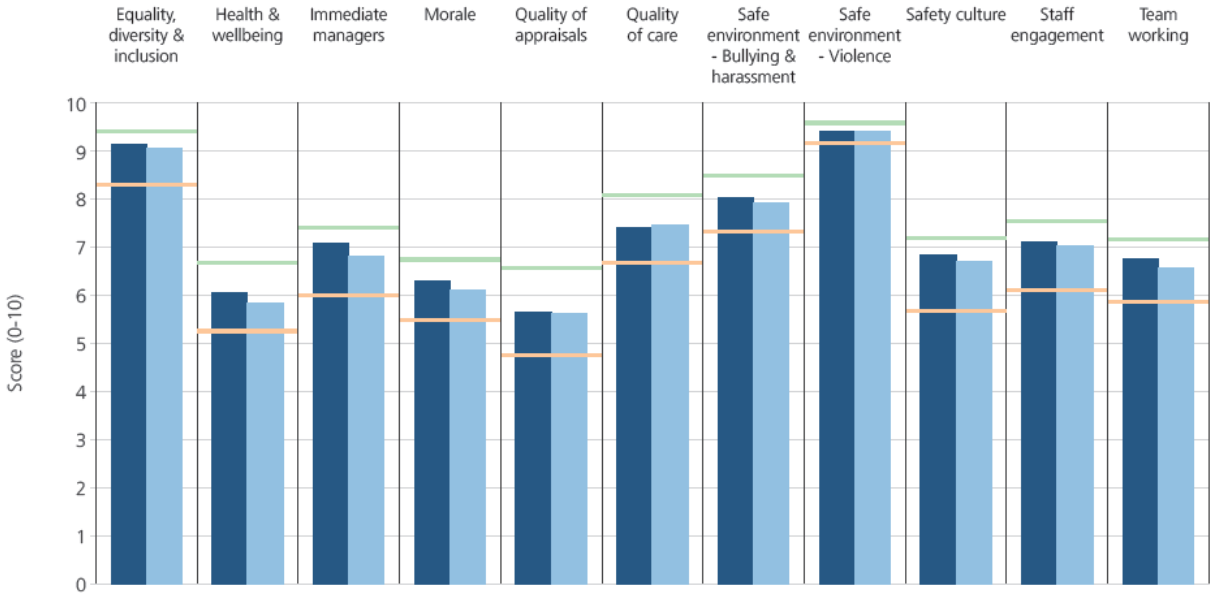
Compliance with the Trust's essential skills training has increased over the last 12 months and currently stands at 92.9%, against a target of 90%.

14. The NHS National Staff Survey 2019

The NHS National Staff Survey (NSS) is recognised as an important tool for ensuring that the views of staff working in the NHS inform local improvements, and are included in local and national assessments of quality, safety, and delivery of the NHS Constitution. The results of the 2019 NSS conducted in the Trust between September and December 2019 can be found below.

The full survey took place between September and December 2019, and all staff employed as at 1 September 2019 had the opportunity to take part. In total 3911 (52%) completed and returned their survey which is above the national average response rate.

The survey results are divided into 11 themes and can be found at the table below. Of the 11 themes, nine demonstrate a statistically significant improvement since 2018 and for two themes there is no statistically significant difference.

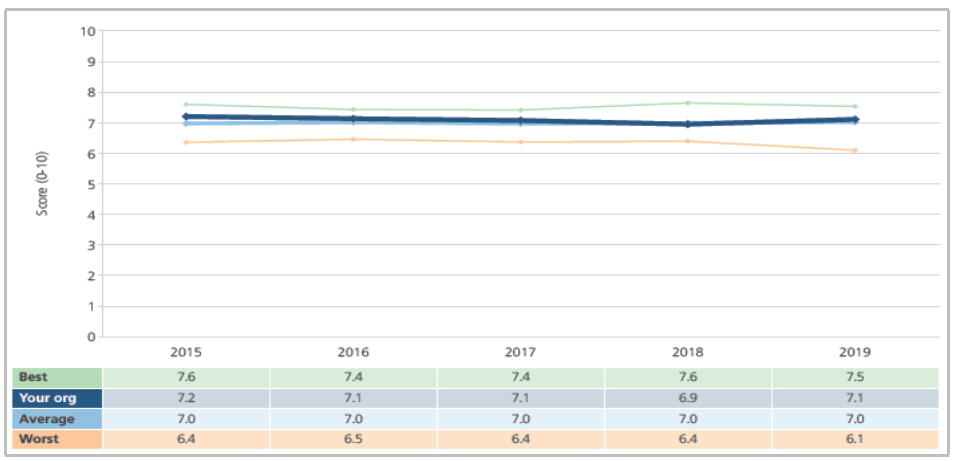


	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.4	6.7	7.4	6.7	6.6	8.1	8.5	9.6	7.2	7.5	7.2
Your org	9.1	6.0	7.1	6.3	5.6	7.4	8.0	9.4	6.8	7.1	6.8
Average	9.0	5.9	6.8	6.1	5.6	7.5	7.9	9.4	6.7	7.0	6.6
Worst	8.3	5.3	6.0	5.5	4.8	6.7	7.3	9.2	5.7	6.1	5.9
Responses	3,875	3,878	3,889	3,850	3,334	3,530	3,852	3,862	3,865	3,896	3,866

During 2019 the Trust launched a targeted campaign to reducing violence, abuse and harassment. Providing a safe environment for staff is important to the Trust and a continued Trust-wide focus on reducing abusive behaviours remains a priority.

Improving Staff Engagement

The overall staff engagement theme is made up of responses to nine questions within three sections; motivation, ability to contribute to achievements and recommendation of the Trust as a place to work and receive care and treatment. The table below shows improvement in the 2019 staff engagement score which is above the national acute trust average.



	2015	2016	2017	2018	2019
Best	7.6	7.4	7.4	7.6	7.5
Your org	7.2	7.1	7.1	6.9	7.1
Average	7.0	7.0	7.0	7.0	7.0
Worst	6.4	6.5	6.4	6.4	6.1

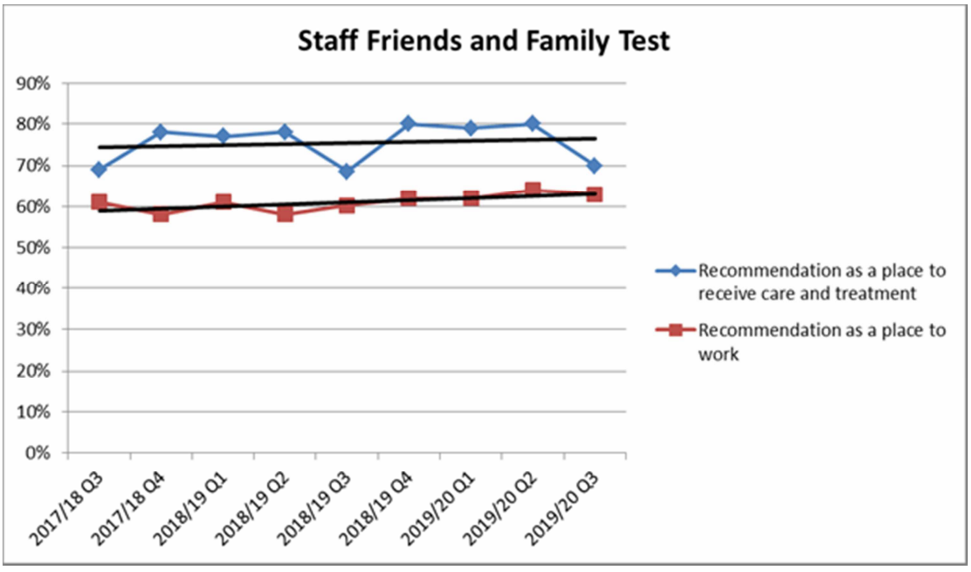
The full findings report of the 2019 NSS will be presented to the Workforce and Organisational Development Committee of the Board in March 2020 and subsequently to Trust Board. An improvement plan will be agreed with the Committee to address those areas most requiring improvement, which will align to other key work streams, such as the three year culture and leadership programme.

15. Quarterly Staff Friends and Family Survey

Since April 2014, the Staff Friends and Family Test (FFT) has been carried out in all NHS trusts. The Staff FFT is helping to promote a significant cultural shift across the NHS, encouraging staff to have both the opportunity and confidence to speak up, and ensuring that the views of staff are increasingly heard and are addressed.

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.

On a quarterly basis staff are asked to respond to the Staff FFT. The table 4 below presents the response by question since 2017/2018. The Trust incorporates feedback from the survey into its quality improvement planning and communications programmes.



16. Workforce Race Equality Standard (WRES)

Data is taken from the annual National Staff Survey and Electronic Staff Records system which is reflected in the nine key indicators measured by the WRES. WRES looks at a number of factors that help demonstrate race equality within Trust processes and services for staff. As a result a number of improvements were identified with members of the BAME staff network and Equality Diversity and Inclusion group to address issues of inequity.

To view the Trusts WRES data and improvement priorities, please go to:
https://www.porthosp.nhs.uk/about-us/equality-and-diversity.htm

17. Workforce Disability Equality Standard (WDES)

This is the second year of gathering data for the Workforce Equality Disability Standard (WDES) which became a national requirement in August 2019. The aim of the standard is to compare experiences of disabled and non-disabled staff though a set of 10 specific indicators. The DisAbility staff network was established in 2019 and has been leading on the development of an improvement plan.

To view the Trusts WDES data and improvement priorities, please go to:
https://www.porthosp.nhs.uk/about-us/equality-and-diversity.htm

18. Gender Pay Gap report

At 31 March 2020, the third Gender Pay Gap report was published, relating to the pay period 31 March 2019. The table below shows the mean and median hourly rates for male and female employees in the Trust and the actual gap in monetary and percentage terms in 2019.

Mean and Median Gender Pay Gap

Mean Hourly Rate			
Gender	2017	2018	2019
Male	£22.76	£22.83	£22.47
Female	£14.68	£15.49	£16.08
Difference	£8.08	£7.34	£6.39
Pay Gap %	35.5%	32.1%	28.4%

Median Hourly Rate			
Gender	2017	2018	2019
Male	£13.65	£17.43	£17.70
Female	£12.15	£14.18	£14.57
Difference	£1.50	£3.26	£3.19
Pay Gap %	11.0%	18.7%	18.0%

To view the Trust's Gender Pay Gap report and improvement priorities, please go to:
https://www.porthosp.nhs.uk/about-us/equality-and-diversity.htm

19. Off-payroll engagements

Off-payroll Engagements over six months and over £245 per day as at 31st March 2020

Number of existing arrangements as at 31st March 2020	4
Of which the number that have existed:	
For less than one year at the time of reporting	3

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 1 April 2019 and 31 March 2020	3
Of which:	
Number assessed as being covered by IR35	2
Number assessed as not being covered by IR35	1
Number engaged directly (through PSC contracted to department) and are on the departmental payroll	1
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

20. Exit packages (audited)

Reporting of compensation schemes - exit packages

Exit Packages 2019/20	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	27	**27**
£10,000 - £25,000	-	3	**3**
Total number of exit packages by type	**-**	**30**	**30**
Total cost (£)	£0	**£130,000**	**£130,000**

Exit Packages 2018/19	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	19	19
£10,000 - £25,000	-	2	**2**
£25,001 - £50,000	-	1	**1**
Total number of exit packages by type	**-**	**22**	**22**
Total cost (£)	£0	**£114,000**	**£114,000**

Exit packages: other (non-compulsory) departure payments				
	2019/20		**2018/19**	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Contractual payments in lieu of notice	30	130	22	114
Total	30	130	22	114
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	0	0	0	0

21. Expenditure on consultancy

The Trust spent a total of £1.8m on external consultancy in the year (£2.7 million in 2018/19).

CHAPTER 3 – FINANCIAL STATEMENTS

ANNUAL ACCOUNTS 2019/20

The accounts of Portsmouth Hospitals NHS Trust for the year ended 31 March 2020 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 15th June 2020 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, and they are based at Grosvenor House, Grosvenor Square, Southampton, SO15 2BE.

The audit fee for the 2019/20 annual accounts for statutory work carried out by external audit is £77,252 exclusive of non-recoverable V.A.T. Of this sum, £57,939 has been charged to 2019/20 and the balance, £19,313, will be charged in 2020/21.

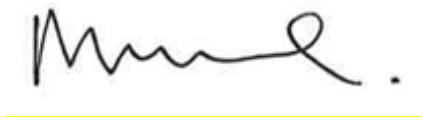
Statement of the Chief Executive's responsibilities as the accountable officer of the trust

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: Chief Executive

Date: 15.06.20

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

Mark Cubbon, Chief Executive

15 June 2020

Mark Orchard, Chief Financial Officer

15 June 2020

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

Opinion

We have audited the financial statements of Portsmouth Hospitals NHS Trust for the year ended 31 March 2020 under the Local Audit and Accountability Act 2014. The financial statements 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 49. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2019/20 HM Treasury's Financial Reporting Manual (the 2019/20 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2019/20 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 (the Accounts Direction).

In our opinion the financial statements:

- give a true and fair view of the financial position of Portsmouth Hospitals NHS Trust as at 31 March 2020 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the National Health Service Act 2006 and the Accounts Directions issued thereunder.

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 below. 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 (C&AG) 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.

Material uncertainty related to going concern

We draw attention to Note 1.2 in the financial statements, which highlights that the Trust has an underlying deficit and is reliant on additional support funding from NHSE&I during the going concern period. This disclosure also highlights the lack of national framework structure beyond July 2020. As stated in Note 1.2, these events or conditions indicate that a material uncertainty exists that may cast significant doubt on the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Emphasis of matter – Property, plant and equipment valuation

We draw attention to Note 1.26 *Sources of estimation uncertainty,* Note 16.1 *Property, plant and equipment 2019/20* and Note 18 *Revaluations of property, plant and equipment* of the financial statements, which describe the valuation uncertainty the Trust is facing as a result of COVID-19 in relation to property valuations. Our opinion is not modified in respect of this matter.

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.

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.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or

our knowledge obtained in the 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 or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of 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 Health Services Act 2006

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

Matters on which we are required to report by exception

We are required 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 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014; 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 2020.

We have nothing to report in these respects

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

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

For 2019/20 the statutory accounts indicate the Trust has a cumulative deficit at 31 March 2020 of £108.8 million over the five-year period to 31 March 2020. On 26 May 2020 we made a referral to the Secretary of State under Sections 30(1)(b) to confirm that the Trust is in breach of its break-even duty.

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 68, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. In preparing the financial statements, the Accountable Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accountable Officer either intends 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 Accountable Officer is responsible 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.

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, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in April 2020, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

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 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 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

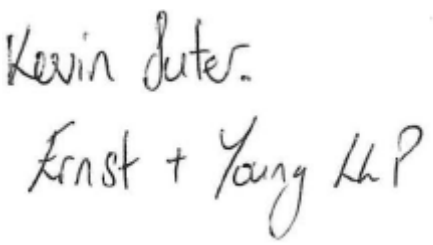
We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Certificate

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

Use of our report

This report is made solely to the Board of Directors of Portsmouth Hospitals NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014 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
23 June 2020

Statement of Comprehensive Income

	Note	2019/20 £000	2018/19 £000
Operating income from patient care activities	3	551,913	501,584
Other operating income	4	87,049	57,118
Operating expenses	6, 8	(617,710)	(575,691)
Operating surplus/(deficit) from continuing operations		**21,252**	**(16,989)**
Finance income	11	184	127
Finance expenses	12	(21,462)	(20,695)
PDC dividends payable		(50)	(675)
Net finance costs		**(21,328)**	**(21,243)**
Other gains / (losses)	13	94	(87)
Surplus / (deficit) for the year		**18**	**(38,319)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	16	(20)
Revaluations	18	(14,644)	7,976
Total comprehensive income / (expense) for the period		**(14,610)**	**(30,363)**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		18	(38,319)
Remove net impairments not scoring to the Departmental		16	(20)
Remove I&E impact of capital grants and donations		491	393
Adjusted financial performance surplus / (deficit)		**525**	**(37,946)**

Statement of Financial Position

		31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	15	3,651	2,693
Property, plant and equipment	16	369,787	380,663
Receivables	24	2,666	3,651
Total non-current assets		**376,104**	**387,007**
Current assets			
Inventories	23	15,092	14,878
Receivables	24	58,998	45,806
Cash and cash equivalents	26	3,902	4,584
Total current assets		**77,992**	**65,268**
Current liabilities			
Trade and other payables	27	(77,426)	(60,283)
Borrowings	29	(132,028)	(19,559)
Provisions	32	(255)	(346)
Other liabilities	28	(1,061)	(828)
Total current liabilities		**(210,770)**	**(81,016)**
Total assets less current liabilities		**241,860**	**371,259**
Non-current liabilities			
Borrowings	29	(209,461)	(330,243)
Provisions	32	(3,805)	(1,702)
Total non-current liabilities		**(213,266)**	**(331,945)**
Total assets employed		**30,060**	**39,314**
Financed by			
Public dividend capital		67,376	62,020
Revaluation reserve		126,383	141,886
Income and expenditure reserve		(163,699)	(164,592)
Total taxpayers' equity		**30,060**	**39,314**

The notes on pages 75 to 122 form part of these accounts.

Signed:

Name Mark Cubbon
Position Chief Executive
Date 15 June 2020

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**62,020**	**141,886**	**(164,592)**	**39,314**
Surplus/(deficit) for the year	-	-	18	**18**
Impairments	-	16	-	**16**
Revaluations	-	(14,644)	-	**(14,644)**
Transfer to retained earnings on disposal of assets	-	(875)	875	**-**
Public dividend capital received	5,356	-	-	**5,356**
Taxpayers' and others' equity at 31 March 2020	**67,376**	**126,383**	**(163,699)**	**30,060**

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**51,428**	**134,456**	**(126,799)**	**59,085**
Surplus/(deficit) for the year	-	-	(38,319)	**(38,319)**
Impairments	-	(20)	-	**(20)**
Revaluations	-	7,976	-	**7,976**
Transfer to retained earnings on disposal of assets	-	(526)	526	**-**
Public dividend capital received	10,592	-	-	**10,592**
Taxpayers' and others' equity at 31 March 2019	**62,020**	**141,886**	**(164,592)**	**39,314**

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	2019/20 £000	2018/19 £000
Cash flows from operating activities			
Operating surplus / (deficit)		21,252	(16,989)
Non-cash income and expense:			
Depreciation and amortisation	6	17,931	17,944
Net impairments	7	16	(20)
Income recognised in respect of capital donations	4	(129)	(251)
(Increase) / decrease in receivables and other assets		(16,347)	3,001
(Increase) / decrease in inventories		(214)	(538)
Increase / (decrease) in payables and other liabilities		19,107	(102)
Increase / (decrease) in provisions		1,934	(305)
Net cash flows from / (used in) operating activities		**43,550**	**2,740**
Cash flows from investing activities			
Interest received		191	124
Purchase of intangible assets		(1,980)	(1,596)
Purchase of Property Plant and Equipment and investment property		(17,951)	(13,958)
Sales of Property Plant and Equipment and investment property		126	53
Net cash flows from / (used in) investing activities		**(19,614)**	**(15,377)**
Cash flows from financing activities			
Public dividend capital received		5,356	10,592
Movement on loans from DHSC	29.2 & 29.3	(820)	33,980
Capital element of finance lease rental payments		(435)	(340)
Capital element of PFI, LIFT and other service concession payments		(7,050)	(6,880)
Interest on loans		(3,315)	(2,345)
Other interest		(1)	(3)
Interest paid on PFI, LIFT and other service concession obligations		(18,076)	(17,887)
PDC dividend (paid) / refunded		(277)	(1,000)
Net cash flows from / (used in) financing activities		**(24,618)**	**16,117**
Increase / (decrease) in cash and cash equivalents		**(682)**	**3,480**
Cash and cash equivalents at 1 April - brought forward		**4,584**	**1,104**
Prior period adjustments			-
Cash and cash equivalents at 1 April - restated		**4,584**	**1,104**
Cash and cash equivalents transferred under absorption	42	-	-
accounting Unrealised gains / (losses) on foreign exchange		-	-
Cash and cash equivalents at 31 March	26.1	**3,902**	**4,584**

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 2019/20 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Note 1.2 Going concern

These accounts have been prepared on a going concern basis, in accordance with the definition as set out in section 4 of the GAM which 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'.

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow their repayment. The affected loans totalling £122.7m are classified as current liabilities within these financial statements. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the Trust.

The Trust will therefore no longer be required to generate surpluses to eliminate its historic debt, and the total net assets will increase by £122.7m during financial year 2020/21 thereby strengthening the value of the balance sheet.

Whilst the Trust has an underlying deficit and is currently reliant on additional support funding during the going concern period, NHS England and Improvement have issued the Trust with a financial improvement trajectory and indicative financial recovery funds which will continue on reducing basis for the remaining four years of the Long Term Plan up to 2023/24.

The Trust has refreshed its financial plan consistent with the trajectory and this has been reviewed by Board members. The Trust and NHS Improvement have a clear understanding of the financial position of the Trust.

DHSC have also previously confirmed the availability of ongoing interim support (where required) to ensure that NHS providers remain operationally viable.

In March 2020 NHS England and Improvement announced revised arrangements for NHS contracting and payment to apply for the first four months of the 2020/21 year due to the Covid-19 pandemic. The

contracting arrangements for the rest of 2020/21 and beyond have not yet been definitively announced but it remains the case that the Government has issued a mandate to NHS England for the continued provision of services in England in 2020/21 and CCG allocations have been set for the remainder of the financial year to 31 March 2021. The Trust can therefore continue to expect NHS funding to flow at similar levels to that previously provided where services are reasonably still expected to be commissioned.

The Trust has prepared a cash forecast for the going concern period modelled on the expectation that the revised contracting and payment arrangements will remain in place until October 2020. The cash forecast shows sufficient liquidity for the Trust to continue to operate but interim support can be accessed if it were required.

These factors all support the adoption of the going concern concept. The underlying deficit, reliance on additional support from NHS England and Improvement and the lack of framework structure beyond July 2020 do, however, indicate the existence of material uncertainty which may cast significant doubt about the Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the Trust were unable to continue as a going concern.

Note 1.3 Subsidiaries

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.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

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 1.4 Revenue from contracts with customers

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

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

Revenue from NHS contracts

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

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.

Provider sustainability fund (PSF) and Financial recovery fund (FRF)

The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

Note 1.5 Other forms of income

Grants and donations

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

Note 1.6 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

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

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

Note 1.7 Expenditure on other goods and services

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

Note 1.8 Discontinued operations

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

Note 1.9 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised where:

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

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. 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 (i.e. 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.

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 all of the following criteria 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. 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**
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 1.10 Intangible Assets

Recognition

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

Internally generated intangible assets

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

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

Software

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

Measurement

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

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

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

Amortisation

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

Useful lives of intangible assets

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 1.11 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-outcost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of

stocks.

Note 1.12 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 1.13 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 and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

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 1.14 Leases

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

The Trust as 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 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk- adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2020:

		Nominal
Short-term	Up to 5 years	0.51%
Medium-term	After 5 years up to 10 years	0.55%
Long-term	Exceeding 10 years	1.99%

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

	Inflation rate
Year 1	1.90%
Year 2	2.00%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.5% in real terms.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 32.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any

excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 33 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 33, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

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

Note 1.17 Public dividend capital

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

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

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

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

Note 1.18 Value added tax

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

Note 1.19 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.

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.

The Trust has not made any gifts.

Note 1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

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 2021. 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 2021, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12

months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2021 for existing finance leases.

For leases commencing in 2021/22, 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.

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020.

The trust has estimated the impact of applying IFRS 16 in 2021/22 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 2021 statement of financial position

	£000
Additional right of use assets recognised for existing operating leases	6,446
Net impact on net assets on 1 April 2021	**6,446**

Estimated in-year impact in 2021/22

Additional depreciation on right of use assets	(1,082)
Additional finance costs on lease liabilities	(126)
Lease rentals no longer charged to operating expenditure	1,185
Other impact on income / expenditure	1
Estimated impact on surplus / deficit in 2021/22	**(22)**
Estimated increase in capital additions for new leases commencing in 2021/22	**-**

Other standards, amendments and interpretations

IFRS 14 Regulatory Deferral Accounts - not EU endorsed. Applies to first time adopted of IFRS after 1 January 2016

Therefore not applicable to DHSC group bodies.

IFRS 16 Leases - Standard is effective at 1 April 2021 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 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

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

The Trust has previously included the impact of the anticipated outcome of the PFI commercial settlement in line with the proposed agreement reached between all parties in December 2017 in the financial statements. The conclusion of these matters has been delayed due to the extended process and timetable which was required to secure the appointment of a replacement service provider. This was achieved in February 2019. As at 31st March 2020 the final negotiations and drafting arrangements in relation to these matters has been able to recommence progress with the December 2017 agreement forming the shared baseline for this work. The Trust has therefore maintained the previous assessment of the financial entries associated with these agreements in the accounts. The balance as at 31st March 2020 of circa £2m is recorded in payables and receivables. The settlement was concluded and the agreement signed in May 2020.

The property valuation exercise was carried out in February 2020 with a valuation date of 31 March 2020. The valuer has declared a 'material valuation uncertainty' in the valuation report, as disclosed in note 16.1.

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 (£628.5m 98%) is derived from 'non-trading' healthcare. Of the total income, 2% (£10.4m) 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	
	2019-20	2018-19	**2019-20**	2018-19	**2019-20**	2018-19
	£000's	£000's	**£000's**	£000's	**£000's**	£000's
Income						
External	**628,519**	548,743	**10,443**	9,959	**638,962**	558,702
Internal	**0**	0	**50,510**	43,234	**50,510**	43,234
Total Income	**628,519**	548,743	**60,953**	53,193	**689,472**	601,936
Expenditure						
Segment costs	**579,505**	545,125	**59,109**	51,584	**638,614**	596,709
Common costs	**50,510**	43,234	**330**	312	**50,840**	43,546
Total Expenditure	**630,015**	588,359	**59,439**	51,896	**689,454**	640,255
Retained surplus/(deficit) for the year	(1,496)	(39,616)	1,514	1,297	18	(38,319)

Note 3 Operating income from patient care activities

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

Note 3.1 Income from patient care activities (by nature)	2019/20 £000	2018/19 £000
Elective income	81,802	81,662
Non elective income	185,177	164,907
First outpatient income	35,549	36,491
Follow up outpatient income	42,275	33,943
A & E income	23,326	19,269
High cost drugs income from commissioners (excluding pass-through costs)	54,851	50,503
Other NHS clinical income	108,093	106,164
Private patient income	2,784	2,344
Agenda for Change pay award central funding*		4,205
Additional pension contribution central funding**	13,618	
Other clinical income	4,439	2,096
Total income from activities	**551,913**	**501,584**

*Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into tariff for individual services.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers 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:	2019/20 £000	2018/19 £000
NHS England	153,878	122,963
Clinical commissioning groups	392,891	369,349
Department of Health and Social Care	-	4,205
Other NHS providers	297	276
Non-NHS: private patients	2,784	2,345
Non-NHS: overseas patients (chargeable to patient)	724	460
Injury cost recovery scheme	665	1,047
Non NHS: other	674	939
Total income from activities	**551,913**	**501,584**

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

	2019/20	2018/19
	£000	£000
Income recognised this year	724	460
Cash payments received in-year	371	195
Amounts added to provision for impairment of receivables	129	22
Amounts written off in-year	176	96

Note 4 Other operating income

	2019/20			2018/19		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	4,998	-	**4,998**	4,760	-	**4,760**
Education and training	19,950	-	**19,950**	19,386	-	**19,386**
Non-patient care services to other bodies	12,138		**12,138**	12,712		**12,712**
Provider sustainability fund (PSF) & Financial recovery fund (FRF)	17,536		**17,536**	-		**-**
Marginal rate emergency tariff funding (MRET)	4,516		**4,516**			
Receipt of capital grants and donations		129	**129**		251	**251**
Charitable and other contributions to expenditure		1,087	**1,087**		184	**184**
Rental revenue from operating leases		1,562	**1,562**		1,515	**1,515**
Other income *	25,133	-	**25,133**	18,310	-	**18,310**
Total other operating income	**84,271**	**2,778**	**87,049**	**55,168**	**1,950**	**57,118**

* other contract income includes £10.5m Pharmacy Sales and £2.7m Income Generation

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

	2019/20	2018/19
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	828	655

Note 5.2 Transaction price allocated to remaining performance obligations

	31 March 2020	31 March 2019
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	£000	£000
within one year	-	-
after one year, not later than five years	-	-
after five years	-	-
Total revenue allocated to remaining performance obligations	**-**	**-**

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

Note 6 Operating expenses

	2019/20	2018/19
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	3,594	3,188
Purchase of healthcare from non-NHS and non-DHSC bodies	13,908	15,249
Staff and executive directors costs	359,161	328,477
Remuneration of non-executive directors	85	71
Supplies and services - clinical (excluding drugs costs)	54,573	52,862
Supplies and services - general	2,058	2,126
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	76,655	72,818
Inventories written down	-	40
Consultancy costs	1,797	2,711
Establishment	6,423	5,866
Premises	17,230	14,504
Transport (including patient travel)	1,011	752
Depreciation on property, plant and equipment	16,909	16,808
Amortisation on intangible assets	1,022	1,136
Net impairments	16	(20)
Movement in credit loss allowance: contract receivables / contract assets	186	-
Movement in credit loss allowance: all other receivables and investments	182	101
Change in provisions discount rate(s)	33	(264)
Audit fees payable to the external auditor		
audit services- statutory audit	93	100
other auditor remuneration (external auditor only)	9	10
Internal audit costs	71	85
Clinical negligence	16,289	18,402
Legal fees	738	652
Insurance	280	370
Research and development	4,345	4,215
Education and training	1,203	1,413
Rentals under operating leases	1,550	1,457
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	35,997	31,287
Hospitality	9	7
Other	2,283	1,268
Total	**617,710**	**575,691**
Of which:		
Related to continuing operations	617,710	575,691
Related to discontinued operations	-	-

Note 6.1 Other auditor remuneration

	2019/20	2018/19
	£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	9	10
Total	**9**	**10**

Note 6.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2018/19: £2m).

Note 7 Impairment of assets

	2019/20	2018/19
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	16	(20)
Total net impairments charged to operating surplus / deficit	**16**	**(20)**
Impairments charged to the revaluation reserve	(16)	20
Total net impairments	**-**	**-**

Note 8 Employee benefits

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	252,208	237,773
Social security costs	25,290	23,381
Apprenticeship levy	1,282	1,194
Employer's contributions to NHS pensions *	44,589	29,285
Temporary staff (external bank) **	26,520	21,126
Temporary staff (agency) **	16,221	21,376
Total gross staff costs	**366,110**	**334,135**
Recoveries in respect of seconded staff	-	-
Total staff costs	**366,110**	**334,135**
Of which		
Permanent Staff Costs capitalised as part of assets	1,831	1,093
Agency Staff Costs capitalised as part of assets **	773	350
	2,604	1,443

* Employers contributions to NHS pensions rose from 14.38% to 20.68% on 1st April 2019.

** Temporary staff was not reported separately as external bank and agency in 2018/19 - the comparator has been amended to reflect this split.

Note 8.1 Retirements due to ill-health

During 2019/20 there were 3 early retirements from the Trust agreed on the grounds of ill-health (3 in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is £266k (£163k in 2018/19).

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

Note 9 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as at 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6%, and the Scheme Regulations were amended accordingly.

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

Note 10 Operating leases

Note 10.1 Portsmouth Hospitals NHS Trust as a lessor

This note discloses income generated in operating lease agreements where Portsmouth Hospitals 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.

	2019/20 £000	2018/19 £000
Operating lease revenue		
Minimum lease receipts	1,562	1,515
Total	**1,562**	**1,515**

	31 March 2020 £000	31 March 2019 £000
Future minimum lease receipts due:		
- not later than one year;	1,562	1,513
- later than one year and not later than five years;	1,049	2,169
- later than five years.	371	555
Total	**2,982**	**4,237**

Note 10.2 Portsmouth Hospitals NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Portsmouth Hospitals 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.

- Solent Industrial Estate - used for Pharmacy and Procurement, the lease period is for 15 years (expires 2020) and has an annual value of £139,000. The property will be vacated in June 2020.

- Mitchell Way lease - used for the health records storage and office buildings, the lease period is for 27 years (expires 2027) and has an annual value of £178,000.

- 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 £585,000.

	2019/20 £000	2018/19 £000
Operating lease expense		
Minimum lease payments	1,550	1,457
Total	**1,550**	**1,457**

	31 March 2020 £000	31 March 2019 £000
Future minimum lease payments due:		
- not later than one year;	1,588	1,430
- later than one year and not later than five years;	4,937	2,377
- later than five years.	4,163	2,019
Total	**10,688**	**5,826**
Future minimum sublease payments to be received	-	-

Note 11 Finance income

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

	2019/2 £00	2018/1 £00
Interest on bank accounts	184	127
Other finance income	-	-
Total finance income	**184**	**127**

Note 12.1 Finance expenditure

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

	2019/20 £000	2018/19 £000
Interest expense:		
Loans from the Department of Health and Social Care	3,307	2,586
Interest on late payment of commercial debt	1	3
Main finance costs on PFI and LIFT schemes obligations	11,587	11,947
Contingent finance costs on PFI and LIFT scheme obligations	6,489	5,940
Total interest expense	**21,384**	**20,476**
Unwinding of discount on provisions	78	219
Other finance costs	-	-
Total finance costs	**21,462**	**20,695**

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

	2019/20 £000	2018/19 £000
Amounts included within interest payable arising from claims made under this legislation	1	3

Note 13 Other gains / (losses)

	2019/20 £000	2018/19 £000
Gains on disposal of assets	126	31
Losses on disposal of assets	(32)	(118)
Total gains / (losses) on disposal of assets	**94**	**(87)**
Other gains / (losses)	-	-
Total other gains / (losses)	**94**	**(87)**

Note 14 Discontinued operations

There are no discontinued operations.

Note 15.1 Intangible assets - 2019/20

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2019 - brought	**10,159**	**10,159**
Additions	1,980	**1,980**
Disposals / derecognition	(2,465)	**(2,465)**
Valuation / gross cost at 31 March 2020	**9,674**	**9,674**
Amortisation at 1 April 2019 - brought forward	**7.466**	**7.466**
Provided during the year	1,022	**1,022**
Disposals / derecognition	(2,465)	**(2,465)**
Amortisation at 31 March 2020	**6,023**	**6,023**
Net book value at 31 March 2020	**3.651**	**3.651**
Net book value at 1 April 2019	**2,693**	**2,693**

Note 15.2 Intangible assets - 2018/19

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2018		
Additions	1,596	**1,596**
Disposals / derecognition	(130)	**(130)**
Valuation / gross cost at 31 March 2019	**10,159**	**10,159**
Amortisation at 1 April 2018	**6.460**	**6.460**
Provided during the year	1,136	**1,136**
Disposals / derecognition	(130)	**(130)**
Amortisation at 31 March 2019	**7,466**	**7,466**
Net book value at 31 March 2019	**2.693**	**2.693**
Net book value at 1 April 2018	**2,233**	**2,233**

Note 16.1 Property, plant and equipment - 2019/20

	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 2019 - brought forward	**26,597**	**317,257**	**3,262**	**469**	**83,342**	**61**	**29,882**	**3,389**	**464,259**
Additions	-	10,392	132	2,526	3,748	-	3,904	7	**20,709**
Reversals of impairments	-	16	-	-	-	-	-	-	**16**
Revaluations *	16	(15,269)	90	-	1,528	1	-	68	**(13,566)**
Reclassifications	-	62	-	(62)	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(9,149)	(22)	(13,485)	(505)	**(23,161)**
Valuation/gross cost at 31 March 2020	**26,613**	**312,458**	**3,484**	**2,933**	**79,469**	**40**	**20,301**	**2,959**	**448,257**
Accumulated depreciation at 1 April 2019 - brought forward	**-**	**556**	-	**-**	**57,793**	**61**	**22,899**	**2,287**	**83,596**
Provided during the year	-	8,527	139	-	5,153	-	2,868	222	**16,909**
Impairments	-	16	-	-	-	-	-	-	**16**
Revaluations	-	-	-	-	1,031	1	-	46	**1,078**
Disposals / derecognition	-	-	-	-	(9,117)	(22)	(13,485)	(505)	**(23,129)**
Accumulated depreciation at 31 March 2020	**-**	**9,099**	**139**	**-**	**54,860**	**40**	**12,282**	**2,050**	**78,470**
Net book value at 31 March 2020	**26,613**	**303,359**	**3,345**	**2,933**	**24,609**	**-**	**8,019**	**909**	**369,787**
Net book value at 1 April 2019	**26,597**	**316,701**	**3,262**	**469**	**25,549**	**-**	**6,983**	**1,102**	**380,663**

* The valuation exercise was carried out in February 2020 with a valuation date of 31 March 2020. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust. The revaluation reflects a reduction in the location factors used by the valuer, unrelated to Covid-19.

Note 16.2 Property, plant and equipment - 2018/19

	Land	Buildings excluding Dwellings (Restated)	Dwellings (Restated)	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018	**25,325**	**327,857**	**3,319**	**-**	**78,471**	**80**	**27,257**	**3,312**	**465,621**
Additions	-	6,717	735	469	10,001	-	2,696	26	**20,644**
Impairments	-	(20)	-	-	-	-	-	-	**(20)**
Revaluations **	1,272	(17,297)	(792)	-	1,034	1	-	51	(15,731)
Disposals / derecognition	-	-	-	-	(6,164)	(20)	(71)	-	**(6,255)**
Valuation/gross cost at 31 March 2019	**26,597**	**317,257**	**3,262**	**469**	**83,342**	**61**	**29,882**	**3,389**	**464,259**
Accumulated depreciation at 1 April 2018 - as previously stated	**-**	**16,328**	**270**	**-**	**57,586**	**79**	**20,352**	**2,015**	**96,630**
Provided during the year	-	8,321	132	-	5,495	1	2,618	241	**16,808**
Reversals of impairments	-	(20)	-	-	-	-	-	-	**(20)**
Revaluations **	-	(24,073)	(402)	-	736	1	-	31	(23,707)
Disposals / derecognition	-	-	-	-	(6,024)	(20)	(71)	-	(6,115)
Accumulated depreciation at 31 March 2019	**-**	**556**	**-**	**-**	**57,793**	**61**	**22,899**	**2,287**	**108,071**
Net book value at 31 March 2019	**26,597**	**316,701**	**3,262**	**469**	**25,549**	**-**	**6,983**	**1,102**	**380,663**
Net book value at 1 April 2018	**25,325**	**311,529**	**3,049**	**-**	**20,885**	**1**	**6,905**	**1,297**	**368,991**

** The 2018/19 comparator has been restated to reset the accumulated depreciation for buildings that were revalued in March 2019. This was omitted in error in the 2018/19 accounts and the previously stated values were Gross Cost Revaluations £8,744k and Accumulated Depreciation Revaluations £768k. There is no impact on the net book value.

Note 16.3 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020									
Owned - purchased	26,613	5,729	3,345	2,933	21,705	-	8,010	909	**69,244**
Finance leased	-	-	-	-	1,625	-	-	-	**1,625**
On-SoFP PFI contracts and other service concession arrangements	-	293,440	-	-	-	-	-	-	**293,440**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	-	-	**-**
Owned - donated	-	4,190	-	-	1,279	-	9	-	**5,478**
NBV total at 31 March 2020	**26,613**	**303,359**	**3,345**	**2,933**	**24,609**	**-**	**8,019**	**909**	**369,787**

Note 16.4 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019									
Owned - purchased	26,597	4,482	3,262	469	22,020	-	6,963	1,102	**64,895**
Finance leased	-	-	-	-	1,976	-	-	-	**1,976**
On-SoFP PFI contracts and other service concession arrangements	-	307,763	-	-	-	-	-	-	**307,763**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	-	-	**-**
Owned - donated	-	4,456	-	-	1,553	-	20	-	**6,029**
NBV total at 31 March 2019	**26,597**	**316,701**	**3,262**	**469**	**25,549**	**-**	**6,983**	**1,102**	**380,663**

Note 17 Donations of property, plant and equipment

The donated assets were received from the Portsmouth Hospitals Charity (registered charity number 1047986).

Note 18 Revaluations of property, plant and equipment

All land and buildings have been restated to modern equivalent asset value based on a valuation carried out in March 2019, refreshed by a desktop valuation at 31st March 2020 by the District Valuer from the Revenue and Customs Government Department.

The valuation exercise was carried out in February 2020 with a valuation date of 31 March 2020. The valuer has declared a 'material valuation uncertainty' in the valuation report as disclosed in Note 16.1.

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 £46.6m

Note 19 Investment Property

The Trust does not hold any investment property.

Note 20 Investments in associates and joint ventures

The Trust does not hold any investments in associates and joint ventures.

Note 21 Other investments / financial assets

The Trust does not hold any other investments or financial assets.

Note 22 Disclosure of interests in other entities

The Trust does not have any interests in other entities.

Note 23 Inventories

	2020 £000	**201 £00**
Drugs	7,590	7,292
Consumables	7,502	7,586
Total inventories	**15,092**	**14,878**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £108,510k (2018/19: £89,986k). Write-down of inventories recognised as expenses for the year were £0k (2018/19: £40k).

Note 24.1 Receivables

	31 March 2020 £000	31 March 2019 £000
Current		
Contract receivables	37,917	25,326
Allowance for impaired contract receivables / assets	(207)	(21)
Allowance for other impaired receivables	(1,005)	(838)
Prepayments (non-PFI)	4,611	4,473
PFI lifecycle prepayments	5,000	7,040
Interest receivable	-	7
PDC dividend receivable	520	293
VAT receivable	3,893	3,104
Other receivables	8,269	6,422
Total current receivables	**58,998**	**45,806**
Non-current		
Contract assets	864	1,001
Prepayments (non-PFI)	330	-
Interest receivable	1,472	2,650
Total non-current receivables	**2,666**	**3,651**
Of which receivable from NHS and DHSC group bodies:		
Current	35,294	20,242
Non-current	1,472	-

Note 24.2 Allowances for credit losses

	2019/20		2018/19	
	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	**21**	**838**	**-**	**799**
Prior period adjustments			-	-
Allowances as at 1 April - restated	**21**	**838**	**-**	**799**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018			21	(21)
New allowances arising	207	397	-	131
Changes in existing allowances	-	-	-	-
Reversals of allowances	(21)	(215)	-	(30)
Utilisation of allowances (write offs)	-	(15)	-	(41)
Allowances as at 31 Mar 2020	**207**	**1,005**	**21**	**838**

Note 24.3 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. The maximum exposures as at 31st March 2020 are in receivables from customers, as disclosed in the trade and other receivables note.

Note 24.4 Other assets

The Trust does not hold any other assets.

Note 25.1 Non-current assets held for sale and assets in disposal groups

The Trust does not have any non-current assets held for sale or assets in disposal groups.

Note 25.2 Liabilities in disposal groups

The Trust does not have any liabilities in disposal groups.

Note 26.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents.

	2019/20	2018/19
	£000	£000
At 1 April	**4,584**	**1,104**
Prior period adjustments		-
At 1 April (restated)	**4,584**	**1,104**
At start of period for new FTs	**-**	**-**
Transfers by absorption	-	-
Net change in year	(682)	3,480
At 31 March	**3,902**	**4,584**
Broken down into:		
Cash at commercial banks and in hand	31	52
Cash with the Government Banking Service	3,871	4,532
Deposits with the National Loan Fund Other	-	-
current investments	-	-
Total cash and cash equivalents as in SoFP	**3,902**	**4,584**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**3,902**	**4,584**

Note 26.2 Third party assets held by the Trust

Portsmouth Hospitals NHS 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 27.1 Trade and other payables

	31 March 2020 £000	31 March 2019 £000
Current		
Trade payables	9,773	10,339
Capital payables	6,161	7,892
Accruals	3,271	2,003
Social security costs	3,826	3,455
Other taxes payable	3,322	3,071
Other payables	51,073	33,523
Total current trade and other payables	**77,426**	**60,283**
Non-current		
Other payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	6,565	6,129
Non-current	-	-

Note 27.2 Early retirements in NHS payables above

The Trust has no liabilities in relation to early retirements (2019/20 £0).

Note 28 Other liabilities

	31 March 2020 £000	31 March 2019 £000
Current		
Deferred income: contract liabilities	1,061	828
Total other current liabilities	**1,061**	**828**
Non-current		
Other deferred income	-	-
Total other non-current liabilities	**-**	**-**

Note 29.1 Borrowings

	31 March 2020 £000	31 March 2019 £000
Current		
Loans from DHSC *	125,534	12,074
Obligations under finance leases	354	435
Obligations under PFI, LIFT or other service concession contracts	6,140	7,050
Total current borrowings	**132,028**	**19,559**
Non-current		
Loans from DHSC *	-	114,288
Obligations under finance leases	997	1,351
Obligations under PFI, LIFT or other service concession contracts	208,464	214,604
Total non-current borrowings	**209,461**	**330,243**

* On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loans totalling £122.7m are classified as current liabilities within these financial statements. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the Trust.

Note 29.2 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2019	**126,362**	**1,786**	**221,654**	**349,802**
Cash movements:				
Financing cash flows - payments and receipts of principal	(820)	(435)	(7,050)	**(8,305)**
Financing cash flows - payments of interest	(3,315)	-	(11,587)	**(14,902)**
Non-cash movements:				
Application of effective interest rate	3,307	-	11,587	**14,894**
Carrying value at 31 March 2020	**125,534**	**1,351**	**214,604**	**341,489**

Note 29.3 Reconciliation of liabilities arising from financing activities - 2018/19

	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2018	**92,005**	**822**	**228,534**	**321,361**
Cash movements:				
Financing cash flows - payments and receipts of principal	33,980	(340)	(6,880)	**26,760**
Financing cash flows - payments of interest	(2,345)	-	(11,947)	**(14,292)**
Non-cash movements:				
Impact of implementing IFRS 9 on 1 April 2018	136	-	-	**136**
Additions	-	1,304	-	**1,304**
Application of effective interest rate	2,586	-	11,947	**14,533**
Carrying value at 31 March 2019	**126,362**	**1,786**	**221,654**	**349,802**

Note 30 Other financial liabilities

The Trust does not have any other financial liabilities.

Note 31 Finance leases

Note 31.1 Portsmouth Hospitals NHS Trust as a lessor

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

Note 31.2 Portsmouth Hospitals NHS Trust as a lessee

Obligations under finance leases where the trust is the lessee.

	31 March 2020 £000	31 March 2019 £000
Gross lease liabilities	**1,351**	**1,786**
of which liabilities are due:		
- not later than one year;	354	435
- later than one year and not later than five years;	907	1,080
- later than five years.	90	271
Net lease liabilities	**1,351**	**1,786**
of which payable:		
- not later than one year;	354	435
- later than one year and not later than five years;	907	1,080
- later than five years.	90	271

Note 32.1 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 2019	**352**	**1,443**	**253**	**-**	**2,048**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**
Change in the discount rate	**(12)**	**45**	**-**	**-**	**33**
Arising during the year	**-**	**664**	**17**	**1,472**	**2,153**
Utilised during the year	(29)	(70)	(38)	-	**(137)**
Reclassified to liabilities held in disposal groups	**-**	**-**	**-**	**-**	**-**
Reversed unused	**(3)**	**(36)**	**(76)**	**-**	**(115)**
Unwinding of discount	**24**	**54**	**-**	**-**	**78**
At 31 March 2020	**332**	**2,100**	**156**	**1,472**	**4,060**
Expected timing of cash flows:					
- not later than one year;	29	70	156	**-**	**255**
- later than one year and not later than five years;	116	280	-	**-**	**396**
- later than five years.	187	1,750	-	**1,472**	**3,409**
Total	**332**	**2,100**	**156**	**1,472**	**4,060**

* 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 32.2 Clinical negligence liabilities

At 31 March 2020, £414,452k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Portsmouth Hospitals NHS Trust (31 March 2019: £414,407k).

Note 33 Contingent assets and liabilities

	31 March 2020 £000	31 March 2019 £000
Value of contingent liabilities		
NHS Resolution legal claims *	(37)	(45)
Employment tribunal and other employee related litigation **	(75)	(123)
Gross value of contingent liabilities	**(112)**	**(168)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(112)**	**(168)**
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.

Note 34 Contractual capital commitments

The Trust has no contractual capital commitments.

Note 35 Other financial commitments

The Trust is not committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangements).

Note 36 On-SoFP PFI, LIFT or other service concession arrangements

Note 36.1 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 2020 £000	31 March 2019 £000
Gross PFI, LIFT or other service concession liabilities	**350,895**	**369,532**
Of which liabilities are due		
- not later than one year;	17,358	18,637
- later than one year and not later than five years;	73,933	74,045
- later than five years.	259,604	276,850
Finance charges allocated to future periods	(136,291)	(147,878)
Net PFI, LIFT or other service concession arrangement obligation	**214,604**	**221,654**
- not later than one year;	6,140	7,050
- later than one year and not later than five years;	32,896	31,368
- later than five years.	175,568	183,236

Note 36.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

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

	31 March 2020 £000	31 March 2019 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**1,327,419**	**1,385,410**
Of which payments are due:		
- not later than one year;	63,972	63,697
- later than one year and not later than five years;	255,888	254,788
- later than five years.	1,007,559	1,066,925

Note 36.3 Analysis of amounts payable to service concession operator

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

	2019/20	2018/19
	£000	£000
Unitary payment payable to service concession operator	**64,830**	**58,698**
Consisting of:		
- Interest charge	11,587	11,947
- Repayment of balance sheet obligation	7,050	6,880
- Service element and other charges to operating expenditure	35,605	30,203
- Capital lifecycle maintenance	3,707	2,644
- Revenue lifecycle maintenance	392	1,084
- Contingent rent	6,489	5,940
Total amount paid to service concession operator	**64,830**	**58,698**

Note 37 Off-SoFP PFI, LIFT and other service concession arrangements

The Trust does not have any off-Statement of Financial Position PFI and LIFT

Note 38 Financial instruments

Note 38.1 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.

All loans received are from the Department of Health 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 38.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2020	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	47,310	-	-	**47,310**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents	3,902	-	-	**3,902**
Total at 31 March 2020	**51,212**	**-**	**-**	**51,212**

Carrying values of financial assets as at 31 March 2019	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	31,897	-	-	**31,897**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents	4,584	-	-	**4,584**
Total at 31 March 2019	**36,481**	**-**	**-**	**36,481**

Note 38.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	125,534	-	**125,534**
Obligations under finance leases	1,351	-	**1,351**
Obligations under PFI, LIFT and other service concession contracts	214,604	-	**214,604**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	70,278	-	**70,278**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2020	**411,767**	**-**	**411,767**

Carrying values of financial liabilities as at 31 March 2019	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	126,362	-	**126,362**
Obligations under finance leases	1,786	-	**1,786**
Obligations under PFI, LIFT and other service concession contracts	221,654	-	**221,654**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	53,756	-	**53,756**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2019	**403,558**	**-**	**403,558**

Note 38.4 Maturity of financial liabilities

	31 March 2020 £000	31 March 2019 £000
In one year or less	202,305	73,314
In more than one year but not more than two years	7,621	83,742
In more than two years but not more than five years	26,182	62,435
In more than five years	175,659	184,067
Total	**411,767**	**403,558**

Note 38.5 Fair values of financial assets and liabilities

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

Note 39 Losses and special payments

	2019/20		2018/19	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	39	16	30	20
Bad debts and claims abandoned	491	200	363	110
Stores losses and damage to property	1	51	2	60
Total losses	**531**	**267**	**395**	**190**
Special payments				
Ex-gratia payments	94	143	89	61
Total special payments	**94**	**143**	**89**	**61**
Total losses and special payments	**625**	**410**	**484**	**251**
Compensation payments received		-		-

Note 40 Gifts

The Trust has not made any gifts.

Note 41 Related parties

Portsmouth Hospitals 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 Ministers, Portsmouth Hospitals 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 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 2020.

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Health Education England	62	20,192	20	60
NHS Coastal West Sussex CCG	0	7,650	51	0
NHS England	7	163,683	238	20,292
NHS Fareham and Gosport CCG	254	119,847	939	1,205
NHS Portsmouth CCG	1	135,706	1,471	1,495
NHS Resolution	16,553	0	0	0
NHS South Eastern Hampshire CCG	254	110,268	637	1,100
NHS West Hampshire CCG	0	12,047	0	812
University Hospital Southampton NHS Foundation Trust	1,843	8,532	730	2,402

The Trust has also received revenue and capital payments from a number of charitable funds, including Portsmouth Hospitals Charity and the League of Friends. Portsmouth Hospitals NHS Trust is the corporate trustee of the Portsmouth Hospitals Charity. The total value of grants made to the Trust by the Charity was £2.3m.

Note 42 Transfers by absorption

The Trust has not been involved in any transfers by absorption.

Note 43 Prior period adjustments

There have been no prior period adjustments.

Note 44 Events after the reporting date

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. Given this relates to liabilities that existed at 31 March 2020, DHSC has updated its Group Accounting Manual to advise this is considered an adjusting event after the reporting period for providers. Outstanding interim loans totalling £122.7m as at 31 March 2020 in these financial statements have been classified as current as they will be repayable within 12 months.

Note 45 Better Payment Practice code

	2019/20 Number	2019/20 £000	2018/19 Number	2018/19 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	103,879	285,622	108,405	291,635
Total non-NHS trade invoices paid within target	43,058	191,705	50,873	205,789
Percentage of non-NHS trade invoices paid within target	41.5%	67.1%	46.9%	70.6%
NHS Payables				
Total NHS trade invoices paid in the year	2,809	15,244	2,555	13,929
Total NHS trade invoices paid within target	2,285	11,660	2,051	11,069
Percentage of NHS trade invoices paid within target	81.3%	76.5%	80.3%	79.5%

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

Note 46 External financing limit

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

	2019/20 £000	2018/19 £000
Cash flow financing	(2,267)	32,568
Finance leases taken out in year	-	1,304
Other capital receipts	-	-
External financing requirement	**(2,267)**	**33,872**
External financing limit (EFL)	574	35,935
Under / (over) spend against EFL	**2,841**	**2,063**

Note 47 Capital Resource Limit

	2019/20 £000	2018/19 £000
Gross capital expenditure	22,689	22,240
Less: Disposals	(32)	(140)
Less: Donated and granted capital additions	(129)	(251)
Plus: Loss on disposal from capital grants in kind	-	-
Charge against Capital Resource Limit	**22,528**	**21,849**
Capital Resource Limit	22,529	22,774
Under / (over) spend against CRL	**1**	**925**

Note 48 Breakeven duty financial performance

	2019/20 £000	2018/19 £000
Adjusted financial performance surplus / (deficit) (control total basis)	525	(37,946)
IFRIC 12 breakeven adjustment	1,183	2,120
Breakeven duty financial performance surplus / (deficit)	**1,708**	**(35,826)**

Note 49 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		(14,877)	159	148	4,293	830
Breakeven duty cumulative position	9,479	(5,398)	(5,239)	(5,091)	(798)	32
Operating income		432,167	446,161	440,231	451,906	469,094
Cumulative breakeven position as a percentage of operating income*		(1.2%)	(1.2%)	(1.2%)	(0.2%)	0.0%

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(2,912)	(23,477)	(17,645)	(30,701)	(35,826)	1,708
Breakeven duty cumulative position	(2,880)	(26,357)	(44,002)	(74,703)	(110,529)	(108,821)
Operating income	484,463	504,572	530,382	543,069	558,702	638,962
Cumulative breakeven position as a percentage of operating income*	(0.6%)	(5.2%)	(8.3%)	(13.8%)	(19.8%)	(17.0%)

* 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 48 and does not count in the performance against the control total for the year.

APPENDIX 1 - Salary and Pension entitlements of senior managers 2019/20 (Audited)

Name	Title	Start date/leaving date (where not in post for full year)	2019/20 Salary (bands of £5,000) £000	2019/20 Expenses Payments (Taxable) (total to nearest £100)	2019/20 Performance Pay and Bonuses (bands of £5,000)	2019/20 Long Term Performance Pay and Bonuses (bands of £5,000)	2019/20 All Pension Related Benefits (bands of £2,500)	2019/20 TOTAL (bands of £5,000)	2018/19 Salary (bands of £5,000) £000	2018/19 Expenses Payments (Taxable) (total to nearest £100)	2018/19 Performance Pay and Bonuses (bands of £5,000)	2018/19 Long Term Performance Pay and Bonuses (bands of £5,000)	2018/19 All Pension Related Benefits (bands of £2,500)	2018/19 TOTAL (bands of £5,000)
Executive Directors in post at 31st March 2020														
Mark Cubbon	Chief Executive		205-210	-	-	-	82.5-85.0	285-290	185-190	-	-	-	95-97.5	280-285
John Knighton	Medical Director		165-170 *	-	-	-	45.0-47.5	200-205	160-165 *	-	-	-	140-142.5	300-305
Mark Orchard	Chief Financial Officer	From 01/10/19	70-75	-	-	-	27.5-30.0	100-105	-	-	-	-	-	-
Nigel Kee	Interim Chief Operating Officer	From 03/09/19	100-105	-	-	-	152.5-155.0	250-255	-	-	-	-	-	-
Penny Emerit	Director of Strategy and Performance		155-160	-	-	-	70.0-72.5	225-230	135-140	-	-	-	37.5-40	170-175
Lois Howell	Director of Governance & Risk		105-110	-	-	-	25-27.5	135-140	100-105	-	-	-	32.5-35	135-140
Liz Rix	Chief Nurse	From 10/06/19	80-85	-	-	-	0.0	80-85	-	-	-	-	-	-
Nicole Cornelius	Director of Workforce & Organisational Development	From 01/10/18	130-135	-	-	-	32.5-35.0	160-165	55-60	-	-	-	0-2.5	55-60
Executive Directors who left during the year ended 31st March 2020														
Adcock Chris	Chief Financial Officer	Until 30/06/19	40-45	0	-	-	10-12.5	50-55	160-165	-	-	-	35-37.5	200-205
Paul Bytheway	Chief Operating Officer	Until 30/06/19	40-45	-	-	-	15-17.5	60-65	145-150	-	-	-	165-167.5	315-320
Emma McKinney	Director of Communications	Until 02/08/19	25-30	-	-	-	7.5-10.0	35-40	80-85	-	-	-	60-62.5	145-150
Executive Directors who left during the year ended 31st March 2019														
Tim Powell	Director of Workforce & Organisational Development (Interim Chief	Until 15/04/18	-	-	-	-	-	-	5-10	-	-	-	0-2.5	5-10
Mark Power	Interim Director of Workforce & Organisational Development	From 11/04/18 until 06/09/18	-	-	-	-	-	-	45-50	-	-	-	(17.5)-(20)	30-35
Theresa Murphy	Chief Nurse	Until 17/03/19	-	-	-	-	-	-	130-135	-	-	-	137.5-140	270-275
Non- Executive Directors in post at 31st March 2020														
Melloney Poole	Chair		35-40	-	-	-	-	35-40	35-40	-	-	-	-	35-40
Christine Slaymaker	Non-Executive Director		5-10	600	-	-	-	5-10	5-10	1,100	-	-	-	5-10
David Parfitt	Non-Executive Director		5-10	1,200	-	-	-	5-10	5-10	1,300	-	-	-	5-10
Gary Hay	Non-Executive Director		5-10	-	-	-	-	5-10	5-10	-	-	-	-	5-10
Roger Burke-Hamilton	Non-Executive Director	From 04/10/18	5-10	-	-	-	-	5-10	0-5	-	-	-	-	0-5
Martin Rolfe	Non-Executive Director	From 20/09/18	5-10	-	-	-	-	5-10	0-5	-	-	-	-	0-5
Non- Executive Directors who left during the year ended 31st March 2020														
N/A			-	-	-	-	-	-	-	-	-	-	-	-
Non- Executive Directors who left during the year ended 31st March 2019														
Jon Watson	Non-Executive Director	Until 16/09/18	-	-	-	-	-	-	0-5	600	-	-	-	0-5
			-	-	-	-	-	-	-	-	-	-	-	-
			-	-	-	-	-	-	-	-	-	-	-	-
			-	-	-	-	-	-	-	-	-	-	-	-
			-	-	-	-	-	-	-	-	-	-	-	-

* Medical Director salary and pension entitlements includes remuneration for work other than management responsibilities of £40k-£45k (£65k-£70k in 2018/19)

Signed: Chief Executive:

Date: 15 June 2020

Salary and Pension entitlements of senior managers (Audited)

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 31/03/2020 (bands of £5,000) £000	Lump sum at pension age related to accrued pension 31/03/2020 (bands of £5,000) £000	Cash equivalent transfer value 31/03/2020 £000	Cash equivalent transfer value 31/03/2019 £000	Real increase in cash equivalent transfer value (bands of £5,000) £000	Emplo Contribu Stakeh Pensi To neare
Mark Cubbon	Chief Executive	5-7.5	2.5-5	50-55	105-110	849	743	85-90	0
John Knighton	Medical Director	2.5-5	0-2.5	70-75	185-190	1,562	1,442	80-85	0
Mark Orchard	Chief Financial Officer	0-2.5	0-2.5	40-45	80-85	634	816	30-35***	0
Nigel Kee	Interim Chief Operating Officer	5-7.5	15-17.5	45-50	140-145	1,125	656	155-160***	0
Penny Emerit	Director of Strategy and Performance	2.5-5	2.5-5	25-30	45-50	368	312	45-50	0
Lois Howell	Director of Governance & Risk	0-2.5	0-2.5	10-15	20-25	214	181	25-30	0
Liz Rix	Chief Nurse	0	0	0	0	0	0	0	0
Nicole Cornelius	Director of Workforce & Organisational Development	0-2.5	0-0	0-5	0**	48	48	30-35	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.

*** For those officers who joined part way through the year, only the increase relating to the time worked at Portsmouth Hospitals NHS Trust is shown

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 value 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: 15 June 2020