Portsmouth Hospitals NHS
NHS Trust

Portsmouth Hospitals NHS Trust Annual Report 2018/2019

Annual report and accounts 2018 – 2019

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WELCOME

2018/19 was a year in which the Trust made progress in many areas. We were delighted to launch our five year strategy in July 2018, responding directly to feedback from staff on the need for a clear and coherent vision for the Trust's future. 'Working Together' was the culmination of many months work and outlines both our vision and strategic aims, underpinned by a set of refreshed Trust values. The strategy launch coincided with our internal restructure to create four clinical Divisions, clinically led and responsible for the quality, performance and financial sustainability of their departments and services. Along with the launch of our strategy this has been a fundamental step towards transforming the organisation.

A central part of our strategy is working together with our partners, building on the positive and collaborative relationships we have established. Throughout the year we have continued to work closely with our military colleagues, system partners, key stakeholders and our local communities with the aim of delivering the best possible care for those we all look after. Much progress has been achieved by this partnership working and we remain firmly focused on maintaining this approach to resolve the challenges which remain.

During the spring of 2018 the Care Quality Commission (CQC) undertook a comprehensive inspection of the Trust. Whilst this resulted in no change to our overall rating as 'Requires Improvement', it was encouraging that they noted some real progress in many areas and acknowledged the clear impetus for change. All of the identified areas for improvement were in areas already known to us and the work to address them is already making an impact.

Many of the challenges the organisation faces are long term issues which we know will not be solved overnight; however, we have continued to drive improvements for our patients across all areas. Perhaps one of the most publicised and perpetual issues for the Trust is our urgent and emergency care pathway, which has remained a challenge. Whilst winter 2018/19 was not as pressured as the one which preceded it we experienced significant and persistent peaks in demand in common with many other parts of the country. Indeed similar levels of pressure were also experienced throughout the height of the summer months. In December our work to make improvements in this area was given a significant boost with the announcement of £58 million of central government funding towards redeveloping our urgent care floor in the hospital. This piece of work, alongside our urgent care transformation programme is central to delivering a better experience for our patients and staff in the longer term.

Our three year culture change programme has continued its roll out, with the recruitment of our first group of Change Agents being a particular highlight. The initial 'Design' phase concluded with a detailed report from our Change Agents about where we need to make improvements and we can now look forward to their ongoing work on how we best implement the required changes. The feedback we received from Professor Duncan Lewis in his report on workplace behaviours within the Trust further underlined the importance of our culture change programme in setting the foundations for an organisation where we can all be proud to work. We look forward to the continued progress in the coming year.

The support we receive from our local community continues to overwhelm us and in 2018/19 was demonstrated yet again with the successful conclusion of our Rocky fundraising appeal, having reached our £2.4 million fundraising target. An extremely generous anonymous donation helped us reach the final amount, securing the future of the Da Vinci robot at the Trust and allowing us to continue to offer leading edge robotic surgery to our patients.

It is not possible to pick out one highlight of the past 12 months, but our staff remain the constant factor in any of our successes. They have delivered with professionalism and where there have been challenges they have responded with an unwavering focus on what is best for our patients. We continue to lead the organisation with immense pride in what the Trust does for its patients and we are grateful to every member of staff for their contribution.

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.

Carillion went into Compulsory Liquidation on 15 January 2018 and contingency plans were enacted to ensure continued delivery of the facilities management services. On 1 February 2019 Engie were confirmed as supplier of Facilities Management (FM) services to the Trust.

Although we are not a University Hospital allied to a medical school, we are a major provider of under-graduate and post-graduate education working with three universities - Southampton, Portsmouth and Bournemouth. 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 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 disablement 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 Defence Medical Group (South) and the Trust remains as important as ever.

Under the command of Wing Commander Emma Redman, the military medical personnel, which encompass 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 robot.

A caring and charitable hospital

Portsmouth Hospitals Charity aims to serve our patients by providing additional facilities and equipment, supporting research and innovation in the development of services and the education of both patients and staff.

The charity supports all wards and departments throughout the Trust and people can choose to support and fundraise for an area of the hospital that is close to their heart.

The charity is grateful for the support it has received from patients, their friends and family, staff, and local businesses.

In May we were proud to announce the conclusion of the Rocky Appeal, having reached the £2.4 million fundraising target and securing the future of the Da Vinci robot at the Queen Alexandra hospital. Since the appeal began in 2014 over 1,000 patients have benefitted from the cutting edge robotic surgery resulting in reduced pain, less need for blood transfusions and a faster recovery time. This would simply not have been possible without the support and generosity of our local community to whom we owe a huge debt of gratitude.

Throughout the year we have also received wonderful support, including the Institute of Healthcare Engineering and Estate Management (IHEEM) who held their annual awards in Manchester and chose to fundraise for the Children's Bubbles Fund on the night, raising £3,138. Business Builders Networking selected us as their chosen charity for the second consecutive year and Astute also chose us as their charity of the year fundraising for cancer information and support, the Neonatal Intensive Care Unit and the Emergency Department. During the year, the Hospital Charity also benefitted from a hugely generous legacy donation of £1.1 million into the General Fund.

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.

We have increased our research activity significantly in the last year, offering more patients access to better care, services and treatments. Last year we were ranked by the National Institute for Health Research as being in the top two large acute trusts nationally reporting the biggest increase in research activity. At the end of 2018-19 we were ranked top Trust in the UK for complexity weighted recruitment to research studies for large acute Trusts.

In the last year we have seen a significant increase in the number of patients taking part in studies,

from 6,368 patients in 2017/18 to 11,789 in 2018/19. This increase was largely due to the Vision–D study (gathering vital signs through technology) which doubled our recruitment during the financial year. 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.

Organisational structure

During 2018 the Trust undertook an internal restructure which resulted in eleven Clinical Service Centers being replaced by four Clinical Divisions; Clinical Delivery, Medicine and Urgent Care, Networked Services, and Surgery and Outpatients.

The Divisional Structure was launched in July 2018. 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 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 in excess of 119,836 type 1 patients.
- We dealt with over 72,000 emergency admissions.
- We saw over 625,000 outpatients and carried out over 61,000 day case admissions
- 5,303 babies were delivered at our hospital sites or at home with our midwifery team.
- Our services were delivered by over 7,000 employees and over 600 volunteers.

Our strategic direction

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

- Fulfill our role for the communities we serve
    - Fulfill 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 6.1.2, the Trust was subject to a comprehensive CQC inspection in April and May 2018, following which the Trust was rated as 'Requires Improvement' and served with a Warning Notice issued under s 29A of the Health & Social Care Act 2008. The Trust has worked to address the findings and requirements set out in the inspection report and notice, and is pleased to confirm that all bar one of the conditions previously applied to the Trust's registration, as a result inspections in earlier years, have been lifted. The remaining condition requires continuing compliance with the provisions of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. The Trust has worked with commissioners, NHSI and other partners to deliver an improvement programme in all relevant areas.

Key issues and risks

Please refer to the Annual Governance Statement 2018/19 from page 32 of this document.

Adoption of going concern

The Trust prepares its accounts as a going concern. Full information can be found at note 12 within the financial statements section of this report.

Year at a glance

April 2018

- The Wessex Kidney Centre, based at the QA was rated ahead of all of our closest neighbouring centres in the UK Kidney Care annual report. Only three other transplant units in England and Wales were judged better by their patients
- We celebrated our re-accreditation for the Macmillan Quality Environment Mark which assess whether cancer care environments meet the standards required by people living with cancer. Our Macmillan centre, the haematology and oncology day unit and the haematology and oncology wards all have this prestigious accreditation,
- The Care Quality Commission undertook their comprehensive inspection of the Trust.

May 2018

- Inaugural Nurse of the Year Awards supported by Paul Thomas, a former patient.
- Conclusion of Rocky Appeal having reached the £2.4 million fundraising target
- We were chosen to be one of NHS Employers Diversity and Inclusion Partners for 2018/19
- Our Patient, Family and Carer Collaborative was nominated for Health and Care's Top 70 Stars Awards, supported by the NHS Confederation

June 2018

- We hosted a visit from Professor Brian Dolan and shared progress made within the Trust on the End PJ Paralysis campaign
- The Technology Trials Unit was launched in partnership with the University of Portsmouth to specialise in research studies in new healthcare technologies.

July 2018

- Celebration of 'NHS70' with a range of events across the Trust including a live broadcast from the hospital
- We launched the Trust five year strategy, 'Working Together' and implemented the Trust's new Divisional structure
- We established a learning exchange partnership with Northumbria Healthcare NHS Foundation Trust to share best practice

August 2017

- Publication of the Care Quality Commission's comprehensive inspection report following the inspection in April and May
- Positive feedback was received from Health Education England following a visit to the trauma and orthopaedic surgical department to assess the support and development provided to surgical trainees.
- Following a national neonatal audit for 2017 our service was rated as 'outstanding' by the Royal College of Paediatrics and Child Health for temperature control within one hour of birth for infants born at less than 32 weeks.
- We agreed an upgrade to our surgical robot to give our patients access to a more advanced model of the technology

September 2018

- Announcement of Bank Partners as our new provider of temporary staff
- It was confirmed that the Trust would benefit from £2.8 million to help prepare for winter.
- Our Annual General Meeting took place focusing on the theme of Organ Donation Week

October 2018

- The annual Hospital Open Day took place looking forward to the Trust becoming smoke free
- Delivery of the Trust's new linear accelerator
- Our haematology team were granted accreditation by the United Kingdom Accreditation Service (UKAS)
- We hosted our second leadership summit on the theme of 'Leading for Improvement'.

November 2018

- Our 'Celebrating Diversity' event was hosted by the BAME network
- Announcement of our Veteran Aware status, having been accredited by the Veterans Covenant Hospital Alliance
- Annual Pride of Portsmouth Awards
- Appointment of Allocate as our e-rostering provider

December 2018

- Announcement of £58 million of funding from the Department of Health and Social Care to transform our urgent care services

January 2019

- The Trust went smoke free across our sites on 14 January 2019
- Mark Esbester, an optometrist working in our ophthalmology department received an MBE in the New Year's honours list
- A Trust wide Quality Review took place with over 50 reviewers taking part including staff, partners and patient representatives

February 2019

- Completion of the Butterfly Suite in the Emergency Department to support those families who suffer loss. The suite was funded through charitable donations led by Sister Lee Campbell
- First meeting of the Trust Research and Innovation Steering Group to oversee implementation of our research and innovation strategy
- Confirmation of funding to support a Child and Adolescent Mental Health liaison service in the hospital from 4pm-midnight seven days a week

March 2019

- Celebration of our research and innovation team having recruited over 10,000 patients to research trials in the course of the last year.
- We were winners of the HSJ Partnership Award for Consultancy Partnership of the year, alongside 2020 Delivery who supported our urgent care improvement work
- Jayne Longstaff was awarded 'Outstanding research professional' at the Wessex Clinical Research Network Awards.

- Sister Karen Gamble and Sister Kirsty Fancey were awarded third place in the category of Hepatology Nurse of the Year at the British Journal of Nursing awards

Statement from Chief Executive Officer on organisational performance

During 2018/19 the Trust has faced a number of challenges across a number of performance areas. The challenges facing the NHS as a whole have been well documented, during the summer months as well as in winter, and our experience reflects that.

This environment has been challenging for our staff, particularly in those areas experiencing the greatest levels of pressure. However, against this backdrop they have continued to deliver the best possible standard of care to our patients which is reflected in the positive feedback from patients in the Family and Friends Test across all services the Trust provides.

It is disappointing that we have not met the four hour operational standard to treat, transfer or discharge patients within four hours. Whilst delivering the 95% target has been challenging across the country, I am acutely aware that this is of no comfort to those of our patients who have had to wait longer than they should. We are implementing an urgent care improvement plan, central to which is the safety of patients to sustain improvements to flow through the hospital to deliver improvements in the performance for patients. We are also delighted to have been awarded funding from the Department of Health and Social Care to transform our Emergency Department and improve the experience of both our patients and our staff. During the year we have seen a reduction in the numbers of patients who are Medically Fit for Discharge in the hospital. This has been delivered through a system wide approach and we continue to work with our partners to focus on patients with extended delays.

Improving our performance in cancer has been a focus of our efforts throughout the year. No-one should have to wait longer than necessary but for those patients awaiting a diagnosis or treatment for cancer this is completely unacceptable. I'm pleased that we significantly improved delivery of cancer care in this year and achieved all of the eight key cancer standards in Quarters one, two and three.

Alongside improving the quality and performance of the care we deliver, the need to provide value for money is also an important objective for NHS organisations. The Trust set a target of delivering a deficit of £29.9 million. In February this forecast was revised to a deficit of £34.8 million. Unfortunately, due to factors beyond our control, we did not deliver this target and our end of year position was a deficit of £37.9 million. However it should be recognized that we delivered over £23 million worth of savings in the year which was 68% of our Cost Improvement target for the year.

Providing opportunities to listen and gain feedback from our patients is hugely important. Users of our services continue to report high levels of satisfaction for the work our staff do and I would like to thank each and every member of staff for their ongoing dedication to ensuring we can deliver the very best care we can to our patients.

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.

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 Performance Dashboard	Target	18/19 (March Cancer Data is provisonal)											
		A	M	J	J	A	S	O	N	D	J	F	M
% Incomplete Pathways < 18 wks	>=92%	! 85.9%	! 86.6%	! 85.9%	! 85.3%	! 84.2%	! 83.3%	! 82.3%	! 81.4%	! 80.2%	! 80.7%	! 81.6%	! **81.2%**
Incomplete Patients waiting >52 wks	0	✗ 1	✗ 1	✗ 1	✓ 0	✗ 4	✗ 4	✗ 3	✗ 1	✓ 0	✗ 1	✗ 2	✓ **0**
Incomplete Patients waiting >40 wks	0	✗ 174	✗ 150	✗ 150	✗ 135	✗ 187	✗ 230	✗ 213	✗ 206	✗ 273	✗ 263	✗ 277	✗ **284**
Diagnostic waits < 6 wks	>=99%	! 97.8%	! 98.0%	✓ 99.0%	✓ 99.6%	! 96.7%	! 95.9%	! 96.8%	! 98.2%	! 97.2%	! 95.9%	! 97.6%	! **97.0%**
Endoscopy waits < 6 wks	>=99%	✓ 99.3%	✓ 99.1%	✓ 99.3%	✓ 99.8%	✓ 99.3%	! 98.8%	! 91.9%	! 97.1%	! 98.1%	! 97.5%	! 98.5%	! **98.7%**
4 hr arrival to admission/transfer/discharge	>=95%	✗ 84.3%	✗ 82.4%	✗ 82.1%	✗ 80.0%	✗ 83.0%	✗ 80.4%	✗ 76.6%	✗ 81.1%	✗ 76.8%	✗ 69.4%	✗ 65.5%	✗ **68.1%**
4 hr combined with Partners	>=95%	! 88.8%	! 87.3%	! 86.9%	✗ 85.6%	! 88.3%	! 86.6%	✗ 83.9%	! 86.9%	✗ 84.0%	✗ 79.0%	✗ 76.8%	✗ **78.4%**
12 hr Trolley waits	0	✓ 0	✗ 2	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ **0**
All 2-week wait referrals	>=93%	✓ 95.9%	✓ 95.9%	✓ 95.8%	✓ 95.1%	✓ 96.7%	✓ 96.8%	✓ 96.5%	✓ 97.7%	✓ 98.1%	✓ 97.7%	✓ 96.4%	✓ **94.0%**
Breast symptomatic 2-week wait referrals	>=93%	✓ 96.3%	✓ 94.0%	✓ 93.2%	✓ 95.6%	✓ 96.5%	✓ 97.8%	✓ 96.6%	✓ 94.0%	✓ 97.9%	✓ 96.2%	✓ 97.6%	✓ **95.0%**
31-day diagnosis to treatment	>=96%	✓ 97.4%	✓ 99.0%	✓ 99.1%	✓ 99.4%	✓ 98.3%	✓ 97.5%	✓ 98.6%	✓ 97.8%	✓ 98.7%	! 95.9%	✓ 98.6%	✓ **96.2%**
31-day subsequent cancers to treatment	>=94%	✓ 96.6%	✓ 97.1%	✓ 98.0%	✓ 98.6%	✓ 98.5%	✓ 100%	✓ 94.5%	✓ 98.7%	! 93.1%	! 93.6%	✓ 94.1%	✓ **94.2%**
31-day subsequent anti-cancer drugs	>=98%	✓ 100%	✓ 100%	✓ 100%	✓ 100%	✓ 100%	✓ 100%	✓ 100%	✓ 100%	✓ 100%	✓ 100%	✓ 100%	✓ **100%**
31-day subsequent radiotherapy	>=94%	✓ 96.7%	✓ 98.1%	✓ 99.6%	✓ 95.4%	✓ 94.5%	✓ 95.7%	✓ 97.0%	✓ 96.4%	✓ 99.2%	! 93.6%	✓ 97.2%	✓ **99.3%**
62-day referral to treatment	>=85%	✓ 86.4%	! 84.2%	✓ 87.0%	✗ 83.3%	✓ 89.0%	✓ 86.2%	✓ 85.4%	✓ 86.1%	✓ 85.4%	✗ 80.7%	✗ 82.1%	✓ **85.1%**
62-day screening to treatment	>=90%	✗ 82.1%	✗ 79.3%	✗ 88.5%	✓ 92.5%	✓ 95.8%	✓ 90.9%	✓ 92.9%	✓ 92.0%	✓ 94.3%	✓ 90.5%	✓ 90.7%	✓ **90.0%**
Cancer maximum wait to treatment 104 days	0	✗ 2	✗ 9	✗ 2	✗ 5	✗ 8	✗ 6	✗ 6	✗ 7	✗ 5	✗ 13	✗ 6	✗ **7**
Cancelled urgent operations	0	✗ 4	✗ 6	✗ 7	✗ 2	✗ 3	✗ 1	✓ 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	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✗ **2**
Total bed days blocked	<1000	✗ 1475	✗ 1308	✗ 1249	✗ 1244	✗ 1274	✗ 1274	✗ 1211	✗ 1100	! 1093	✓ 901	✗ 1385	
Delayed Transfers of Care	<=3.5%	✓ 3.3%	✗ 4.4%	✗ 4.1%	✗ 3.8%	✗ 4.4%	✗ 4.6%	✗ 5.0%	✓ 2.4%	✓ 1.9%	✓ 2.2%	✓ 2.4%	✓ **2.4%**
30 days emergency readmissions	N/A	✗ 6.7%	✗ 7.1%	✗ 7.5%	✗ 7.5%	✗ 7.6%	✗ 7.6%	✗ 8.1%	✗ 7.0%	✗ 7.8%	✗ 7.8%	✗ 7.6%	
Ambulance delays > 30 mins (PHT validated)	0	✗ 141	✗ 32	✗ 49	✗ 130	✗ 23	✗ 105	✗ 177	✗ 198	✗ 251	✗ 667	✗ 723	✗ **542**
Ambulance delays > 60 mins (PHT validated)	0	✗ 90	✗ 4	✗ 9	✗ 99	✗ 39	✗ 74	✗ 137	✗ 62	✗ 96	✗ 293	✗ 581	✗ **481**

During the past year the Trust continued to experience significant pressure across several performance measures, partly as a result of high levels of unscheduled care demand, including a 5% increase in A&E attendances compared with the previous year. This had an impact on the delivery of both scheduled care and the 4 hour national access standard, and these targets have not been achieved. The Trust, working with community partners and supported by the national improvement team, has developed a robust recovery plan. Central to this is the safety of patients, with incremental and sustained pathway enhancements to improve flow through the hospital.

There has been an 11% increase in referrals for patients with suspected cancer. This increase in referrals had a consequent increase in demand for diagnostics and affected delivery of the six week diagnostic standard. Demand in the year for magnetic resonance imaging (MRI) has increased by 1%, ultrasound by 7% and computerized tomography (CT) scanning by 47%.

Cancer services have focused on pathway redesign and reducing delays for patients in preparation for the new 28 day to diagnosis standard. Whilst both the number of cancer referrals and the number of confirmed diagnoses of cancer have increased, performance has improved, with delivery of the 62 day standard in 10 out of 12 months.

The Trust was not commissioned to achieve the Referral to Treatment (RTT) standard in 2018/19, but instead has focused on the maintenance of the waiting list size in line with national guidance. The Trust has reduced the number of patients waiting for treatment by over 1,000 since August 2018.

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 five 'Never Events' occurred in the last year. Three of the events resulted in no or low harm for the patient whilst one was categorised as moderate harm and one severe. 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 learnt and such incidents do not recur.

Date of incident	Nature of incident
April 2018	Wrong site procedure, stent placed in incorrect ureter (no harm).
August 2018	Wrong site procedure, incorrect joint injected (low harm).
October 2018	Misplaced Naso-gastric tube- feeding commenced (moderate harm).
December 2018	Medical air administered in place of oxygen (no harm).
March 2019	Wrong site surgery, incorrect bone removed (severe harm).

The Hospital Standardised Mortality Ratio (HSMR) of 101.8 (January 2017 – December 2017) and SHMI (Summary Hospital-level Mortality Indicator) of 101.69 (July 2016 – June 2017) have reduced significantly from 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, in particular sepsis. The Trust is achieving the target for screening for sepsis but has further to do to deliver the treatment commenced within one hour standard. The Trust has employed a senior nurse to lead on improving patient outcomes who will work alongside the established deteriorating patient group to deliver these improvements.

The Trust has worked hard throughout the year to reduce avoidable harm to patients, for example reducing the overall incidence of pressure ulcers by a further 15% and falls resulting in harm by 14%.

A safe hospital - infection prevention

The Trust aims to provide its patients with safe and effective care in a clean hospital environment. A key focus this year has been reducing the rate of infections caused by C. Difficile. The Trust was therefore delighted to end the year with a substantial improvement in the number of these infections. In 2018/19 the Trust had the lowest number of C. Difficile infections in the Hampshire and Isle of Wight region. This was achieved through working with clinical colleagues, as well as with Engie facilities management staff, to improve the standard of cleaning and disinfection throughout the Trust.

Trust teams have continued to work hard to reduce, wherever possible, the transmission of a wide range of healthcare associated infections. The focus in the coming year will be to reduce the numbers of staphylococcus aureus infections, such as MRSA or MSSA, and the number of E.coli bloodstream infections. This will mean a greater emphasis on the stringent use of antibiotics and skin suppression treatments, especially in patients who have surgery or are frequent attenders to the Trust.

This winter the Trust introduced a rapid screening test for influenza. This test can be performed at the patient's bedside and results are available within 20-30 minutes. This has resulted in a seismic shift in the way patients presenting with flu are tested and treated. Sick patients received treatment with antivirals promptly, and were nursed appropriately in isolation, whilst patients who tested flu negative could be triaged to appropriate providers (depending on their condition) in a seamless and timely fashion. Staff and patients have responded well to the flu vaccination campaign, with record numbers of staff and long stay or vulnerable patients receiving their flu jab at the Trust.

The basis of good infection prevention remains high standards of hand hygiene. For this reason, the Trust has continued to provide hand hygiene outreach sessions as well as refresher training and hand hygiene audits to both our colleagues and the general public in Trust open days. Trust staff have also undertaken out-reach visits to schools and health care establishments in the community, to spread the message that 'Clean Hands Save Lives'.

Improved participation and engagement

The Trust's aim is to deliver continuously improvement to the experience of patients, families and carers who use our services. To achieve this, Trust needs to continue to improve the way in which it engages with, includes and involves people. In recent years the Trust has successfully developed a

vibrant participation and engagement community.

The Patient, Family and Carer Collaborative, the lay-led group which leads the Trust's engagement and involvement work, includes current and recent patients, carers, primary care patient participation group members, representatives of HealthWatch Portsmouth and Hampshire and a number of special interest groups. This work was recognised in 2018 with three NHS70 Parliamentary Award nominations, and the Pride of Portsmouth Inclusivity Award.

The group was asked by the Trust's Chief Executive to advise on the development of the Trust Strategy – Working Together. On publication of the paper, members of the group reported that they could hear their conversations with the Board in the documents – a reflection of the organisational commitment to listening, hearing and acting on feedback from people who use Trust services. The Trust continues its pledge actively to involve people in the running of their local hospital and is currently working in partnership with patients and community partners in the design and development of new IT strategy, and the cancer strategy

In addition to strategy design and development, the Trust is actively involving people who use its services in the monitoring of the quality of those services. 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
- Patient story telling – learning and development programmes are increasingly including people who have experience of local hospital care, both good and not so good.
- Policy and guideline development – most recently the collaborative have advised on the production of the new discharge guidelines.

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.

NHS Choices

The NHS Choices website affords an opportunity for patients, families and carers who have accessed Trust services to provide valuable 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 allows patients to award hospitals a rating out of five stars and by the end of 2018/19, the Trust had an overall 4.5 star rating.

Freedom of Information

The Trust received 725 Freedom of Information requests in 2018/19, an increase of 9% on the 665 requests in 2017/18. The Trust continues to embrace its duty of openness and transparency, and has made a full or partial disclosure of information in approximately 92% of requests. The reasons for non-disclosure in the remainder of cases include legal exemption, the cancellation of the request, information not held or information already published. Compliance with issuing a response within 20 working days is currently at 69.5%, down from 85% in 2017/18. Measures to address compliance

have been put into place, including filling vacancies within the team and authorising overtime to clear the backlog. Two complaints were made to the Information Commissioner's Office with regard to delays in responding to specific requests. Both complaints have now been closed.

Patient care

The Trust has a policy in place for handling complaints that adheres to 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.

Staff at the Trust work hard every day to try to provide the best possible care for their patients, and to support relatives and visitors. The Trust is keen to find new ways of seeking the views of patients and visitors. This provides opportunities to identify where things may not be going as well as they should, and to make changes to help improve standards of care so that all patients, relatives and visitors have a positive experience when they come into hospital.

It is recognized that despite everyone's efforts, things may not go as well as hoped every day, 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 a '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 accessible. PALS aim to resolve any difficulties experienced, as quickly as possible and to rebuild and support people's confidence in the Trust's services.

PALS Volunteers also do an excellent job of helping the Trust ensure that patients have a smooth and safe transition from hospital back to the comfort of their home environment. The volunteers supported thousands of patients over the last year by, for example, spending time in the discharge lounge, as well

As other inpatient areas, just having a friendly chat and making sure that arrangements are in place to Support patients when they get home from hospital.

The majority of feedback gathered by 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 2018/19 the Trust documented 4,997 plaudits - many more verbal plaudits are not recorded on the system so the total number is undoubtedly much higher.

The number of formal complaints received in 2018/19 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.

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 other encompassing legislation including:

- The NHS Act 2006
- Section 46 of the Health and Social Care Act
- 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 that could impact on health or patient care.

Such work is carried out through the Hampshire and Isle of Wight Local Resilience Forum and the Local Health Resilience Partnership, 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. Later in 2019/20 the Trust will be holding a full live play exercise of its Incident Response Plan, something required every 3 years.

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 2018, NHSE concluded that the EPRR assurance assessment was 'substantially compliant' and acknowledged the extensive work undertaken in the year.

Financial performance

The Financial Statements are shown from page 61 of this report. The accounts are also available from the Director of Finance on 023 9228 6649 or at: http://www.porthosp.nhs.uk/about-us/publications/publications-index.htm.

Performance against the key targets is shown below.

Performance Area	Objective	Outcome
Income and Expenditure	Meet control total of £29.9m deficit, including PSF funding Meet control total of £34.0m deficit excluding STF funding	Not achieved - Deficit for the year was £37.9m, with no PSF funding. Not achieved - Deficit for the was £37.9m, with no PSF Funding
External Financing Limit (this is the maximum amount the Trust can raise cash through financing outside of the NHS)	Managing within the cash limit agreed with the Department of Health	Achieved
Capital resource limit (this is the maximum amount the Trust can spend on fixed assets)	Managing capital expenditure within the capital resource limit agreed with the Department of Health	Achieved
Capital Cost Absorption Rate	Making at least 3.5% return on the trust's net relevant assets	Achieved return of 3.5%
Cost Improvement Programme	Deliver identified efficiency schemes	Not achieved – delivered £23.9m against a target of £35.3m

Signed: 

Mark Cubbon, Chief Executive
Date: 22.05.19

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.

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.

Roger Burke-Hamilton (from 4th October 2018)

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. Roger 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 an Associate Non-Executive Director of the Board.

Commodore Inga J Kennedy CBE QHNS QARNNS (from 5th April 2018)

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. Although her roots still lie in the north east of Scotland, Commodore Kennedy now lives in Fareham.

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 (from 20th September 2018)

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 serviceproviders.

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.

Brigadier (Retired) Jonathan Forbes Watson MBE MA (until 31st August 2018): Brigadier Watson joined the Army after graduating and was commissioned into the Devonshire and Dorset Regiment. During a 30 year career he served in Great Britain, Northern Ireland, Kenya, Germany, Bosnia, Canada, Sierra Leone, Iraq and Afghanistan. He left the Army in 2012 and during his time as a member of the Trust Board he was CEO of Veterans Outreach Support, a Portsmouth based charity that provides welfare, wellbeing, peer mentoring and mental health support to ex- service personnel from all three services and the merchant marine. Brigadier Watson is a Fellow of the Chartered Management Institute, and was an Associate Non- Executive Director of the Board.

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. He was Clinical Director for the Department of Critical

Care from 2010 – 2016, during which 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.

Theresa Murphy – Chief Nurse (until 17th March 2019)

Ms Murphy qualified in general nursing in 1987 and then went on to specialise in neuroscience, and critical care nursing, having held key clinical and managerial posts in both teaching and general hospitals. She joined Portsmouth Hospitals NHS Trust in September 2017. Theresa was awarded the Florence Nightingale leadership scholarship for 2012, and is an Honorary Professor for the City of London University, and has an LLB. Ms Murphy held Board level responsibility for nursing, infection prevention and control, safeguarding people, patient experience and engagement.

Paul Bytheway – Chief Operating Officer

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.

Chris Adcock – Chief Financial Officer

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.

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

Emma McKinney – Director of Communications and Engagement

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. She 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.

Nicole Cornelius – Director of Workforce and Organisational Development (from 1st October 2018)

Ms Cornelius joined the Trust as Director of Workforce and Organisational Development in October 2018. She has over 30 years' experience working in the public sector, including the role of Director of HR and Corporate Services for Hampshire Constabulary and senior roles within 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 has a Master's Degree. She is also a member of the Independent Advisory Panel to the Military.

Tim Powell – Interim Chief Executive (until July 2017) and Director of Workforce and Organisational Development (from July 2017 until 16 April 2018)

Mr Powell joined the Trust in November 2011, as Director of Workforce and Organisational Development, with a wide range of public sector experience and was appointed the role of Chief Executive in May 2016. He was previously Director for Human Resources and Organisational Development at the London Development Agency, delivering economic development and regeneration priorities for the capital, including preparations for the London 2012 Olympics. Before this he spent five years as HR Director at Transport for London following 17 years at Royal Mail Plc.

Mark Power – Interim Director of Workforce and Organisational Development (from 11th April 2018 until 6th September 2018)

Mr Power joined the Trust having previously gained Human Resources experience in the NHS. He had worked within NHS Improvement as a Senior Trust Resourcing Associate, as well as spending seven year years in NHS Director posts (Oxford University Hospitals NHS Foundation Trust and Dorset County Hospital NHS Trust). His experience includes public and private sector backgrounds, as well as 15 years as a Lieutenant Commander for the Royal Navy.

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 50 of this report.

BOARD EFFECTIVENESS

All Executive Directors and Non-Executive Directors have annual appraisals and performance development plans. They also undertake 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.

The Trust underwent a 'Well-Led' inspection by the CQC in May 2018, and the report and resulting rating of 'Requires improvement' has informed the Board's regular structured development sessions. An associated programme of collective and individual development work has been in place throughout 2018/19, which will continue during 2019/20. The Board has also commenced a self-assessment process with a view to seeking external review of its performance against the CQC/NHSI Well-Led framework.

AUDIT COMMITTEE

The Board Committee structure is set out in the Annual Governance Statement on page 32 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
- Roger Burke-Hamilton

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.

REGISTER OF INTERESTS

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 http://pht/HospitalCommunications/Documents/Forms/AllItems.aspx

Please right-click and open the hyper-link above and scroll down the list of documents in this section of the web-site to the 'Register of Interests' item.

DISCLOSURE OF INTERESTS

There were no payments to Board members during 2018/19 other than those made to them in their capacity as executive or non-executive directors of the Board.

SHADOW COUNCIL OF GOVERNORS

The Trust established a shadow Council of Governors in 2007 in anticipation of an application for Foundation Trust Status. The Council was comprised of elected posts representing Portsmouth City, Havant and East Hampshire, Fareham and Gosport, patient groups, carer groups and staff.

The Council had two advisory groups which met periodically throughout the year to review different aspects of the Trust and make recommendations for improvement.

The Council also met with the Trust Board to challenge and comment on Trust plans, and co-organised Trust Open Days. The shadow Governors held public constituency meetings throughout the year at which Trust members asked questions, gave feedback and heard about new initiatives.

However, having acknowledged that seeking Foundation Trust status was no longer part of the Trust's strategy, it was decided in the early part of 2018 that the formal Shadow Council of Governors should be disbanded. The final meeting of the Shadow Council took place on 1 May.

The Trust is extremely appreciative of the dedicated service of all the shadow Governors who have served the Trust, its patients and the wider community since 2007, and is very grateful that a number of former shadow Governors have continued to support the Trust in other roles.

COUNTER-FRAUD

During 2018/19 the Counter Fraud Service was provided by the Hampshire and Isle of Wight Fraud and Security Management Service (HIoW F&SMS) which provides a specialist service for a fixed cost, underpinned by a risk sharing agreement between the Trust and the F&SMS. 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 service. 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 which was agreed and reviewed throughout the year. There is a programme of fraud awareness work, including maintenance of a Fraud, Bribery and Corruption Policy, production and promotion of leaflets, posters and newsletters, and delivery of face to face fraud training and drop in sessions. 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 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) when appropriate.

As reported in the more detailed description of information governance arrangements set out in the Annual Governance Statement (page 32), the Trust experienced five externally reportable serious incidents in 2018/19 and these were reported using the Data Protection and Security Toolkit.

DIRECTORS' CONFIRMATION CONCERNING AUDIT INFORMATION

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: 22.05.19

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 2019 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 underwent significant review and revision during 2018/19. Work was undertaken to improve the identification, assessment, recording and management of strategic and operational risks, and this work will continue into 2019/20.

During 2018/19, the Board Assurance Framework was refined to enable better oversight of:

- risks to the delivery of the Trust's organisational objectives as set out in the Trust strategy, Working Together (adopted in July 2018), and,
- the assurance available to demonstrate the effective management of those risks

The Board Assurance Framework has been presented to the Board of Directors throughout 2018/19, 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. Since January 2018 all meetings of the Trust Board and its committees have concluded with a consideration of whether of the matters discussed during the meeting should be added to the Board Assurance Framework. The Board Assurance Framework has also been used more effectively during 2018/19 to plan for 2019/20 - for example the Internal Audit plan has been more closely aligned with the risks reported in the Board Assurance Framework.

Work required to improve the management of operational risk continues. The majority of clinical risks registers have been reviewed and updated, and work on the corporate functions' risk registers began in March 2018. 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 both clinical divisional and corporate function risk registers on a quarterly basis at the Quality & Performance Committee.

The Corporate 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. The Corporate Risk Register is also presented quarterly to the Trust Board for review, having been scrutinised in advance by the Quality & Performance Committee. A new Risk Management Strategy, which reflects the arrangements described above, was adopted by the Trust Board in July 2018.

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; and
- 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 2018/9 from a variety of sources, including:

- Internal and external reviews and inspections
- Internal and External Audit activities
- Counter fraud activity
- Risk assessments
- Care Quality Commission Fundamental Standards for Quality and Safety
- Complaints, safety learning events and claims
- Alerts received from the Central Alert System
- Consultation with staff and patients
- Mandatory/statutory targets
- Service 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 Quality & Performance Committee reviews all divisional risk registers and the draft corporate 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 2018/19, 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 2019, the highest scoring risks remain concentrated around meeting the demand for unscheduled care and the potential for 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 Fundamental Standards, 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.

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 2018/19 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. Most of the other risks have moved up and down the BAF, indicating that the BAF is regularly reviewed, and reflects accurately both the 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 fulfill 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 Corporate Risk Register.

The Corporate 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 who is 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:

Risk	Risk rating	Mitigation
Effectiveness of governance structures		
Divisional governance structures are relatively immature, leading to risk that information about performance, quality and finances will not reach the Board, and be addressed, in a timely way.	Moderate	• The Trust's Executive Directors meet monthly with the leadership team of each division at Performance & Accountability meetings to review these matters. • The quality of divisional clinical governance meetings is reviewed on a regular basis, and feedback provided to the relevant leadership teams. • Reviews of the quality of care group governance activity will commence in 2019/20.
The responsibilities of directors and subcommittees		
Reporting lines and accountabilities between the board, its subcommittees and the executive team		
The Trust comprehensively revised its corporate governance structure in April 2018 and re-allocated key governance functions between the committees, leading to risk that there is inadequate scrutiny of, and response to, key performance, quality and finance information	Low	• The Board will conduct a review of the effectiveness of the new committees after a full year of their operation • The Board has commenced a Well-Led review process and will act on the findings of its self-assessment and associated external review
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) presented to the Board has been revised a number of times during 2018/19, leading to risk that relevant information about performance, quality and finances is inadequately presented and analysed, and consequently inadequately addressed	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. • The Committee effectiveness review and Well-Led review planned for 2019/20 will help to provide assurance that the IPR is working effectively.

5. THE 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 12 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 2018/19 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 2019, the Trust Board comprised the Chairman, five independent Non-Executive Directors (plus two independent Associate Non-Executive Directors) and nine Executive Directors Four of the Executive Directors are non-voting (Director of Workforce & Organisational Development, Director of Strategy and Performance, Director of Communications & Engagement and Director of Governance & Risk).

The Trust Board has made a series of decisions to improve its effectiveness and ensure its impact as at an appropriate strategic level. The revised Board Committee structure was implemented in April 2018 to improve the Board's oversight and management of planning, performance and risk. As a further support for this, the Board has also focused on the form and function of the Integrated Performance Report to ensure that its metrics are appropriate, triangulated and provide analysis of the available data. The Board has also been involved in the implementation of the divisional restructure, implemented in July 2018, as well as engaging with key emergent issues during the year (e.g. responding to the CQC's inspections in April and May 2018). The Board has stressed the need for its decisions to have an impact across the Trust, based on insightful input that allows for genuine 'ward to board' interaction. This will continue to be a key area of development in 2019/20.

In addition, the Board is developing new methods for ensuring that co-ordination across committees provides comprehensive coverage of Trust issues. One particular example has been a joint meeting of committee chairmen to consider the Operating Plan for 2019/20; this took the various perspectives of the different committees (e.g., quality, finance and workforce) and used them to examine proposals from these viewpoints, creating a cohesive plan for the oversight and governance of the delivery of the plan during the coming year.

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:

TRUST BOARD ATTENDANCE RECORD

	05-Apr-18	03-May-18	07-Jun-18	05-Jul-18	02-Aug-18	06-Sep-18	04-Oct-18	01-Nov-18	06-Dec-18	03-Jan-19	07-Feb-19	07-Mar-19	04-Apr-19	01-May-19
Executive Directors														
Mark Cubbon	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nicole Cornelius							✓	✓	✓	✓	✓	X	✓	✓
Mark Power		✓	✓	✓	✓	✓								
John Knighton	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chris Adcock	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Theresa Murphy	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	✓			
Paul Bytheway	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Emma McKinney	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓
Lois Howell	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Penny Emerit	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Non-Executive Directors														
Melloney Poole	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Christine Slaymaker	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓
David Parfitt	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓
Gary Hay	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jon Watson	✓	✓	X	X	X									
Inga Kennedy	✓	✓	✓	X	✓	✓	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.

5.3. Board committees

Since the committee restructure of April 2018, the following committees report to the Trust Board (all with Non-Executive Directors as Chairmen):

- 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. 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 2018/19. It was chaired by a Non-Executive Director, who submits a regular report to the Trust Board.

- Remuneration Committee (mandatory)
  The Remuneration Committee has delegated authority from the Trust Board to determine the broad remuneration policy and performance management framework and to set individual

remuneration arrangements for the Trust's Executive Directors. The Committee is chaired by the Trust Chairman.

- 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 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 OD 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.

6. QUALITY GOVERNANCE ARRANGEMENTS

During 2018/19 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 and performance elements were reviewed in detail, by the Quality and Performance Committee monthly, and key issues were escalated to the Board as required. The Trust continues to strive to reach sustainable improvement in its performance against its priorities,

including the referral to treatment (RTT) target and four-hour access standard.

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.

In the year the annual clinical audit plan is linked to the Trust's priorities and risks and is monitored by the Clinical Effectiveness Steering Group, 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 organisation.

The Trust revised its mortality review process in 2017/18 in line with the National Quality Board guidance, and the impact of this process has continued to improve throughout 2018/19. The mortality review panel meets every 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. This group reports to the Trust's Quality and Performance Committee.

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 an organisation's registration when non-compliance is identified.

The Trust was subject to a full CQC inspection in February and May 2015, following which the Trust was rated as 'Requires Improvement'. The Trust was subsequently subject to various inspections by the CQC which resulted in the following conditions being placed upon the Trust registration:

- **Section 31 (AMU) issued 03 March 2017 following inspection 28 February 2017**
  The notice required the Trust to ensure sufficient staffing levels and skill mix in AMU and the GP triage referral area to meet the needs of patients, and to ensure appropriate Standing Operating Procedures are in place.

- **Section 31 (Mental Health) issued 12 May 2017 following inspection 10 and 11 May 2017**
  The notice related to ensuring suitably qualified and competent staff in the Emergency Decision Unit to provide safe, good quality care to patients with mental health problems. That appropriate risk assessments and treatment plans are completed for patients presenting to

the emergency department. Ensuring the identification and oversight of vulnerable patients across the organisation and that Deprivation of Liberty Safeguards and the Mental Capacity Act requirements are being applied appropriately.

- **Section 29a Warning Notice issued 4 July 2017 following inspections 16, 17 and 28 February and 10 and 11 May 2017**
  The notice related to issues of privacy and dignity, consent to treatment, safety across the acute medical pathway, safeguarding of vulnerable adults and governance arrangements.

- **Section 31 (Diagnostic and Screening Procedures) issued 28 July 2017**
  The notice related to the backlog of radiology reporting.

The Trust has worked with commissioners, NHSI and other partners to deliver an improvement programme in all of these areas.

The Trust was subject to a further inspection by the CQC in April and May 2018. The ratings issued at the conclusion of the inspection are as set out below:

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

A warning notice was issued to the Trust by the CQC in August 2018, setting out the areas of practice where the Trust was found to be at risk of breaching the regulations cited above. The notice included a number of actions the Trust must take and should take by 30 October 2018. In response, the Trust developed and implemented a quality recovery plan, the delivery of which has been overseen by a multi-agency group, including representation from the Trust's commissioners (the local CCGs and NHS England), regulators (the CQC and NHS Improvement) and other relevant stakeholders (eg, Healthwatch).

In December 2018, all of the conditions listed above were removed from the Trust's registration, apart from the requirement to ensure that Deprivation of Liberty Safeguards and the Mental Capacity Act are being applied appropriately.

The Trust continues to work on a range of projects to ensure that the improvements delivered during 2018/19 and recognised by the removal of the conditions on its registration are sustained. A revised approach to quality governance is in development, in partnership with the CCGs, for delivery in early 2019/20 to promote a comprehensive and integrated quality improvement programme which balances compliance activities with the pursuit of aspirational and ambitious improvement.

As a result of the enforcement notices 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 becoming a fully inclusive employer.

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. The Trust also recognises 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 and the EDI Group maintains oversight and delivery of this and identifies key actions for improvement. The EDI Group will also ensure 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 table below provides a high level summary of the Trust's workforce by protected characteristic and staff group:

Staff Group	Age	Disability			Ethnic Origin		
	Largest Age Group and %	Yes (%)	No (%)	Not Stated (%)	White (%)	BAME (%)	Not Stated (%)
Additional Clinical Services	51-55, 14%	1.4%	15.5%	6.8%	20.6%	2.8%	0.2%
Administrative and Clerical	56-60, 16%	1.3%	10.5%	6.9%	17.9%	0.7%	0.1%
Estates and Ancillary	56-60, 29%	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%
Medical and Dental	26-30, 22%	0.7%	10.4%	3.0%	9.6%	4.1%	0.4%
Nursing and Midwifery Registered	26-30, 18%	1.4%	16.5%	13.5%	25.7%	5.4%	0.3%
Scientific, Therapeutic & Technical	31-35, 18%	0.5%	7.6%	3.9%	10.6%	1.2%	0.2%
Trust	**26-30, 16%**	**5.3%**	**60.5%**	**34.2%**	**84.5%**	**14.3%**	**1.2%**

Staff Group	Sexual Orientation			Marital Status			Maternity
	LGB (%)	Heterosexual (%)	Not Stated (%)	Married/Civil Partnership (%)	Single (%)	Not Stated (%)	Maternity Leave (%)
Additional Clinical Services	0.7%	17.4%	5.5%	11.3%	11.8%	0.5%	21.3%
Administrative and Clerical	0.3%	13.8%	4.6%	9.1%	9.1%	0.5%	9.2%
Estates and Ancillary	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%
Medical and Dental	0.2%	10.4%	3.5%	8.3%	5.3%	0.6%	15.9%
Nursing and Midwifery Registered	0.6%	21.1%	9.7%	17.0%	13.6%	0.8%	38.0%
Scientific, Therapeutic & Technical	0.2%	8.9%	3.0%	6.0%	5.6%	0.3%	15.6%
Trust	**2.0%**	**71.6%**	**26.4%**	**51.7%**	**45.5%**	**2.8%**	**100.0%**

Staff Group	Top 5 Religions/Beliefs					Gender	
	Atheism (%)	Christianity (%)	Islam (%)	Other - Not an Option (%)	Not Stated (%)	Male (%)	Female (%)
Additional Clinical Services	10.7%	6.8%	3.1%	2.6%	0.1%	4%	20%
Administrative and Clerical	8.5%	5.5%	2.5%	1.9%	0.2%	4%	14%
Estates and Ancillary	0.0%	0.1%	0.0%	0.0%	0.0%	0%	0%
Medical and Dental	5.3%	3.9%	1.7%	0.8%	1.2%	8%	7%
Nursing and Midwifery Registered	15.3%	10.1%	3.3%	2.4%	0.1%	3%	28%
Scientific, Therapeutic & Technical	5.5%	3.5%	1.9%	0.7%	0.2%	3%	9%
Trust	**46.2%**	**30.5%**	**12.8%**	**8.6%**	**1.8%**	**22%**	**78%**

During 2018, focus was placed on re-establishing a BAME staff network which now has more than 200 members, with 16 'champions' who help to shape and influence the EDI agenda. An internal BAME development programme was launched with 24 delegates and an essentials training package designed around EDI responsibilities and unconscious bias. In addition, an LGBT+ equality forum has been established, which meets quarterly, helping to formulate new and existing policies and procedures. Further improvements are being developed with those staff with protected characteristics or from a minority background.

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 NQB model, are regularly received by Board. A Workforce and OD 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. The Trust has an active Bank and uses Agency staff as necessary to ensure critical gaps are filled and services maintained for all staff groups.

11. CARBON REDUCTION

As indicated in the main body of the annual report, the Trust is committed to reducing its carbon footprint.

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

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.

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), which were reviewed in detail during 2018/19, and revised as necessary. Compliance with SFIs is reported to the Audit Committee. Any beaches which may occur are reported to the Committee together with an explanation, actions taken to prevent any reoccurrence and, where appropriate, details of any sanctions applied. The Trust continues to review its arrangements for devolved accountability and delegated limits.

The duties and responsibilities of the Finance and Infrastructure Committee include review of the Trust's financial and performance management, and the scrutiny and approval, under delegated authority, of the investment appraisal of business cases and wider business development opportunities.

15. INFORMATION GOVERNANCE (IG)

The Director of Governance and Risk is the nominated Senior Information Risk Officer (SIRO) 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 representation 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 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).

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

- Failure to meet regulatory and contractual obligations as a result of non-compliance with IG training and the DSPT (scored at 16)
- Risk of enforcement action/financial penalty from the Information Commissioner's Office for failing to meet subject access requests in line with Data Protection Act deadlines (scored at 16)
- Risk of exposure of confidential data as a result of continued use of fax machines in some clinical areas (scored at 12)
- Potential risk of failure of cyber security defenses leading to inability to deliver safe patient care (scored at 12)

The Trust's Data Security and Protection Toolkit 2018/19 was submitted on time but classified as "standards not fully met". An action plan was submitted for those standards that were not met, covering:

Standard 3.3.1: 95% of staff must successfully complete the Level 1 Data Security Awareness training
• The Trust achieved a training completion rate of 89.7%.
Standard 10.2.1: Basic due diligence has been undertaken against each supplier according to ICO guidance
• the Trust has identified all suppliers dealing with person-identifiable data (PID) but cannot at this stage confirm that appropriate due-diligence was carried out to the standard required by the ICO at the time of commencement of the associated services or contracts. A retrospective review of relevant records is underway, and any absent due-diligence checks will be completed.

The Trust holds minimal data in public 'cloud-based' services, and the vast majority remains within the Trust's private cloud. The IT Department approach is to conduct a risk-based Information Governance/Cyber Security due diligence assessment for any new 'cloud-based' services. This does not remove 100% of the risk, but it enables the Trust to understand the potential risks and develop solutions to mitigate these.

16. INFORMATION GOVERNANCE INCIDENTS

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 – these are 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 32), the Trust experienced five reportable serious incidents in 2018/19 which were reported using the Data Security and Protection Toolkit which are summarised below.

Externally Reportable Incidents

Ref:	Date of Incident	Nature of incident	Nature of data involved	Number of data subjects potentially affected	Notification Steps
9339	21/02/2019	Breach of patient confidentiality during conversations between staff	Special Category	1	Closed – no further action
7791	02/01/2019	Disclosure of a confidential address to a known third	Personal	2	Closed – no further action
3464/ 3406	06/09/2018	Access to patient records by an unauthorised member of staff	Special Category	2	Closed – no further action
1966	26/07/2018	Unauthorised access to patient records by employee of another Trust working in the hospital	Special Category	14	Open – still under investigation
1366	12/07/2018	Failure to provide timely information about approximately 6139 patients to their GPs, arising from technology error.	Special Category	6319	Not required to report as no harm.

17. QUALITY ACCOUNT

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 Trust published its Quality Account in June 2018, which set out the priorities for 2018/19 and reflected on its achievements in 2017/18. Consultation with internal stakeholders and the Patient Collaborative is currently underway to inform the 2018/19 Quality Account which will be published in June 2019 and will be available on the Trust website. This will set out the priorities for 2019/20 and will include patient safety, patient experience and clinical effectiveness indicators.

To provide assurance on the accuracy and data quality of the Quality Account, data submissions must be accompanied by a data validation form signed by both the data owner and their line manager. The majority of quality metrics are reported monthly to the Board and the Quality and

Performance Committee quarterly. This ensures regular oversight of progress and assurance of actions being taken to address any shortfalls. An external review of the Quality Account was undertaken in June 2019 by the external auditors, Ernst & Young LLP. This concluded that the Quality Account was prepared in line with the criteria set out in the Regulations.

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 Corporate Risk Register
- Preparation and publication of the 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 Corporate 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 to be that the Trust has reasonable and effective risk management, control and governance processes in place.

19. SIGNIFICANT INTERNAL CONTROL ISSUES

Audit	Key concerns identified	Trust response
Data Security & Protection Toolkit	• No evidence had been supplied in connection with a number of mandated statements required by the Toolkit	• Evidence was collected and submitted to NHS Digital in respect of all mandatory statement by the deadline of 31.03.19
Integrated performance Report (IPR)	• Lack of consistency in approach to IPR contents and their presentation • Data quality is not assured • Not all performance indicators are associated with targets	• The matters raised have been addressed in subsequent iterations of the IPR
Whistleblowing and incident reporting	• There is potential for confusion on the part of staff about the different roles fulfilled by the incident reporting system and the Freedom to Speak Up Guardian and Advocates	• The Freedom to Speak Up role has subsequently been widely promoted • Management teams have been reminded of the importance of free and frank reporting of incidents • The report of the CQC's visit in February included explicit reference to staff reporting that "…they were able to raise concerns to local management without fear of retribution." And that "…they felt supported and were encouraged to be open and transparent."
Safeguarding	• A small number of incidents of the use of handcuffs on persons under the age of 18 was found • A discrepancy between the number of incident of restraint reported by the Security Team and by clinical staff was found	• The use of handcuffs for restraint has been ceased • A task and finish group to review the management and recording of restraint incidents has been established

CONCLUSION

The Trust has identified the internal control issues identified at paragraph 18 above, and has plans in place to address these, most of which have already commenced their implementation to ensure that

the statement of internal control for 2018/19 is unqualified.

Accountable Officer:	Mark Cubbon
Organisation:	Portsmouth Hospitals NHS Trust
Signature:	
Date:	**22.05.19**

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 7,530 full time equivalents and is the largest employer in Portsmouth.

2. REMUNERATION COMMITTEE

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

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

- Agree the remuneration and terms of service for each executive director, including performance related pay
- Agree overall remuneration in terms of service for senior managers not on National contracts
- Agree any termination arrangements required for executive directors
- Monitor the performance of executive directors
- 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.

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

Salary and pension entitlements of senior managers are shown on pages 115 and 116 of this report.

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.

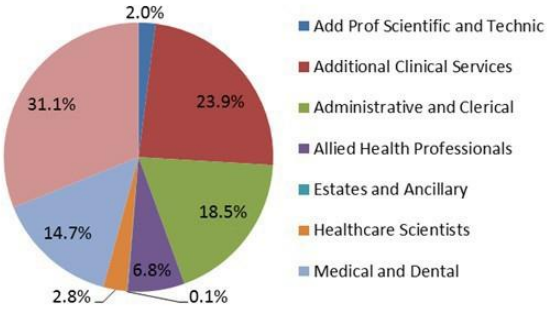
6. RESOURCING

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: 2018/19 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 8% of the total workforce establishment. This is 0.3% decrease in comparison to this time last year.

Investment has been made in 2018/19 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 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

The Trust is privileged to have a vibrant community of volunteers, ranging in age from 17 years to over 90, and including a number of pets. The volunteers provide essential support to patients, families, carers and staff and help improve their experience of the Trust's care. The successful

recruitment programme continues with an average of 20 – 30 people applying to be a volunteer each month. In December 2018 the Trust joined the Daily Mail's campaign to recruit more volunteers to the NHS. The campaign highlights how volunteers help to provide the best support possible to the staff and patients in hospitals. This gives the Trust a great opportunity to grow its 'Happy to Chat' volunteer workforce. The Happy to Chat volunteers spend time with patients who might be lonely, isolated or anxious or who may not have visitors of their own.

Celebrating Volunteers

On 19th December 2018 the voluntary services team welcomed some of the Trust's 600 volunteers to a coffee and mince pie Christmas get together to thank them for all that the volunteers do to help improve the experience of patients, their families and carers. Melloney Poole OBE, the Trust's Chairman joined the volunteers and presented them with a 'Hidden Heroes' award to thank them and show her appreciation for all that they do.

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 range of support and activities for staff.

Key health and safety activities over this year have included a full Trust-wide audit of sharps disposal, increased sharps awareness training and improved reporting of incidents. During the year there has been an increase in mental health awareness training and support; the service now has the support of two Registered Mental Health Nurses.

Progress in the Health and Wellbeing CQUIN (Commissioning for Quality & Innovation target) continues. Over the year the Trust has increased the provision of stress awareness and resilience training. 73.67% of frontline staff were vaccinated against seasonal flu which was an improvement on uptake by 1.5% 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 role. During 2018/19 the Trust's FTSU service has been acknowledged by the CQC as well-understood and effective.

10. FAIR PAY POLICY

On pages 115 and 116 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 2018/19 was £190k-£195k, which was the Chief Executive and his salary was comparable with 2017/18 (taking into account part year office of Chief Executive in 2017/18). The salary was 7.42 times (2017/18, 8.03 times) the median remuneration of the workforce which was £25,934 (2017/18, £20,549) both of these relate to Band 5 staff members.

In 2018/19, no employees received remuneration in excess of the highest-paid director (2017/18, 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 maintained at 3.7%. 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

			2018/19	2017/18
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	236,116	1,657	**237,773**	227,750
Social security costs	23,381	-	**23,381**	22,423
Apprenticeship levy	1,194	-	**1,194**	1,148
Employer's contributions to NHS pensions	29,285	-	**29,285**	27,953

			2018/19	2017/18
	Permanent	**Other**	**Total**	**Total**
	£000	**£000**	**£000**	**£000**
Temporary staff	-	42,502	**42,502**	41,519
Total gross staff costs	**289,976**	**44,159**	**334,135**	**320,793**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**289,976**	**44,159**	**334,135**	**320,793**
Of which				
Costs capitalised as part of assets	1,443	-	**1,443**	764
			2018/19	**2017/18**
	Permanent	**Other**	**Total**	**Total**
	Number	**Number**	**Number**	**Number**
Medical and dental	966	72	**1,038**	995
Administration and estates	1,235	22	**1,257**	1,227
Healthcare assistants and other support staff	-	177	**177**	-
Nursing, midwifery and health visiting staff	3,535	443	**3,978**	3,489
Scientific, therapeutic and technical staff	657	35	**692**	1,186
Healthcare science staff	182	-	**182**	203
Total average numbers	**6,575**	**749**	**7,324**	**7,100**
Of which:				
Number of employees (WTE) engaged on capital projects	21	-	**21**	12

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 social media platforms. Recognising the critically important role of all staff in meeting the challenges faced by the Trust, the Board supports a three year culture change programme based on a model of Collective Leadership – where every member of staff takes responsibility for the success of the organisation in delivering continually improving, high quality and compassionate care. The programme is structured in three phases; *Discovery, Design and Deliver* and was formally launched in March 2018.

Using a nationally supported, evidenced based framework, a number of staff known as 'change agents' undertook a cultural audit of the Trust to establish what the culture is like now and what it needs to be in the future to successfully deliver the Trust's strategy, Working Together. In addition, best practice in other organisations was considered to see what might be learnt about their leadership and culture.

The Change Agents' findings were presented to the Board and work has now commenced on designing a number of interventions in response to those findings. It is important to acknowledge that culture change takes time. Many changes and improvements are already underway and there are great examples of innovation and improvement across the Trust – but these are in pockets. The purpose of this work is to help the Trust move from 'requires improvement' to 'outstanding'.

The staff appraisal rate is currently 80.7%, which remains below the 85% target. The appraisal form has been streamlined as a result of feedback from line managers and a comprehensive appraisal training session is accessible to all staff with a line management responsibility as part of the 'Passport to Manage' essential training programme. In 2018/19 142 managers attended the Passport to Manage training. Compliance with the Trust's essential skills training has decreased and currently stands at 89.2%, against a target of 90%. This matter will be addressed by the Workforce & Organisational Development Committee.

14. THE NATIONAL NHS STAFF SURVEY 2018

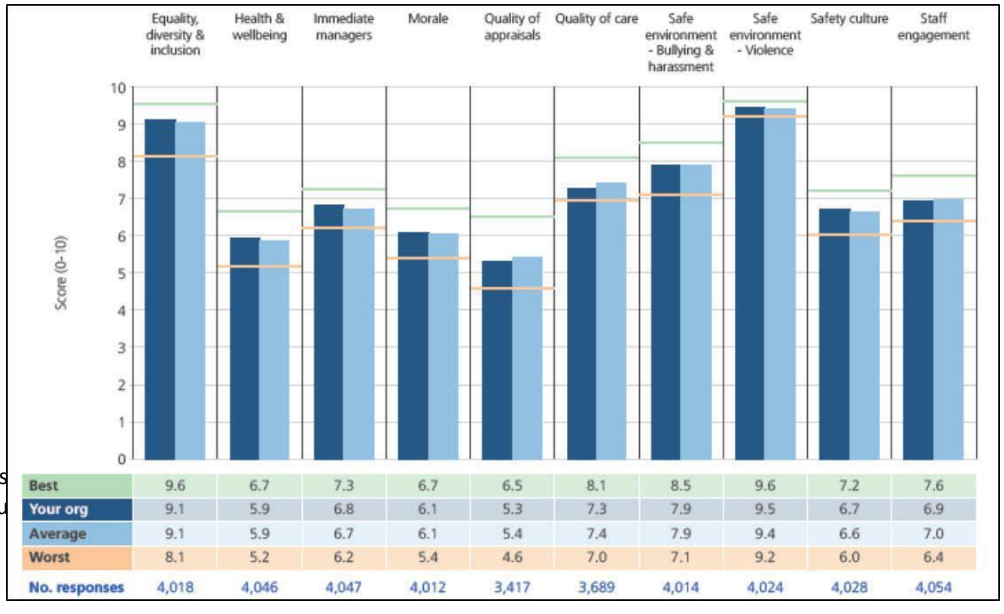
The NHS National Staff Survey (NSS) is recognised as an important tool for ensuring that the views of staff working in the NHS inform local improvements, and are included in local and national assessments of quality, safety, and delivery of the NHS Constitution. The results of the 2018 NSS conducted in the Trust between September and December 2018 can be found below.

A full census survey took place between September and December 2018, and all staff employed as at the 1st September 2018 had the opportunity to take part. In total 4,076 (57%) completed and returned their survey which is 2% lower than 2017 but 23% higher than the average England acute trust response rate. There are 89 acute trusts within the benchmark group.

Table two below summarises the survey results by ten themes against the acute trust benchmark. Of the ten themes,

- three are better than average; immediate managers, safe environment – violence and safety culture,
- four are average; equality, diversity and inclusion, health and well-being, morale and safe environment – bullying and harassment
- three are worse than average; quality of appraisals, quality of care and staff engagement.

Table 2: NHS Staff Survey results by themes

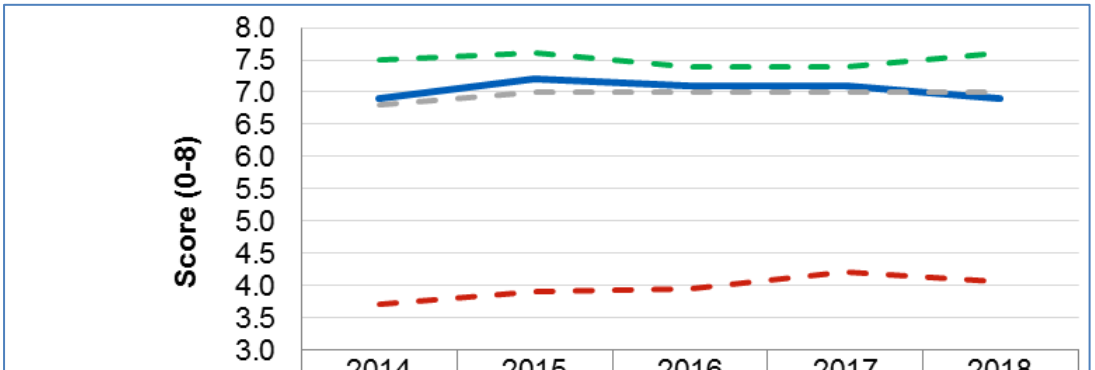


	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.6	6.7	7.3	6.7	6.5	8.1	8.5	9.6	7.2	7.6
Your org	9.1	5.9	6.8	6.1	5.3	7.3	7.9	9.5	6.7	6.9
Average	9.1	5.9	6.7	6.1	5.4	7.4	7.9	9.4	6.6	7.0
Worst	8.1	5.2	6.2	5.4	4.6	7.0	7.1	9.2	6.0	6.4
No. responses	4,018	4,046	4,047	4,012	3,417	3,689	4,014	4,024	4,028	4,054

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. Table three presents the results for this theme since 2014 and shows a decline in the year on year score, which for 2018 is just below the acute trust average.

* *The staff engagement score is based on a 0-10pt scale.*

Table 3: Staff engagement



	2014	2015	2016	2017	2018
Best Score	7.5	7.6	7.4	7.4	7.6
PHT	6.9	7.2	7.1	7.1	6.9
Avg Score	6.8	7.0	7.0	7.0	7.0
Worst Score	3.7	3.9	3.9	4.2	4.1

The full findings report of the 2018 NSS was presented to the Workforce and Organisational Development Committee of the Board in March and full Trust Board in April 2019. An improvement plan is being 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

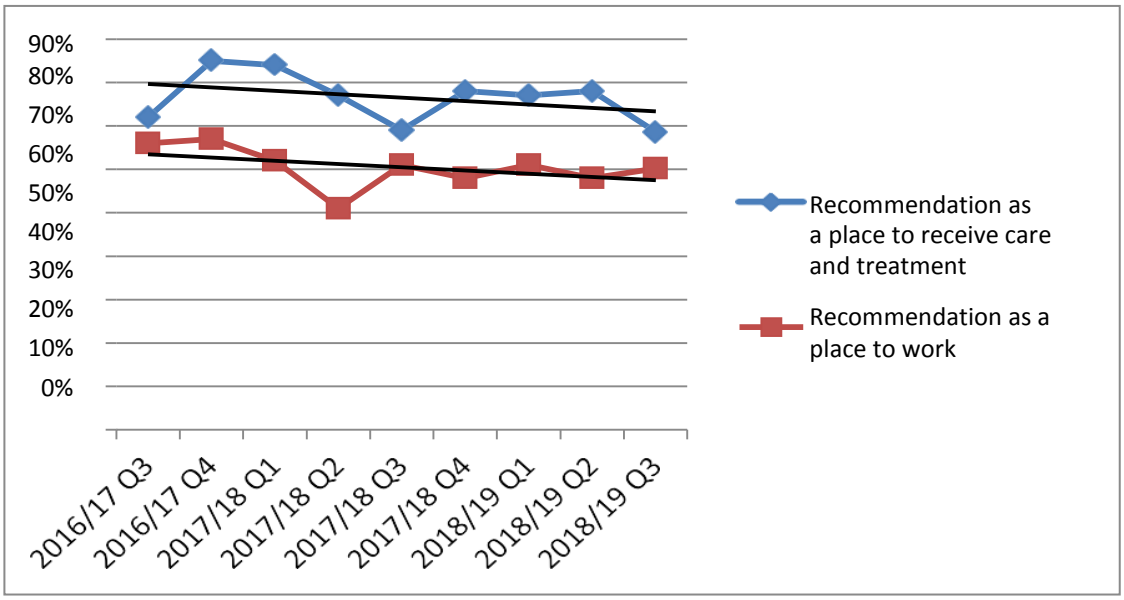
Since April 2014, the Staff Friends and Family Test (FFT) has been carried out in all NHS trusts. The Staff FFT is helping to promote a significant cultural shift across the NHS, encouraging staff to have both the opportunity and confidence to speak up, and ensuring that the views of staff are increasingly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

response by question which shows a downward trend since 2016/2017.

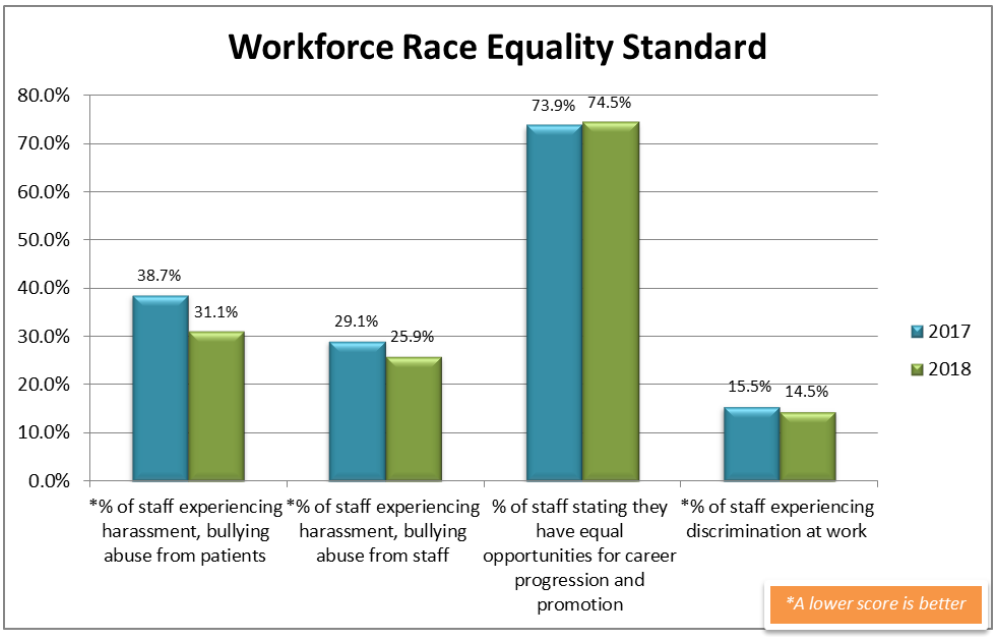
Table 4: Staff Friends and Family Test



16. WORKFORCE RACE EQUALITY STANDARD (WRES)

This standard is part of the Trust's national reporting to measure the experience of Black, Asian, Minority Ethnic (BAME) staff at the Trust. In total, 437 BAME staff completed and returned a NSS which is 12% of the total responses and is representative of the total BAME employed workforce. The WRES is made up of 9 indicators, four of which are taken from the NSS results. It is pleasing to see improvements in the NSS reporting for the WRES in all 4 indicators (see table five below):

Table 5: Workforce Race Equality Standard

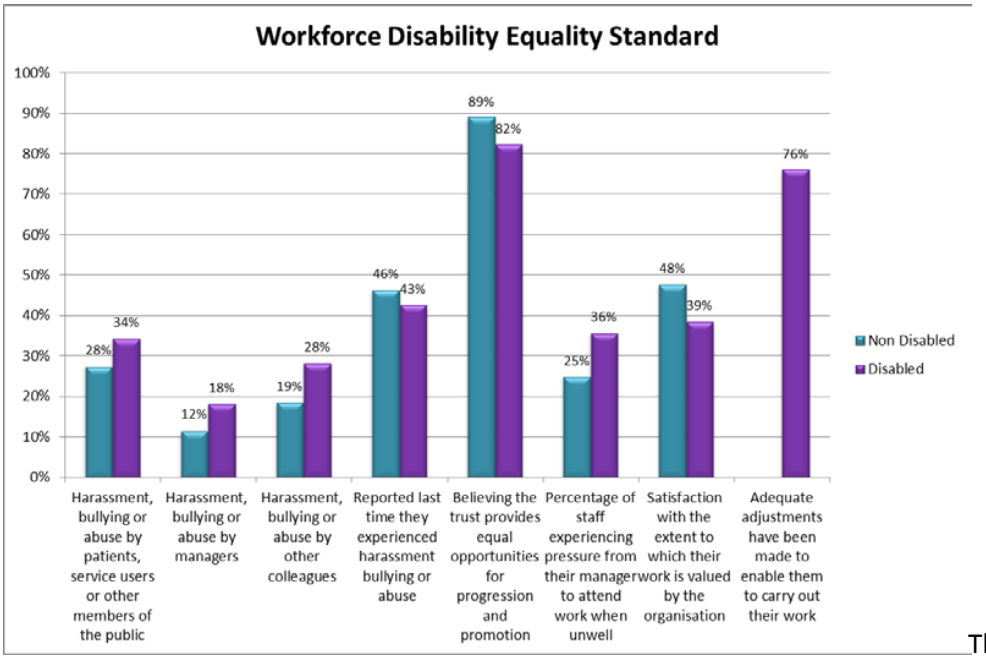


This encouraging movement suggests that the focussed work during 2018 on improving the experience of BAME staff has had a positive impact.

17. WORKFORCE DISABILITY EQUALITY STANDARD (WDES)

The Trust is beginning to gather data for the Workforce Equality Disability Standard (WDES) which will become a national requirement in August 2019. There is no comparison to previous years available and, at this point in time, there is no national benchmark. 719 staff who said they have a disability completed the NSS; this is 22% of all responses and shows disparity with the 5% of staff reporting a disability on the Electronic Staff Record. Table six below summarises the findings:

Table 6: Workforce Disability Equality Standard



The overall staff engagement score for disabled staff was 6.6 compared with 7.00 for non-disabled staff. To support the implementation of the WDES, a Disabled Staff network is being established to help gain further insight and understanding of the experiences of disabled staff, and further shape improvement priorities.

Improvement plans are being developed at both Trust and divisional level to address those areas that had most declined since the 2017 survey or which are below the national acute average.

18. OFF-PAYROLL ENGAGEMENTS

Off-payroll Engagements over six months and over £245 per day as at 31st March 2019

Number of existing arrangements as at 31st March 2019	2
Of which the number that have existed:	
For less than one year at the time of reporting	2

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 2018 and 31 March 2019	4
Of which:	
Number assessed as being covered by IR35	3
Number assessed as not being covered by IR35	1
Number engaged directly (through PSC contracted to department) and are on the departmental payroll	2
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

19. EXIT PACKAGES

Reporting of compensation schemes - exit packages

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	
Total number of exit packages by type	**-**	**22**	**22**
Total cost (£)	£0	**£114,000**	**£114,000**

Exit Packages 2017/18	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	18	**18**
£10,000 - £25,000	-	2	**2**
Total number of exit packages by type	**-**	**20**	**20**
Total cost (£)	£0	**£88,000**	**£88,000**

Exit packages: other (non-compulsory) departure payments				
	2018/19		2017/18	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Contractual payments in lieu of notice	22	114	20	88
Total	22	114	20	88
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

20. EXPENDITURE ON CONSULTANCY

The Trust spent a total of £2.7m on external consultancy in the year in support of the delivery of a number of key initiatives, including clinical pathway reviews, harm reviews and major estates projects.

CHAPTER 3 – FINANCIAL STATEMENTS

ANNUAL ACCOUNTS 2018/19

The accounts of Portsmouth Hospitals NHS Trust for the year ended 31 March 2019 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 HM Treasury.

The accounts were approved by the Audit Committee, with delegated authority from the Board, at a meeting on 22 May 2019 and have been audited. The auditor's report on the financial statements is unqualified and is incorporated in the annual report.

EXTERNAL AUDITOR

The Trust's external auditor is Paul King, Ernst & Young LLP and he is based at Wessex House, 19 Threefield Lane, Southampton, Hampshire, SO14 3QB.

The audit fee for the 2018/19 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 2018/19 and the balance, £19,313, will be charged in 2019/20.

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

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

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

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

Signed: Chief Executive

Date: 22/05/19

Statement of directors' responsibilities in respect of the accounts

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

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

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

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

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

22/05/19

Chris Adcock, Chief Financial Officer

22/05/19

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 2019 under the Local Audit and Accountability Act 2014. The financial statements comprise the Trust's Statement of Comprehensive Income, the Trust Statement of Financial Position, the Trust Statement of Changes in Taxpayers' Equity, the Trust Statement of Cash Flows and the related notes 1 to 50. 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 2018-19 HM Treasury's Financial Reporting Manual (the 2018-19 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2018/19 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 2019 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 indicates that the Trust has been unable to meet its financial targets and has reported a deficit of £35.8 million for the year and has a cumulative deficit of £110.5 million as at 31 March 2019. The Trust is reliant on continued revenue support loans from the Department of Health and Social Care to continue operating. 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.

Other information

The other information comprises the information included in the annual report, set out on pages 1 to 63, 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.

We have nothing to report in these respects.
In respect of the following we have matters to report by exception:

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

We 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 2018/19 the statutory accounts indicate the Trust has a cumulative deficit at 31 March 2019 of £110.5 million over the five-year period from 1 April 2014 to 31 March 2019. On 28 May 2019 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.

Proper arrangements to secure economy, efficiency and effectiveness

We report to you, if we are not satisfied that the Trust has put in place proper arrangements to secure economy efficiency and effectiveness in its use of resources.

Basis for qualified conclusion

The Trust reported a deficit of £35.8 million in its financial statements for the year ending 31 March 2019, thereby breaching its duty under paragraph 2 (1) of Schedule 5 the National Health Service Act 2006, to break even. The Trust also only achieved £23.9 million (68 per cent) of its Cost Improvement Plan Target of £35.1 million.

This issue is evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Qualified conclusion (Except for)

On the basis of our work, having regard to the guidance issued by the C&AG in November 2017, with the exception of the matter(s) reported in the basis for qualified conclusion paragraph above, we are satisfied that, in all significant respects, Portsmouth Hospitals NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

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 63, 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 C&AGl in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The C&AG 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 2019.

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.

Paul King (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Southampton
29 May 2019

The maintenance and integrity of the Portsmouth Hospitals NHS Trust web site is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Statement of Comprehensive Income

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	501,584	483,719
Other operating income	4	57,118	59,350
Operating expenses	6, 8	(575,691)	(555,307)
Operating surplus/(deficit) from continuing operations		**(16,989)**	**(12,238)**
Finance income	11	127	55
Finance expenses	12	(20,695)	(18,844)
PDC dividends payable		(675)	(1,367)
Net finance costs		**(21,243)**	**(20,156)**
Other gains / (losses)	13	(87)	(107)
Surplus / (deficit) for the year		**(38,319)**	**(32,501)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(20)	(40)
Revaluations	17	7,976	11,631
Total comprehensive income / (expense) for the period		**(30,363)**	**(20,910)**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		(38,319)	(32,501)
Remove net impairments not scoring to the Departmental expenditure limit		(20)	(40)
Remove I&E impact of capital grants and donations		393	768
Adjusted financial performance surplus / (deficit)		**(37,946)**	**(31,773)**

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	14	2,693	2,233
Property, plant and equipment	15	380,663	368,991
Receivables	23	3,651	5,532
Total non-current assets		**387,007**	**376,756**
Current assets			
Inventories	22	14,878	14,340
Receivables	23	45,806	48,419
Cash and cash equivalents	26	4,584	1,104
Total current assets		**65,268**	**63,863**
Current liabilities			
Trade and other payables	27	(60,283)	(57,384)
Borrowings	30	(19,559)	(7,946)
Provisions	32	(346)	(311)
Other liabilities	29	(828)	(655)
Total current liabilities		**(81,016)**	**(66,296)**
Total assets less current liabilities		**371,259**	**374,323**
Non-current liabilities			
Borrowings	30	(330,243)	(313,415)
Provisions	32	(1,702)	(1,823)
Total non-current liabilities		**(331,945)**	**(315,238)**
Total assets employed		**39,314**	**59,085**
Financed by			
Public dividend capital		62,020	51,428
Revaluation reserve		141,886	134,456
Income and expenditure reserve		(164,592)	(126,799)
Total taxpayers' equity		**39,314**	**59,085**

The notes on pages 72 to 114 form part of these accounts.

Name :

Position: **Chief Executive**

Date: **22 May 2019**

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' 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' equity at 31 March 2019	**62,020**	**141,886**	**(164,592)**	**39,314**

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**50,907**	**123,094**	**(94,527)**	**79,474**
Surplus/(deficit) for the year	-	-	(32,501)	**(32,501)**
Impairments	-	(40)	-	**(40)**
Revaluations	-	11,631	-	**11,631**
Transfer to retained earnings on disposal of assets	-	(229)	229	**-**
Public dividend capital received	521	-	-	**521**
Taxpayers' equity at 31 March 2018	**51,428**	**134,456**	**(126,799)**	**59,085**

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 and Social Care 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	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(16,989)	(12,238)
Non-cash income and expense:			
Depreciation and amortisation	6	17,944	18,077
Net impairments	7	(20)	(40)
Income recognised in respect of capital donations	4	(251)	(248)
(Increase) / decrease in receivables and other assets		3,001	(12,022)
(Increase) / decrease in inventories		(538)	(474)
Increase / (decrease) in payables and other liabilties		(102)	4,292
Increase / (decrease) in provisions		(305)	29
Net cash generated from / (used in) operating activities		**2,740**	**(2,624)**
Cash flows from investing activities			
Interest received		124	52
Purchase of intangible assets		(1,596)	(959)
Purchase of property, plant, equipment and investment property		(13,958)	(9,596)
Sales of property, plant, equipment and investment property		53	63
Net cash generated from / (used in) investing activities		**(15,377)**	**(10,440)**
Cash flows from financing activities			
Public dividend capital received		10,592	521
Movement on loans from the Department of Health and Social Care		33,980	35,014
Capital element of finance lease rental payments		(340)	(617)
Capital element of PFI, LIFT and other service concession payments		(6,880)	(5,819)
Interest on loans		(2,345)	(1,669)
Other interest		(3)	(16)
Interest paid on PFI, LIFT and other service concession obligations		(17,887)	(17,123)
PDC dividend (paid) / refunded		(1,000)	(1,330)
Net cash generated from / (used in) financing activities		**16,117**	**8,961**
Increase / (decrease) in cash and cash equivalents		**3,480**	**(4,103)**
Cash and cash equivalents at 1 April - brought forward		**1,104**	**5,207**
Cash and cash equivalents at 31 March	26.1	**4,584**	**1,104**

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 2018/19 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.

Note 1.1.1 Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 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'.

Board members have reviewed this in view of a planned break-even position for 2019/20, a cumulative deficit position of £110.5m and cumulative working capital financing of £122.3m in the form of revenue support loans from DHSC.

The long-term plan for the NHS published in January 2019 and the five year settlement announced in summer 2018 (which will introduce an extra c£33 billion a year (nominal) into the NHS by 2023-24) represent the Government's and consequently DHSC's commitment to continue to fund the core activities of the NHS. The Government have set the NHS five financial tests in return for this investment, which will support improvement in the underlying financial position of all NHS providers and commissioners.

DHSC is considering next steps following the recommendations provided in an independent review on NHS financing, which alongside complimentary work by NHS England and Improvement on the broader financial architecture in the system, should support the longer-term recovery plans for NHS providers.

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

The Trust and NHS Improvement have a clear understanding of the financial position of the Trust and the position is well recognised and understood.

The Trust has a remedial action plan to recover its recurrent in-year financial position over a three year period.

The 2019/20 financial plan has been set in line with the requirements of the second year of the financial improvement trajectory. A significant change to the NHS financial architecture in 2019/20, provides additional non recurrent resources into the provider sector which has enabled the Trust to bridge the in-year deficit and set a breakeven plan.

The Trust's control total for 2019/20 is a break even position which includes £17.5m of PSF and FRF funding and is expected to be achieved by the Trust which is reliant on achieving the financial plan.

The Trust's financial strategy will be refreshed in 2019/20, in support of the Trust's overall strategy and to meet the requirements of the NHS Long Term Plan.

The Trust continues to be a lead partner within the Portsmouth and South East Hampshire system partnership. The partnership contributes to financial sustainability through the work it has done to align operational plans for 2019/20 and in identifying opportunities to maximise resources across the system.

These factors, together with contractual arrangements in place with the main commissioners, a 2019/20 break-even budget and a balanced cash forecast for the next twelve months all support the adoption of the going concern basis for the preparation of these accounts.

The conditions described above 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 Interests in other entities
The Trust does not have any interests in other entities.

Note 1.4.1 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). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

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.

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.

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 it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4.2 Revenue grants and other contributions to expenditure
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4.3 Other income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

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

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

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

dates, are anticipated to have similar disposal dates and are under single managerial control.

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

Note 1.7.2 Measurement

Valuation

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

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

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

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

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).

Subsequent expenditure

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

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful 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 income.

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

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

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

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

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.3 De-recognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable ie:
  - management are committed to a plan to sell the asset

- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

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

Note 1.7.4 Donated and grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

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

Note 1.7.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions
PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability.

Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, 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 reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	10	73
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 1.8 Intangible assets
Note 1.8.1 Recognition

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

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

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the trust intends to complete the asset and sell or use it
- the trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
- the trust can measure reliably the expenses attributable to the asset during development.

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

Note 1.8.2 Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

Amortisation

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

Note 1.8.3 Useful economic life 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
Information technology	2	5
Development expenditure	2	5
Websites	2	5
Software licences	2	5
Licences & trademarks	2	5
Patents	2	5
Other (purchased)	2	5
Goodwill	2	5

Note 1.9 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 1.10 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 1.11 Financial assets and financial liabilities
Financial assets and financial liabilities are recorded in line with IFRS 9 – Financial Instruments. The year ending 31st March 2019 is the first year since IFRS was implemented.

Note 1.11.1 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.

Note 1.11.2 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.

Note 1.11.3 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 1.12 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.12.1 The trust as lessee
Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as 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. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

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

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

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

Note 1.12.2 The trust as 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 1.13 Provisions
The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 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 1.14 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 1.15 Public dividend capital

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

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

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:

i. donated assets (including lottery funded assets),
ii. average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
iii. any PDC dividend balance receivable or payable.

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

Note 1.16 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 1.17 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 monetary items arising on settlement of the transaction are recognised in income or expense in the period in which they arise.

Note 1.18 Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.19 Losses and special payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

Note 1.20 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 1.21 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 recognizing 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 note 1.7). 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 1.22 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 within it's financial statements. 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. As at 31st March 2019 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 it's previous assessment of the financial entries associated with these agreements in the accounts. The value of income included in the year ending 31st March 2018 was £3.3m. The balance as at 31st March 2019 is recorded in payables and receivables.

Note 1.23 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 1.24 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.25 Standards, amendments and interpretations in issue but not yet effective or adopted
Standards Issued or amended but not yet adopted in the FReM:
- **IFRS 14** Regulatory Deferral Accounts: Applies to first time adopters of IFRS after 1st January 2016, therefore not applicable to DHSC bodies.
- **IFRS 16** Leases: Application required for accounting periods beginning on or after 1st January 2020, but not yet adopted by the FReM: early adoption is not therefore permitted.
- **IFRS 17** Insurance Contracts: Application required for accounting periods beginning on or after 1st January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- **IFRIC 23** Uncertainty over Income Tax Treatments: Application required for accounting periods beginning on or after 1st January 2019.

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 (£549.1m 98%) is derived from 'non-trading' healthcare. Of the total income, 2% (£10.0m) 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	
	2018-19	2017-18	**2018-19**	2017-18	**2018-19**	2017-18
	£000's	£000's	**£000's**	£000's	**£000's**	£000's
Income						
External	**548,743**	533,427	**9,959**	9,642	**558,702**	543,069
Internal	**0**	0	**43,234**	41,099	**43,234**	41,099
Total Income	**548,743**	533,427	**53,193**	50,741	**601,936**	584,168
Expenditure						
Segment costs	**545,125**	525,982	**51,584**	49,261	**596,709**	575,243
Common costs	**43,234**	41,099	**312**	328	**43,546**	41,427
Total Expenditure	**588,359**	567,081	**51,896**	49,589	**640,255**	616,670
Retained surplus/(deficit) for the year	(39,616)	(33,654)	1,297	1,152	(38,319)	(32,502)

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1

Note 3.1 Income from patient care activities (by nature)	2018/19 £000	2017/18 £000
Elective income	81,662	84,306
Non elective income	164,907	141,124
First outpatient income	36,491	43,562
Follow up outpatient income	33,943	36,222
A & E income	19,269	17,837
High cost drugs income from commissioners (excluding pass-through costs)	50,503	46,289
Other NHS clinical income	106,164	106,143
Private patient income	2,344	3,064
Agenda for Change pay award central funding	4,205	-
Other clinical income	2,096	5,172
Total income from activities	**501,584**	**483,719**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2018/19 £000	2017/18 £000
NHS England	122,963	120,537
Clinical commissioning groups	369,349	358,610
Department of Health and Social Care	4,205	-
Other NHS providers	276	288
Non-NHS: private patients	2,345	3,064
Non-NHS: overseas patients (chargeable to patient)	460	392
Injury cost recovery scheme	1,047	576
Non NHS: other	939	252
Total income from activities	**501,584**	**483,719**

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

	2018/19	2017/18
	£000	£000
Income recognised this year	460	392
Cash payments received in-year	195	231
Amounts added to provision for impairment of receivables	22	93
Amounts written off in-year	96	58

Note 4 Other operating income

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	4,760	4,691
Education and training (excluding notional apprenticeship levy income)	19,386	16,708
Non-patient care services to other bodies	12,712	12,912
Provider sustainability / sustainability and transformation fund income (PSF / STF)	-	6,636
Other contract income *	18,310	16,326
Other non-contract operating income		
Receipt of capital grants and donations	251	248
Charitable and other contributions to expenditure	184	98
Rental revenue from operating leases	1,515	1,731
Total other operating income	**57,118**	**59,350**

* Other contract income includes £10.2m Pharmacy Sales and £2.2m of income generation schemes

Note 5 Additional information on revenue from contracts with customers recognised in the period

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

Note Transaction price allocated to remaining performance obligations

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

	2018/19	2017/18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	3,188	3,287
Purchase of healthcare from non-NHS and non-DHSC bodies	15,249	16,044
Staff and executive directors costs	328,477	316,527
Remuneration of non-executive directors	71	66
Supplies and services - clinical (excluding drugs costs)	52,862	54,149
Supplies and services - general	2,126	2,031
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	72,818	68,289
Inventories written down	40	243
Consultancy costs	2,711	2,611
Establishment	5,866	4,002
Premises	14,504	11,091
Transport (including patient travel)	752	576
Depreciation on property, plant and equipment	16,808	16,943
Amortisation on intangible assets	1,136	1,134
Net impairments	(20)	(40)
Movement in credit loss allowance: contract receivables / contract assets	-	
Movement in credit loss allowance: all other receivables and investments	101	(144)
Increase/(decrease) in other provisions	-	-
Change in provisions discount rate(s)	(264)	20
Audit fees payable to the external auditor		
audit services- statutory audit	100	110
other auditor remuneration (external auditor only)	10	-
Internal audit costs	85	70
Clinical negligence	18,402	22,181
Legal fees	652	392
Insurance	370	294
Research and development	4,215	3,502
Education and training	1,413	1,426
Rentals under operating leases	1,457	1,440
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI)	31,287	27,674
Hospitality	7	6
Other	1,268	1,383
Total	**575,691**	**555,307**

Note 6.1 Other auditor remuneration

Other auditor remuneration relates to the completion of the audit on the Trust's Quality Account.

Note 6.2 Limitation on auditor's liability

The limitation on auditors liability for external audit work is £2m (2017/18: £2m).

Note 7 Impairment of assets

	2018/19 £000	2017/18 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	(20)	(40)
Total net impairments charged to operating surplus / deficit	**(20)**	**(40)**
Impairments charged to the revaluation reserve	20	40
Total net impairments	**-**	**-**

Note 8 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	237,773	227,750
Social security costs	23,381	22,423
Apprenticeship levy	1,194	1,148
Employer's contributions to NHS pensions	29,285	27,953
Temporary staff (including agency)	42,502	41,519
Total gross staff costs	**334,135**	**320,793**
Recoveries in respect of seconded staff	-	-
Total staff costs	**334,135**	**320,793**
Of which		
Costs capitalised as part of assets	1,443	764

Note 8.1 Retirements due to ill-health

During 2018/19 there were 3 early retirements from the trust agreed on the grounds of ill-health (2 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £163k (£85k in 2017/18).

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

Note 9 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and

financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

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.

	2018/19	2017/18
Operating lease revenue	**£000**	**£000**
Minimum lease receipts	1,515	1,731
Total	**1,515**	**1,731**

	31 March 2019	31 March 2018
	£000	**£000**
Future minimum lease receipts due:		
- not later than one year;	1,513	1,492
- later than one year and not later than five years;	2,169	1,308
- later than five years.	555	602
Total	**4,237**	**3,402**

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.

- Railway Triangle lease - used for Pharmacy Manufacture, the lease period is for 30 years (expires 2036) and has an annual lease value of £102,000.
- Solent Industrial Estate - used for Pharmacy and Procurement, the lease period is for 15 years (expires 2020) and has an annual value of £148,000.
- Fort Southwick office buildings and car parks - used for off site car parking and administration, the lease period is for 10 years (expires 2019) and has an annual value of £512,000.
- 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 £176,000.

	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	1,457	1,440
Total	**1,457**	**1,440**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due:		
- not later than one year;	1,430	1,440
- later than one year and not later than five years;	2,377	3,098
- later than five years.	2,019	2,264
Total	**5,826**	**6,802**
Future minimum sublease payments to be received	-	-

Note 11 Finance income

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

	2018/19	2017/18
	£000	£000
Interest on bank accounts	127	55
Other finance income	-	-
Total finance income	**127**	**55**

Note 12.1 Finance expenditure

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

	2018/19	2017/18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	2,586	1,791
Interest on late payment of commercial debt	3	16
Main finance costs on PFI and LIFT schemes obligations	11,947	12,251
Contingent finance costs on PFI and LIFT scheme obligations	5,940	4,872
Total interest expense	**20,476**	**18,930**
Unwinding of discount on provisions	219	(86)
Other finance costs	-	-
Total finance costs	**20,695**	**18,844**

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

	2018/19	2017/18
	£000	£000
Amounts included within interest payable arising from claims under this legislation	3	16

Note 13 Other gains / (losses)

	2018/19	2017/18
	£000	£000
Gains on disposal of assets	31	32
Losses on disposal of assets	(118)	(139)
Total gains / (losses) on disposal of assets	**(87)**	**(107)**
Other Gains / (losses)	-	-
Total other gains / (losses)	**(87)**	**(107)**

Note 14 Discontinued operations

There are no discontinued operations.

Note 14.1 Intangible assets - 2018/19

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2018 - brought forward	**8,693**	**8,693**
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 - brought forward	**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 14.2 Intangible assets - 2017/18

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2017	**7,734**	**7,734**
Additions	959	**959**
Valuation / gross cost at 31 March 2018	**8,693**	**8,693**
Amortisation at 1 April 2017	**5,326**	**5,326**
Provided during the year	1,134	**1,134**
Amortisation at 31 March 2018	**6,460**	**6,460**
Net book value at 31 March 2018	**2,233**	**2,233**
Net book value at 1 April 2017	**2,408**	**2,408**

Note 15.1 Property, plant and equipment - 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
Valuation/gross cost at 1 April 2018 - brought forward	**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	6,776	(390)	-	1,034	1	-	51	**8,744**
Disposals / derecognition	-	-	-	-	(6,164)	(20)	(71)	-	**(6,255)**
Valuation/gross cost at 31 March 2019	**26,597**	**341,330**	**3,664**	**469**	**83,342**	**61**	**29,882**	**3,389**	**488,734**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**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	-	-	-	-	736	1	-	31	**768**
Disposals / derecognition	-	-	-	-	(6,024)	(20)	(71)	-	**(6,115)**
Accumulated depreciation at 31 March 2019	**-**	**24,629**	**402**	**-**	**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**

Note 15.2 Property, plant and equipment - 2017/18

	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 2017 - as previously stated	24,429	312,506	3,609	-	75,289	79	25,449	3,259	444,620
Prior period adjustments	-	-	-	-	-	-	-	-	-
Valuation / gross cost at 1 April 2017 - restated	24,429	312,506	3,609	-	75,289	79	25,449	3,259	444,620
Additions	-	4,715	-	-	4,564	-	1,816	-	**11,095**
Impairments	-	(40)	-	-	-	-	-	-	**(40)**
Revaluations	896	10,676	(290)	-	1,056	1	-	53	**12,392**
Disposals / derecognition	-	-	-	-	(2,438)	-	(8)	-	**(2,446)**
Valuation/gross cost at 31 March 2018	25,325	327,857	3,319	-	78,471	80	27,257	3,312	465,621
Accumulated depreciation at 1 April 2017 - as previously stated	-	8,032	131	-	53,417	77	17,835	1,750	81,242
Prior period adjustments	-	-	-	-	-	-	-	-	-
Accumulated depreciation at 1 April 2017 - restated	-	8,032	131	-	53,417	77	17,835	1,750	81,242
Provided during the year	-	8,336	139	-	5,705	1	2,525	237	**16,943**
Reversals of impairments	-	(40)	-	-	-	-	-	-	**(40)**
Revaluations	-	-	-	-	732	1	-	28	**761**
Disposals / derecognition	-	-	-	-	(2,268)	-	(8)	-	**(2,276)**
Accumulated depreciation at 31 March 2018	-	16,328	270	-	57,586	79	20,352	2,015	96,630
Net book value at 31 March 2018	25,325	311,529	3,049	-	20,885	1	6,905	1,297	368,991
Net book value at 1 April 2017	24,429	304,474	3,478	-	21,872	2	7,614	1,509	363,378

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

	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 2018									
Owned - purchased	25,325	4,611	3,049	-	18,195	1	6,873	1,297	**59,351**
Finance leased	-	-	-	-	949	-	-	-	**949**
On-SoFP PFI contracts and other service concession arrangements	-	302,563	-	-	-	-	-	-	**302,563**
Owned - donated	-	4,355	-	-	1,741	-	32	-	**6,128**
NBV total at 31 March 2018	**25,325**	**311,529**	**3,049**	**-**	**20,885**	**1**	**6,905**	**1,297**	**368,991**

Note 16 Donations of property, plant and equipment
The donated assets were received from the Portsmouth Hospitals NHS Trust Charity.

Note 17 Revaluations of property, plant and equipment
All land and buildings are recorded based on a valuation carried out as at 31 March 2019 by the District Valuer from the Valuation Office Agency and in line with Note 1.7.2.

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 £45.7m

Note 18 Investment Property
The Trust does not hold any investment property.

Note 19 Investments in associates and joint ventures
The Trust does not hold any investments in associates and joint ventures.

Note 20 Other investments / financial assets
The Trust does not hold any other investments or financial assets.

Note 21 Disclosure of interests in other entities
The Trust does not have any interests in other entities.

Note 22 Inventories

	2019	2018
	£000	£000
Drugs	7,292	6,544
Consumables	7,586	7,796
Total inventories	**14,878**	**14,340**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £89,986k (2017/18: £103,855k). Write-down of inventories recognised as expenses for the year were £40k (2017/18: £243k).

Note 23 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	25,326	
Trade receivables*		26,482
Allowance for impaired contract receivables / assets*	(21)	
Allowance for other impaired receivables	(838)	(799)
Prepayments (non-PFI)	4,473	5,219
PFI lifecycle prepayments	7,040	6,970
Interest receivable	7	4
PDC dividend receivable	293	-
VAT receivable	3,104	3,303
Other receivables	6,422	7,240
Total current trade and other receivables	**45,806**	**48,419**
Non-current		
Contract receivables*	1,001	
PFI lifecycle prepayments	2,650	4,509
Other receivables	-	1,023
Total non-current trade and other receivables	**3,651**	**5,532**
Of which receivables from NHS and DHSC group bodies:		
Current	20,242	22,769

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 23.1 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward		**859**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	21	(21)
New allowances arising	-	131
Reversals of allowances	-	(30)
Utilisation of allowances (write offs)	-	(41)
Allowances as at 31 Mar 2019	**21**	**898**

Note 23.2 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables
	£000
Allowances as at 1 Apr 2017	**799**
Increase in provision	131
Amounts utilised	(41)
Unused amounts reversed	(30)
Allowances as at 31 Mar 2018	**859**

Note 23.3 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 2019 are in receivables from customers, as disclosed in the trade and other receivables note.

Note 24 Other assets

	2019	2018
Current	£000	£000
Other assets	-	-
Total other current assets	**-**	**-**
Non-current		
Other assets	-	-
Total other non-current assets	**-**	**-**

Note 25 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 25.1 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. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2018/19	2017/18
	£000	£000
At 1 April	**1,104**	**5,207**
Transfers by absorption	-	-
Net change in year	3,480	(4,103)
At 31 March	**4,584**	**1,104**
Broken down into:		
Cash at commercial banks and in hand	52	50
Cash with the Government Banking Service	4,532	1,054
Total cash and cash equivalents as in SoFP	**4,584**	**1,104**
Bank overdrafts (GBS and commercial banks)	-	-
Total cash and cash equivalents as in SoCF	**4,584**	**1,104**

Note 26.2 Third party assets held by the trust

The trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

Note 27.1 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	10,339	9,432
Capital payables	7,892	4,550
Accruals	2,003	3,964
Social security costs	3,455	3,267
Other taxes payable	3,071	2,877
PDC dividend payable	-	32
Accrued interest on loans*		136
Other payables	33,523	33,126
Total current trade and other payables	**60,283**	**57,384**
Non-current		
Other payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	6,129	7,529

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note . IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 27.2 Early retirements in NHS payables above

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

	31 March 2019 £000	31 March 2019 Number	31 March 2018 £000	31 March 2018 Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-

Note 28 Other financial liabilities

The Trust does not have any 'other' financial liabilities.

Note 29 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	828	655
Total other current liabilities	**828**	**655**
Non-current		
Other non-current liabilities	-	-
Total other non-current liabilities	**-**	**-**

Note 30 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Loans from the Department of Health and Social Care	12,074	820
Obligations under finance leases	435	246
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle	7,050	6,880
Total current borrowings	**19,559**	**7,946**
Non-current		
Loans from the Department of Health and Scoial Care	114,288	91,185
Obligations under finance leases	1,351	576
Obligations under PFI, LIFT or other service concession contracts	214,604	221,654
Total non-current borrowings	**330,243**	**313,415**

Note 30.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	Finance leases £000	PFI and LIFT schemes £000	Total £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 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 Portsmouth Hospitals NHS Trust is the lessee.

	31 March 2019 £000	31 March 2018 £000
Gross lease liabilities	**1,786**	**822**
of which liabilities are due:		
- not later than one year;	435	246
- later than one year and not later than five years;	1,080	576
- later than five years.	271	-
Net lease liabilities	**1,786**	**822**
of which payable:		
- not later than one year;	435	246
- later than one year and not later than five years;	1,080	576
- later than five years.	271	-

Note 32.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs £000	Pensions: injury benefits* £000	Legal claims** £000	Total £000
At 1 April 2018	**367**	**1,566**	**201**	**2,134**
Change in the discount rate	4	(268)	-	**(264)**
Arising during the year	-	-	94	**94**
Utilised during the year	(23)	(70)	(8)	**(101)**
Reversed unused	-	-	(34)	**(34)**
Unwinding of discount	4	215	-	**219**
At 31 March 2019	**352**	**1,443**	**253**	**2,048**
Expected timing of cash flows:				
- not later than one year;	23	70	253	**346**
- later than one year and not later than five years;	92	280	-	**372**
- later than five years.	237	1,093	-	**1,330**
Total	**352**	**1,443**	**253**	**2,048**

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within early departure costs.

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

Note 32.2 Clinical negligence liabilities

At 31 March 2019, £414,407k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Portsmouth Hospitals NHS Trust (31 March 2018: £410,842k).

Note 33 Contingent assets and liabilities

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
NHS Resolution legal claims *	(45)	(63)
Employment tribunal and other employee related litigation **	(123)	(123)
Gross value of contingent liabilities	**(168)**	**(186)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(168)**	**(186)**
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 were shown as not disclosed in 2017/18. The value is 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

The Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI schemes.

Note 36.1 Imputed finance lease obligations

Portsmouth Hospitals NHS Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2019 £000	31 March 2018 £000
Gross PFI, LIFT or other service concession liabilities	**369,532**	**388,359**
Of which liabilities are due		
- not later than one year;	18,637	18,826
- later than one year and not later than five years;	74,045	73,748
- later than five years.	276,850	295,785
Finance charges allocated to future periods	(147,878)	(159,825)
Net PFI, LIFT or other service concession arrangement obligation	**221,654**	**228,534**
- not later than one year;	7,050	6,880
- later than one year and not later than five years;	31,368	29,528
- later than five years.	183,236	192,126

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

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

	31 March 2019 £000	31 March 2018 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**1,385,410**	**1,319,022**
Of which liabilities are due:		
- not later than one year;	63,697	57,979
- later than one year and not later than five years;	254,788	231,916
- later than five years.	1,066,925	1,029,127

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:

	2018/19 £000	2017/18 £000
Unitary payment payable to service concession operator	**58,698**	**54,591**
Consisting of:		
- Interest charge	11,947	12,251
- Repayment of finance lease liability	6,880	5,819
- Service element and other charges to operating expenditure	30,203	27,091
- Capital lifecycle maintenance	2,644	3,303
- Revenue lifecycle maintenance	1,084	583
- Contingent rent	5,940	4,872
- Addition to lifecycle prepayment	-	672
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	-	-
Total amount paid to service concession operator	**58,698**	**54,591**

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 obligations.

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. The Trust was reliant on accessing Interim Deficit Financing cash in 2018/19 from the Department of Health. The Trust has a break-even plan for 2019/20 and is not anticipating accessing Deficit Funding in 2019/20.

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

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	31,897	-	-	**31,897**
Cash and cash equivalents at bank and in hand	4,584	-	-	**4,584**
Total at 31 March 2019	**36,481**	**-**	**-**	**36,481**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	£000	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	31,455	-	-	-	**31,455**
Cash and cash equivalents at bank and in hand	1,104	-	-	-	**1,104**
Total at 31 March 2018	**32,559**	**-**	**-**	**-**	**32,559**

Note 38.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
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**
Trade and other payables excluding non financial liabilities	53,756	-	**53,756**
Total at 31 March 2019	**403,558**	**-**	**403,558**

	Other financial liabilities	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Loans from the Department of Health and Social Care	92,005	-	**92,005**
Obligations under finance leases	822	-	**822**
Obligations under PFI, LIFT and other service concession contracts	228,534	-	**228,534**
Trade and other payables excluding non financial liabilities	51,242	-	**51,242**
Total at 31 March 2018	**372,603**	**-**	**372,603**

Note 38.4 Fair values of financial assets and liabilities

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

Note 38.5 Maturity of financial liabilities

	31 March 2019	31 March 2018
	£000	£000
In one year or less	73,314	59,188
In more than one year but not more than two years	83,742	18,993
In more than two years but not more than five years	62,435	101,175
In more than five years	184,067	193,247
Total	**403,558**	**372,603**

Note 39 Losses and special payments

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	30	20	14	6
Bad debts and claims abandoned	363	110	257	79
Stores losses and damage to property	2	60	3	283
Total losses	**395**	**190**	**274**	**368**
Special payments				
Ex-gratia payments	89	61	120	60
Total special payments	**89**	**61**	**120**	**60**
Total losses and special payments	**484**	**251**	**394**	**428**
Compensation payments received		-		-

Note 40 Gifts

The Trust has not made any gifts.

Note 41.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018.

The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £136k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classifiction of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £2,414k.

Note 41.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers

replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Note 42 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 2019.

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£	£	£	£
NHS Coastal West Sussex CCG	0	7,361	474	0
NHS England	4	123,415	165	6,582
NHS Fareham and Gosport CCG	293	113,779	708	2,014
NHS Portsmouth CCG	21	124,113	964	2,790
NHS Resolution	18,726	0	0	0
NHS South Eastern Hampshire CCG	123	104,541	552	1,295
NHS West Hampshire CCG	0	10,886	0	73
University Hospitals Southampton NHS Foundation Tru	1,626	9,384	747	2,777
Health Education England	15	19,764	0	20

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 £315k.

Note 43 Transfers by absorption

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

Note 44 Prior period adjustments

There have been no prior period adjustments.

Note 45 Events after the reporting date

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

Note 46 Better Payment Practice code

	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	108,405	291,635	99,396	277,813
Total non-NHS trade invoices paid within target	50,873	205,789	63,750	218,090
Percentage of non-NHS trade invoices paid within target	46.9%	70.6%	64.1%	78.5%
NHS Payables				
Total NHS trade invoices paid in the year	2,555	13,929	2,484	12,775
Total NHS trade invoices paid within target	2,051	11,069	2,025	9,717
Percentage of NHS trade invoices paid within target	80.3%	79.5%	81.5%	76.1%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later. The Trust did not meet this target, primarily due to payment run restrictions as part of the in-year management of working capital.

Note 47 External financing

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

	2018/19 £000	2017/18 £000
Cash flow financing	32,568	33,202
Finance leases taken out in year	1,304	0
Other capital receipts	0	0
External financing requirement	33,872	33,202
External financing limit (EFL)	35,935	34,045
Under / (over) spend against EFL	2,063	843

Note 48 Capital Resource Limit

	2018/19 £000	2017/18 £000
Gross capital expenditure	22,240	12,054
Less: Disposals	(140)	(170)
Less: Donated and granted capital additions	(251)	(248)
Charge against Capital Resource Limit	21,849	11,636
Capital Resource Limit	22,774	12,921
Under / (over) spend against CRL	925	1,285

Note 49 Breakeven duty financial performance

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

Note 50 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
		£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		(14,877)	159	148	4,293	830	(2,912)	(23,477)	(17,645)	(30,701)	(35,826)
Breakeven duty cumulative position	9,479	(5,398)	(5,239)	(5,091)	(798)	32	(2,880)	(26,357)	(44,002)	(74,703)	(110,529)
Operating income		432,167	446,161	440,231	451,906	469,094	484,463	504,572	530,382	543,069	558,702
Cumulative breakeven position as a percentage of operating income		(1.2%)	(1.2%)	(1.2%)	(0.2%)	0.0%	(0.6%)	(5.2%)	(8.3%)	(13.8%)	(19.8%)

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year. This adjustment is shown at Note 50 and does not count in the performance against the control total for the year.

Salary and Pension entitlements of senior managers 2018/19

Name	Title	Start date/leaving date (where not in post for full year)	2018/19						2017/18					
			Salary (bands of £5,000) £000	Expenses Payments (Taxable) (total to nearest £100)	Performance Pay and Bonuses (bands of £5,000)	Long Term Performance Pay and Bonuses (bands of £5,000)	All Pension Related Benefits (bands of £2,500)	TOTAL (bands of £5,000)	Salary (bands of £5,000) £000	Expenses Payments (Taxable) (total to nearest £100)	Performance Pay and Bonuses (bands of £5,000)	Long Term Performance Pay and Bonuses (bands of £5,000)	All Pension Related Benefits (bands of £2,500)	TOTAL (bands of £5,000)
Executive Directors in post at 31st March 2019														
Mark Cubbon	Chief Executive	From 31/07/17	185-190	-	-	-	95-97.5	280-285	115-120	-	-	-	-	115-120
John Knighton	Medical Director	From 11/06/17	160-165 *	-	-	-	140-142.5	300-305	130-135	-			**160-162.5**	295-300
Adcock Chris	Director of Finance		160-165	-	-	-	35-37.5	200-205	160-165	-	-	-	40-42.5	205-210
Paul Bytheway	Chief Operating Officer	From 01/11/17	145-150	-	-	-	165-167.5	315-320	60-65	-	-	-	**40-42.5**	100-105
Penny Emerit	Director of Strategy and Performance	From 08/01/18	135-140	-	-	-	37.5-40	170-175	30-35	-	-	-	**5-7.5**	35-40
Lois Howell	Director of Governance & Risk	From 02/01/18	100-105	-	-	-	32.5-35	135-140	25-30	-	-	-	**0-2.5**	25-30
Emma McKinney	Director of Communications	From 04/12/17	80-85	-	-	-	60-62.5	145-150	25-30	-	-	-	-	25-30
Nicole Cornelius	Director of Workforce & Organisational Development	From 01/10/18	55-60	-	-	-	0-2.5	55-60						
Executive Directors who left during the year ending 31st March 2019														
Tim Powell	Director of Workforce & Organisational Development (Interim Chief Executive from 27/05/16 to 31/07/17)	Until 15/04/18	5-10	-	-	-	0-2.5	5-10	160-165	-	-	-	17.5-20	180-185
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	30-35	-	-	-	**15-17.5**	50-55
Executive Directors who left during the year ending 31st March 2018														
Simon Holmes	Medical Director	Until 11/06/17	-	-	-	-	-	-	40-45 **	-	-	-	0-2.5	40-45
Rob Haigh	Director of Unscheduled Care	From 18/07/16 to 22/10/17	-	-	-	-	-	-	115-120 ***	700	-	-	32.5-35	150-155
Nicola Ryley	Interim Director of Nursing	From 22/05/17 to 18/08/17	-	-	-	-	-	-	30-35	-	-	-	-	30-35
Rebecca Kopecek	Interim Director of Workforce and Organisational Development	From 27/05/16 to 31/07/17	-	-	-	-	-	-	30-35	-	-	-	12.5-15	45-50
Sheila Roberts	Interim Chief Operating Officer	From 06/02/17 to 30/09/17	-	-	-	-	-	-	85-90	-	-	-	-	85-90
Non- Executive Directors in post at 31st March 2019														
Melloney Poole	Chair (Non-Executive Director from 01/05/17 until 01/11/17)	From 01/05/17	35-40	-	-	-	-	35-40	15-20	-	-	-	-	15-20
Christine Slaymaker	Non-Executive Director	From 15/05/17	5-10	1,100	-	-	-	5-10	05-10	**900**	-	-	-	5-10
David Parfitt	Non-Executive Director	From 15/05/17	5-10	1,300	-	-	-	5-10	05-10	**700**	-	-	-	5-10
Gary Hay	Non-Executive Director	From 01/01/18	5-10	-	-	-	-	5-10	0-5	-	-	-	-	0-5
Roger Burke-Hamilton	Non-Executive Director	From 04/10/18	0-5	-	-	-	-	0-5	-	-	-	-	-	-
Martin Rolfe	Non-Executive Director	From 20/09/18	0-5	-	-	-	-	0-5	-	-	-	-	-	-
Non- Executive Directors who left during the year ending 31st March 2019														
Jon Watson	Non-Executive Director	From 07/12/17 until 16/09/18	0-5	600	-	-	-	0-5	0-5	-	-	-	-	0-5
Non- Executive Directors who left during the year ending 31st March 2018														
Greg Brown	Non- Executive Director	From 07/12/17 until 15/03/18	-	-	-	-	-	-	0-5	-	-	-	-	0-5
Sir Ian Carruthers	Chair	Until 16/06/17	-	-	-	-	-	-	5-10	1,200	-	-	-	5-10
Nellthorp Mark	Non- Executive Director (Interim Chair 19/06/17 to 31/10/17)	Until 30/11/17	-	-	-	-	-	-	10-15	-	-	-	-	10-15
Conway Elizabeth	Non- Executive Director	Until 28/04/17	-	-	-	-	-	-	0-5	-	-	-	-	0-5
Michael Attenborough-Cox	Non- Executive Director	Until 31/10/17	-	-	-	-	-	-	0-5	200	-	-	-	0-5

* Medical Director salary includes remuneration for work other than management responsibilities of £65k-£70k (£55k-£60k in 2017/18)
** Former Medical Director includes remuneration for work other than management responsibilities of £5k-£10k in 2017/18
*** Director of Unscheduled Care includes remuneration for work other than management responsibilities of £30k-£35k in 2017/18

Signed: Chief Executive:

Date: 22/05/2019

Salary and Pension entitlements of senior managers

B) Pension Benefits

Name	Title	Real increase in pension at retirement age (bands of £2,500) £000	Real increase in pension lump sum at retirement age (bands of £2,500) £000	Total accrued pension at 31/03/2019 (bands of £5,000) £000	Lump sum at pension age related to accrued pension 31/03/2019 (bands of £5,000) £000	Cash equivalent transfer value 31/03/2019 £000	Cash equivalent transfer value 31/03/2018 £000	Real increase in cash equivalent transfer value **** (bands of £5,000) £000	Employers Contribution to Stakeholder Pension* To nearest £100
Mark Cubbon	Chief Executive	5-7.5	5-7.5	45-50	95-100	743	568	160-165	0
John Knighton	Medical Director	7.5-10	12.5-15	70-75	195-200	1,524	1,225	275-280	0
Adcock Chris	Director of Finance	2.5-5	(2.5)-0	45-50	105-110	816	675	125-130	0
Paul Bytheway	Chief Operating Officer	7.5-10	15-17.5	40-45	90-95	656	444	200-205	0
Penny Emerit	Director of Strategy and Performance	2.5-5	0-2.5	20-25	40-45	312	236	70-75	0
Lois Howell	Director of Governance & Risk	0-2.5	0-2.5	10-15	20-25	181	132	45-50	0
Emma McKinney	Director of Communications	2.5-5	0-2.5	10-15	0**	123	70	50-55	0
Nicole Cornelius	Director of Workforce & Organisational Development	0-2.5	0-2.5	0-5	0**	15	0	5-10***	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 va;ue of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the members accrued benefits and any contingent spouse's pension payable from the scheme. CETV's are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

REAL INCREASE IN CETV
This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Signed: Chief Executive:

Date: 22/05/2019