Portsmouth Hospitals NHS
NHS Trust

Annual Report
2013/14

The best hospital, providing the best care, staffed by the best people.

Contents

This Annual Report reflects on our performance over the last year and articulates our vision for the future. The structure of the report is as follows:

Chairman's Introduction

It has been an enjoyable and busy year for us all in the hospital trust, facing some challenges as well as celebrating many successes. We hope you will enjoy reading more about our work in this annual report.

Changes in the commissioning of local health services, replacing Primary Care Trusts with Clinical Commissioning Groups run by General Practitioners (GPs), have now happened and key relationships within the NHS have embedded and are maturing. It is vital that we continue to work together to meet the needs of our patients as a whole health system, and much effort and focus has been put in to achieve this.

We provide acute and specialist services to three local commissioners across a large population for the Portsmouth and South East Hampshire area. Our demographic continues to be complex and diverse, in particular we have an older than national average patient profile, bringing with it extra healthcare demands.

Some of our performance targets have been challenging throughout the past year, in particular meeting our 4 hour waiting time and managing unscheduled care. This was due in part to exceptionally busy demands on our services throughout the year and our cancer referrals, for example, rose significantly due to national awareness campaigns.

We continued to evolve and improve our services this year, for example bringing in seven day working to ensure the safety of our patients and deliver high quality outcomes. We have also continued to improve our services through innovation and technology and our research and development work goes from strength to strength and this is nationally recognised. We remain committed to putting the patient first through excellent clinical care and ensuring that the patient experience is a positive one.

We have continued on our journey to become an NHS Foundation Trust. We believe it is the right thing for both the Trust and for the people we serve. As a Foundation Trust we will be able to secure real benefits for local people, run for and governed by our members. We remain committed to providing sustainable high quality patient care and are working tirelessly to ensure we are ready when the time comes for authorisation.

I have very much enjoyed my role as Interim Chair, and continue to be inspired by the commitment and hard work of all of our staff, volunteers, members and governors. My sincere thanks go to them all for their support and they deserve huge recognition for their inspirational patient focused care which delivers some of the best clinical outcomes in the country. This annual report serves as a summary of the last year's achievements and we all look forward to another exciting year ahead.

Alan Cole

Interim Chairman

Chief Executive's Foreword

Dear reader,

I welcome you to the annual report which reflects on some of our great successes and achievements over the last twelve months and also looks towards the challenges to come. It has been a year of challenge given the ever increasing financial and clinical standards that need to be met. That said, we have ended the year in a better than anticipated position due to the huge commitment and efforts of all our staff, thus we enter the new year with confidence and optimism.

Much work has been done in the last year to position ourselves as the provider of choice and we remain committed to delivering great care and services to our local population in a way that best meets their health needs. Our decisions through the year have been driven by our continual efforts to improve the quality of our wide ranging services for our patients. This could not have been done without the commitment of the Clinical Service Centres who have increasingly throughout the year, risen to the challenges. We are determined that our organisation continues to be run by experienced clinicians with the support of our managers. Our management capability and capacity has significantly increased and there has been a greater than ever emphasis on frontline staff being involved in decision making. We will build on this in future years.

This year we have continued to capture the extraordinary talent of our staff that has allowed us to continue to innovate and improve care for our patients. We are treating a larger than ever number of patients within nationally recognised clinical trials as part of our research and development agenda. We will continue to drive this next year as there is compelling evidence that patients treated within the context of clinical trials generally have improved outcomes and experiences.

We have had a year of high-definition surgery using our da Vinci robot. We are unique in our performance of robotic surgery, offering a wide range of surgical specialties including colorectal, head and neck, urology and gynaecology. Due to the expertise of our surgeons, da Vinci has specifically chosen us as a European training centre.

We continue to perform extremely well, as judged by our clinical outcomes and patient experience across a range of services. These include renal transplantation, neonatology, maternity, diabetes, rheumatology, cardiology, stroke and many aspects of cancer care. Our performance in the National Hip Fracture Database Report also deserves a special mention as we were ranked first nationally on a range of quality indicators. We have continued to perform very well in other areas, achieving many of our key indicators despite the increasing demands on our services.

It is recognised that this winter was a particularly challenging one for the NHS. Like many hospital Trusts up and down the country we struggled with our emergency pathway despite some real improvement initiatives and frustratingly missed the standard on many occasions. This is not about chasing statistics, but ensuring our patients have a good experience whilst in our care. Much effort is being made to make continuous improvements in this area, including a significant investment in the Oceano software package for managing patient flow in the emergency department. This coming year will focus on getting a sustainable solution to this care pathway.

Our staff are our biggest asset and I was delighted to launch a new way of working at the Trust this year called Listening into Action (LiA). This is a fundamental shift in the way we work, manage and lead our staff and placing them at the centre of change. A large number of our staff continue to engage in LiA at all levels as part of our wider organisational development strategy. We have seen some real benefits for both patients and staff with the removal of unnecessary interventions and barriers that get in the way.

Looking ahead, we remain totally committed to continually improving care for our patients. This will be underpinned by an exciting and challenging transformation programme that seeks to eliminate waste with a real focus on process improvement. It is the commitment of myself and the Board that safety and quality will not be compromised, even in the face of financial pressures. We have continued to run our hospital well this year, and are proud of our achievements and of being able to report a small surplus despite the various challenges.

This is a significant achievement and a credit to all of our staff.

Staff engagement and further improvement will be the key priorities for the year going forward. This is a great organisation and the hard work and contributions of our staff, volunteers, members and governors is valued by both my Executive team and the Trust Board. Together, we thank them all for their continued support and commitment throughout the past year.

Ursula Ward

Chief Executive

About the Trust

Portsmouth Hospitals NHS Trust is one of the largest acute hospital trusts in the country treating over half a million patients each year. The Trust is the second largest employer in Portsmouth. We are also a major provider of training and education to a wide range of health professionals. Further, we are actively engaged in the national agenda regarding research and development and have a reputation for being an innovative organisation.

Who we care for

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

Our population is characterised by its diversity – the rural and the urban, areas of wealth juxtaposed with real pockets of deprivation, and gaps in life expectancy.

Our hospitals and centres

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 South East Hampshire. Further our birthing centres and dialysis units that are strategically located to meet our patients needs continue to be important and attractive environments for our patients.

- **Queen Alexandra Hospital**
  We are organised into 10 Clinical Service Centres (CSC's) - Clinical Support; Emergency Medicine; Head & Neck; Medicine; Medicine for Older People, Rehabilitation & Stroke; Renal & Transplantation; Cancer & Surgery; Theatres, Anaesthetics & Critical Care; Trauma, Orthopaedics, Rheumatology & Pain; Women & Children. These centres are very much clinically led and managed.
- **St Mary's Treatment Centre**
  The Trust has a number of clinical staff based at St Mary's providing midwifery, dermatology and disablement services.
- **Gosport War Memorial Hospital**
  We offer a range of services at Gosport War Memorial Hospital including the Blake Maternity Unit, Minor Injuries Unit, rehabilitation services and diagnostics.
- **Petersfield Community Hospital**
  We are responsible for a number of services at Petersfield Hospital including the Cedar Rehabilitation Ward and the Grange Maternity Unit.

Private Patient Unit

We have a Private Patient Unit within Queen Alexandra Hospital for patients with private medical insurance, or who are paying directly for themselves. Income generated by private patient services goes back into our general finances to support improvements in services, which benefit our NHS patients.

A five year plan has been developed ensuring we will continue to develop private patient services. These will be based on the inpatient ward on G Floor, with links across the Trust.

Working alongside our military personnel

We have a longstanding and excellent relationship with the Ministry of Defence with military personnel from all three Armed Services working within our Ministry of Defence Hospital Unit (MDHU) – the largest unit in the UK. They work in partnership with their civilian NHS colleagues treating both civilian and military patients.

The Commanding Officer is Commander Danny Follington, Royal Navy, who works closely with the Trust to ensure an outcome that is mutually beneficial to both parties and the local population it serves.

At any particular time a fifth of the MDHU staff are either deployed or on call to provide medical assistance anywhere in the world. Recently we have seen personnel from the MDHU deployed on board HMS Illustrious to assist with the humanitarian mission in the Philippines.

The MDHU puts a lot of emphasis on its charitable activities and in 2013 alone raised approximately £8,000 for charities including the Rocky Appeal, Service Benevolent Funds, SSAFA (Soldiers, Sailors, Air Force Association) and a number of other local groups.

Our journey to become an NHS Foundation Trust

We continue to push forward on our journey to become an NHS Foundation Trust (NHS FT). We believe it is the right thing for both the Trust and for the people we serve. As an NHS FT we will be able to secure real benefits for local people in three key areas:

- ***Accountable to local people***
  Patients, carers, members of the public and staff will be able to have more input in how hospital services are provided and to influence the way services are developed in the future.
- ***More flexibility***
  At the moment our local flexibility is limited because we are closely managed by the Department of Health. There are many decisions we cannot make locally without seeking central authorisation. However, as an NHS FT we will have more freedom to make our own decisions without delay, enabling us to respond quickly to local priorities. Although still accountable to the Department of Health, we will be directly answerable to our members and their elected governor representatives.
- ***Greater financial freedom***
  As an NHS FT we will have greater financial freedoms. We will be able to raise finance more quickly and will have greater flexibility over how we spend and invest our money.

Our Vision

Our vision is to be recognised as a world-class hospital, leading the field through innovative healthcare solutions focused on the best outcome for our patients and delivered in a safe, caring and inspiring environment with quality at the heart of everything we do.

Put simply we aim to be:

the **best hospital**

providing the **best care**

staffed by the **best people**

Our Values

The values defining and underpinning the way we do things are:

- Respect & dignity
- Quality of care
- Working together
- Efficiency

How we plan to deliver our vision

Delivering the ambitious vision set out above will require changes in the way we work, the way we interact and contract with our partners, the way we use technology to streamline our workflow, and in the way that we use our facilities and estate. These changes are described in a series of enabling strategies. In summary:

- Our foremost focus will be to embed and improve quality in everything that we do. Whilst our ***quality strategy*** is about changing what we do and how we work, the litmus test of our success is maintaining our existing quality, standardising the highest quality across everything we do and trying to drive standards higher every single day.
- We have a splendid modern facility but we need to use it more intensively. Our ***business development strategy*** describes how we will retain our existing market share, attract patients from outside our natural catchment area, develop new services and revenue streams, develop further networks with neighbouring hospitals and repatriate NHS work from local private providers. Taken together, we intend significant growth of activity on the Queen Alexandra Hospital site.
- To do this we will need to work smarter. Our ***information management and technology strategy*** describes how we will use technology to improve the quality of patient care and patient experience through a focused drive to mainstream technology to improve workflow which will increase productivity and create space for the expansion of our clinical services.

Our foremost focus will be to embed and improve quality in everything that we do.

- Our ***workforce strategy*** describes how we will change the shape and size of our most important asset, our workforce. To support delivery of the clinical strategy we will improve productivity through smarter ways of working and better use of technology to create additional capacity from the existing workforce. We will introduce new models of employment which will increase flexibility and cost competitiveness. We will invest heavily in training and development to facilitate and support these changes.
- All of this will have an impact on our estate, both Queen Alexandra Hospital and the offsite facilities we currently run. Our ***estates and facilities strategy*** describes how we will create capacity at the QAH site through productivity improvement and the introduction of healthcare at home models. As we create capacity we will accommodate the growth anticipated through the clinical strategy, repatriate off site services back to the QAH site, where clinically appropriate. This will need a shift in organisational capability.
- Our ***leadership and skills strategy*** describes our values and how we will engage our staff in making the Trust a great place to work and in developing a culture of continuous improvement where accountability for decision making is devolved to the most appropriate level. The strategy describes how we will keep hold of our best people, develop a pool of future talent and develop a leadership brand which will help attract the best people.
- Finally, our ***research, enterprise and innovation strategy*** underpins all of the above. It describes how we will deliver the highest quality, evidenced care for our patients through embedding a culture of research and innovation that is driven by clinical leadership.

Review of the year

APRIL

We launch our Listening into Action (LiA) strategy

The da Vinci robot arrives

MAY

A new museum area opens in Queen Alexandra Hospital which documents the history of the anaesthetic department

A new gynaecology ambulatory care environment ward is set up on A Level

First operation using the da Vinci robot takes place at Queen Alexandra

The Department of Critical Care is granted Academic Department status by the University of Portsmouth

JUNE

We are announced as one of the Trusts spearheading the trend in clinical research as we increase the number of studies from 126 in 2011/12 to 137 in 2012/13.

JULY

The Trust is recognised as meeting all standards following an unannounced inspection from health watchdog the Care Quality Commission

Midwives deliver a bonny baby boy just one minute before the birth of Prince George in London and the hospital receives much media attention

The Trust wins a £466,000 Department of Health grant to improve the hospital's environment for people with dementia.

AUGUST

New figures show that 78 patients received a life-saving or enhancing kidney transplant during 2012/13 at Queen Alexandra Hospital, accounting for 2.6 % of all kidney transplant operations carried out across the UK

Members of the Trust's Ministry of Defence Hospital Unit run and row for 24 hours to raise money for the hospital's Rocky Appeal and the Royal Air Force Benevolent Fund.

The Grange birthing centre in Petersfield receives £26,500 from NHS Environment for a new state-of-the-art birthing pool.

SEPTEMBER

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The Trust hosts its fifth Best People Awards ceremony where both individuals and teams are recognised for their outstanding achievements and contributions over the past year.

The diabetes specialist team commences a 24/7 service at Queen Alexandra

NHS England announces that our maternity services are among the best in the country

Journalist and TV presenter Fiona Phillips officially opens our Memory Lane room for patients with dementia

The Trust launches its new software system, Oceano, to enable more effective management of patients attending the Emergency Department.

The hospital is ranked as one of the best hospitals in the country for providing high-quality and safe care under the Care Quality Commission's Intelligent Monitoring report

Totton Dialysis Unit undergoes a £50,000 refurbishment

OCTOBER | **NOVEMBER** | **DECEMBER** | **JANUARY** | **FEBRUARY** | **MARCH**

The Trust is announced as the winner of four categories in the annual Best of Health Awards, organised by The News

Our 100th laparoscopic live donor operation is performed

The Trust delivers 18 babies on Christmas Day and 19 babies on New Year's Day.

The Acute Oncology Service team is commended after being shortlisted for a national Quality In Care Excellence Award

The eHealth Insider features an article on the My Birthplace app, created by Portsmouth midwives to help expectant mothers decide where they want to have their babies

The hospital receives much media attention as a new drug for breast cancer, Kadcyla, is made available for patients following successful trials – one of which was at QAH

Best Hospital

We continued to perform well and to deliver excellent clinical outcomes in many areas during 2013/14. Whilst we have much to be proud of in the quality of care we give to our patients we also faced a number of challenges throughout the last year.

Key performance targets

We continue to work hard to deliver high quality care that meets the National Standards as outlined in the Everyone Counts Planning Guidance, these standards include the following:

- ***9 Cancer Standards*** - we have achieved all 9 standards for the year and these include patients being seen within 2 weeks of an urgent referral for suspected cancer; treatment started within 62 days of that referral; and treatment within 31 days of a diagnosis of cancer, including patients who require subsequent treatments. This has been achieved despite a 36% increase in cancer referrals
- ***18 week referral to treatment target*** – we have treated over 4,000 (9.5%) more elective patients than in the previous year and have achieved the 90% target for admitted treatment within 18 weeks in 10 out of 12 months. The 95% target for patients having outpatient treatment within 18 weeks has been achieved in every month and we have ensured that less than 8% of patients are waiting longer than 18 weeks for either admitted or non-admitted care in every month. We have had no breaches of the maximum waiting time target of 52 weeks and continue to work towards delivery of an internal stretch target of 0 patients waiting more than 35 weeks for treatment. However, we would acknowledge there have been some specialty fails which we will pay particular attention to in the year ahead.
- ***Access to emergency care*** – we have faced a challenging year and have failed to deliver the 95% four-hour wait standard for accident and emergency in 11 out of 12 months. This is especially disappointing given some real improvements that have been implemented, for example reducing ambulance handover times, telephone advice for our GP colleagues and improving the time to assessment for patients in the department. Further, a number of internal initiatives have been implemented to improve patient flow. These include a seven-day ambulatory provision which provides immediate treatment for patients without the need for an overnight stay in hospital, an urgent care centre and a community assessment lounge in the Emergency Department. We have also worked with community providers to establish 'in-reach' services to ensure the timely transfer of frail, elderly patients to their discharge destination.
- ***Stroke care*** – we achieved all four indicators at year end including ensuring patients receive 90% of their care in a specialist stroke unit, patients receiving a CT scan within 60 minutes of arrival, and ensuring high risk patients are seen and treated within 24hours. The fourth indicator - patients being admitted directly to a stroke unit – proved difficult earlier in the year but has seen month on month improvement over the last six months and at year end achieved the target of 90%.
- We have achieved the standard for patients receiving **primary angioplasty** following a heart attack within 60 minutes of arrival at the hospital in every month.

Care Quality Commission

The Care Quality Commission (CQC) is the independent health watchdog whose job is to ensure hospitals, care homes, GPs, dentists and all other care services in England provide people with safe, effective, compassionate and high quality care.

This year we have had two unannounced inspections, one on 16th May 2013 in response to concerns that some standards were not being met. Four outcomes were inspected of which the CQC found the Trust to be meeting all of the standards:

- ***Outcome 1:*** Respecting and involving people who use services.
- ***Outcome 4:*** Care and welfare of people who use services.
- ***Outcome 6:*** Co-operating with other providers.
- ***Outcome 9:*** Management of medicines.

On the 13th March 2014 the CQC undertook a further inspection as part of their themed inspection programme, specifically focusing on dementia.

Our finances

We continue with our programme of work to ensure the Trust's long term financial sustainability. This year set a challenging savings target of £20.5m, as part of the nationally required 4% cost improvement programme for NHS acute trusts. At the start of the financial year £5.4m of these savings plans were unidentified and the Trust had a year-end planned deficit of £5m.

In addition to the original 2013/14 programme, and in order to ensure delivery of the planned year-end financial position, transformation plans were agreed to improve capacity, review medical and nursing workforce, and eliminate needless waste. These plans included reductions in unnecessary lengths of stay in hospital beds and improvement in the utilisation of theatres, to deliver both quality and financial benefits and complement the original programmes of work, which were across areas such as non-clinical workforce, medicines management and clinical supplies procurement.

In order to meet access targets for patients, after taking into account the impact of commissioner-led demand management schemes aimed at reducing the volumes of people treated in hospital, the Trust provided for significant increases in patient volumes above the contracted activity originally planned by commissioners in 2013/14.

In recognition of the progress made by the Trust, underpinned by some real transformation, the Trust Development Authority (TDA) agreed £4m of financial support and this, along with the increased patient volumes and further strengthening of internal management arrangements, has led to the achievement of a small surplus in 2013/14, against the original planned deficit of £5m.

Prompt Payment Code

The Trust is a signatory to the Prompt Payment Code, administered by the Institute of Credit Management. This means the Trust is committed to paying all suppliers within agreed payment terms and ensuring there are processes in place to deal with issues which may delay payment.

Countering Fraud

We adopt best practice procedures to tackle fraud, as recommended by NHS Protect. All fraud concerns are investigated by our Local Counter Fraud specialist or NHS Protect as appropriate, and the local Counter Fraud Specialist provides the Audit Committee with a regular update on any current investigations.

The Trust publicises its policies and procedures on counter fraud on the corporate website, and counter fraud awareness training is mandatory for all staff as part of their trust induction.

The Trust continues to benefit from superb facilities, opened in 2009. The £256 million funding of this was by way of a Private Finance Initiative scheme under which the Trust pays £47 million a year to fund the "mortgage", site maintenance and all facility management services.

Our sustainability report 2013/14

We continue to drive improvements in our environmental performance. The Trust uses energy and water, buys supplies, produces waste and has associated transport needs including staff commuting, business travel and patient and visitor transport. The Government has set a target of a 10% reduction in our carbon footprint by 2015 and a 20% reduction by 2020. We fully support this strategy and are working hard to achieve it. Full details of our performance and plans are available on our website.

Quality Accounts

The Trust Quality Accounts highlight the quality initiatives and improvements that have been achieved over the past year. The document, which is published on 30 June each year on both the trust website and NHS Choices, can be found at www.porthosp.nhs.uk

Information Governance

The confidentiality and security of information regarding our patients and staff is maintained through our governance and controls policies. 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 loss or damage to personal data is graded and the more serious must be reported to the Department of Health and the Information Commissioner's Office.

We did not experience any serious incidents in 2013/14. Further information can be found at www.porthosp.nhs.uk

Category	Information Governance Breach Type	Total
A	Corruption or inability to recover electronic data	0
B	Disclosed in error	5
C	Lost in transit	0
D	Lost or stolen hardware	0
E	Lost or stolen paperwork	2
F	Non-secure disposal – hardware	0
G	Non-secure disposal – paperwork	1
H	Uploaded to website in error	0
I	Technical security failing (including hacking)	0
J	Unauthorised access/disclosure	1
K	Other	0

Information Governance Toolkit

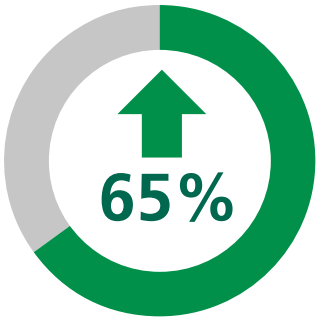
The Toolkit is an online system which allows NHS organisations and partners to assess themselves against Department of Health Information Governance policies and standards. Our Information Governance Toolkit submission for 2013/14 was 86%, an improvement on our 2012/13 score of 85%. Importantly, the Trust's submission is graded as "Satisfactory", as the minimum expected level of compliance was achieved against all 45 Toolkit standards.

We have identified the following key areas to work on in 2014/15:

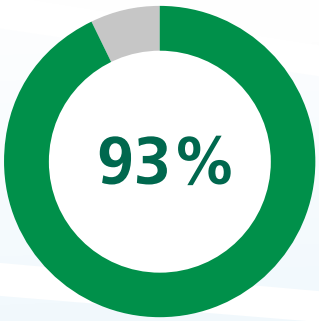
- Accessibility and staff uptake of Information Governance Training
- Business Continuity and System Security Plans for key information assets
- Implementation of recommendations arising from 2013 Caldicott 2 Information Governance Review

Freedom of Information

We received 513 Freedom of Information requests in 2013/14, an increase of 65 per cent on 2012/13.



We embrace our duty of openness and have made full or partial disclosure of information in approximately 93% of requests.

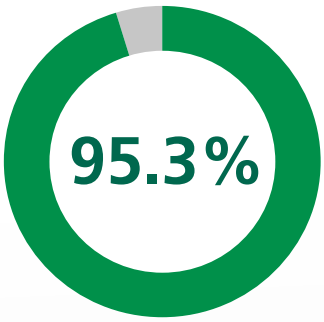


The remainder includes non-disclosure due to legal exemption, the request for information being cancelled, information not held or the information already being published.

Patient safety

The Trust continues to actively promote a culture of safety, which is reflected in the effective reporting of incidents and near misses.

- We exceeded our 95 per cent target for risk assessments for Venous Thrombo-Embolism (VTE) – potentially fatal blood clots – at 95.3 per cent



- We missed our target for grade 3 and 4 pressure ulcers, with 33 against an end of year target of 25. Although this is very disappointing, the Trust responded rapidly and robustly with additional interventions which resulted in a dramatic decrease in avoidable pressure damage in February and March 2014.
- We had 35 moderate or serious falls against a target of 34

Falls Prevention

We remain committed to preventing falls wherever possible, and to reducing the distress, pain, injury, loss of confidence and independence or even death which can be associated with a fall. Since 2011, the hospital has seen a 19% reduction in inpatient falls and a 16% reduction in those where the patient sustained an injury.

Falls and fall-related injuries are a common and serious problem for older people. Those aged 65 and older are at the highest risk of falling, with 30% of people over 65 and 50% of people over 80 falling at least once a year. Their chance of falling increases with the combination of multiple long term and acute illnesses, for example people with dementia are up to eight times more likely to fall than those without the disease.

We have a dedicated falls prevention team which is well known for its innovation and, as such, is regularly consulted by other hospitals. Just some of our initiatives to help reduce falls are:

- **FallSafe bundle**
  The care bundle consists of a number of clinical actions which when combined, have been shown to reduce the incidence of inpatient falls. The actions are then included within the patient's medical notes so other staff remain well informed. This improves the process of care for patients at risk of falling.

  Following a successful first phase, this scheme has now been rolled out across all hospital wards. The use of a falls care plan is now firmly embedded and is in use within all inpatient areas and is being used to help staff identify and manage individual risk factors.

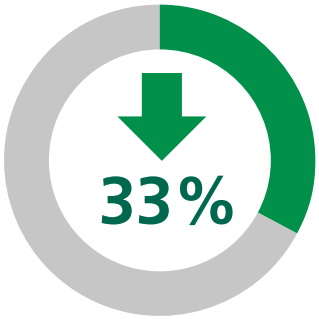
- **Falls alarms**
  We use falls alarms to alert staff when forgetful patients try and move by themselves without asking for help. These act as a trigger both for the patient to remain in bed until staff can assist them, and also to catch the attention of nursing staff. We are a beacon hospital working with the company that provides these products and are currently involved in trialling several new products that should result in both a reduction in falls and a consequential cost saving.

- **Dementia care**
  We were awarded £466,000 by the Department of Health last year to improve wards where people with dementia are typically cared for. This enabled new flooring as well as improved signage, new ceiling tiles to improve the acoustics in the wards, coloured handrails, improved lighting, colour-coded rooms, brightly coloured toilet seats, and visual personalisation of bed spaces.

- **Further improvements**
  We have introduced extra low height beds for some patients and anti-slip socks for those that might forget to put their slippers on. We are currently producing a DVD that will demonstrate to staff what it's like to have hearing problems in our busy hospital. This is filmed from the patients' perspective and highlights how difficult it can be for someone hard of hearing to be fully aware of everything going on around them. Hearing loss is a common cause of disorientation and can lead to falls.

Infection prevention

We have made excellent progress in reducing Healthcare Associated Infections (infections that are acquired as a result of healthcare interventions). Our levels of MRSA bloodstream infections continued to fall and the year-end MRSA bacteraemia total was 33% less than the previous year.



Rates of Clostridium difficile (C diff) have also fallen further and we ended the year within our target of 30 hospital acquired cases. This was a further reduction compared to the previous year where 40 cases were recorded against an objective of 67.

We have also managed to complete another year without any ward closures due to the winter vomiting bug Norovirus. This significant reduction in these infections is due to the hard work and commitment of all members of staff at PHT. We take pride in having a clean and safe environment for our patients. Cleanliness across the Trust is audited on a daily basis and we can take some assurance that external bodies, such as the CQC, have complemented us on our cleaning and decontamination standards. There is no room for complacency as other infection strains emerge.

Our Hospital Sterilisation and Disinfection Unit (HSDU) specialises in the cleaning, decontamination and sterilisation of medical devices within the organisation and for some external healthcare providers. The HSDU has performed very well during the past 12 months achieving success in key performance indicators, quality targets and maintaining its BSI certification. In 2013/14 the HSDU reprocessed 157,371 surgical instrument sets. This activity is expected to increase in 2014/15.

Health and Safety Performance

The management of health and safety across the Trust has continued to improve throughout the year. Although we have experienced a number of RIDDOR reportable incidents, data collected for 2013/14 still indicates that we are seeing a downward trend in the total number of staff incidents that are being reported throughout the trust.

The total number of incidents reported for this period, at the time of collation, was 583 showing a 19% decrease in the numbers reported for 2012/13 and nearly a 50% decrease over a five year period.

To meet the requirements of the Health and Safety (Sharps Instruments in HealthCare) Regulations, which came into force in May 2013, the Trust has begun the implementation and rollout of 'safety needles', work will continue with this initiative throughout the coming year.

Emergency planning

We are prepared for emergencies which might occur either in the hospital or in the community. Over the past year we have continued to keep staff up-to-date and aware of their role in the event of a major incident. There is a requirement under the Civil Contingency Act 2004 that we exercise our Major Incident Response plans on a yearly basis. In 2013/14 we were involved in two external agency exercises, one of which involved receiving 'contaminated patients' from the dockyard.


Emergency Department

Best Care

We believe that providing the best care is all about getting the basics right and adopting innovative approaches to how we treat our patients.

Understanding what is important to our patients and their families

We have continued to develop better ways of understanding what is important to our patients and families to help further improve their experience. A new system for the collection and analysis of feedback from patients has been introduced. This allows us to run local surveys for specific departments and measure the effectiveness of any improvements that we make. We continue to develop better links with the local community and are working with colleagues from health and social care to ensure effective communication with those people who use our services.

Friends and Family Test

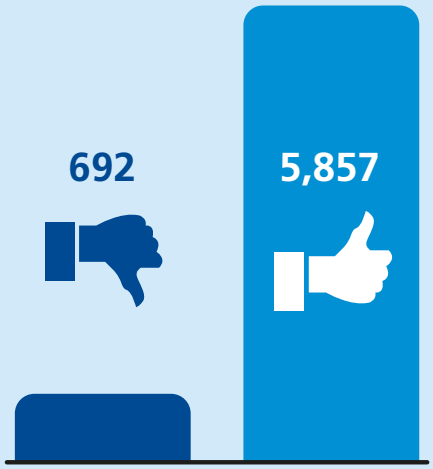
In February 2013 we introduced the national 'Friends and Family Test'. This is a simple question asked of patients at the point of discharge about their experience and whether they would recommend the hospital to a friend or family member. In August the first Friends and Family test results were made available at a national level, marking a commitment to transparency, openness and public participation.

The score for Portsmouth Hospitals NHS Trust showed that with regards to our emergency department, the score was significantly higher than the national average, which indicates that more patients are satisfied with the treatment received in the department than in other places in the country. Our inpatient scores met the national average.

In October 2013 the test was rolled out across all maternity services in England. Maternity services provided by Portsmouth Hospitals NHS Trust were found to be among the best in the country. The majority of women using our services who were surveyed said that it was "extremely likely" they would recommend our maternity care to their friends and family.

Patient plaudits and complaints

All of our services are focused on improving care and the patient experience. Whilst our services continue to win many plaudits we fully recognise the need to respond quickly and effectively to feedback. Our ten Clinical Service Centres (CSCs) aim to resolve any concerns through close involvement with the Patient Advice and Liaison Service (PALS).



between 1 April 2013 and 31 March 2014

However, we are not complacent and each complaint is thoroughly investigated with the intention of agreeing the best resolution at local level. The Trust Board receives regular reports on the number and nature of complaints and the lessons learnt from these are used to further improve performance and patient experience.

	National Average PLACE score	Portsmouth Hospitals PLACE score
Cleanliness	95.74%	98.95%
Condition, Appearance and Maintenance	88.75%	94.03%
Privacy, Dignity and wellbeing	88.87%	94.77%
Food and Hydration	84.98%	87.09%

Patient-Led Assessments of the Care Environment (PLACE) assessment

April 2013 saw the introduction of PLACE, the new system for assessing the quality of the patient environment, replacing the old Patient Environment Action Team (PEAT) inspections. The assessments apply to all hospitals, hospices and day treatment centres providing NHS funded care.

This involved local people entering our hospital as part of a team to assess how the environment supports patient's privacy and dignity, food, cleanliness and to assess general building maintenance. It focused entirely on the care environment and did not cover clinical care provision or how well staff were doing their job.

The Patient and Public Involvement Group

During the year the group awarded grants from the hospital's charitable funds to a number of wards and departments that, with their patients, have identified ways in which patient experience can be improved. These include communication aids for people in the form of picture cards; furniture for resident parents in the children's unit, and a teaching aid for staff to increase awareness of the challenges faced by people with hearing impairment. Patients, for whom English is not their first language, and those with hearing impairments, are provided with an interpreting service to ensure that they can participate in discussions regarding their care and treatment.

We performed very well in the first publication of the PLACE results with our scores significantly higher than the national average for all quality markers, showcasing the hospital's high standards.

Care recognition

Our departments and staff have continued to receive many awards and honours for their hard work and dedication.

May 2013: The diabetes teams from Portsmouth Hospitals NHS Trust and Southern Health NHS Foundation Trust are shortlisted for two national British Medical Journal Improving Health Awards for their innovative work with diabetes. The teams are shortlisted in the Diabetes Team of the Year and Clinical Leadership Team of the Year categories.

May 2013: MDHU Portsmouth staff win British Medical Journal Team of the Year award

May 2013: Portsmouth's Rheumatology Unit is nominated for best service model award by the British Society for Rheumatology.

July 2013: Portsmouth Hospitals NHS Trust wins a Department of Health grant to improve QA hospital's environment for people with dementia. Over 100 hospitals and care homes were successful, including ourselves being awarded £466,382.00

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APRIL | MAY | JUNE | JULY | AUGUST | SEPTEMBER

April 2013: Much improved results for Portsmouth Hospitals NHS Trust are reported in the 2012 inpatient survey published by the Care Quality Commission

June 2013: Portsmouth Hospitals is shortlisted for two awards at the 32nd annual Health Service Journal Awards for work efficiency and improving patient safety.

August 2013: Shortlisted for the acute sector innovation category for the Health Service Journal (HSJ) Awards, and the child and adolescent services category by the Nursing Times Awards.

2013: Queen pital is ranked for the numbers here key quality ip fracture care

November 2013: The Trust has three teams shortlisted for HSJ Awards

January 2014: Hazel Hartnett and Jenny Goulden, from the Renal and Transplantation service, have a paper accepted for the British Renal Society Annual Conference

January 2014: The Critical Care Team is awarded a Certificate of Achievement for being an outstanding learning environment for student nurses in 2013

March 2014: Sue Kenworthy is shortlisted as a finalist in the Chief Scientific Officer's Award for Clinical Leadership category of the Advancing Healthcare Awards

OCTOBER | NOVEMBER | DECEMBER | JANUARY | FEBRUARY | MARCH

October 2013: Diabetes service is nominated in The Guardian's Healthcare Innovation Awards for reducing hospital admissions through the super six model of care, the hypoglycaemia pathway (in partnership with South Central Ambulance Service), and the diabetes inpatient service.

October 2013: The Portsmouth diabetes team is shortlisted for their project on 'Hearing Voices: Do it in STYle' by the Nursing

October 2013: The Best Practice Rheumatology Awards 2013 recognise ground-breaking and innovative practice in rheumatology and musculoskeletal services.

December 2013: All of the maternity services scored very highly, between 8-9 out of 10 points, in the second CQC survey looking at maternity services.

February 2014: The Transplantation Team complete their 100th Laparoscopic Kidney Donation operation, a significant milestone for the Unit

A Patient's Story

Forty-nine-year-old Sean Colbourne shared the experience of his care at Queen Alexandra Hospital last September. He said he has "nothing but praise" for the team of doctors and nurses who cared for him following his diagnosis of chronic heart failure and is now halfway through a four-year heart failure clinical trial with the Trust.

"Both my GP and I knew that something was wrong when I gained three stone in weight in eight months despite living off a liquid diet – we just had to figure out what," said Sean, from Southsea.

After being referred to several different places for tests and still no diagnosis, Sean was sent to QA Hospital's cardiology ward for a scan and was immediately admitted as an emergency patient.

"I was diagnosed with chronic heart failure as I had severe fluid retention and was carrying in excess of 30 litres of fluid which was putting a massive strain on my heart," he said.

Sean was put on water tablets to help release the excess fluid and ease the pressure it was putting on his heart; amazingly Sean lost six-and-a-half stone in the two weeks that he was in hospital, something that not only amazed him, but also the doctors and nurses that were caring for him.

"The staff said they'd never seen anyone with that much fluid before and they were surprised I hadn't had a heart attack," said Sean. "The doctor said that if I'd had a heart attack, because of the severity of my condition, it could have been fatal. I'm so lucky to be alive; I owe so much to both my GP and the doctors and nurses at QA.

"I noticed the difference the tablets were making straight away. After just two days I was finally able to eat a sandwich, which was the first solid produce I'd eaten in over six months."

After leaving hospital Sean was put on a number of tablets for his heart, water-retention and diabetes, and later enrolled onto a four-year heart failure clinical trial which he has since been on for over two years. Sean said that he has total trust in QAs cardiac team.

"I was one of the lucky ones that have come out the other side," he said.

"I wanted to do the trial to try and help the doctors find a solution to what I'm now living with. I have a 21-year-old son and if something was to go wrong with his heart in the future I now have reassurance that trials are being done to combat and overcome heart disease. I'm seeing this through to the end. The support from the staff at QA and my wife Elaine and son Harry has been my saving grace.

> "There are a lot of stories in the press that give the NHS a bad name but I have nothing but praise for the team at QA and can't fault them in any way. The staff are always at the end of the phone for me, and since being discharged I see a consultant regularly. I honestly cannot thank the staff enough."

Innovation and Research

We believe that high quality research is fundamental and we aspire to be a nationally recognised centre of innovation, which will help to improve the health and wellbeing of our patients in Portsmouth.

Research and Development

We continue to make a significant contribution to research and development in the NHS. We currently have 282 research studies taking place, with over 300 staff involved. In the past year we have also recruited 6,176 people to take part in our research projects. Thanks to these patients who take part, our researchers are constantly learning how to deal more effectively with a range of medical conditions, and how to improve the lives of many of our patients.

We undertake a wide range of research for many different organisations, but we also have our own programme of research studies. We have dedicated research staff embedded within our clinical teams and we have been commended for our innovative approaches and successful research delivery by a number of organisations and research sponsors.

Success in recruitment to research studies

- 217 of our 282 research studies were studies supported by the National Institute for Health Research (NIHR). In The Guardian Trust Research Activity league tables for 2013 we were the fourth highest recruiting organisation to NIHR studies out of 45 large acute trusts.
- We were the top recruiting organisation for several multi-centre trials and we are now being approached to advise other centres on how to recruit.
- We have used innovative recruitment practices, such as weekend clinics, in order to ensure convenient and easy patient access to recruitment to clinical research.
- In respiratory care we began screening our first patients for our Respect Meso study, which looks into early specialist palliative care services in patients newly diagnosed with mesothelioma.
- On International Clinical Trials Day, in May 2013, we supported the NIHR initiative 'OK to ask about clinical research' in order to encourage our patients to ask their doctor or nurse if there were any studies they could participate in relating to their condition.

Success in research workforce

- We have expanded our team of clinical academic nurses, midwives, and allied health professionals. They undertake research in public health and long term conditions, ageing and dementia, maternity care, and fundamental care in hospital.
- We have speciality group leads that direct research in diabetes and renal medicine for the Wessex region.
- Our Lead Research Nurse has played a key part in the development of a national 'Fundamentals of Clinical Research Nursing' course. Eight of our research nurses are studying on this course.
- We hosted a successful research conference in 2013 with 139 of our research staff attending, and have another conference planned for 2014.

Success in research innovation

- Our respiratory team has played a significant role in the development of a community-based collaborative 'iBreathe' which is a registry of eligible patients who have agreed to be contacted about future potential research opportunities.

Success through involving our patients and public

- We have continued to develop our patient and public involvement in research activities, with more patients and the public being involved at all stages in research studies. We also appointed a dedicated Patient & Public Involvement Officer.
- In respiratory care our LASER study has been designed and developed with significant public and patient involvement.
- We are continuing to develop our website to make it more public and patient focused www.porthosp.nhs.uk/Research-Department.

Building capacity for the future

- We now have a dedicated pathology service which supports our research studies, and we have continued to expand our Clinical Trial Pharmacy Service. Both of these services are key to supporting our on-going research studies and the development of new research studies.
- We have a dedicated research environment which aims to enhance the experience of those patients involved in our research studies, with comfortable and quiet waiting and assessment areas.
- The vision of the newly formed Wessex Academic Health Science Network (Wessex AHSN) is to encourage discovery and innovation throughout the Wessex health system. One of the priority areas is to provide better services for people with long term conditions. Our Director of Research, Professor Anoop Chauhan, has been appointed as the Wessex AHSN Respiratory Lead with a network-wide role to deliver improved healthcare through innovation in respiratory services.

We recognise that innovation is key to improving performance and growth. Our aim is to create an environment that nurtures new ideas for the benefit of our local patient population and that supports those ideas from proof of concept through to implementation.

Innovation in patient care

Oceano

The Oceano electronic clinical management system was introduced into the Emergency Department in January 2014 to enable more effective management of patients. We invested £800,000 in the system which is designed to reduce paperwork for our clinical and administrative staff; enhance initial triage assessment; provide patient alerts for clinical staff to act promptly on; assist with clinical observations; help with electronic ordering of investigations reducing delays; and reporting of diagnostic tests, which will further contribute to the delivery of safer and more effective care. Its alerting features are designed to reduce risk, increase patient throughput and deal with key performance indicators such as the 4-hour wait target. The project team led by Dr Eliot Wilkinson, managed the project from start to finish enabling the first phase of the system to 'go live' at the end of January. Work is now commencing on the second phase of the project which will enable Oceano to integrate with the Patient Administration System (PAS) and other clinical systems within the Trust.

My Birthplace app

Our midwives have co-created an app to help expectant mothers decide where they want to have their babies. Government policy promotes choice regarding place of birth, but inconsistent information makes it a difficult decision for many women. This innovative project utilises a bespoke Smartphone or tablet application to improve the decision making process for women and their partners. The app will provide better outcomes for women as well as cost savings in Portsmouth. Local data suggests that lack of information regarding choice is resulting in low risk women giving birth in the consultant unit, thus increasing their risk of intervention.

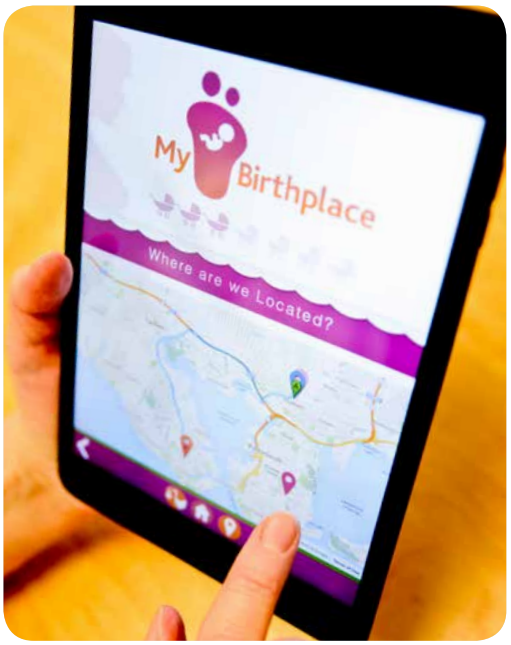
We secured £72,000 funding from the Health Foundation to develop the app. The Health Foundation was looking for projects that deliver information to patients in innovative ways and identified us as a Trust whose innovative ideas help to improve the quality of healthcare.

The app, which was developed over 15 months, was piloted with around 230 low risk women due to have babies in October and November, who used it between weeks 25 and 36 of pregnancy during the summer of 2013.

Of the pilot group 166 women had their babies in October or November 2013. At 12 weeks of pregnancy only 45 per cent of these women had a recorded preferred place of birth. However, after having access to the app, a preference was recorded for 86 per cent of these women at 36 weeks of pregnancy.

The app is web-based and can be used on any device. It takes national data, information about local services such as a map of local birth centres and information on inter-hospital transfer rates.

A group of midwives collaborated on the content of the tool and a freelance technical expert wrote the app. It has been refined



following feedback from the pilot and will be officially rolled out to Portsmouth maternity services in spring 2014.

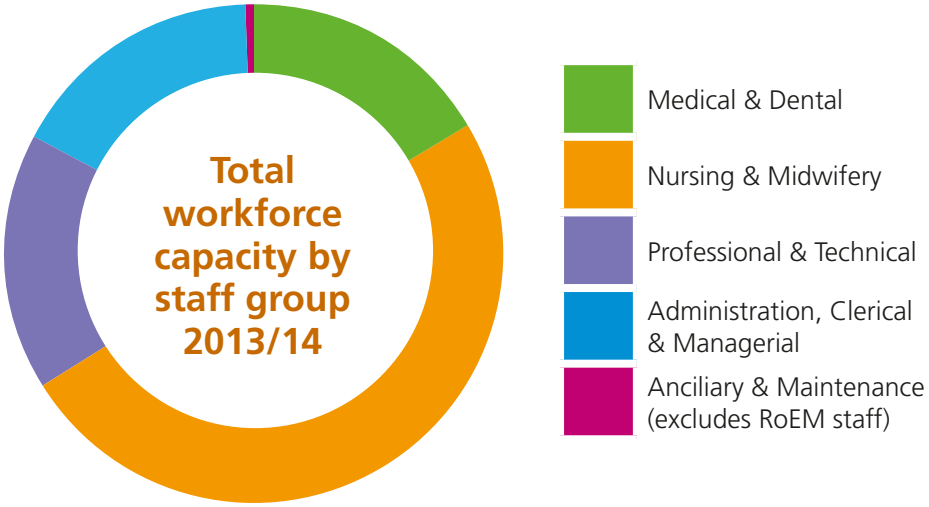
We are now keen to be able to develop the app for use elsewhere, by localising it for other communities. This would be a commercial venture, with any profit invested in developing other apps.

da Vinci robot

The Board made a strategic decision to invest in robotic surgery. There are only 14 high-definition da Vinci robots in the country and we were able to secure one in April 2013. Queen Alexandra Hospital is unique as it performs robotic surgery across a wide range of surgical specialties including colorectal, head and neck, urology and gynaecology. As such, we are intending to become a European training centre for the new da Vinci robot.

Best People

The Trust directly employs around 7,000 people and we are the second largest employer in the city.

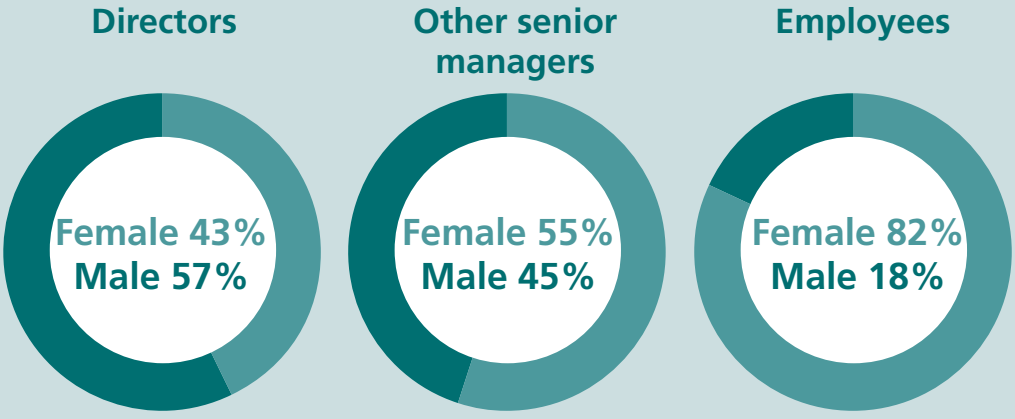


Total workforce capacity 2013/14

Increased non-elective activity has resulted in additional nursing and medical staff working in the organisation, specifically within the Emergency Department and medical specialties. Staffing levels are monitored in detail on a shift by shift basis, to ensure safe staffing levels. Investment in front line staffing continues with targeted growth to improve the skill mix of ward areas in particular. The Trust also employs a number of temporary staff to allow for flexibility in resourcing throughout the year.

Equality and diversity

The Trust is fully committed to employee equal opportunities and the equality and diversity policy is published on the website. The gender breakdown of the workforce includes:



Each person that we treat deserves the same level of access, outcomes, experience, dignity and respect. There are many services that do this well; however we know that we don't always get it right. We know that health inequalities in access, patient experience and outcomes still exist. By recognising that every patient has different needs and circumstances, we can best meet those needs and improve outcomes by delivering a personal form of care, using, strengthening and supporting the diverse talents of our workforce. To develop this culture we also need to ensure we treat our staff, as well as our patients, fairly.

Skilled staff

We recognise that a healthy and well-motivated workforce is fundamental to the delivery of good care. To this end there are a number of initiatives and supporting policies aimed at continuing to enhance the capabilities of our staff.

During 2013/14 the Learning and Development department and the Workforce and Organisational Development team forged strong links to review learning and education opportunities and align these to workforce and leadership priorities within the Trust.

A change to the way in which funding is provided to hospitals for training and education has enabled the department to strengthen the support for learners on placement. It has also allowed us to increase the simulation opportunities for learners and Trust staff with over 1,000 staff participating in a range of programmes, including newly qualified staff undertaking sessions on recognising deteriorating patients.

Apprenticeships

- We continue to support a range of apprenticeship programmes.
- We have recruited more than 30 new apprentices to our Business & Administrative apprenticeship programme, a number of whom were in the 16-18 age range and several have been successful in obtaining permanent employment.
- We have also supported over 40 of our existing staff with their personal development on a range of apprenticeships including Business & Administration, Customer Services and Management.
- The Trainee Health Care Support Worker post has also been created. It was launched in September as part of the on-going work to widen participation of individuals in posts at Band 1-4 and is extremely well evaluated.

Professional education

We have maintained a high standard of medical education throughout the Trust, offering a wide range of undergraduate and postgraduate training with some areas receiving the highest A* grades for quality. The reputation for training in certain specialty areas across medicine and surgery has led to trainees travelling not just from around the country, but internationally to be trained in Portsmouth.

- In October 2013 we were visited by the Chairs and Chief Executives of Health Education England (HEE) and Wessex Local Education and Training Board (LETB). We were commended for the quality of education provided in the Trust and the different opportunities available to learners.
- We were also asked to collaborate with HEE regarding our new clinician's assistant role, which aims to supplement the current healthcare workforce and ensure targeted investigations for patients.
- Our partnership with Southampton Solent University, to support assistant and associate practitioner staff to undertake a foundation degree, continues to expand allowing small, specialist staff groups at this level to receive education and training to fit them for their roles. This is funded externally.
- The Portsmouth Pathology Service NVQ centre, based at Queen Alexandra Hospital, continues to provide high quality programmes for pathology support staff at career framework levels 2, 3 and 4. This year it will also be offering the assessor and internal verifier qualifications as well as technical apprenticeships. Discussions are underway to expand this service across Wessex.
- A BTEC for pharmacy assistants has also been introduced and enables us to offer apprenticeships in pharmaceutical science at level 2.

Internships

In our drive to increase the quality of education and have clinical staff with up to date information and knowledge, we have introduced innovative education internship opportunities. The internships offer an education qualification underpinned by mentorship and assessed teaching hours to enable clinical staff to gain qualifications and experience whilst retaining their clinical role and being able to take learning back into practice.

- We have learning champions in the Bands 1-4 workforce who organised a highly successful learning event for their colleagues that was attended by several universities, colleges and journals. These champions ensure colleagues are aware of learning opportunities and facilitate the link between practice and learning and development.
- We continue to support many staff in undertaking further academic qualifications at a number of local and national universities with over 1,200 staff currently learning with a college, university or conference.

Clinical skills

We also have a comprehensive clinical skills portfolio which is responsive to both staff and Trust requirements.

- A dementia training plan has been developed this year. This aims to identify and implement educational resources to develop a trained and competent workforce across the Trust with the knowledge and skills to continue to provide informed, compassionate and person centred care to patients and their families living with dementia.
- The ability to transfer learning to improve patient care is of great importance to the Trust. We have invested in an education outcomes project and are beginning to review early data on the learning we provide and how it makes a difference to patient care. We intend to expand this over the next year to provide evidence of patient care improving as a consequence of learning.

Staff engagement and consultation

Effective two-way communication between the Trust, our staff, patients and the wider community is crucial. During the past year we have worked hard to increase the variety of methods to achieve this, which include a weekly message from the Chief Executive, a monthly staff magazine, staff surveys and various social media platforms.

Listening into Action

In April 2013 we introduced a new staff engagement initiative called Listening into Action (LiA). Our staff are the people who really know what needs to be done on the ground to improve our services. LiA puts them at the centre of change – using their knowledge, ideas and enthusiasm to make changes that have a big impact.

Our LiA journey started with our Chief Executive holding six 'big conversations' with hundreds of staff, in May 2013, when she asked them what gets in the way of delivering the very best care for our patients, and what changes would have the biggest impact.

Following these meetings 14 teams began to use the LiA methodology in addressing areas for improvement highlighted at the big conversations, with each team led by a clinician, a nurse and an operational manager. Several actions have followed including:

- an improvement in the efficiency of portering journeys to and from the imaging department;
- the identification and initiation of an additional ultrasound room resulting in more patients being scanned;
- improvements in the speed of the availability of test results in vascular imaging;

- earlier identification of patients who are fit to leave hospital;
- a centralised referral document which has improved the speed of patient referrals within the Trust;
- more training on electronic clinical information systems for clinical staff;
- a revised care plan in the Medical Assessment Unit that better meets the needs of our patients;
- embedded our values into our people policies such as recruitment and performance review;
- improved signposting on the Queen Alexandra site;
- the adoption of the '#hellomyname is' campaign to ensure that all staff introduce themselves to patients.

Within the LiA methodology is the idea of a 'Quick Win', this is a high impact action that can be taken almost immediately to address an area of concern or to make a significant high impact improvement. So far there have been more than 20 Quick Wins that have immediately benefited both patients and staff including:

- the introduction of the Nurse in Charge badge which ensures patients, relatives and colleagues in the ward areas know who to go to with urgent or complex issues;
- patient pagers in outpatient departments so that patients can leave the department for a coffee or a stroll whilst waiting for their appointment;
- dementia awareness training for the security team to support staff, patients and relatives when called to deal with an incident;
- introducing an Information Technology drop in session so that staff can get responses to problems and queries more quickly;
- moving patient seating in the main reception so that patients, carers and relatives can see when their lift or taxi has arrived to collect them;
- the introduction of the 'Please take me back to the nearest reception scheme', whereby all Trust staff take responsibility for lone wheelchairs and return them so that they are more readily available for patient use.

Staff surveys

In September 2013 all Trust staff were asked to complete the NHS National Staff Survey and the results were published by Quality Health in February 2014. The NHS Staff Survey is recognised as an important way of ensuring that the views of staff working in the NHS inform local improvements and input in to local and national assessments of quality, safety, and delivery of the NHS Constitution.

We chose to survey all staff in 2013 and 3,750 staff took the opportunity to complete and return a survey, this is a 57% response rate and is above average for acute trusts in England and compares with a response rate of 56% in the 2012 survey.

The direction of travel is positive with scores demonstrating an increase in areas such as training, senior managers acting on staff feedback, the care of patients being our top priority and staff recommending our hospital as a good place to work or receive treatment. We will continue to work with our colleagues to address those areas where we can still improve. This will build on the work we have already started with our Listening into Action (LiA) programme, which has seen clinicians and staff being put at the centre of change for the benefit of our patients, our workforce and the organisation as a whole.

Whilst pleased with our progress over the last twelve months, it is clear that there is still much work to be done in developing and supporting our staff. The NHS has undergone unprecedented change in the last 12 months and we are committed to supporting staff through these changes.

The full details of the 2013 staff survey can be found at www.nhsstaffsurveys.com

Staff side consultation and negotiation

Consultation and negotiation between management and staff at Portsmouth Hospitals NHS Trust is conducted through the Joint Consultative Negotiating Committee and the Doctors and Dentists Negotiating Committee which includes a mix of recognised trade unions and elected staff representatives who meet on a monthly basis. The purpose of both is to provide a constructive forum for discussion, consultation and exchange of views on matters of common interest affecting the trust, with an opportunity for staff to influence strategic and operational decisions and their application.

Whistleblowing

The principles of the 'speaking up' charter, introduced in October 2012, have been practiced within Portsmouth Hospitals NHS Trust since 2007. We offer a confidential whistleblowing hotline and we do not place any restrictive covenants on former employees who may wish to raise issues around risk to the safety of patients, staff or the public. Seven issues were raised by staff this year, all of which were investigated and action taken.

Equality and diversity

We have a strong commitment to equality and diversity. By recognising that each patient has different needs and circumstances we can best meet those needs and improve outcomes by delivering a personal form of care through strengthening and supporting the diverse talents of our workforce. To develop this culture we also need to ensure we treat staff, as well as patients, fairly. 6.7% of our staff are from Black and Minority Ethnic (BME) communities. Our Equality and Diversity Committee meets bi-monthly and receives comments and feedback from across the Trust.

Sickness absence

Our sickness absence rate for the last year (as of January 2014) was 3.4% - higher than our internal target of 3% but lower than the national average of 3.97%.

Ill health and sickness absence can significantly affect service delivery and patient care as well as having a direct financial impact, therefore, we have several measures in place to ensure that absence is managed appropriately. Through the comprehensive Management of Attendance Policy and Wellbeing guidance, managers are supported by a dedicated Absence Management Team within the Operational HR Department. The team regularly meet with and advise managers on the application of the policy and helps them identify timely and appropriate solutions with any sickness absence concerns. The dedicated advisors also provide relevant absence related information, statistics and automated notifications to managers to assist them in proactively tackling sickness absence.

To contribute to the on-going development of managers the Operational HR Department also provides 'bite size' training sessions covering all areas of attendance management, as well as providing management briefing documents. Employees are also supported through management referrals to the Occupational Health Department and Fit4Work Scheme.

Staff recognition

Best People Awards and the Chairman's Awards

These awards recognise individuals and teams nominated by their peers who have demonstrated excellence in their particular field:

- ***The Chief Executive's Award*** for outstanding achievement in 2013 went to: Dr Sean Kerr, Consultant, Anaesthetics; Dr Rachael Harrison, Consultant, Radiology; Aaron Murphy, Patients Services Assistant, Carillion
- ***The Chairman's Award*** went to: Sue Garland, learning beyond registration lead; Lucy Rutter, LiA lead; Communications team
- ***Best Inspirational Leader Award*** went to: Clinical Support CSC Management Team - Dr Simon Ward, Paul Knight and Alison Fitzsimons
- ***Best Team Award*** went to the Robot theatre team
- ***Best Innovator Award*** went to the Falls champion team
- ***Best Customer Care Award*** went to Laldin Puia, Health Care Support Worker, Cardiology
- ***Best adoption of LiA Award*** went to the Medical Assessment Unit nursing team – Debbie Briggs, Anita De Havilland and Samantha Feiven
- ***40 Years' Service Award*** went to: Lynn Longworth, Midwife, Maternity department; Elaine Morgan, Clerical Officer, Respiratory outpatients; Angela Hume, Staff Nurse, Theatres; Malcolm Howard, Technician, Theatres; David Massey, Biomedical Scientist, Blood Sciences; Patrick O'Neil, Pharmacy Technician

Employee of the Month

This scheme recognises staff that have made a substantial contribution to patient care, or acted above and beyond the call of duty. Everyone working within the Trust is eligible and a selection panel chooses the winner from staff and public nominations. Each winner receives an award and a certificate and their photograph is prominently displayed in the hospital's main entrance. Our Employee of the Year was:

- Andy Gillon, Health Care Support Worker, Ark Royal Ward, Gosport War Memorial Hospital

The Portsmouth News Best of Health Awards 2013

Readers nominated health heroes in twelve different categories. A number of our staff were shortlisted for the awards highlighting the calibre of staff that we have working for us.

Our staff won four of the twelve categories including:

- Hospital Doctor of the Year: Asha Senapati, Lower GI Consultant
- Hospital Nurse of the Year: Jeanette Barnes, Senior Staff Nurse
- Hospital Team of the Year: Paediatric team
- Midwife of the Year: Joanne Warwick, Community Midwife

Our departments and staff have continued to receive many awards and honours for their hard work and dedication to their job.

Our valued volunteers

Our volunteers benefit the Trust in numerous ways including helping ward staff at meal times, directing patients and visitors to their destinations, helping with some administrative support and assisting with patient surveys.

The Chief Executive held a Listening into Action event with the volunteers in November 2013 to better understand how voluntary services could be improved.

The Trust has also increased the number of Pets for Therapy Dogs to enhance the patient experience.

We are very proud of, and grateful to, our loyal volunteers who support the League of Friends, Hospital Radio, our Chaplaincy and the Macmillan and Rocky organisations.

League of Friends

The League of Friends is a volunteer group which helps to raise money for the hospital. There are over 400 members of the team and 100 active volunteers who help run the League of Friends shop in Queen Alexandra Hospital and take trollies with refreshments to the wards, theatre and outpatient areas.

Fundraising

The generous contributions of colleagues, as well as a wide cross-section of our community, raises thousands of pounds to support a variety of initiatives across the Trust that would not otherwise have been be affordable.

Last year saw the beginning of the final phase of the Rocky Appeal to fund a state of the art da Vinci Surgical Robot. We aim to be at the forefront of this dynamic new surgical technology and are proud to have some of the most innovative and experienced surgeons and surgical teams in the NHS here at Queen Alexandra Hospital. For more information about the da Vinci Surgical Robot appeal see www.porthosp.nhs.uk/get-involved/rocky-appeal.htm

Other teams in the Trust are delighted to have received funds from generous donors to provide a variety of resources including new safes for each of our wards and funding for an innovative magnetic clinical patient information signage system that gives staff clear simple information about patient needs.

All of the funds that are donated to the Trust can be designated according to donor wishes and the Trust is proud to work with many generous groups, companies and individuals who, together, demonstrate the power of giving.

Boats of Bounty

This is a unique way of recording donations in memory of a loved one or from a fundraising event. The Boats of Bounty has three types of donation:

Gold for donations of £1,000 or more

Silver for donations of £500 - £999

Bronze for donations of £250 - £499

Each sail boat is engraved with the donor's specific wording and placed by them, if they wish, on the Boats of Bounty board situated along the main entrance corridor, on A level, at Queen Alexandra Hospital. To date, the donations amount to £47,949.09.

Outlook

The drive to seamlessly integrate services between organisations is likely to continue. Safe staffing will continue to be centre stage along with the provision of safe services 7 days a week.

The political drive to treat more patients in their own home or a setting closer to home is set to continue with the recently announced Better Care Fund which will see resources transferred from health to support social care from 2014/15.

We know that the tariff arrangements for emergency care are unlikely to change in the short term, the aging demographic will result in the hospital seeing more frail and elderly patients, many of them as emergencies, volumes in key specialties such as cancer are forecast to increase further and too many patients still wait too long for treatment.

All this means that the environment in which the hospital operates will continue to become more challenging. In response we have developed an ambitious new strategy to accelerate the transformation of the organisation including building our clinical offering in some areas; changing the setting of existing clinical services to move more care outside of the hospital; remodelling our workforce to maximise productivity and flexibility; and changing the way we use our estate as we move the QAH site to a health campus shared with other key partners.

These changes will not be easy. We will be making these at a time of intense scrutiny in the run up to the general election in 2015 and this will require joint working with all of our key stakeholders.

What we will focus on

In the coming years we will continue on the journey we have started, with particular emphasis on accelerating the pace of transferring responsibility to our frontline staff, and accelerating the pace at which we give staff the ability to speak up.

During the next three years we will transform our services in line with patient and population needs with a particular focus on unscheduled care, care of the frail and elderly and long term conditions. We will reposition the hospital as the hub of the local healthcare system providing expertise, leadership and governance across all pathways whilst directly delivering complex aspects of medical care for our population.

We will build on our existing areas of specialist expertise - including minimally invasive and robotic surgery and sub-specialist care in cardiology, diabetes, neonatal expertise, aspects of orthopaedics and stroke. We will grow our business in areas where we excel - further developing our existing tertiary referral units in renal medicine, kidney transplantation and cancer services. We will seek to grow our market share for elective care and further develop the facilities for insured and self-pay patients who choose to be treated privately.

Building on the aspirations of our clinicians, and in line with national commissioning trends, we will offer a greatly enhanced consultant led service every day of the week as well as an extended day service for a number of clinical specialties.

Patients at the Heart of Our Vision

High quality care for our patients is at the heart of everything we do – for Portsmouth Hospitals Trust that means we must provide comprehensive, high quality healthcare for both our local population of 675,000 and the extended population for whom we provide specialist and regional services. In line with national commissioning intentions we will engage with staff to facilitate the delivery of the highest quality patient care and will work with patient representatives to increase participation and include patients as co-designers within the system. Our intention is to provide the highest quality clinical outcomes, patient reported outcomes and patient experience.

Transformation Agenda

We will transform our services in line with patient and population needs with a particular focus on unscheduled care, care of the frail and elderly and long term conditions. This will provide the quality of care required for the changing demographics and healthcare needs of our population in the future. We will ensure that our pathways are clinically effective and provide easy access for patients at every stage, whilst delivering efficient services that provide both value for money and excellent clinical outcomes.

Working with Partners

Collaborative working with others across our health system is crucial for the efficiency and sustainability of our local health economy. We will foster good working relationships with local partners and work with them to redesign the delivery of care in line with local needs and existing and future plans for integration of health and social care. This will include local community providers and social services but also other major acute providers throughout our region and beyond.

We will prioritise the development and delivery of integrated care pathways in partnership with other providers within the local health economy, with particular emphasis on frail and elderly patients.

Profitability

Our priority is to deliver safe and effective patient care which represents value for money.

24/7 Care

Building on the aspirations of our clinicians and in line with national commissioning trends, we will offer a greatly enhanced consultant led service 7 days a week as well as an extended day service for a number of clinical specialties. We will ensure effective clinical outcomes irrespective of the day of admission and robust and efficient pathway management throughout the week and the weekend. Patients accessing healthcare out of normal working hours should experience the same high quality service led by senior clinical staff. Improved efficiency of care will help to reduce hospital length of stay.

Research, Training and Innovation

We will endeavour to incorporate research and innovation into all aspects of our services.

We will aim to:

- build strong strategic research, innovation, teaching and community partnerships and networks to improve opportunities;
- empower staff and patients to drive innovation of healthcare;
- drive quality and safety through research and evidence-based care;
- promote continual improvement and high quality training for staff and students;
- remove outdated practices that are not proven to value patients;
- establish the hospital as a national leader in the healthcare environment.

Governance

Council of Governors

Our Council of Governors continues to operate in 'shadow' form, which means that it performs the majority of the duties and functions of the Council of Governors at a Foundation Trust but without formal legal status. It comprises elected posts representing Portsmouth City, Havant and East Hampshire, Fareham and Gosport, patient groups and staff. A further ten appointed posts cover strategic partners.

The Council has two advisory groups which meet throughout the year to review different aspects of the trust and make recommendations for improvement. The Council also meets with the Board periodically to challenge and comment on trust plans. It co-organises trust Open Days and holds public constituency meetings where Trust members can ask questions, give feedback and hear about new initiatives. The Council gives local people a chance to comment on the running of their hospital.

Fareham and Gosport constituency

Richard Mackay, Lucy Docherty, Mary Sheppard, David Gattrell

Havant and East Hampshire constituency

Roland Howes, Jocelyn Booth, Kate Bowskill

Portsmouth City constituency

Sarah Edmonds, Syd Rapson (until October 2013)

Parent/Carer constituency

Pepe Chisenga

Staff Governors

Dr Jocelyn Wace (until January 2014), Leslie Jones, Nicholas Courtneidge (until December 2013), Jayne Jempson (from January 2014)

Mr Anthony Evans (from March 2014)

Appointed Governors

Cllr Peter Edgar, Hampshire County Council

Stephen Arkle, University of Portsmouth

Norman Robson, West Sussex

Surgeon Commodore Robin McNeill-Love, Ministry of Defence (from August 2013)

Cllr Gwen Blackett, Havant Borough Council

Cllr Will Purvis - Portsmouth City Council

Dr Tim Wilkinson - Portsmouth CCG (from April 2013)

Julia Barton - Fareham and Gosport CCG (from April 2013)

Adel Resouly - South East Hants CCG (from April 2013)

Lyn Robertshaw – Coastal West Sussex CCG (from August 2013)

The Trust Board:

- Comprises a Chairman, Non-Executive Directors and Executive Directors;
- Sets strategic direction and monitors performance against locally and nationally set objectives;
- Is accountable for ensuring that high standards of performance are maintained;
- Promotes links between the Trust and the local community.

The Board has two mandatory committees whose members are solely Non-Executives:

- The Audit Committee provides an independent and objective review of our internal controls; and
- The Remuneration and Nominations Committee approves substantive appointments of Executive Directors and approves their remuneration, including any bonuses

Three of the Non-Executive Directors sit on the Audit Committee. They are Alan Cole, Steve Erskine and Professor Timothy Higenbottam.

Non-Executive Directors

Alan Cole
Deputy Chairman and Interim Chairman from January 2013
Alan joined the Board in 2006. He is a management accountant who has worked for the past six years as Financial Director of an IT Software start-up company which was acquired in 2012 by a global IT company. Prior to this he held a number of senior financial positions at the multinational information services firm, IBM. He has wide experience of leading professional, multi-disciplinary, client-focused teams. Alan became the Trust's Interim Chairman from 1 January 2013.

Elizabeth Conway
Elizabeth joined the Trust Board in October 2009 following 20 successful years as a marketing specialist in the pharmaceutical and health care industry. During this time she was responsible for leading and implementing communication strategies and marketing campaigns for companies such as Glaxo Smith Kline and Astra Zeneca and charities including Cancer Research UK.

Steve Erskine
Steve joined the Trust Board in May 2011. His background is in information technology, logistics and service management and he currently works for L-3 ASA, a division of a large US technology provider to military, law enforcement and commercial markets. Steve was previously a Deputy Director in the Home Office, responsible for the delivery of a range of operational services, and a main Board Director at Ordnance Survey.

Professor Timothy Higenbottam
Tim joined the Trust Board in May 2011 and has worked in medical science for 30 years in Cambridge and Sheffield. For the last decade he has worked in the pharmaceutical industry in the clinical development of new therapies. He is Senior Partner in Transcrip-Partners LLP a specialist CRO and chairman of the Professional Standards Committee of the Faculty of Pharmaceutical Medicine Royal College of Physicians.

Mark Nellthorp
Mark is a Deputy Director at HM Revenue and Customs and a Fellow of the Chartered Management Institute. He joined the Trust Board in December 2007 and is the Senior Independent Director.

Executive Directors

Ursula Ward - Chief Executive
The Chief Executive is responsible for leading the Trust and developing and delivering the organisation's strategy and objectives. Ursula has a clinical background, primarily in cardiology and cancer care. She spent five years in academia before pursuing a career in general management. She was appointed to the Trust in 1999 as Director of Nursing and Midwifery, progressing to Deputy Chief Executive in 2002. She was appointed as Acting Chief Executive in March 2004 and appointed substantively to the role in June 2004.

Ben Lloyd – Director of Finance and Investment and Deputy Chief Executive
Ben joined the Trust in April 2013. He has over 20 year's experience in senior finance roles within the health sector. Prior to joining the trust, he spent two and half years with Circle after a series of roles within the NHS, including Director of Finance and Performance with a Strategic Health Authority and Director of Finance at a large provincial teaching hospital.

Simon Holmes - Medical Director
Simon has been a Consultant Urologist with the Trust since 1995 holding the position of Clinical Director for Urology from 2001 to 2005. He was appointed Honorary Senior Lecturer in the Academic Department of Surgery of Portsmouth University in 2002 and was also appointed as Medical Director for Central South Coast Cancer Network in 2007. Simon became Medical Director in August 2010.

Cherry West - Chief Operating Officer
Cherry joined the Trust in January 2011 as Chief Operating Officer, following 14 years in various operational delivery and performance roles, the most recent of which was at the Norfolk and Norwich University Hospital Foundation Trust. Cherry has a clinical background. During her early career, she worked in the area of clinical physiology having trained in medical physics. She holds a postgraduate diploma in Health Planning and Management from University of London (LSE), an MSc in Physiology from University College London, and an MBA from Henley Management College.

Tim Powell - Director of Workforce and Organisational Development
Tim joined the Trust in November 2011 with a wide range of public sector experience. 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.

Julie Dawes – Director of Nursing, left March 2014.
Julie joined the NHS as a nurse in 1981 and became a registered nurse in 1984. She has specialised in cancer services and palliative care and worked as a Ward Sister, Matron, General Manager and Senior Nurse in both the acute and community sectors. Julie has worked in Leeds, Southampton and the South Central Strategic Health Authority and specialises in patient experience and patient safety. She became Chief Nurse at Portsmouth Hospitals in January 2009 and then Director of Nursing in July 2010.

Director's interests

So far as each of the Directors is aware, there is no relevant audit information of which the trust's auditors are unaware. Each Director has taken the steps that a Director ought to have taken to make him/herself aware of any relevant audit information and to establish that the auditors are aware of such information.

The following table details this declaration further:

Surname	First Name	Job title	Interests (Y/N)	Details
Cole	Alan	Interim Chairman	No	
Conway	Elizabeth	Non Executive Director	No	
Dawes	Julie	Director of Nursing	No	
Erskine	Steve	Non Executive Director	No	
Higenbottam	Timothy	Non Executive Director	Yes	Research & Development Director Allergy Therapeutics Ltd UK
Holmes	Simon	Medical Director	No	
Lloyd	Ben	Director of Finance & Investment	Yes	Holder of Circle Partnership shares
Nellthorp	Mark	Non Executive Director	No	
Powell	Tim	Director of Workforce and Organisational Development	No	
Ward	Ursula	Chief Executive	No	
West	Cherry	Chief Operating Officer	No	

Statutory Accounts

Annual Report 2013/14

The accounts of Portsmouth Hospitals NHS Trust for the year ended 31st March 2014 have been prepared in accordance with the financial records maintained by the Trust and the accounting standards and policies for the NHS laid down by the Secretary of State with the approval of the Treasury.

The accounts were approved by the Audit Committee, with delegated authority from the Board, at a meeting on the 5th June and have been audited. The auditor's certificate is unqualified and is incorporated in the annual report.

External Auditor

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

The audit fee for the 2013/14 annual accounts for statutory work carried out by external audit is £118,000 exclusive of non-recoverable V.A.T. Of this sum, £88,500 has been charged to 2013/14 and the balance, £29,500, will be charged in 2014/15.

Financial Summary

The following financial information is a summary taken from the Trust's Annual Accounts shown on pages 66 to 132 of this report. The accounts are also available at www.porthosp.nhs.uk or the Director of Finance and Investment on 02392 286000.

Financial Performance in 2013/14

The Trust's performance against its statutory duties was as follows:

- The Trust made a revenue surplus of £830k including a number of technical adjustments; which are explained below.
- The Trust is obliged to reflect the public dividend capital dividend within its accounts necessary to achieve a 3.5% return on average net relevant assets and for 2013/14 this was £980k.
- The Trust's cash flow was contained within its External Financing Limit.
- The Trust's capital expenditure was contained within its Capital Resource Limit.

Technical Adjustments to revenue position

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 Government Departmental expenditure. This requires Trust's to consider the technical adjustments in relation to PFI accounting and accounting policy changes, as summarised below:

- PFI Accounting (IFRIC12) Adjustment - the incremental revenue expenditure resulting from the application of International Financial Reporting Standards (IFRS) to PFI schemes, which has no cash impact and is not chargeable for overall budgetary purposes, is excluded when measuring Breakeven performance.
- Other Accounting Policy Changes – These consist of accounting policy changes relating to impairments and the removal of the donated asset and government grant reserves.

Finance Director's Report

The Trust has ended the 2013/14 financial year with a reported surplus of £830k. This position consists of both the 'retained' surplus of £2,802k and the 'technical' adjustments (see above) as summarised below:

	£'000	£'000
Retained surplus for the year		2,802
IFRIC 12 adjustments (UK GAAP to IFRS)	2,830	
Impairments (Asset Revaluations)	(5,079)	
Adjustment in respect of donated asset reserve	277	(1,972)
Adjusted Retained Surplus		**830**

The achievement of a surplus for the 2013/14 financial year means the Trust has achieved it's 5 year cumulative break even duty. The Trust set a challenging savings target of £20.5m as part of the nationally required 4% cost improvement programme for NHS acute trusts. At the start of the year £5.4m of these savings were unidentified and the Trust had a year end planned deficit of £5m.

In addition to the original 2013/14 programme, in order to ensure delivery of the planned year-end financial position, transformation plans were agreed to improve capacity, review medical & nursing workforce and eliminate needless waste. These plans included reductions in unnecessary lengths of stay in hospital beds and improvement to the utilisation of theatres, to deliver both quality and financial benefits and complement the original programmes of work, which were across areas such as non-clinical workforce, medicines management and clinical supplies procurement.

In order to meet access targets (maximum waiting times) for patients, after taking into account of the impact of demand management schemes led by our commissioners (Clinical Commissioning Groups) aimed at reducing the volumes of people treated in hospital, the Trust has provided for significant increases in patient volumes above that originally planned by commissioners in 2013/14 contracted activity.

In recognition of the progress made by the Trust in its transformation, the Trust Development Authority (TDA) agreed £4m of financial support and this, along with the increased patient volumes and further strengthening of internal management arrangements, has led to the achievement of a £0.8m surplus in 2013/14, against that originally planned deficit of £5m.

Audit Committee

The Trust has an Audit Committee comprising three Non-Executive Directors and the committee membership during 2013/14 was:

- **Steve Erskine**
  Non-executive Director and Committee Chairman
- **Alan Cole**
  Non Executive Director and Interim Trust Chairman.
- **Tim Higenbottam**
  Non-executive Director

Representatives from External Audit and Internal Audit attend the Audit Committee along with the Director of Finance, Company Secretary, Head of Financial Accounting, Head of Governance and Head of Risk Management. Where it is determined by the Chairman that the Committee should meet purely as an Audit Committee then the executive directors and other Trust officers are excluded.

The Audit Committee gives specific consideration to matters of probity, the propriety, regularity of public finances and value for money, which arise from the work of the external auditors and the Trust's "local counter fraud specialist" and internal audit service.

The Committee also reviews the adequacy of structures, processes and responsibilities for managing key risks facing the organisation.

Remuneration Committee

Terms of Reference and Membership

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

The Trust has an established Remuneration Committee whose main functions are to:-

- Make recommendations to the Board on remuneration and terms of service for each executive director, including performance pay.
- Make recommendations to the Board on the overall remuneration in terms of service for senior managers not on National contracts.
- Make recommendations to the Board on any termination arrangements for executive directors.
- Monitor the performance of executive directors.
- Make recommendations to the Board on Special/Exceptional payments covering any individual member of staff or staff group.

The Committee membership in 2013/14 comprised;

- **Alan Cole**
  Non-executive Director & Interim Chairman
- **Mark Nellthorp**
  Non-executive Director & Senior Independent Director
- **Elizabeth Conway**
  Non-executive Director
- **Steve Erskine**
  Non-executive Director
- **Tim Higenbottam**
  Non-executive Director

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.

Statement of Policy

The Committee has absolute discretion over the terms, conditions and remuneration of the Chief Executive and executive directors. This discretion is exercised through the following guiding principles:-

- That all decisions are made within the legally constituted powers of the Trust.
- Ensuring that all executive directors' remuneration represents value for money.
- The need to attract, retain and motivate, high quality executive directors.

The Committee makes satisfactory arrangements to ensure it receives adequate independent advice on remuneration arrangements elsewhere in the NHS and other similar organisations, as well as trends and developments in the area of employment benefits, and terms and conditions of employment for directors.

Directors' remuneration reviews take account of the size, scope, complexity and impact of the individual job, considering any appropriate market rates and/or special circumstances, as well as national guidance and with regard to other pay settlements in the NHS and the public sector.

To ensure the Trust meets its strategic and key performance targets the chief executive officer and executive directors have annual performance objectives set which are reviewed annually by the Remuneration Committee. Subject to affordability up to an additional 3% of base pay can be used as non-recurrent performance payment, as an incentive to the achievement of these objectives.

All other senior managers have been offered or have transferred onto national terms and conditions that include a pay band range and an annual pre-set incremental recurrent increase subject to satisfactory performance.

Appointments and Termination

The Chair and non-executives are lay people drawn from the community served by the Trust. They are accountable to the Secretary of State. They hold the executive directors to account and use their skills and experience to help the Board as it develops health strategies, and ensures the delivery of high quality services to patients. These lay people are also expected to draw from their experience in the local communities to make sure that the interest of the patient remains paramount.

The executive directors of the Board were appointed through an open and transparent competitive process following National Good Practise Guidelines from the Department of Health. All executive directors have been appointed on an open-ended contract subject to standard periods of notice. Their employment is subject to Codes of Conduct and Accountability for NHS Boards, a Code of Conduct for NHS managers and the Trust's Disciplinary Policy Procedures.

In the event that a director's contract of employment is terminated without notice for any reason other than gross misconduct or repudiatory breach, the Remuneration Committee can exercise its discretion for compensation for the financial loss relating to the loss of office. There have been no awards of this nature.

Salaries and Allowances/ Pension Benefits 2013/14

On pages 134-135 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 2013/14 was £185k-£190k, which was the Chief Executive and her salary was comparable with 2012/2013. The Chief Executive's salary was 6.6 times (2012/13, 6.4 times) the median remuneration of the workforce which was £28,082 (2012/13, £28,405).

In 2013/14, no employees received remuneration in excess of the highest-paid director (2012/13, one in the range £190k - £195k).

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.

Pension Liabilities

The Trust's accounting policy can be seen at note 1.8 in the Trust's Annual Accounts.

Treasury Management

The Trust is restricted in its external investment to a maximum of £50k. Surplus balances above this level are held within the Government Banking Service or, if the interest rate and timing is favourable, the National Loans Fund temporary deposit facility.

Charges for information

The Trust has complied with Treasury guidance on setting charges for information.

Disclosure of Interests

- **Tim Higenbottam** a Non-Executive Director, is a Partner and one of the owners of the TranScrip Partners LLP which is a contract research organisation and also a director and joint owner of HMAE Ltd., a commercial and residential property company. Neither organisation has any business dealings with Portsmouth Hospitals NHS Trust.
- **Elizabeth Conway** a Non-Executive Director, is a Director of Brand Marketing Works and Northlands House (Management) Ltd. Neither organisation has any business dealings with Portsmouth Hospitals NHS Trust.
- **Alan Cole** a Non-Executive Director and Interim Chair, is Owner of Simply Green Garden Designs Ltd. The company has no business dealings with Portsmouth Hospitals NHS Trust.

In addition to those disclosures above, two Medical Consultants employed by the Trust are shareholders in The Learning Clinic Ltd, the company that provides VitalPAC (a clinical information system used by the Trust to gather inpatients' vital signs data). The total expenditure with the Learning Company Ltd in 2013/14 was £553k.

Activity Trends

Activity By Modality

Activities	2007/8 Outturn	2008/9 Outturn	2009/10 Outturn	2010/11 Outturn	2011/12 Outturn	2012/13 Outturn	2013/14 Outturn
ED Attends (incl. eye emergency)	115,585	116,636	120,307	122,488	126,949	132,657	132,104
Non-Elective	65,801	68,263	68,496	67,620	68,575	67,031	66,702
New Outpatients	150,343	160,653	158,499	159,723	159,576	151,180	146,559
Follow-up outpatients	292,995	300,641	283,930	282,872	287,881	275,374	277,250
Ward Attenders	4,462	5,078	5,369	5,459	5,315	5,996	5,835
Elective Cases	17,367	15,975	14,410	13,979	14,363	14,084	13,870
Day-cases	41,818	45,300	42,603	41,080	42,302	44,481	45,880

'Off-Payroll' Engagements

The tables below set out information on the number of 'off-payroll' engagements at a cost of over £220 per day that were in place as of 31 March 2014 and new 'off-payroll' engagements between 1 April 2013 and 31 March 2014 at a cost of over £220 per day and lasted more than six months.

'Off-payroll' engagements in place > £220 per day as at 31 March 2014

	Number
Number of existing engagements as of 31 March 2014	1
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

Existing 'off-payroll' engagements have been assessed as to whether assurance is required that the individual is paying the correct amount of tax. This assurance has been sought.

Engagements between 1 April 2013 and 31 March 2014 > £220 per day and over 6 months

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014	2
Number of new engagements which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	2
Number for whom assurance has been requested	2
Of which:	
assurance has been received	2
assurance has not been received	0
engagements terminated as a result of assurance not being received	0

Trust Certificates

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

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. 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 with the approval of the Treasury 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.

05 June 2014 Date  Chief Executive

Statement of directors' responsibilities in respect of the accounts

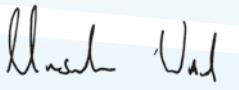
The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised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

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

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

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

By order of the Board

05 June 2014 Date  Chief Executive

05 June 2014 Date  Finance Director

Independent auditor's report to the directors of Portsmouth Hospitals NHS Trust

Issue of audit opinion on the financial statements

In our audit report for the year ended 31 March 2014 issued on 6 June 2014 we reported that, in our opinion,the financial statements:

- gave a true and fair view of the financial position of Portsmouth Hospitals NHS Trust as at 31 March 2014 and of its expenditure and income for the year then ended; and
- had been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Issue of value for money conclusion

In our audit report for the year ended 31 March 2014 issued on 6 June 2014 we reported that, in our opinion, in all significant respects, Portsmouth Hospitals NHS Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2014.

Certificate

In our report dated 6 June 2014, we explained that we could not formally conclude the audit on that date until we had completed the work to provide assurance on the Trust's annual quality accounts. We have now completed this work. No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave an unqualified opinion and value for money conclusion.

We certify that we have completed the audit of the accounts of Portsmouth Hospitals NHS Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Helen Thompson

for and on behalf of Ernst & Young LLP Southampton

26 June 2014

Governance Statement

Scope of responsibility

The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this organisation, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets, for which I am personally responsible, as set out in the Accountable Officer Memorandum.

I recognise the importance of working constructively with partner organisations, not only to develop services which meet the health and social needs of the population, but also to manage the risks associated with the achievement of our strategic objectives. To this end, the Trust has met regularly throughout the year with local Clinical Commissioning Groups and the Trust Development Authority to ensure that there is a system of accountability from the Trust to its partners and the public.

This partnership working is essential, and a key element, in supporting our vision of enabling our local population to achieve the best possible health outcomes, live healthy lives and have access to a choice of high quality services when and where needed.

The governance framework of the organisation

The Trust has developed its governance structures over a period of time to deliver an integrated governance agenda. The Trust recognises the importance of responsible, accountable, open and effective governance and with this in mind, the Board meets in public each month.

To underpin an effective governance framework, the Board was supported during 2013/14 by a robust committee structure. This included the following subcommittees:

- Audit Committee (mandatory)
- Appointments and Remuneration Committee (mandatory)
- Governance and Quality Committee, which is supported by the Risk Assurance Committee, both of which are chaired by non executive directors
- Finance Committee which is chaired by a non executive director

In addition to the above the Senior Management Team (SMT) meeting has an executive function. It is responsible for the general management of business on behalf of the Board, with members including the Executive Directors, Chiefs of Service, General Managers, and Heads of Nursing from the ten Clinical Service Centres. There are two reporting lines into SMT, the Operational Delivery Group (ODG) and the Clinical Service Centres monthly performance reviews. ODG and the monthly performance review meetings support the monitoring and delivery of access, quality, financial, and workforce targets in line with the Trust Business Plan.

Attendance records are maintained for all the above committees. The Trust proposes to take this robust structure forward into 2014/15

There are clear reporting lines to the Trust Board from these sub board committees and each non executive director chair is invited to provide a summary report, as well as the meeting minutes, at each Trust Board meeting. This allows Trust Board members to ask any questions they might have about the work of these committees and provides the chairs with an opportunity to bring any issues they wish to the attention of the Trust Board. Through this process, Board members can ask for, and be provided with, any additional assurance that is thought necessary to ensure effective governance.

The Trust Board has also received, and considered in detail each month, the Integrated Performance Report, which consists of a detailed report on quality, operations, finance and workforce throughout the year. This enables the Board to monitor the Trust's performance against national priorities as set out in the NHS Trust Development Authority 'Accountability

Framework' 2013/14, NHS Constitution, and 'Everyone Counts, Planning for Patients' 2013/14. The Trust has continued to improve performance against these national priorities including Referral to Treatment, cancer, stroke and PCI (percutaneous coronary intervention). The Emergency Department four hour standard has not been achieved. MRSA bacteraemia target of zero has not been achieved (4 declared – 3 attributed to the Trust with one found to be avoidable and 2 unavoidable, and 1 case pending investigation at year end). Both of these issues are reflected within the Board Assurance Framework and Risk Register and both continue to have comprehensive work plans associated with them to further mitigate the risk as we move into 2014/15. During 2013/14 emerging risks were recognised around the referral to treatment times within some specialities for elective and cancer waits, robust mitigating actions and controls ensured that performance was achieved for the year.

The Board Assurance Framework has been presented and considered at the Trust Board every month. Other reports have also been received as part of the Trust Board reporting schedule or on an exception basis. The Trust proposes to continue with this programme of reporting during 2014/15.

The Trust Board continually seeks to improve its effectiveness as part of our preparation for a Foundation Trust application and regularly reviews its work streams and meeting agendas to ensure that it is strategically focused. The Trust Board and the Council of Governors have jointly reviewed progress against the strategic objectives of the organisation to ensure that they remain relevant and SMART. The organisation is wholly committed to developing both Trust Board and all other staff members through different initiatives such as the 'Healthy Board', 'The Well Led Organisation' and 'Listening in to Action'

To ensure the Trust Board continues to undertake its duties appropriately, the Chairman conducts annual assessments of the Non-executive Directors and the Chief Executive, and regularly assesses the effectiveness of the Executive Directors. A comprehensive attendance report at Trust Board meetings was kept throughout the year and, whilst non-attendance was rare, when it has occurred, an appropriately briefed deputy has attended on behalf of the absent Executive Director.

The Trust Board fully subscribes to the principles within the 2013 Corporate Governance Code. Arrangements in place for the discharge of statutory functions have been checked for any irregularities, and they are legally compliant.

Risk assessment

The organisation's risk management function 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 to manage them efficiently, effectively and economically.

Risks continued to be identified proactively and reactively during 2013/14, from a variety of sources, including:

- Internal and external reviews and inspections
- Internal and External Audit
- Risk assessments
- Care Quality Commission Essential Standards of Quality and Safety
- Complaints, incidents 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. New and emerging risks identified during 2013/14 have included the challenges around meeting unscheduled as well as scheduled care demand (in some services), threat to specialist services such as vascular surgery due to the centralisation agenda, and maintaining budgetary control and achievement of the savings programme.

The risk and control framework

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 losses, 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 remains in place.

Whilst I retain overall accountability for the management of risk, I have delegated various aspects of that management to designated Directors. However, elements of responsibility also lie with our employees and the structure of the organisation ensures there is adequate capacity to fulfil these responsibilities. To ensure that our employees are supported in their responsibilities for risk management, the Trust has in place an education and training programme, which includes risk management and health and safety training for all staff. Training in these elements is mandatory for all staff and regular reports are provided to the Trust Board by the Learning and Development team, to ensure compliance.

There are a number of high level Committees in place which support the management of risk. These include the:

- **Audit Committee**, to provide the Trust Board with an independent and objective review of internal control.
- **Governance and Quality Committee**, which ensures that there is continuous and measurable improvement in the quality of the services provided and ensures that the Trust Board receives assurances that the risks associated with its activities are managed appropriately. The Committee also monitors the implementation of the Trust's Quality Improvement Strategy, in addition to the monitoring of compliance with national standards and local requirements.
- **Risk Assurance Committee**, which promotes effective risk management and maintains and monitors the Board Assurance Framework and the Risk Register through which the Board monitors the arrangements that are in place to achieve a satisfactory level of internal control, safety and quality. The Committee also promotes local level responsibility and accountability and challenges risk assessment, mitigation, risk assurance arrangements, and outcomes in any area of Trust activity where robust controls are not evident, in order to raise standards and ensure continuous improvement.
- **Finance Committee**, scrutinises the financial performance on a monthly basis. This committee is chaired by a non executive director and is attended by two other non executive directors and the executive team.

In addition, and to ensure robust risk management and assurance across all spheres of organisational activity, there are other Committees and Groups with specific responsibility for various aspects of quality and risk management. These include the:

- **Clinical Effectiveness Steering Group:** to provide direction and to formally report on progress against the key work-streams relating to clinical effectiveness across the Trust, taking into account national best practice guidance. The Group considers the clinical effectiveness implications from national reports, national/local clinical audit reports, and enquiries, making recommendations for local practice where required. The Group monitors the Trust's national audit programme and local clinical audit plan which is based on the Trust priorities.

The Group reports into the Governance and Quality Committee, the clinical audit programme is also scrutinised by the Audit Committee.

- **Patient Safety Steering Group:** to provide direction and report on progress against key work-streams relating to patient safety across the Trust, which build on our good clinical reputation and differentiate us not only in terms of quality but also influence Patient Choice and Commissioning. The Group reports into the Governance and Quality Committee.
- **Patient Experience Steering Group:** to provide direction and formally report on progress against the key work-streams relating to patient experience across the Trust, taking into account national best practice guidelines and patient feedback. The Group reports into the Governance and Quality Committee.
- **Health and Safety Committee:** to effectively identify and review health and safety risks within the organisation.
- **Information Governance Steering Group:** to promote effective information governance and to establish and maintain a framework which ensures that all information is dealt with legally, securely, efficiently and effectively.
- **Serious Incident Review Group:** to provide a high level forum which oversees and monitors the effective reporting and review of internal serious incidents requiring investigation (SIRIs) and receives details of external enquiry reports and associated recommendations in relation to incidents of relevance to the Trust, as and when appropriate. This group is chaired by the Director of Nursing and Medical Director. The Trust has declared 3 never events during 2013/14, none of which resulted in permanent harm to patients, who have all been fully involved and briefed on the findings and actions being taken as a result. This group monitors all SIRI recommendations until assured that actions have been completed and ensures that wider dissemination of learning is built into the process. The Group reports into the Patient Safety Steering Group and Governance and Quality Committee.

In addition, governance committees have been established within all Specialties and Clinical Service Centres. The Clinical Service Centre structure has been purposely designed so that their management teams and clinical staff can better influence the care of their patients.

The management of risk is further underpinned by the Board Assurance Framework and fully developed and comprehensive Risk Registers.

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, Clinical Service Centre (CSC) or Corporate Department. All risk registers are maintained in the same format and reviewed at least quarterly, to aid monitoring of the implementation of action plans necessary for mitigation.

Any risk that cannot be managed at Specialty/Department level, or has the potential to affect the whole of the CSC, is escalated to the relevant CSC Governance Committee for consideration and potential inclusion on the CSC Risk Register. Similarly, it is the responsibility of the CSC Governance Committees to escalate any risk that cannot be managed at CSC level or may have a trust-wide impact to the Risk Assurance Committee (RAC) for consideration and possible escalation to the Trust Risk Register.

The Trust Risk Register contains all of the Trust's identified corporate risks; either those that threaten the achievement of our strategic objectives or those which cannot be managed by the CSCs and/or have the potential to impair or affect the operational or financial ability of the Trust to deliver core services, or which may adversely affect the Trust's profile or reputation. Risks contained within the Trust Risk Register are explicitly linked through cross referencing on the document, to the strategic risks within the Board Assurance Framework if not directly replicated. Each risk has an identified responsible lead and monitoring committee.

The Trust Risk Register and Board Assurance Framework are reviewed monthly by the Risk Assurance Committee to ensure that both remain dynamic and interlinked processes that provide risk information and assurance to the Board.

Where deterrents to risks arising are appropriate these are proactively considered and are in place, examples are the employment of counter fraud services and security management services.

Assurance Framework

The Assurance Framework contains those risks that specifically threaten the achievement of our strategic aims. The risks are cross referenced to the Care Quality Commission's Essential Standards for Quality and Safety, with each risk being allocated a senior responsible lead and a monitoring committee. The responsibility for monitoring the Framework is included within the Terms of Reference for the relevant Committees.

The Trust Board and the Risk Assurance Committee review the Assurance Framework each month and the Audit Committee reviews it at each of its bi-monthly meetings. This ensures close scrutiny and assists in informing the Board's areas of focus, with the Audit Committee providing a degree of independent inspection.

During the year 2013/14 the Trust has identified, through review of the Assurance Framework, a number of risks rated 16 and above; that is, risks which pose a serious threat to achievement of the corporate objectives. The 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 as described above. At the close of the year the highest scoring risks remain concentrated around meeting the demand for unscheduled care. This has been the subject of detailed internal and external scrutiny with extensive action plans in place to mitigate the risks to the Trust.

An Internal Audit, designed to ensure that adequate and effective controls over the Risk Management and Assurance Framework process are in place was undertaken during 2013/14. The final report provided in March 2014 demonstrated substantial assurance.

Care Quality Commission

The Trust was subject to an unannounced CQC visit in May 2013 and was found to be fully compliant with the standards inspected. In March 2014 the CQC carried out a review of the quality of care provided to people with dementia as part of a themed inspection programme. The Trust was found to be compliant with all three standards inspected. The Trust therefore remains registered with the CQC without conditions.

To further support sustained compliance with the CQC Standards a series of peer review challenge sessions and ward visits were undertaken during 2013/14. During the year the methodology has evolved to reflect the new CQC inspection approach. Compliance with the CQC standards is reported quarterly to the Trust Board within the Quality report.

The new CQC Intelligent Monitoring Report placed the Trust in Band 4 in October 2013 and Band 6 (lowest risk) in March 2014.

An internal audit in August 2013 regarding CQC Compliance and Monitor returns reported substantial assurance.

Quality Account

The Trust published its fourth Quality Account in June 2013, which set out the priorities for 2013/14 and reflected on its achievements in 2012. Extensive consultation with internal and external stakeholders is currently underway to inform the Quality Account which will be published in June 2014 and available on the Trust website. This will set out the priorities for the coming year 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. All of the quality metrics are reported to the Board on either a monthly or quarterly basis to ensure regular sight of progress. An external review of the Quality Account was undertaken in June 2013 by external auditors – Ernst & Young. With the exception of the matter reported in the basis for the qualified conclusion relating to reconciliation of NRLS and Trust data for patient safety incidents, the Account was found to be consistent with the requirements set out in the regulations and guidance.

Information Governance

The Trust has an Information Governance Steering Group, chaired by the Information Governance Manager and with representation from across the Trust, including the Senior

Information Risk Owner. The Group takes responsibility for overseeing compliance with Information Governance requirements, including: reviewing all relevant serious incidents and risks and gathering evidence and assurance across the six broad initiatives within the Information Governance Toolkit.

Risks to information security are managed via the Trust's incident reporting mechanisms and Risk Registers and during 2013/14 there were no incidents which required reporting to the Information Commissioner.

The Trust's Information Governance Toolkit submission for 2013/14 demonstrated 86% compliance, and attained "Satisfactory" by achieving the minimum level of expected compliance against all 45 standards.

Foundation Trust

The Trust remains committed to becoming an NHS Foundation Trust and continues to work with the Trust Development Authority to be in the position where it is able to submit a credible FT application towards the end of 2014.

For such an application to be successful, the Trust will need to demonstrate that it is able to consistently comply with a series of demanding metrics – financial, operational, quality - and is making significant progress towards doing so.

Carbon Reduction Strategy

The Trust continues to drive improvements in its environmental performance towards the targets set by the Department of Health for reducing our carbon footprint due to energy use, procurement and waste disposal. We will begin looking closely at other sources of carbon emission such as transport and anaesthetic gases and identify what we can do to minimise those.

The Sustainable Development Unit (SDU) of NHS England has published a new strategy for 2014 to 2020 and we will update our strategy during 2014 to reflect this latest development. The SDU have also published new guidance on sustainability reporting and we will update our performance reports in line with the new template during April 2014.

We are compliant with our obligations under the CRC Energy Efficiency Scheme, the European Union Emissions Trading Scheme and the Energy Efficiency of Buildings Directive.

The Government has set a target of a 34% reduction in carbon footprint by 2020 and a 50% reduction by 2025. We back this strategy and are working hard to achieve it in the following ways. We are working with our PFI Partner to identify practical ways to reduce our energy consumption, identifying potential "invest to save" schemes as well as operational improvements. We have commenced a series of briefings for our staff on reducing their energy use whilst at work and at home and will be delivering further briefings on procurement, transport and waste disposal. Waste segregation and recycling schemes continue to be extended throughout the organisation and these are contributing to a significant carbon saving. Our Procurement Service is ensuring that tenderers for goods and services demonstrate their commitment to sustainability thereby ensuring our supply chain carbon footprint is minimised.

We have signed up as a participant in NHS Sustainability Day 2014 and with the support of our partners will use it as an opportunity to promote carbon reduction to our staff, visitors and the general public.

Pension Scheme Assurance

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 deductions from salary, employers contributions, and payments into the scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Stakeholders

The Trust engages with internal and external stakeholders in a number of different ways, to support service improvements and minimise risk. These include:

- Council of Governors
- Participation in the annual staff survey
- Participation in the annual patient survey

- Participation in the National Cancer Patient survey
- Our Listening into Action Programme which has resulted in a number of Big Conversations with staff from across the organisation
- Use of real time patient feedback
- Open meetings with the Chief Executive
- Chief Executive's weekly message
- Chief Executive's monthly team brief
- Review of the Trust's voluntary services workforce
- Trust open days
- Specialty open days
- Overview and Scrutiny Committee members meeting

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 is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and the Head of Internal Audit's opinion is one of substantial assurance. Executive Directors and senior managers within the organisation who have responsibility for the development and maintenance of the system of internal control also provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls to manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by:

- 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
- The review of all Internal Audit reports by the Risk Assurance Committee. This process provides assurance that any risks identified by Internal Audit are discussed for potential inclusion on the Trust Risk Register
- External Audit
- The work of the Local Counter Fraud Specialists, which is regularly reported to the Audit Committee
- Care Quality Commission Essential Standards of Quality and Safety self-assessment and registration process
- Publication of the Quality Accounts, following wide consultation with stakeholders
- Announced and unannounced visits by the Care Quality Commission
- Monthly reports of Serious Incidents
- Monthly Quality Exception reports
- Quarterly Quality Account reports: amongst other matters, these provide: aggregated information on complaints, claims and incidents, patient experience, patient safety and clinical effectiveness
- Health and Safety reports
- Monthly review of the Board assurance Framework
- Six monthly review of the high levels risks (15+) from the Trust risk register
- Monthly Business Intelligence reports
- Monthly reports from key directors, including Finance, Nursing and the Chief Operating Officer

Significant issues

The Trust continues to operate with a requirement to deliver a challenging cost improvement programme. Whilst budgetary control has been delivered, this issue has been raised on the Risk Register and Board Assurance Framework throughout the year and will continue to be a high profile risk for the organisation into 2014/15. Mitigating actions have been overseen by the Finance Committee to ensure that robust controls are in place, and have been underpinned by the further embedding of a quality impact assessment process to ensure that whilst cost improvements are delivered, any adverse impact on the quality or safety of services is mitigated against. The Trust received an unqualified value for money conclusion from External Audit. The Trust achieved the year end position by the identification of both recurrent and non-recurrent savings and received commissioner non-recurrent funding from NHS England via the Trust Development Authority recognising the Transformation Programme underway within the Trust.

The Trust continues to manage significant challenges in meeting the demand for unscheduled care. This issue stands out within the Trust Risk Register and Board Assurance Framework throughout the year and remains one of our key risks going into 2014/15. The Trust has continued to see an increase in unscheduled care demand and, as a result, has not met the Emergency Department performance target in 2013/14. There is a system wide programme which has been refreshed and pace of change accelerated to mitigate this risk, with involvement of partners from across the health economy. The Trust continues to focus on patient flow throughout the hospital to ensure that all services are running as efficiently and effectively as possible. The Trust is working hard with primary and social care partners to manage the unscheduled care demand across the whole health economy and this work continues into 2014/15.

Accountable Officer: Ursula Ward

Organisation: Portsmouth Hospitals NHS Trust

05 June 2014 Date

 Signature

Annual Accounts

Statement of Comprehensive Income for year ended 31 March 2014

	NOTE	2013-14 £000s	2012-13 £000s
Gross employee benefits	10.1	**(254,196)**	(251,038)
Other operating costs	8	**(194,529)**	(182,562)
Revenue from patient care activities	5	**415,891**	389,875
Other Operating revenue	6	**53,203**	62,031
Operating surplus/(deficit)		**20,369**	18,306
Investment revenue	12	**53**	40
Other gains and (losses)	13	**(96)**	3,342
Finance costs	14	**(16,544)**	(16,443)
Surplus/(deficit) for the financial year		**3,782**	5,245
Public dividend capital dividends payable		**(980)**	(1,220)
Transfers by absorption - gains		**0**	0
Transfers by absorption - (losses)		**0**	0
Net Gain/(loss) on transfers by absorption		**0**	0
Retained surplus/(deficit) for the year		**2,802**	4,025

Other Comprehensive Income

	2013-14 £000s	2012-13 £000
Impairments and reversals taken to the Revaluation Reserve	**(5,079)**	0
Net gain/(loss) on revaluation of property, plant & equipment	**14,899**	855
Net gain/(loss) on revaluation of intangibles	**0**	0
Net gain/(loss) on revaluation of financial assets	**0**	0
Other gain /(loss) (explain in footnote below)	**0**	0
Net gain/(loss) on revaluation of available for sale financial assets	**0**	0
Net actuarial gain/(loss) on pension schemes	**0**	0
Other Pension Remeasurements	**0**	
Reclassification Adjustments		
On disposal of available for sale financial assets	**0**	0
Total Comprehensive Income for the year*	**12,622**	4,880

Financial performance for the year	**2013-14 £000s**	2012-13 £000
Retained surplus/(deficit) for the year	**2,802**	4,025
Prior period adjustment to correct errors and other performance adjustments	**0**	0
IFRIC 12 adjustment (including IFRIC 12 impairments) *	**2,830**	0
Impairments (excluding IFRIC 12 impairments) **	**(5,079)**	0
Adjustments in respect of donated gov't grant asset reserve elimination ***	**277**	268
Adjustment re Absorption accounting	**0**	0
Adjusted retained surplus/(deficit)	**830**	4,293

The adjustments to financial performance identified above relate to the following:

* As a result of a change in accounting standards (UKGAAP to IFRS) NHS bodies were obliged to bring PFI schemes onto the, "Statement of Financial Position" which generally had an impact on an organisation's reported Revenue position. This adjustment identifies and removes any negative revenue impact (see note 43.1 on page 131 for more details).

** Where the Trust suffers a downward valuation in assets held (generally buildings or land) this may in certain circumstances be classified as an impairment and shown as a charge to the Trust's Revenue account. As asset valuations recover then the increase in value of assets is shown as a credit to the Revenue account to the extent of the previous impairment. The impact of impairments distorts the Trust's financial performance and are removed (see note 17 on page 110 for more details).

*** The Treasury has changed the accounting treatment for funding donated capital assets and the impact on the Revenue account is removed at this line (see note 1.13 on page 79 for more details).

The notes on pages 74 to 133 form part of this account.

Statement of Financial Position as at 31 March 2014

	NOTE	**31 March 2014 £000s**	31 March 2013 £000s
Non-current assets:			
Property, plant and equipment	15	**312,412**	302,238
Intangible assets	16	**2,084**	1,571
Investment property	18	**0**	0
Other financial assets		**0**	0
Trade and other receivables	22.1	**2,444**	2,776
Total non-current assets		**316,940**	306,585
Current assets:			
Inventories	21	**11,963**	11,973
Trade and other receivables	22.1	**29,221**	21,430
Other financial assets	24	**0**	0
Other current assets	25	**0**	0
Cash and cash equivalents	26	**7,169**	554
Total current assets		**48,353**	33,957
Non-current assets held for sale	27	**0**	0
Total current assets		**48,353**	33,957
Total assets		**365,293**	340,542
Current liabilities			
Trade and other payables	28	**(44,201)**	(32,927)
Other liabilities	29	**0**	0
Provisions	35	**(743)**	(3,140)
Borrowings	30	**(5,644)**	(4,630)
Other financial liabilities	31	**0**	0
Working capital loan from Department	30	**0**	0
Capital loan from Department	30	**(1,332)**	(1,332)
Total current liabilities		**(51,920)**	(42,029)
Net current assets/(liabilities)		**(3,567)**	(8,072)
Non-current assets plus/less net current assets/liabilities		**313,373**	298,513
Non-current liabilities			
Trade and other payables	28	**0**	0
Other liabilities	31	**0**	0

Provisions	35	**(1,797)**	(1,785)
Borrowings	31	**(244,820)**	(248,681)
Other financial liabilities	30	**0**	0
Working capital loan from Department	30	**0**	0
Capital loan from Department	30	**(2,674)**	(4,006)
Total non-current liabilities		**(249,291)**	(254,472)
Total Assets Employed:		**64,082**	44,041

FINANCED BY: TAXPAYERS' EQUITY

Public Dividend Capital	**50,217**	42,798
Retained earnings	**(40,423)**	(43,312)
Revaluation reserve	**54,288**	44,555
Other reserves	**0**	0
Total Taxpayers' Equity:	**64,082**	44,041

The notes on pages 74 to 133 form part of this account.

The financial statements on pages 66 to 73 were approved by the Audit Committee, with delegated authority from the Board, on 5th June, 2014 and signed on its behalf by

Chief Executive: 

Date: **05 June 2014**

Statement of Changes in Taxpayers' Equity For the year ended 31 March 2014

	Public Dividend Capital £000s	Retained earnings	Revaluation reserve £000s	Other reserves £000s	Total reserves £000s
Balance at 1 April 2013	**42,798**	**(43,312)**	**44,555**	**0**	**44,041**
Changes in taxpayers' equity for 2013-14					
Retained surplus/(deficit) for the year		2,802			**2,802**
Net gain / (loss) on revaluation of property, plant, equipment			14,899		**14,899**
Net gain / (loss) on revaluation of intangible assets			0		**0**
Net gain / (loss) on revaluation of financial assets			0		**0**
Net gain / (loss) on revaluation of available for sale financial assets			0		**0**
Impairments and reversals			(5,079)		**(5,079)**
Other gains/(loss) (provide details below)				0	**0**
Transfers between reserves		87	(87)	0	**0**
Transfers under Modified Absorption Accounting - PCTs & SHAs		0			**0**
Transfers under Modified Absorption Accounting - Other Bodies		0			**0**
Reclassification Adjustments					
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	0	**0**
Transfers between Revaluation Reserve & Retained Earnings in respect of assets transferred under absorption		0	0		**0**
On Disposal of Available for Sale financial Assets			0		**0**
Reserves eliminated on dissolution	0	0	0	0	**0**
Originating capital for Trust established in year	0				**0**
New PDC Received - Cash	13,619				**13,619**
New PDC Received/(Repaid) - PCTs and SHAs Legacy items paid for by Department of Health	0				**0**
PDC Repaid In Year	(6,200)				**(6,200)**
PDC Written Off	0				**0**
Transferred to NHS Foundation Trust	0	0	0	0	**0**
Other Movements	0	0	0	0	**0**
Net Actuarial Gain/(Loss) on Pension				0	**0**
Other Pensions Remeasurement				0	**0**
Net recognised revenue/(expense) for the year	**7,419**	**2,889**	**9,733**	**0**	**20,041**

Transfers between reserves in respect of modified absorption - PCTs & SHAs		0	0	0	**0**
Transfers between reserves in respect of modified absorption - Other Bodies		0	0	0	**0**
Balance at 31 March 2014	**50,217**	**(40,423)**	**54,288**	**0**	**64,082**
Balance at 1 April 2012	**42,298**	**(48,015)**	**44,378**	**0**	**38,661**
Changes in taxpayers' equity for the year ended 31 March 2013					
Retained surplus/(deficit) for the year		4,025			4,025
Net gain / (loss) on revaluation of property, plant, equipment			855		855
Net gain / (loss) on revaluation of intangible assets			0		0
Net gain / (loss) on revaluation of financial assets			0		0
Net gain / (loss) on revaluation of assets held for sale			0		0
Impairments and reversals			0		0
Movements in other reserves				0	0
Transfers between reserves		678	(678)	0	0
Release of reserves to Statement of Comprehensive Income			0		0
Reclassification Adjustments					
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	0	0
Transfers between Revaluation Reserve & Retained Earnings Reserve in respect of assets transferred under absorption		0	0		0
On Disposal of Available for Sale financial Assets			0		0
Reserves eliminated on dissolution	0	0	0	0	0
Originating capital for Trust established in year	0				0
New PDC Received	10,500				10,500
PDC Repaid In Year	(10,000)				(10,000)
PDC Written Off	0				0
Transferred to NHS Foundation Trust	0	0	0	0	0
Other Movements in PDC In Year	0				0
Net Actuarial Gain/(Loss) on Pension				0	0
Net recognised revenue/(expense) for the year	**500**	**4,703**	**177**	**0**	**5,380**
Balance at 31 March 2013	**42,798**	**(43,312)**	**44,555**	**0**	**44,041**

Statement of cash flows for the year ended 31 March 2014

	NOTE	**2013-14 £000s**	2012-13 £000s
Cash Flows from Operating Activities			
Operating Surplus/(Deficit)		**20,369**	18,306
Depreciation and Amortisation		**15,830**	16,549
Impairments and Reversals		**(5,079)**	0
Other Gains/(Losses) on foreign exchange		**0**	0
Donated Assets received credited to revenue but non-cash		**(875)**	(504)
Government Granted Assets received credited to revenue but non-cash		**0**	0
Interest Paid		**(16,397)**	(16,331)
Dividend (Paid)/Refunded		**(987)**	(1,265)
Release of PFI/deferred credit		**0**	0
(Increase)/Decrease in Inventories		**10**	(558)
(Increase)/Decrease in Trade and Other Receivables		**(7,460)**	(2,836)
(Increase)/Decrease in Other Current Assets		**0**	0
Increase/(Decrease) in Trade and Other Payables		**10,224**	(9,217)
(Increase)/Decrease in Other Current Liabilities		**0**	0
Provisions Utilised		**(2,432)**	(1,117)
Increase/(Decrease) in Provisions		**(100)**	2,941
Net Cash Inflow/(Outflow) from Operating Activities		**13,103**	5,968
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest Received		**53**	40
(Payments) for Property, Plant and Equipment		**(6,625)**	(7,663)
(Payments) for Intangible Assets		**(942)**	(1,194)
(Payments) for Investments with DH		**0**	0
(Payments) for Other Financial Assets		**0**	0
(Payments) for Financial Assets (LIFT)		**0**	0
Proceeds of disposal of assets held for sale (PPE)		**14**	9,979
Proceeds of disposal of assets held for sale (Intangible)		**0**	0
Proceeds from Disposal of Investment with DH		**0**	0
Proceeds from Disposal of Other Financial Assets		**0**	0

Proceeds from the disposal of Financial Assets (LIFT)	**0**	0
Loans Made in Respect of LIFT	**0**	0
Loans Repaid in Respect of LIFT	**0**	0
Rental Revenue	**0**	0
Net Cash Inflow/(Outflow) from Investing Activities	**(7,500)**	1,162
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**5,603**	7,130
CASH FLOWS FROM FINANCING ACTIVITIES		
Public Dividend Capital Received	**13,619**	10,500
Public Dividend Capital Repaid	**(6,200)**	(10,000)
Loans received from DH - New Capital Investment Loans	**0**	0
Loans received from DH - New Revenue Support Loans	**0**	0
Other Loans Received	**0**	0
Loans repaid to DH - Capital Investment Loans Repayment of Principal	**(1,332)**	(1,332)
Loans repaid to DH - Revenue Support Loans	**0**	0
Other Loans Repaid	**0**	0
Cash transferred to NHS Foundation Trusts	**0**	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(5,075)**	(6,607)
Capital grants and other capital receipts (excluding donated / government granted cash receipts)	**0**	504
Net Cash Inflow/(Outflow) from Financing Activities	**1,012**	(6,935)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	**6,615**	195
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**554**	359
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies	**0**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end	**7,169**	554

Notes to the accounts

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the NHS Trusts Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2013-14 NHS Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual 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 NHS Trusts Manual for Accounts permits a choice of accounting policy, the accounting policy which 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 by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.2 Acquisitions and discontinued operations

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

1.3 Movement of assets within the DH Group

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

Other transfers of assets and liabilities within the Group are accounted for in line with IAS20 and similarly give rise to income and expenditure entries.

For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, Treasury has agreed that a modified absorption approach should be applied. For these transactions only, gains and losses are recognised in reserves rather than the SOCNE/ SOCNI."

1.4 Charitable Funds

For 2013-14, the divergence from the FReM that NHS Charitable Funds are not consolidated with NHS Trust's own returns is removed. However, the Trust has determined that consolidation is not beneficial to the users of the accounts, as detailed in Note 1.32 - Subsidiaries.

1.5 Pooled Budgets

The Trust has no pooled budgets.

1.6 Critical accounting judgements and key sources of estimation uncertainty

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

1.6.1 Critical judgements in applying accounting policies

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

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

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

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

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

Land & Property Valuation. The Trust is required to show its land and property at fair value in its statement of financial position (see notes 1.10 and 1.12).

Impairment of Assets. At each balance sheet 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.

1.6.2 Key sources of estimation uncertainty

There are no key assumptions concerning the future, or other key sources of estimation uncertainty, at the statement of financial position date that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

1.7 Revenue

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

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

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

Interest revenue is accrued on a time basis, by reference to the principal outstanding and interest rate applicable.

The Trust sells some goods, such as drugs, to other NHS Trusts and outside bodies. Revenue is recognised on delivery of the goods to the customer.

1.8 Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, except for bonuses earned but not yet awarded.

The cost of leave 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.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions 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 not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the Trust of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.9 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.10 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- 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 a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

Valuation

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

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

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

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The Trust now uses the GDP deflator to calculate indexation on equipment assets with a life of more than 5 years (medium and long term assets) and values short term assets (with a life of less than 5 years) at historic cost.

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

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.11 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

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

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

Measurement

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

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.12 Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

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

At each reporting period end, 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 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.

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

"Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.

AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments

do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval."

1.13 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.14 Government grants

The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.15 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.16 Leases

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

The trust as lessee

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

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

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

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

The Trust as lessor

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 so as to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the 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 on a straight-line basis over the lease term.

1.17 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) for the fair value of services received;

b) Payment for the PFI asset, including finance costs; and

c) Payment for the replacement of components of the asset during the contract ('lifecycle replacement)'.

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised when the operator invoices for them (approximately one quarter in arrears) and are measured initially at their fair value.

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 finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the Trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Other assets contributed by the Trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.18 Inventories

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

1.19 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.

1.20 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates of 1.8% for pensions and -1.9% (short term), -0.65% (medium term) and +2.2% (long term) for inujury benefits.

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

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.21 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at note 35.

1.22 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 the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.23 Carbon Reduction Commitment Scheme (CRC)

CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the Trust makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.24 Contingencies

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

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

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

1.25 Financial assets

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

Financial assets are initially recognised at fair value.

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

Financial assets at fair value through profit and loss

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

Held to maturity investments

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

Available for sale financial assets

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

Loans and receivables

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

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.26 Financial liabilities

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

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

Financial guarantee contract liabilities

Financial guarantee contract liabilities are subsequently measured at the higher of:

The premium received (or imputed) for entering into the guarantee less cumulative amortisation.

The amount of the obligation under the contract, as determined in accordance with IAS 37 *Provisions, Contingent Liabilities and Contingent Assets;* and

Financial liabilities at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Trust's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.27 Value Added Tax

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

1.28 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign

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

1.29 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. Details of third party assets are given in Note 44 to the accounts.

1.30 Public Dividend Capital (PDC) and PDC dividend

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

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets, net assets transferred from NHS bodies dissolved on 1 April 2013 and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

1.31 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 NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.32 Subsidiaries

Material entities over which the Trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows 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 NHS Trust General Charitable Fund', 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. Details of the transactions with the charity are included in the related parties note (Note 41).

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.

1.33 Associates

Material entities over which the Trust has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the Trust's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the Trust's share of the entity's profit/loss

and other gains/losses. It is also reduced when any distribution is received by the Trust from the entity.

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

1.34 Joint ventures

Material entities over which the Trust has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures.

The Trust is not part of any joint ventures.

1.35 Joint operations

Joint operations are activities undertaken by the Trust in conjunction with one or more other parties but which are not performed through a separate entity. The Trust records its share of the income and expenditure; gains and losses; assets and liabilities; and cashflows.

1.36 Research and Development

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

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

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2013-14. The application of the Standards as revised would not have a material impact on the accounts for 2013-14, were they applied in that year:

IAS 27 Separate Financial Statements - subject to consultation

IAS 28 Investments in Associates and Joint Ventures - subject to consultation

IFRS 9 Financial Instruments - subject to consultation - subject to consultation

IFRS 10 Consolidated Financial Statements - subject to consultation

IFRS 11 Joint Arrangements - subject to consultation

IFRS 12 Disclosure of Interests in Other Entities - subject to consultation

IFRS 13 Fair Value Measurement - subject to consultation

IPSAS 32 - Service Concession Arrangement - subject to consultation"

2. Pooled Budgets

The Trust does not have any pooled budget arrangements.

3. 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 (£436.5m 96.6%) is derived from 'non-trading' healthcare. Of the total income, 3.4% (£15.2m) 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	
	2013-14	2012-13	**2013-14**	2012-13	**2013-14**	2012-13
Income	**£000s**	£000s	**£000s**	£000s	**£000s**	£000s
External	**455,459**	436,685	**13,635**	15,221	**469,094**	451,906
Internal	**0**	0	**38,685**	36,780	**38,685**	36,780
Total Income	**455,459**	436,685	**52,320**	52,001	**507,779**	488,686
Surplus/(Deficit)						
Segment Costs	**414,822**	396,730	**51,226**	51,151	**466,048**	447,881
Common Costs	**38,685**	36,780	**244**	242	**38,929**	37,022
Surplus/(deficit) before interest	**1,952**	3,175	**850**	608	**2,802**	3,783

4. Income generation activities

The main Trust income generation activities relate to Pharmacy Trading and drug manufacturing where the Trust purchases in bulk, manufactures and sells drugs, mainly to other NHS Organisations.

Pharmacy Trading has been shown as a separate operating segment at Note 3.

5. Revenue from patient care activities

	2013-14	2012-13
	£000s	£000s
		£000s
NHS Trusts	**81**	0
NHS England	**94,144**	0
Clinical Commissioning Groups	**316,703**	0
Primary Care Trusts		384,109
Strategic Health Authorities		0
NHS Foundation Trusts	**250**	0
Department of Health	**0**	0
NHS Other (including Public Health England and NHS Property)	**0**	392
Non-NHS:		
Local Authorities	**0**	0
Private patients	**2,344**	1,776
Overseas patients (non-reciprocal)	**133**	145
Injury costs recovery	**1,506**	1,313
Other	**730**	2,140
Total Revenue from patient care activities	**415,891**	389,875

6. Other operating revenue

	2013-14 £000s	2012-13 £000s
Recoveries in respect of employee benefits	**0**	0
Patient transport services	**0**	0
Education, training and research	**16,833**	17,157
Charitable and other contributions to revenue expenditure - NHS	**0**	0
Charitable and other contributions to revenue expenditure -non- NHS	**204**	136
Receipt of donations for capital acquisitions - NHS Charity	**875**	504
Receipt of Government grants for capital acquisitions	**0**	0
Non-patient care services to other bodies	**14,252**	17,084
Income generation	**17,333**	18,070
Rental revenue from finance leases	**0**	0
Rental revenue from operating leases	**1,712**	564
Other revenue	**1,994**	8,516
Total Other Operating Revenue	**53,203**	62,031
Total operating revenue	**469,094**	451,906

7. Revenue

	2013-14 £000s	2012-13 £000s
From rendering of services	**468,173**	451,179
From sale of goods	**921**	727
	469,094	451,906

8. Operating expenses

	2013-14 £000s	2012-13 £000s
Services from other NHS Trusts	**4,752**	6,822
Services from CCGs/NHS England	**42**	
Services from other NHS bodies	**11**	12
Services from NHS Foundation Trusts	**5,955**	2,701
Services from Primary Care Trusts		3,127
Total Services from NHS bodies*	**10,760**	12,662
Purchase of healthcare from non-NHS bodies	**7,476**	5,562
Trust Chair and Non-executive Directors	**50**	55
Supplies and services - clinical	**97,763**	90,085
Supplies and services - general	**16,696**	15,820
Consultancy services	**2,381**	1,765
Establishment	**3,909**	4,046
Transport	**5,387**	5,146
Premises	**25,102**	18,463
Hospitality	**97**	
Insurance	**401**	
Legal Fees	**404**	
Impairments and Reversals of Receivables	**232**	136
Inventories write down	**67**	70
Depreciation	**15,401**	16,326
Amortisation	**429**	223
Impairments and reversals of property, plant and equipment	**(5,079)**	0
Impairments and reversals of intangible assets	**0**	0
Impairments and reversals of financial assets	**0**	0
Impairments and reversals of non current assets held for sale	**0**	0
Impairments and reversals of investment properties		0
Audit fees	**144**	171
Other auditor's remuneration	**0**	0
Clinical negligence	**9,328**	8,308
Research and development (excluding staff costs)	**0**	0
Education and Training	**1,394**	1,271
Change in Discount Rate	**(118)**	413
Other **	**2,305**	2,040
Total Operating expenses (excluding employee benefits)	**194,529**	182,562

* Services from NHS bodies does not include expenditure which falls into a category below

** Includes £764k for NHS SBS Ltd for financial services (£752k 2012/13)

Employee Benefits		
Employee benefits excluding Board members	**253,017**	249,681
Board members	**1,179**	1,357
Total Employee Benefits	**254,196**	251,038
Total Operating Expenses	**448,725**	433,600

9 Operating Leases

Operating leases mostly relate to property and the most significant are:

- Railway Triangle lease - used for Pharmacy Manufacture, the lease period is for 30 years (expires 2036) and has an annual lease value of £98,000.
- Solent Industrial Estate - used for Pharmacy and Procurement, the lease period is for 15 years (expires 2020) and has an annual value of £147,000.
- 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 £841,000.

9.1 The Trust as lessee

	Land £000s	Buildings £000s	Other £000s	**2013-14 Total £000s**	2012-13 £000s
Payments recognised as an expense					
Minimum lease payments				**1,722**	1,649
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**1,722**	1,649
Payable:					
No later than one year	491	734	306	**1,531**	1,510
Between one and five years	1,521	2,273	509	**4,303**	4,287
After five years	140	1,998	0	**2,138**	2,903
Total	**2,152**	**5,005**	**815**	**7,972**	**8,700**
Total future sublease payments expected to be received:				**572**	2,184

9.2 The Trust as lessor

This mainly relates to the sub-leases of the Rehab Building to Solent NHS Trust and Southern Health NHS Foundation Trust, the Quad Building to University Hospitals Southampton NHS Foundation Trust, the Gym Building to NHS Property Services Ltd and the PET Scanner to InHealth.

	2013-14 £000	2012-13 £000
Recognised as revenue		
Rental revenue	**1,712**	564
Contingent rents	**0**	0
Total	**1,712**	564
Receivable:		
No later than one year	**1,637**	453
Between one and five years	**2,061**	1,333
After five years	**932**	424
Total	**4,630**	2,210

10 Employee benefits and staff numbers

10.1 Employee benefits

		2013-14	
	Total £000s	Permanently employed £000s	Other £000s
Employee Benefits - Gross Expenditure			
Salaries and wages	**215,268**	196,653	18,615
Social security costs	**15,140**	15,140	0
Employer Contributions to NHS BSA - Pensions Division	**23,973**	23,973	0
Other pension costs	**0**	0	0
Termination benefits	**0**	0	0
Total employee benefits	**254,381**	235,766	18,615
Employee costs capitalised	**185**	185	0
Gross Employee Benefits excluding capitalised costs	**254,196**	235,581	18,615

Employee Benefits - Gross Expenditure 2012-13	Total £000s	Permanently employed £000s	Other £000s
Salaries and wages	211,045	192,099	18,946
Social security costs	15,295	15,295	0
Employer Contributions to NHS BSA - Pensions Division	22,378	22,378	0
Other pension costs	0	0	0
Termination benefits	2,403	2,403	0
TOTAL - including capitalised costs	251,121	232,175	18,946
Employee costs capitalised	83	83	0
Gross Employee Benefits excluding capitalised costs	251,038	232,092	18,946

In 2012-13 there were rows for 'other post-employment benefits' and 'other employment benefits'. These are now included within the 'Salaries and wages' row.

10.2 Staff Numbers

	2013-14 Total Number	Permanently employed Number	Other Number	2012-13 Total Number
Average Staff Numbers				
Medical and dental	**877**	777	100	841
Ambulance staff	**0**	0	0	0
Administration and estates	**1,045**	990	55	1,049
Healthcare assistants and other support staff	**12**	11	1	19
Nursing, midwifery and health visiting staff	**2,931**	2,658	273	2,869
Nursing, midwifery and health visiting learners	**0**	0	0	0
Scientific, therapeutic and technical staff	**1,176**	1,127	49	1,211

Social Care Staff	**0**	**0**	0	0
Other	**0**	**0**	0	0
TOTAL	**6,041**	**5,563**	478	5,989
Of the above - staff engaged on capital projects	**12**	7	5	3

10.3 Staff Sickness absence and ill health retirements

	2013-14 Number	2012-13 Number
Total Days Lost	**41,554**	43,865
Total Staff Years	**5,327**	5,483
Average working Days Lost	**7.80**	8.00

These figures are calendar year figures.

	2013-14 Number	2012-13 Number
Number of persons retired early on ill health grounds	**3**	10

	£000s	£000s
Total additional pensions liabilities accrued in the year	**133**	556

10.4 Exit Packages agreed in 2013-14

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of oth departures agre
	Number	£	Number
Less than £10,000	**0**	**0**	
£10,000-£25,000	**6**	**116,552**	
£25,001-£50,000	**6**	**235,612**	
£50,001-£100,000	**10**	**688,505**	
£100,001 - £150,000	**6**	**687,314**	
£150,001 - £200,000	**2**	**361,106**	
>£200,000	**0**	**0**	
Total number of exit packages by type (total cost	**30**	**2,089,090**	

* Agrees to Note 10.5

** Exit Packages were not analysed in the same way in 2012-13 so the 2012-13 comparative note does not agree with note 10.5 below. In included. Had all 'other' departures been shown, this would have reported 19 'other' departures at a cost of £209k in 2012-13, as analysed in note 10.5.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pensions Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

10.5 Exit packages - Other Departures analysis

	2013-14**		2012-13	
	Agreements	**Total value of agreements**	Agreements	Total value of agreements
	Number	**£000s**	Number	£000s
Voluntary redundancies including early retirement contractual costs	**0**	**0**	0	0
Mutually agreed resignations (MARS) contractual costs	**0**	**0**	1	19
Early retirements in the efficiency of the service contractual costs	**0**	**0**	0	0
Contractual payments in lieu of notice	**15**	**52**	18	190
Exit payments following Employment Tribunals or court orders	**1**	**33**	0	0
Non-contractual payments requiring HMT approval*	**2**	**16**	0	0
Total	**18**	**101**	19	209

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period

As a single exit packages can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 10.4 which will be the number of individuals.

* includes any non-contractual severance payment made following judicial mediation, and 0 relating to non-contractual payments in lieu of notice.

** See Note 10.4, sub note ** for explanantion of 2012-13 difference to Note 10.4

No non-contractual payments were made to individuals where the payment value was more than 12 months' of their annual salary.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report.

2013-14				2012-13		
ner eed	**Cost of other departures agreed**	**Total number of exit packages**	**Total cost of exit packages**	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	£	**Number**	**£**	Number	Number	Number
16	**51,841**	**16**	**51,841**	0	0	0
1	**15,880**	**7**	**132,432**	0	1	1
1	**33,389**	**7**	**269,001**	0	0	0
0	**0**	**10**	**688,505**	1	0	1
0	**0**	**6**	**687,314**	0	0	0
0	**0**	**2**	**361,106**	0	1	1
0	**0**	**0**	**0**	0	0	0
18	**101,110 ***	**48**	**2,190,200**	1	2	3
			**	£85,998	£187,044	£273,042

2012-13 only 'other' departures relating to those officers identified on the Senior Managers Remuneration Report in the Annual Report were

10.6 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the 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 the scheme liability is carried out annually by the scheme actuary 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 are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2014, is based on valuation data as 31 March 2013, updated to 31 March 2014 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. 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 scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

11 Better Payment Practice Code

11.1 Measure of compliance

	2013-14 Number	**2013-14 £000s**	2012-13 Number	2012-13 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**87,402**	**210,944**	82,415	201,136
Total Non-NHS Trade Invoices Paid Within Target	**81,090**	**196,441**	78,251	187,975
Percentage of NHS Trade Invoices Paid Within Target	**92.78%**	**93.12%**	94.95%	93.46%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,088**	**35,436**	2,243	31,201
Total NHS Trade Invoices Paid Within Target	**1,583**	**25,531**	1,864	27,208
Percentage of NHS Trade Invoices Paid Within Target	**75.81%**	**72.05%**	83.10%	87.20%

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

11.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2013-14 £000s	2012-13 £000s
Amounts included in finance costs from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**0**	0

12 Investment Revenue

	2013-14 £000s	2012-13 £000s
Rental revenue		
PFI finance lease revenue (planned)	**0**	0
PFI finance lease revenue (contingent)	**0**	0
Other finance lease revenue	**0**	0
Subtotal	**0**	0
Interest revenue		
LIFT: equity dividends receivable	**0**	0
LIFT: loan interest receivable	**0**	0
Bank interest	**53**	40
Other loans and receivables	**0**	0
Impaired financial assets	**0**	0
Other financial assets	**0**	0
Subtotal	**53**	40
Total investment revenue	**53**	40

13 Other Gains and Losses

	2013-14 £000s	2012-13 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**(96)**	(108)
Gain/(Loss) on disposal of assets other than by sale (intangibles)	**0**	0
Gain/(Loss) on disposal of Financial Assets other then held for sale	**0**	0
Gain (Loss) on disposal of assets held for sale	**0**	3,450
Gain/(loss) on foreign exchange	**0**	0
Change in fair value of financial assets carried at fair value through the SoCI	**0**	0
Change in fair value of financial liabilities carried at fair value through the SoCI	**0**	0
Change in fair value of investment property	**0**	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	**0**	0
Total	**(96)**	3,342

14 Finance Costs

	2013-14 £000s	2012-13 £000s
Interest		
Interest on loans and overdrafts	**123**	156
Interest on obligations under finance leases	**4**	19
Interest on obligations under PFI contracts:		
- main finance cost	**13,233**	13,540
- contingent finance cost	**3,037**	2,615
Interest on obligations under LIFT contracts:		
- main finance cost	**0**	0
- contingent finance cost	**0**	0
Interest on late payment of commercial debt	**0**	0
Total interest expense	**16,397**	16,330
Other finance costs	**0**	1
Provisions - unwinding of discount	**147**	112
Total	**16,544**	16,443

15.1 Property, plant and equipment

2013-14	Land	Buildings excluding dwellings
	£000's	£000's
Cost or valuation:		
At 1 April 2013	**23,865**	**239,683**
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	0
Transfers under Modified Absorption Accounting - Other Bodies	0	0
Additions of Assets Under Construction		
Additions Purchased	0	2,634
Additions Donated	0	0
Additions Government Granted	0	0
Additions Leased	0	0
Reclassifications	0	0
Reclassifications as Held for Sale and reversals	0	0
Disposals other than for sale	0	0
Upward revaluation/positive indexation	0	14,898
Impairments/negative indexation	0	(5,079)
Reversal of Impairments	0	0
Transfers to NHS Foundation Trust	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0
At 31 March 2014	**23,865**	**252,136**
Depreciation		
At 1 April 2013	**0**	**0**
Reclassifications	0	0
Reclassifications as Held for Sale and reversals	0	0
Disposals other than for sale	0	0
Upward revaluation/positive indexation	0	809
Impairments	0	0
Reversal of Impairments	0	(5,079)
Charged During the Year	0	6,653
Transfers to NHS Foundation Trust	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0
At 31 March 2014	**0**	**2,383**
Net Book Value at 31 March 2014	**23,865**	**249,753**
Asset financing:		
Owned - Purchased	23,865	80,544
Owned - Donated	0	3,396
Owned - Government Granted	0	0
Held on finance lease	0	0
On-SOFP PFI contracts	0	165,813
PFI residual: interests	0	0
Total at 31 March 2014	**23,865**	**249,753**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings
	£000's	£000's
At 1 April 2013	16,041	21,354
Movements (specify)	305	8,706
At 31 March 2014	**16,346**	**30,060**

Additions to Assets Under Construction in 2013/14
There were no additions to assets under construction in 2013/14.

Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
£000's	£000's	£000's	£000's	£000's	£000's	**£000's**
2,695	**0**	**70,327**	**128**	**16,909**	**3,032**	**356,639**
0	0	0	0	0	0	**0**
0	0	0	0	0	0	**0**
	0					**0**
1		4,920	0	2,357	0	**9,912**
0	0	875	0	0	0	**875**
0	0	0	0	0	0	**0**
0		0	0	0	0	**0**
0	0	0	0	0	0	**0**
0	0	0	0	0	0	**0**
0	0	(990)	(6)	(1,064)	0	**(2,060)**
169	0	1,264	2	0	70	**16,403**
0	0	0	0	0	0	**(5,079)**
0	0	0	0	0	0	**0**
0	0	0	0	0	0	**0**
0	0	0	0	0	0	**0**
2,865	**0**	**76,396**	**124**	**18,202**	**3,102**	**376,690**
0	**0**	**42,218**	**124**	**11,299**	**760**	**54,401**
0		0	0	0	0	**0**
0		0	0	0	0	**0**
0		(879)	(6)	(1,064)	0	**(1,949)**
13		663	2	0	17	**1,504**
0	0	0	0	0	0	**0**
0	0	0	0	0	0	**(5,079)**
100		6,148	1	2,277	222	**15,401**
0	0	0	0	0	0	**0**
0		0	0	0	0	**0**
113	**0**	**48,150**	**121**	**12,512**	**999**	**64,278**
2,752	**0**	**28,246**	**3**	**5,690**	**2,103**	**312,412**
2,752	0	23,961	3	5,649	2,103	**138,877**
0	0	2,465	0	41	0	**5,902**
0	0	0	0	0	0	**0**
0	0	1,820	0	0	0	**1,820**
0	0	0	0	0	0	**165,813**
0	0	0	0	0	0	**0**
2,752	**0**	**28,246**	**3**	**5,690**	**2,103**	**312,412**

Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	**Total**
£000's	£000's	£000's	£000's	£000's	£000's	**£000's**
1,977	0	4,943	11	16	213	**44,555**
156	0	514	0	0	52	**9,733**
2,133	**0**	**5,457**	**11**	**16**	**265**	**54,288**

15.2 Property, plant and equipment prior-year

2012-13	Land	Buildings excluding dwellings
	£000s	£000s
Cost or valuation:		
At 1 April 2012	23,865	243,199
Additions - Assets Under Construction		
Additions - purchased	0	3,317
Additions - donated	0	0
Additions - government granted	0	0
Reclassifications	0	0
Reclassifications as Held for Sale and reversals	0	0
Disposals other than by sale	0	0
Revaluation & indexation gains	0	0
Impairments	0	0
Reversals of impairments	0	0
Transfer to NHS Foundation Trust	0	0
Transfers (to)/from Other Public Sector Bodies under absorption accounting	0	0
At 31 March 2013	**23,865**	**246,516**
Depreciation		
At 1 April 2012	0	0
Reclassifications	0	0
Reclassifications as Held for Sale and reversals	0	0
Disposals other than for sale	0	0
Upward revaluation/positive indexation	0	0
Impairments	0	0
Reversal of Impairments	0	0
Charged During the Year	0	6,833
Transfer to NHS Foundation Trust	0	0
Transfers (to)/from Other Public Sector Bodies under absorption accounting	0	0
At 31 March 2013	0	6,833
Net book value at 31 March 2013	**23,865**	**239,683**
Purchased	23,865	236,353
Donated	0	3,330
Government Granted	0	0
Total at 31 March 2013	**23,865**	**239,683**
Asset financing:		
Owned	23,865	80,140
Held on finance lease	0	0
On-SOFP PFI contracts	0	159,543
PFI residual: interests	0	0
Total at 31 March 2013	**23,865**	**239,683**

Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
£000s	£000s	£000s	£000s	£000s	£000s	£000s
2,260	0	69,783	170	17,740	2,952	359,969
	0					0
553		2,546	0	1,261	0	7,677
0	0	481	0	0	0	481
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	(4,144)	(46)	(2,092)	0	(6,282)
0	0	1,661	4	0	80	1,745
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
2,813	**0**	**70,327**	**128**	**16,909**	**3,032**	**363,590**
0	0	38,757	165	10,681	529	50,132
0		0	0	0	0	0
0		0	0	0	0	0
0		(3,858)	(46)	(2,092)	0	(5,996)
0		872	4	0	14	890
0	0	0	0	0	0	0
0	0	0	0	0	0	0
118		6,447	1	2,710	217	16,326
0		0	0	0	0	0
0	0	0	0	0	0	0
118	0	42,218	124	11,299	760	61,352
2,695	**0**	**28,109**	**4**	**5,610**	**2,272**	**302,238**
2,695	0	25,572	4	5,541	2,272	296,302
0	0	2,537	0	69	0	5,936
0	0	0	0	0	0	0
2,695	**0**	**28,109**	**4**	**5,610**	**2,272**	**302,238**
2,695	0	27,950	4	5,610	2,272	142,536
0	0	159	0	0	0	159
0	0	0	0	0	0	159,543
0	0	0	0	0	0	0
2,695	**0**	**28,109**	**4**	**5,610**	**2,272**	**302,238**

15.3 Property, plant and equipment

The donated assets were received from the Portsmouth Hospitals NHS Trust Charity.

All land and buildings have been restated to modern equivalent asset value based on a valuation carried out in April 2009 by the District Valuer from the Revenue and Customs Government Department and then updated to current market value at the end of each financial year.

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 following asset lives:

- Software and Licences: 3 to 5 years
- Information Technology: 5 years
- Plant & Machinery: between 5 and 15 years
- Transport Equipment: 7 years
- Buildings excluding Dwellings: between 1 and 44 years
- Dwellings: between 4 and 33 years
- Furniture and Fittings: 15 years

Gross carrying amount of fully depreciated assets still in use is £22,947,745


Breast Cancer

16.1 Intangible non-current assets

2013-14	IT - in-house & 3rd party software	Computer Licenses
	£000's	£000's
At 1 April 2013	**0**	**4,197**
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	0
Transfers under Modified Absorption Accounting - Other Bodies	0	0
Additions - purchased	0	942
Additions - internally generated	0	0
Additions - donated	0	0
Additions - government granted	0	0
Additions - leased	0	0
Reclassifications	0	0
Reclassified as Held for Sale and Reversals	0	0
Disposals other than by sale	0	(14)
Revaluation & indexation gains	0	0
Impairments charged to reserves	0	0
Reversal of impairments charged to reserves	0	0
Transfer to NHS Foundation Trust	0	0
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0
At 31 March 2014	**0**	**5,125**
Amortisation		
At 1 April 2013	**0**	**2,626**
Reclassifications	0	0
Reclassified as Held for Sale and Reversals	0	0
Disposals other than by sale	0	(14)
Revaluation or indexation gains	0	0
Impairments charged to operating expenses	0	0
Reversal of impairments charged to operating expenses	0	0
Charged during the year	0	429
Transfer to NHS Foundation Trust	0	0
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0
At 31 March 2014	**0**	**3,041**
Net Book Value at 31 March 2014	**0**	**2,084**
Asset Financing: Net book value at 31 March 2014 comprises:		
Purchased	0	2,064
Donated	0	20
Government Granted	0	0
Finance Leased	0	0
On-balance Sheet PFIs	0	0
Total at 31 March 2014	**0**	**2,084**

Revaluation reserve balance for intangible non-current assets

	£000's	£000's
At 1 April 2013	0	0
Movements (specify)	0	0
At 31 March 2014	**0**	**0**

Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Total
£000's	£000's	£000's	£000's
0	**0**	**0**	**4,197**
0	0	0	0
0	0	0	0
0	0	0	942
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	(14)
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	**0**	**0**	**5,125**
0	**0**	**0**	**2,626**
0	0	0	0
0	0	0	0
0	0	0	(14)
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	429
0	0	0	0
0	0	0	0
0	**0**	**0**	**3,041**
0	**0**	**0**	**2,084**
0	0	0	2,064
0	0	0	20
0	0	0	0
0	0	0	0
0	0	0	0
0	**0**	**0**	**2,084**

£000's	£000's	£000's	£000's
0	0	0	0
0	0	0	0
0	**0**	**0**	**0**

16.2 Intangible non-current assets prior year

2012-13	IT - in-house & 3rd party software	Computer Licenses
	£000s	£000s
Cost or valuation:		
At 1 April 2012	0	3,160
Additions - purchased	0	1,171
Additions - internally generated	0	23
Additions - donated	0	0
Additions - government granted	0	0
Reclassifications	0	0
Reclassified as held for sale	0	0
Disposals other than by sale	0	(157)
Revaluation & indexation gains	0	0
Impairments	0	0
Reversal of impairments	0	0
Transfer to NHS Foundation Trust	0	0
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0
At 31 March 2013	**0**	**4,197**
Amortisation		
At 1 April 2012	0	2,560
Reclassifications	0	0
Reclassified as held for sale	0	0
Disposals other than by sale	0	(157)
Revaluation or indexation gains	0	0
Impairments charged to operating expenses	0	0
Reversal of impairments charged to operating expenses	0	0
Charged during the year	0	223
Transfer to NHS Foundation Trust	0	0
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0
At 31 March 2013	**0**	**2,626**
Net book value at 31 March 2013	0	1,571
Net book value at 31 March 2013 comprises:		
Purchased	0	1,534
Donated	0	37
Government Granted	0	0
Total at 31 March 2013	**0**	**1,571**

Licenses and Trademarks £000s	Patents £000s	Development Expenditure - Internally Generated £000s	Total £000s
0	0	0	3,160
0	0	0	1,171
0	0	0	23
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	(157)
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	**0**	**0**	**4,197**
0	0	0	2,560
0	0	0	0
0	0	0	0
0	0	0	(157)
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	223
0	0	0	0
0	0	0	0
0	**0**	**0**	**2,626**
0	0	0	1,571
0	0	0	1,534
0	0	0	37
0	0	0	0
0	**0**	**0**	**1,571**

16.3 Intangible non-current assets

Intangible assets are not revalued and are amortised over 3-5 years.

There are currently no internally generated intangible assets.

None of the intangible assets have been assessed as having indefinite useful lives.

There are a number of fully amortised licenses still in use.

17 Analysis of impairments and reversals recognised in 2013-14

	2013-14 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price *	(5,079)
Total charged to Annually Managed Expenditure	**(5,079)**
Total Impairments of Property, Plant and Equipment changed to SoCI	**(5,079)**
Intangible assets impairments and reversals charged to SoCI	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	**0**
Total Impairments of Intangibles charged to SoCI	**0**
Financial Assets charged to SoCI	
Loss or damage resulting from normal operations	0
Total charged to Departmental Expenditure Limit	**0**
Loss as a result of catastrophe	0
Other	0
Total charged to Annually Managed Expenditure	**0**

Total Impairments of Financial Assets charged to SoCI	**0**
Non-current assets held for sale - impairments and reversals charged to SoCI.	
Loss or damage resulting from normal operations	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	**0**
Total impairments of non-current assets held for sale charged to SoCI	**0**
Total Impairments charged to SoCI - DEL	**0**
Total Impairments charged to SoCI - AME	**(5,079)**
Overall Total Impairments	**(5,079)**

Donated and Gov Granted Assets, included above	
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0

* The impairment reversal relates to a general upward District Valuer's valuation of the Trust's land and property which reverses impairments shown in previous years.

17 Analysis of impairments and reversals recognised in 2013-14

	Total	Property Plant and Equipment	Intangible Assets	Financial Assets	Non-Current Assets Held for Sale
	£000s	£000s	£000s	£000s	£000s
Impairments and reversals taken to SoCI					
Loss or damage resulting from normal operations	**0**	0	0	0	0
Over-specification of assets	**0**	0	0		
Abandonment of assets in the course of construction	**0**	0	0		0
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**	**0**	**0**
Unforeseen obsolescence	**0**	0	0		0
Loss as a result of catastrophe	**0**	0	0	0	0
Other	**0**	0	0	0	0
Changes in market price *	**(5,079)**	(5,079)	0		0
Total charged to Annually Managed Expenditure	**(5,079)**	**(5,079)**	**0**	**0**	**0**
Total Impairments of Property, Plant and Equipment changed to SoCI	**(5,079)**	**(5,079)**	**0**	**0**	**0**

Donated and Gov Granted Assets, included above	**£000s**
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	**0**
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	**0**

* The impairment reversal relates to a general upward District Valuer's valuation of the Trust's land and property which reverses impairments shown in previous years.

18 Investment property

The Trust has no investment property.

19 Commitments

19.1 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2014	31 March 2013
	£000s	£000s
Property, plant and equipment	**1,336**	0
Intangible assets	**0**	0
Total	**1,336**	0

19.2 Other financial commitments

The Trust has not entered into any non-cancellable contracts other than the PFI contract.

20 Intra-Government and other balances

	Current receivables	**Non-current receivables**	**Current payables**	**Non-current payables**
	£000s	**£000s**	**£000s**	**£000s**
Balances with other Central Government Bodies	**11,240**	**0**	**4,049**	**0**
Balances with Local Authorities	**98**	**0**	**0**	**0**
Balances with NHS bodies outside the Departmental Group	**1**	**0**	**73**	**0**
Balances with NHS Trusts and Foundation Trusts	**6,590**	**0**	**3,037**	**0**
Balances with Public Corporations and Trading Funds	**1**	**0**	**560**	**0**
Balances with bodies external to government	**11,291**	**2,444**	**36,482**	**0**
At 31 March 2014	**29,221**	**2,444**	**44,201**	**0**
prior period:				
Balances with other Central Government Bodies	8,564	0	4,460	0
Balances with Local Authorities	97	0	0	0
Balances with NHS bodies outside the Departmental Group	1	0	167	0
Balances with NHS Trusts and Foundation Trusts	4,156	0	1,934	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	8,612	2,776	26,366	0
At 31 March 2013	**21,430**	**2,776**	**32,927**	**0**

21 Inventories

	Drugs	Consumables	Work in Progress
	£000s	£000s	£000s
Balance at 1 April 2013	**4,472**	**7,501**	**0**
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	0	
Transfers under Modified Absorption Accounting - Other Bodies	0	0	0
Additions	56,812	43,568	0
Inventories recognised as an expense in the period	(56,160)	(44,163)	0
Write-down of inventories (including losses)	(57)	(10)	0
Reversal of write-down previously taken to SOCI	0	0	0
Transfers (to) Foundation Trusts	0	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0
Balance at 31 March 2014	**5,067**	**6,896**	**0**

22.1 Trade and other receivables

	Current		Non-current	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000s	£000s	**£000s**	£000s
NHS receivables - revenue	**15,839**	7,749	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**0**	0	**0**	0
Non-NHS receivables - revenue	**2,311**	2,044	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**2,882**	1,942	**980**	1,333
Provision for the impairment of receivables	**(809)**	(642)	**0**	0
VAT	**2,964**	4,289	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**2,604**	0	**0**	0
Interest receivables	**3**	2	**0**	0
Finance lease receivables	**0**	0	**0**	0
Operating lease receivables	**0**	56	**0**	0
Other receivables	**3,427**	5,990	**1,464**	1,443
Total	**29,221**	21,430	**2,444**	2,776
Total current and non current	**31,665**	24,206		
Included in NHS receivables are prepaid pension contributions:	**0**			

The great majority of trade is with NHS England and Clinical Commissioning Groups. As these bodies are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

Energy	Loan Equipment	Other	Total	Of which held at NRV
£000s	£000s	£000s	£000s	£000s
0	**0**	**0**	**11,973**	**0**
	0	0		0
0	0	0		0
0	0	0	**100,380**	0
0	0	0	**(100,323)**	0
0	0	0	**(67)**	0
0	0	0	**0**	0
0	0	0	**0**	0
0	0	0	**0**	0
0	**0**	**0**	**11,963**	**0**

22.2 Receivables past their due date but not impaired

	31 March 2014 £000s	31 March 2013 £000s
By up to three months	**5,455**	4,150
By three to six months	**1,145**	186
By more than six months	**675**	559
Total	**7,275**	4,895

22.3 Provision for impairment of receivables

	2013-14 £000s	2012-13 £000s
Balance at 1 April 2013	**(642)**	(560)
Transfers under Modified Absorption Accounting - PCTs & SHAs	**0**	
Transfers under Modified Absorption Accounting - Other Bodies	**0**	
Amount written off during the year	**65**	54
Amount recovered during the year	**89**	38
(Increase)/decrease in receivables impaired	**(321)**	(174)
Transfer to NHS Foundation Trust	**0**	
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	**0**	0
Balance at 31 March 2014	**(809)**	(642)

Non-NHS debts greater than one year old and Non-NHS debts less than one year old but assessed as doubtful have been provided for.

23 NHS LIFT investments

The Trust has no LIFT investments.

24.1 Other Financial Assets - Current

The Trust has no 'Other Financial Assets - Current'.

24.2 Other Financial Assets - Non Current

The Trust has no 'Other Financial Assets - Non Current'.

24.3 Other Financial Assets - Non Current - Capital Analysis

The Trust has no 'Other Financial Assets - Non Current - Capital'.

25 Other Current Assets

The Trust has no 'Other Current Assets'.

26 Cash and Cash Equivalents

	31 March 2014 £000s	31 March 2013 £000s
Opening balance	**554**	359
Net change in year	**6,615**	195
Closing balance	**7,169**	554
Made up of		
Cash with Government Banking Service	**7,107**	494
Commercial banks	**44**	29
Cash in hand	**18**	31
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**7,169**	554
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**7,169**	554
Patients' money held by the Trust, not included above	**1**	0

27 Non-current assets held for sale

	Land	Buildings, excl. dwellings	Dwellings	Asset Under Construction and Payments on Account
	£000s	£000s	£000s	£000s
Balance at 1 April 2013	0	0	0	0
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	0		
Transfers under Modified Absorption Accounting - Other Bodies	0	0	0	0
Plus assets classified as held for sale in the year	0	0	0	0
Less assets sold in the year	0	0	0	0
Less impairment of assets held for sale	0	0	0	0
Plus reversal of impairment of assets held for sale	0	0	0	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0
Transfers to Foundation Trust	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0
Balance at 31 March 2014	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2014	**0**	**0**	**0**	**0**

The Trust has no Non Current Assets Held For Sale as at 31 March 2014.

Balance at 1 April 2012	6,350	0	0	0
Plus assets classified as held for sale in the year	0	0	0	0
Less assets sold in the year	(6,350)	0	0	0
Less impairment of assets held for sale	0	0	0	0
Plus reversal of impairment of assets held for sale	0	0	0	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0
Transfers to Foundation Trust	0	0	0	0
Transfers (to)/from other public sector bodies	0	0	0	0
Revaluation	0	0	0	0
Balance at 31 March 2013	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2013	0	0	0	0

	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Intangible Assets	Financial Assets	**Total**
	£000s	£000s	£000s	£000s	£000s	£000s	**£000s**
	0	0	0	0	0	0	**0**
	0	0	0	0	0	0	**0**
	0	0	0	0	0	0	**0**
	0	0	0	0	0	0	**0**
	0	0	0	0	0	0	**0**
	0	0	0	0	0	0	**0**
	0	0	0	0	0	0	**0**
	0	0	0	0	0	0	**0**
	0	0	0	0	0	0	**0**
	0	0	0	0	0	0	**0**
	0	**0**	**0**	**0**	**0**	**0**	**0**
	0	**0**	**0**	**0**	**0**	**0**	**0**
	0	0	0	0	0		**6,350**
	0	0	0	0	0		**0**
	0	0	0	0	0		**(6,350)**
	0	0	0	0	0		**0**
	0	0	0	0	0		**0**
	0	0	0	0	0		**0**
	0	0	0	0	0		**0**
	0	0	0	0	0		**0**
	0	0	0	0	0		**0**
	0	**0**	**0**	**0**	**0**		**0**
	0	0	0	0	0		0

28 Trade and other payables

	Current	
	31 March 2014	31 March 2013
	£000s	£000s
NHS payables - revenue	**5,897**	2,121
NHS payables - capital	**0**	0
NHS accruals and deferred income	**0**	0
Non-NHS payables - revenue	**2,795**	2,311
Non-NHS payables - capital	**3,349**	2,292
Non-NHS accruals and deferred income	**6,984**	4,691
Social security costs	**948**	563
VAT	**0**	0
Tax	**163**	304
Payments received on account	**0**	0
Other	**24,065**	20,645
Total	**44,201**	32,927
Total payables (current and non-current)	**44,201**	32,927

The Trust has no non-current payables.

29 Other liabilities

The Trust has no 'other liabilities'.

30 Borrowings

	Current		Non-current	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000s	£000s	**£000s**	£000s
Bank overdraft - Government Banking Service	**0**	0		
Bank overdraft - commercial banks	**0**	0		
Loans from Department of Health	**1,332**	1,332	**2,674**	4,006
Loans from other entities	**0**	0	**0**	0
PFI liabilities:				
Main liability	**5,162**	4,504	**243,483**	248,645
Lifecycle replacement received in advance	**0**	0	**0**	0
LIFT liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**482**	126	**1,337**	36
Other (describe)	**0**	0	**0**	0
Total	**6,976**	5,962	**247,494**	252,687
Total other liabilities (current and non-current)	**254,470**	258,649		

Loans - repayment of principal falling due in:

	31 March 2014 DH £000s	Other £000s	**Total £000s**
0-1 Years	1,332	5,644	**6,976**
1 - 2 Years	1,332	5,193	**6,525**
2 - 5 Years	1,342	17,972	**19,314**
Over 5 Years	0	221,655	**221,655**
TOTAL	**4,006**	**250,464**	**254,470**

31 Other financial liabilities

The Trust has no 'Other Financial Liabilities'.

32 Deferred revenue

	Current		**Non-current**	
	31 March 2014 £000s	31 March 2013 £000s	**31 March 2014 £000s**	31 March 2013 £000s
Opening balance at 1 April 2013	**1,228**	1,108	**0**	0
Deferred revenue addition	**1,491**	1,228	**0**	0
Transfer of deferred revenue	**(1,228)**	(1,108)	**0**	0
Current deferred Income at 31 March 2014	**1,491**	1,228	**0**	0
Total deferred income (current and non-current)	**1,491**	1,228		

33 Finance lease obligations as lessee

The finance lease obligations relate mainly to the da Vinci Surgical Robot. The lease started in April 2013 and is a 5 year lease. The finance lease payments in 2013/14 were assessed as £446,000

Amounts payable under finance leases (Other)	Minimum lease payments		Present value of minimum lease payments	
	31 March 2014 £000s	31 March 2013 £000s	**31 March 2014 £000s**	31 March 2013 £000s
Within one year	**483**	129	**482**	126
Between one and five years	**1,337**	37	**1,337**	36
After five years	**0**	0	**0**	0
Less future finance charges	**(1)**	(4)		
Minimum Lease Payments / Present value of minimum lease payments	**1,819**	162	**1,819**	162

Included in:		
Current borrowings	**482**	126
Non-current borrowings	**1,337**	36
	1,819	162

Finance leases as lessee	**31 March 2014 £000s**	31 March 2013 £000s
Future Sublease Payments Expected to be received	**0**	0
Contingent Rents Recognised as an Expense	**0**	0

34 Finance lease receivables as lessor

The Trust has no finance leases as lessor.

35 Provisions

Comprising:

	Total £000s
Balance at 1 April 2013	**4,925**
Transfers under Modified Absorption Accounting - PCTs & SHAs	**0**
Transfers under Modified Absorption Accounting - Other Bodies	**0**
Arising During the Year	**453**
Utilised During the Year	**(2,432)**
Reversed Unused	**(435)**
Unwinding of Discount	**147**
Change in Discount Rate	**(118)**
Transfers to NHS Foundation Trusts (for Trusts becoming FTs only)	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	**0**
Balance at 31 March 2014	**2,540**
Expected Timing of Cash Flows:	
No Later than One Year	**743**
Later than One Year and not later than Five Years	**441**
Later than Five Years	**1,356**

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2014	115,669
As at 31 March 2013	112,020

* Relate to those staff who retired for the benefit of the service before their normal retirement age, the calculation is based on life expectancies as published by the Governement Actuaries Department and to injury benefits paid to staff injured during the course of their duties discounted over the recipients estimated life.

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

*** Relates to Carbon Reduction

**** Relates to staff redundancies to take place during 2014/15

36 Contingencies

	31 March 2014 £000s	31 March 2013 £000s
Contingent liabilities		
Equal Pay	**0**	0
Other (Legal Claims)*	**(282)**	(49)
Amounts Recoverable Against Contingent Liabilities	**0**	0
Net Value of Contingent Liabilities	**(282)**	(49)

* The Trust has contingent liabilities relating to employer and public liability claims. A provision has been established where the likelihood of a payment is more certain (see Note 35).

Contingent Assets

The Trust has no contingent assets.

Early Departure Costs £000s	Legal Claims £000s	Other £000s	Redundancy £000s
1,907	360	269	2,389
0	0	0	0
0	0	0	0
0	184	269	0
(18)	(97)	(219)	(2,098)
0	(165)	(111)	(159)
147	0	0	0
(118)	0	0	0
0	0	0	0
0	0	0	0
1,918 *	**282 ****	**208 *****	**132 ******
121	282	208	132
441	0	0	0
1,356	0	0	0

37 PFI and LIFT - additional information

The information below is required by the Department of Heath for inclusion in national statutory accounts

Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI	**2013-14 £000s**	2012-13 £000s
Total charge to operating expenses in year - OFF SOFP PFI	**0**	0
Service element of on SOFP PFI charged to operating expenses in year	**28,282**	25,003
Total	**28,282**	25,003

Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI		
No Later than One Year	**27,279**	30,649
Later than One Year, No Later than Five Years	**109,116**	122,596
Later than Five Years	**593,318**	697,265
Total	**729,713**	850,510

The estimated annual payments in future years are expected to be materially different from those which the [organisation] is committed to make materially different from those which the [organisation] is committed to make during the next year. The likely financial effect of this is:		
Estimated Capital Value of Project - off SOFP PFI	**0**	0
Value of Deferred Assets - off SOFP PFI	**0**	0
Value of Reversionary Interest - off SOFP PFI	**0**	1,000

Imputed "finance lease" obligations for on SOFP PFI contracts due	**2013-14**	2012-13
	£000s	£000s
No Later than One Year	**18,160**	17,737
Later than One Year, No Later than Five Years	**71,233**	70,567
Later than Five Years	**369,533**	388,361
Subtotal	**458,926**	476,665
Less: Interest Element	**(210,281)**	(223,516)
Total	**248,645**	253,149

Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due	**2013-14**	2012-13
Analysed by when PFI payments are due	**£000s**	£000s
No Later than One Year	**5,162**	
Later than One Year, No Later than Five Years	**21,828**	
Later than Five Years	**221,655**	
Total	**248,645**	0

Number of on SOFP PFI Contracts	
Total number of on SOFP PFI contracts	**1**
Number of on PFI contracts which individually have a total commitments value in excess of £500m	**0**

Present Value Imputed "finance lease" obligations for off SOFP PFI contracts due	**2013-14**	2012-13
Analysed by when PFI payments are due	**£000s**	£000s
No Later than One Year	**0**	
Later than One Year, No Later than Five Years	**0**	
Later than Five Years	**0**	
Total	**0**	0

Number of on SOFP PFI Contracts	
Total Number of off PFI contracts	**0**
Number of off PFI contracts which individually have a total commitments value in excess of £500m	**0**

38 Impact of IFRS treatment - current year

	2013-14	2012-13
	£000s	£000s
The information below is required by the Department of Heath for budget reconciliation purposes		
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g PFI / LIFT)		
Depreciation charges	**6,547**	6,711
Interest Expense	**16,270**	16,155
Impairment charge - AME	**0**	0
Impairment charge - DEL	**0**	0
Other Expenditure	**28,283**	22,388
Revenue Receivable from subleasing	**0**	0
Impact on PDC dividend payable	**(353)**	(654)
Total IFRS Expenditure (IFRIC12)	**50,747**	44,600
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)	**(47,917)**	(45,563)
Net IFRS change (IFRIC12)	**2,830**	(963)
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12		
Capital expenditure 2013-14	**2,282**	3,870
UK GAAP capital expenditure 2013-14 (Reversionary Interest)	**6,065**	5,856

39 Financial Instruments

39.1 Financial risk management

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

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

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

Interest rate risk
The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the strategic health authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk
Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2014 are in receivables from customers, as disclosed in the trade and other receivables note.

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

39.2 Financial Assets

	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000s	£000s	£000s	£000s
Embedded derivatives	0			**0**
Receivables - NHS		13,475		**13,475**
Receivables - non-NHS		5,911		**5,911**
Cash at bank and in hand		7,169		**7,169**
Other financial assets	0	0	0	**0**
Total at 31 March 2014	**0**	**26,555**	**0**	**26,555**
Embedded derivatives	0			0
Receivables - NHS		7,749		7,749
Receivables - non-NHS		3,501		3,501
Cash at bank and in hand		554		554
Other financial assets	0	0	0	0
Total at 31 March 2013	**0**	**11,804**	**0**	**11,804**

39.3 Financial Liabilities

	At 'fair value through profit and loss'	Other	Total
	£000s	£000s	£000s
Embedded derivatives	0		**0**
NHS payables		3,533	**3,533**
Non-NHS payables		38,126	**38,126**
Other borrowings		4,006	**4,006**
PFI & finance lease obligations		250,464	**250,464**
Other financial liabilities	0	0	**0**
Total at 31 March 2014	**0**	**296,129**	**296,129**
Embedded derivatives	0		0
NHS payables		2,121	2,121
Non-NHS payables		30,761	30,761
Other borrowings		5,338	5,338
PFI & finance lease obligations		253,311	253,311
Other financial liabilities	0	0	0
Total at 31 March 2013	0	291,531	291,531

40 Events after the end of the reporting period

There are no material events to report.

41 Related party transactions

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

During the year none of the Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Portsmouth Hospitals NHS 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 2014.

	Expenditure £000	Income £000	Payables £000	Receivables £000
NHS Coastal West Sussex CCG	0	7,332	0	1,470
NHS England	35	97,277	54	1,581
NHS Fareham and Gosport CCG	0	96,009	802	1,511
NHS Litigation Authority	9,688	0	0	0
NHS Portsmouth CCG	32	109,813	1,021	2,378
NHS South Eastern Hampshire CCG	0	85,112	545	1,151
NHS West Hampshire CCG	0	9,125	0	176
University Hospitals Southampton NHS Foundation Trust	944	8,193	368	2,044

The Trust has also received revenue and capital payments from a number of charitable funds, including Portsmouth Hospitals NHS Trust General Charitable Fund and the League of Friends. Portsmouth Hospitals NHS Trust is the corporate trustee of Portsmouth Hospitals NHS Trust General Charitable Fund.

42 Losses and special payments

The total number of losses cases in 2013-14 and their total value was as follows:

	Total Value of Cases £s	**Total Number of Cases**
Losses	**168,720**	**418**
Special payments	**85,077**	**127**
Total losses and special payments	**253,797**	**545**

The total number of losses cases in 2012-13 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	159,787	310
Special payments	118,101	125
Total losses and special payments	277,888	435

Details of cases individually over £250,000

There were no individual cases over £250,000

43. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set fo

43.1 Breakeven performance

	2005-06	2006-07	2007-08
	£000s	£000s	£000s
Turnover	357,591	372,407	409,985
Retained surplus/(deficit) for the year	1,096	857	7,299
Adjustment for:			
Timing/non-cash impacting distortions:			
Pre FDL(97)24 Agreements	0	0	0
2006/07 PPA (relating to 1997/98 to 2005/06)	0		
2007/08 PPA (relating to 1997/98 to 2006/07)	(323)	(533)	
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0	0
Adjustments for Impairments			
Adjustments for impact of policy change re donated/ government grants assets			
Consolidated Budgetary Guidance - Adjustment for Dual Accounting under IFRIC12*			
Adsorption Accounting Adjustment			
Other agreed adjustments	0	0	0
Break-even in-year position	**773**	**324**	**7,299**
Break-even cumulative position	**1,586**	**1,910**	**9,209**

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS [organisation]'s finar expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (whic measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and th

	2005-06	2006-07	2007-08
	%	%	%
Materiality test (I.e. is it equal to or less than 0.5%):			
Break-even in-year position as a percentage of turnover	0.22	0.09	1.78
Break-even cumulative position as a percentage of turnover	0.44	0.51	2.25

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have not been restated to IFRS and rem

or those years.

2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s
422,836	432,167	446,161	440,231	451,906	**469,094**
159	(77,052)	6,254	1,779	4,025	**2,802**
0	0	0	0	0	**0**
111	60,097	(6,095)	(3,097)	0	**(5,079)**
			22	268	**277**
	2,078	0	1,444	0	**2,830**
				0	**0**
0	0	0	0	0	**0**
270	**(14,877)**	**159**	**148**	**4,293**	**830**
9,479	**(5,398)**	**(5,239)**	**(5,091)**	**(798)**	**32**

ncial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental
h would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when
he removal of the donated asset and government grant reserves) to maintain comparability year to year.

2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %
0.06	-3.44	0.04	0.03	0.95	0.18
2.24	-1.25	-1.17	-1.16	-0.18	0.01

main on a UK GAAP basis.

43.2 Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

43.3 External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2013-14 £000s	2012-13 £000s
External financing limit (EFL)	**(2,967)**	(7,438)
Cash flow financing	**(5,603)**	(7,130)
Unwinding of Discount Adjustment	**147**	0
Finance leases taken out in the year	**2,228**	0
Other capital receipts	**0**	(504)
External financing requirement	**(3,228)**	(7,634)
Under/(Over) Spend against EFL	**261**	196

43.4 Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2013-14 £000s	2012-13 £000s
Gross capital expenditure	**11,730**	9,354
Less: book value of assets disposed of	**(96)**	(6,638)
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**(875)**	(504)
Charge against the capital resource limit	**10,759**	2,212
Capital resource limit	**15,392**	3,700
(Over)/underspend against the capital resource limit	**4,633**	1,488

44 Third party assets

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

	31 March 2014 £	31 March 2013 £
Third party assets held by the Trust	**927**	465


ROSEMARY
BUCK

Salary and Pension entitlements of senior managers 2013/14

Name	Title	Start date/leaving date (where not in post for full year)	Salary (bands of £5000) £000	Expenses Payments (Taxable) (total to nearest £100)
Executive Directors in post at 31st March 2014				
Ward Ursula	Chief Executive		£185-£190	£5,000
Lloyd Ben	Director of Finance and Investment	From 01/04/2013	£160-£165	
West Cherry	Chief Operating Officer		£120-£125	
Holmes Simon	Medical Director		£145-£150	
Dawes Julie	Director of Nursing		£125-£130	
Powell Tim (non voting)	Director of Workforce & Organisational Development		£115-£120	
Executive Directors who left during the year				
Toole Robert D	Director of Finance and Investment	To 31/08/2012	£0	
Eley Richard	Director of Finance and Investment	From 10/09/2012 to 05/04/13	£0-£5	
Hardisty Dominic (non voting)	Director of Strategy and Business Development	To 31/12/2012	£0	
Non- Executive Directors in post at 31st March 2014				
Cole Alan	Non- Executive Director (Interim Chair from January 2013)		£20-£25	£400
Nellthorp Mark	Non- Executive Director		£5-£10	
Conway Elizabeth	Non- Executive Director		£5-£10	
Erskine Steve	Non- Executive Director		£5-£10	
Higenbottam Tim	Non- Executive Director		£5-£10	
Non- Executive Directors who left during the year				
David Rhind	Chairman	To 31/12/2012	£0	

* Payment for medical duties includes a national clinical excellence award. This payment was reported separately to 31/03/2013

** Includes payment in lieu of notice (R Toole 6 months, D Hardisty 3 Months)

*** Mutually Agreed Resignation Scheme (MARS)

Pension Benefits

Name	Title	Real increase in pension at age 60 (bands of £2500) £000	Real increase in pension lump sum at age 60 (bands of £2500) £000
Ward Ursula	Chief Executive	0-2.5	5-7.5
Lloyd Ben	Director of Finance and Investment	0-2.5	(3)-(3.5)
West Cherry	Chief Operating Officer	0-2.5	2.5-5
Holmes Simon	Medical Director	0-2.5	5-7.5
Dawes Julie	Director of Nursing	0-2.5	2.5-5
Powell Tim (non voting)	Director of Workforce & Organisational Development	0-2.5	N/A**

* The Trust has not made contributions to stakeholder pensions

** No lump sum is shown for employees who only have membership in the 2008 Section of the NHS Pension Scheme.

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

Cash equivalent transfer values
A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital va;ue of the pension scheme benefits accrued by a member at a particul
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, contribu
valuation factors for the start and end of the period."

2013/14				2012/13		
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 £5000) £000**	**Other Remuneration (bands of £5000) £000**	**Benefits in Kind Rounded to the nearest £100**
		0-2.5		£185-£190		
		0-2.5		£0		
		0-2.5		£120-£125		
		0-2.5		£140-£145	£35-£40*	
		0-2.5		£125-£130		
		0-2.5		£110-£115		
				£135-£140**		
				£105-£110		
				£115-£120**	£10-£15***	
				£10-£15		
				£5-£10		
				£5-£10		
				£5-£10		
				£5-£10		
				£15-£20		

Total accrued pension at age 60 at 31 March 2014 (bands of £5000) £000	**Lump sum at age 60 related to accrued pension 31 March 2014 (bands of £5000) £000**	**Cash equivalent transfer value 31/03/2014 £000**	**Cash equivalent transfer value 31/03/2013 £000**	**Real increase in cash equivalent transfer value (bands of £5000) £000**	**Employers Contribution to Stakeholder Pension* To nearest £100**
60-65	180-185	1,154	1,061	70-75	0.0
30-35	95-100	570	512	45-50	0.0
35-40	115-120	750	695	40-45	0.0
70-75	210-215	1,428	1,316	80-85	0.0
45-50	140-145	1,098	818	260-265	0.0
5-10	N/A**	77	54	20-25	0.0

lar point in time. The benefits valued are the members accrued benefits and any contingent spouse's pension payable from the scheme. CETV's

utions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market

Thank you to the patients and staff who gave permission to be featured in the report.

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