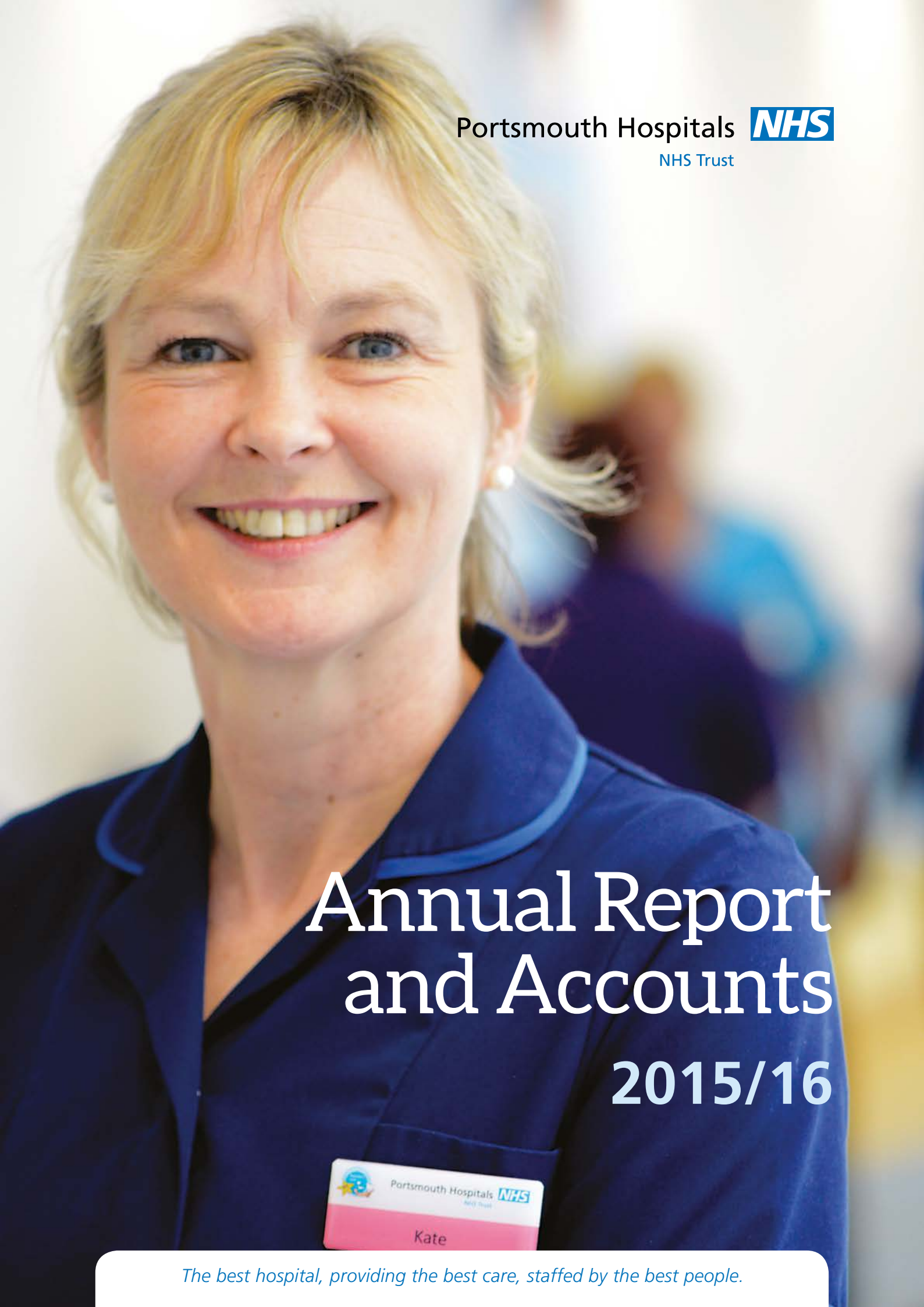
Portsmouth Hospitals NHS
NHS Trust



Annual Report and Accounts

2015/16

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

A Patient's Story

Noah Yaxley

"I'm so grateful for all the amazing care he's had at QA"

Elisabeth Yaxley, Mum

Noah Yaxley, who was born with an incredibly rare genetic variation, has spent much of his young life in the children's ward at Queen Alexandra Hospital.

The toddler was born with chromosome deletion 1Q44. This means he has several medical problems, including seizures which can be triggered if his body drops below a certain temperature, or if he comes into contact with water. It also means that he is susceptible to infections and has visual issues, breathing issues and a heart condition.

Despite all of this, Noah is a very happy toddler, and his mum, Elisabeth Yaxley, has been so impressed with the care that he has received at QA that she has devoted much of her time to fundraising towards new kit, which can be used to help other young patients.

She said: "Noah has been through a lot, and I have to be incredibly careful with him. While all mums will make sure their child goes out in a coat or covered by an umbrella, I really have to make sure of that or there may be serious consequences. Noah is a little fighter and, despite all of his health issues, he's a really happy little boy.

"I'm so grateful for all the amazing care he's had at QA and I just want to give something back. Raising money for much-needed equipment is the best way for me to do that."

Dr Roy Sievers, consultant paediatrician at Portsmouth Hospitals NHS Trust, said: "Noah was born with an extremely rare genetic variation and has become a regular visitor to the children's unit at QA with several medical problems which have included visual issues, breathing issues, infections, a heart condition, and puzzling seizures with unique triggers.

"We are very grateful to Noah's family and friends for choosing to support us by funding a new Optiflow Machine, which allow us to support babies and young children with breathing difficulties requiring more than simple oxygen support. Noah himself used a similar machine during one of his admissions.

"We use these frequently, particularly in the winter months. The main condition for which these babies require support is bronchiolitis, this happens yearly in epidemics each winter – it is not uncommon for us to have 20-30% of the ward occupied by babies with bronchiolitis. This piece of kit will make a huge difference to many of these babies."

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1 Introduction from the Chairman and Chief Executive

This last year has been a very challenging time for NHS colleagues across the country. In the national headlines we saw much commentary on the NHS' financial constraints; unscheduled care pressures; missed national targets; ever increasing demand on services and, of course, the junior doctors' strike action. We have not been immune to these pressures ourselves.

Despite pressures on our finances resulting in a disappointing deficit at year end, and the unprecedented demands on our unscheduled care pathway, we continue to be a very well performing hospital Trust.

Our reputation for patient centred care continues to grow, and we were recognised as being among the best in 2015 when the Care Quality Commission (CQC) ranked us as outstanding for the levels of care we give our patients. This is something we are hugely proud of.

Their full inspection of our services was against the five domains of safe, effective, caring, responsive and well led. They rated our critical care service as outstanding, along with maternity and gynaecology, children and young people's services and outpatient's services rated as good. Whilst the overall rating given by the CQC for the hospital Trust was 'requires improvement' we have much to celebrate.

The CQC also conducted an unannounced visit in February, with a review specifically focussed on unscheduled care. This visit resulted in an enforcement notice requiring immediate actions to ensure improvements in the emergency care pathway. We took immediate action through the implementation of a trust improvement plan. Every staff member played their part in these improvements which were focussed on keeping the patient at the heart of everything we do.

Last winter proved to be one of the most difficult and challenging in the history of the NHS. Locally we worked hard with our NHS partners in the health community, putting in place plans for more community based care, aiming to reduce admissions to hospital and improving timely discharge of patients to alternative providers.

We welcomed some new colleagues to the Trust including Chris Adcock, Director of Finance and Ed Donald, Chief Operating Officer. We also saw the retirement of Alan Cole, Deputy Chairman and our thanks go to him for his unwavering support to the Board over the last few years.

We are proud to host military colleagues from all three services in the hospital. The professional and highly regarded relationship between military doctors, nurses and allied health care professionals continues to flourish. We were delighted to welcome a new Commanding Officer, Lt. Col. Adam Shorrock, in 2015. We were also delighted to receive an Employer Recognition Scheme Silver Award in recognition of our support of military reservists.

A personal highlight for us both was being able to recognise many of our staff at the Best People Awards in November. As always, it was a heartening reminder of the real difference that our staff make to patients on a daily basis.

Throughout the year, our teams and individuals have also been highly regarded and acclaimed in local and national awards, placing us among the highest performers in the country for care, research and innovation.

We were delighted to have been recognised as being among the top NHS places to work, and a prestigious award was given to us by the Health Service Journal, Nursing Times and NHS Employers. Indeed, the results of our annual staff survey showed further improvements and our organisation rates highly in being both a place to work and to receive treatment.

Looking ahead we recognise that the NHS will continue to face increasing demands and pressure on our hospital trust will not ease. However, we are well placed to provide safe patient centred care, to deliver against national standards and to perform at the highest levels in many of these standards. We will continue to improve on our financial strength and sustainability and above all continue to provide outstanding, well led services.

Together we thank you all for your continued support and commitment throughout the past year.

Sir Ian Carruthers
Chairman

Ursula Ward
Chief Executive

2 One year, numerous achievements – our year in review

There have been many achievements and successes in 2015/16. A summary of our highlights includes:

April

- We worked with the Wessex Asthma Network holding a special event to assist medics with cutting edge inhaler devices
- Portsmouth Hospitals Charity was re-launched aiming to raise funds for the many wards at Queen Alexandra Hospital
- We launched our My Birthplace app which advises expectant mothers on the different options and locations to give birth

May

- Our Diabetes Team was shortlisted in the BMJ Clinical Leadership Awards for their work with 'Diabetes with STYLE (Safe Transition to Young Adult Life) a programme to increase attendance rates for under 25-year-olds living with diabetes

June

- We were rated 'Outstanding' in overall care and 'Requires Improvement' overall by the CQC following their formal inspection

July

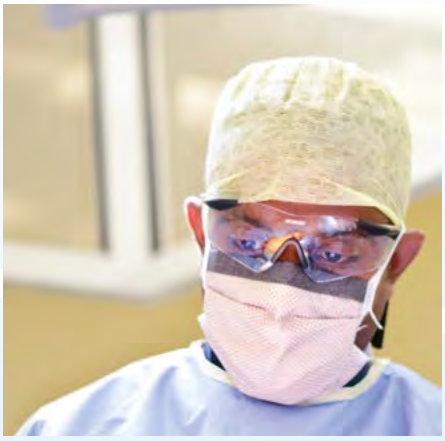
- We were recognised as one of HSJ's top 100 places to work
- We launched our Stop the Red Clocks initiative
- We launched an innovative new app called MyCOPD
- We were named as a finalist in the prestigious Personnel Today Awards for Employee Engagement
- Our Hospital at Night team was nominated for the E-health insider awards celebrating achievements around technology in healthcare

August

- The Ministry of Defence Hospital Unit becomes Defence Medical Group South
- Our Home from Hospital service is launched, working alongside the Royal Voluntary Service and funded by Legal & General
- We score highly in the Patient-led Assessment of the Care Environment (PLACE), an annual mandatory inspection

September

- We were published in the BMJ as we cut Norovirus outbreaks by over 90%
- MISSION Asthma wins a prestigious national HSJ award
- Together with Oxford University Hospitals NHS Foundation Trust we win £1.8m funding to develop an early warning system responding to patient deterioration
- Jane Pelling, Stoma Care Sister, receives a national award for her work and care with patients living with colostomy bags after surgery
- The newly named Portsmouth Enablement Centre is launched following patient feedback
- We win the HSJ value in healthcare awards: value and improvement in the use of diagnostics



October

- Our supply chain team, South of England Procurement Services, wins Highly Acclaimed at the prestigious EHI 2015 awards - Best use of IT to support healthcare business efficiency category
- Teams and individuals are celebrated at The News Best of Health Awards
- We were recognised for our support of military reservists and receive an employer recognition scheme silver award
- Our maternity services are highly commended at the NICE shared learning awards held in Liverpool
- We held our annual, Governor led, hospital open day
- Our Wessex Renal Unit celebrates 50 years of service

November

- We win a prestigious HSJ award for our work using technology to improve patient care (VitalPac)
- We held our annual Best People awards celebrating our staff
- Professor Pradeep Bhandari receives a medal for his contribution to UK Endoscopy

December

- We were part of the world's biggest ovarian cancer screening trial, the results of which were published in the Lancet
- We held a Theatre Open Day allowing staff to see behind the scenes of our 27 theatres
- Jackie Pomroy, Head of Supply Chain for NHS South of England Procurement Services, won the GS1 Healthcare champion award

January

- Our IT department was awarded a three-star rating for their work by the Service Desk Institute. This was given after a rigorous audit which assessed the department against nine key areas including leadership, customer satisfaction, policy and strategy and social responsibility
- We announced the creation of a new lung cancer patient support group, which was launched by staff to support those affected by the disease
- Maternity Services at Portsmouth Hospitals were highly rated by new mums in the Care Quality Commission Annual Maternity Survey

February

- The national NHS Staff Survey rated us in the top 20% of acute hospital trusts
- The maternity team featured live on TV on Good Morning Britain
- We unveiled a new state-of-the-art CT scanner, which can capture an image of the heart in a quarter of a second

March

- Our diabetes team are nominated for a national BMJ 'Clinical Leadership Team of the Year' Award
- The learning and development team are presented the Quality Mark by the National Skills Academy for Health – a certificate awarded to organisations that provide outstanding healthcare training

3 Best Hospital, Best People, Best Care

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

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

As well as being responsible for the building works, The Hospital Company also entered into a long term agreement to provide Facilities Management services to the hospital. Portsmouth Hospitals NHS Trust makes annual payments for the PFI facility to cover loan and interest payments as well as payments for the provision of the Trust's facilities and services including estates, portering, cleaning, security, catering and car parking.

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

Included within our modern buildings are:

- 28 theatres - with four dedicated endoscopy theatres
- Four state of the art linear accelerators
- Two purpose built interventional radiology suites, three MRI scanners, three CT scanners and a PET scanner
- State of the art pathology laboratory
- Neonatal Unit, Level 3
- Hyper acute stroke unit
- Superb critical care facilities

Our Emergency Department is one of the busiest in the country treating in excess of 144,000 patients each year. We also see over 502,000 outpatients and carry out over 53,000 day case operations. Our maternity services deliver around 6,000 babies per year, making it one of the largest maternity services on the south coast. We are also home to the Wessex Renal and Transplant Unit and hold prestigious Cancer Beacon Status for Head and Neck Cancer Services.

Although we are not a University Hospital allied to a medical school, we are a major provider of under-graduate and post-graduate education working with three universities - Southampton, Portsmouth and Bournemouth. We have a significant reputation for our research and innovation and are actively involved in the national agenda in these fields. We continue to rank in the top 20% nationally for our research activity.

Providing the best care across South East Hampshire

We are organised into ten 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 clinically led and managed.

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 area in excess of two million people.

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

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

- St Mary's Hospital - midwifery, dermatology and enablement services
- Gosport War Memorial Hospital - a range of services including the Blake Maternity Unit, Minor Injuries Unit, rehabilitation services and diagnostics
- Petersfield Community Hospital - we manage the Cedar Rehabilitation Ward and run the Grange Maternity Unit
- Fareham Community Hospital – rehabilitation services and outpatient clinics
- Havant Community Services – diagnostics and outpatient clinics

The Trust's Harbour Private Patient Service is located on the top floor of Queen Alexandra Hospital. Harbour provides for patients with private medical insurance, or for those who wish to pay for themselves. Harbour offers an increased choice to patients and provides private care that is supported within the comprehensive infrastructure of the NHS Trust. This service is increasingly attractive to patients from a wide geography, choosing our hospital Trust for its clinical excellence, the range of specialist staff skills and the equipment not available elsewhere - for example our laparoscopic Da Vinci robot.

The demand from patients for the service continues to grow and delivers an increasingly significant positive contribution to the financial position of the Trust. All the income generated from Harbour goes back into our general finances to help support improvements in services which benefit our NHS patients.

Treating an older population with multiple health problems

Over the coming years our local population is forecast to grow in line with the England average, to approximately 695,000. However the age profile of this community is atypical, we already serve a population with an age profile which reflects the expected average cross-section in England in 2032.

We are in the first cohort of hospitals facing the challenges of an ageing population:

- **By 2032 28% of our catchment population will be over 65 years of age, significantly higher than the England average of 22%**
- **The trend for over 75s suggests that by 2032 this group will account for 16% of the local population compared to the England average of 11%**

This sub segment of the catchment population already puts pressure on our local health economy. Our ageing demographic brings with it the added challenge of multiple clinical needs. There is also a lower life expectancy and higher prevalence of disease and poor health compared to other areas within our region.

In addition to this some of the Portsmouth, Gosport, and Havant wards within our local catchment area face severe deprivation, this places an additional demand on our acute service provision, particularly emergency care. Approximately 85% of our current inpatient bed occupancy is related to patients arriving as emergencies in the unscheduled care pathway.

Challenges within our operating environment

It has continued to be a challenging year for the NHS and our hospital Trust has not been immune to this. We have worked with a range of partners to refine and implement sustainable plans to provide sufficient capacity and speedy access to our services.

The hospital was clearly under pressure during the last year, and our emergency department has been very congested at times, more so than many other hospitals in our region. The efforts of our staff to deliver patient focused care were recognised by the Care Quality Commission, although they did identify some areas for immediate action. We have worked hard to ensure these were enacted through effective leadership, resourcing and support of the trust's improvement plan. We will continue to ensure that any necessary changes are appropriately supported and implemented.

In the last year we saw:

144,000 Emergency attendances

502,000 outpatients

65,000 emergency admissions

6,000 births this year

80,000 planned admissions to hospital

A safe hospital – measuring our performance

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

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 eight National Cancer Standards and five of these have been achieved in every quarter.

High quality care has been delivered in most specialties in the last 12 months, with continuing world class performance in our Critical Care, Maternity, Paediatrics and Neonatology.

The Trust always aims to place the patient at the centre of everything, and we are proud of our proven track record in safety. This is evidenced by zero 'Never' Events. Also, the SMR (Standardised Mortality Ratio) of 101.7 and SHMI (Summary Hospital-level Mortality Indicator) of 105.4 are within the expected ranges for the Trust, when benchmarked nationally.

We have worked hard throughout the year to reduce avoidable harm to patients, for example further reducing the prevalence of pressure ulcers, falls and Clostridium difficile (C.diff).

We have met both our diagnostic 6 week standard waiting times in 10 out of 12 months and achieved the Referral to Treatment waiting time standard in every month. Similarly the standards for Coronary Heart Disease are improving.

A safe hospital - infection prevention

Our aim is to provide all patients with safe and effective care in a clean and safe environment. We have continued our hard work in reducing Healthcare Associated Infections and last year saw us perform better than the national average for both MRSA bloodstream infections and C.diff.

During 2015/16, we had 29 cases of hospital attributed C.diff infections against a target of 40. This means that our performance has positively exceeded our target by 27%. Our performance with MRSA bloodstream infections was also improved on the previous year, with zero avoidable and zero unavoidable cases attributed to the Trust.

This year we introduced hydrogen peroxide fogging machines, which we use to ensure that we have a clean and safe environment to deliver our clinical care, even if the area has previously been used to care for infectious patients. Our pioneering work to reduce outbreaks of Norovirus and other viral gastrointestinal infections by 90% over a 5 year period was published in the prestigious BMJ journal for Safety and Effectiveness, highlighting our infection prevention strategy to a national audience.

The significant reduction in these infections is due to the hard work and engagement of all members of our staff.

Our strategic direction

Our mission is to be the best hospital, providing the best care, staffed by the best people and we set ourselves five strategic goals to ensure that we deliver our vision. These are:

Deliver safe, high quality patient centered care:

- Year on year improvement in national, local and quality account metrics
- Achieve top 20% position across acute Trusts
- Year on year reduction in avoidable harm
- Maintain compliance against Care Quality Commission outcomes
- Deliver good patient experience as measured by the Friends and Family Test
- Consistently achieve all access standards in line with commissioning and regulatory requirements
- Partner with other organisations to deliver joined up emergency care
- Safeguard vulnerable groups through robust safeguarding procedures

Develop a reputation for excellence in innovation, research and development and education in the top 20% of our peers:

- Year on year increase in patient recruitment to clinical trials
- Establishment of academic/ innovation centre within PHT
- Work in collaboration with Academic Health Science Networks to develop innovation and research projects
- Become a hospital of choice within Wessex for trainees

Become the hospital of choice for general, specialist and selected services:

- Maintain referral patterns from General Practitioner surgeries in the local catchment area and beyond
- Maintain and grow specialist services with local national and international reputation
- Maintain and grow the Renal and Transplantation service to remain a centre of excellence in the UK

Be a hospital whose staff recommend the Trust as a place to work and a place to receive treatment:

- Ensure the best people are employed with the best skills in the right place at the right time
- Make the Trust a great place to work and learn
- Develop individual and collective responsibility and accountability for delivering performance improvements
- Nurture a culture of compassion and care for patients

Develop sufficient financial strengths to adapt to change and invest in the future:

- Develop financial capability across the Trust and ensure a year on year surplus which is re-invested into services
- Develop a rolling five-year Integrated Business Plan underpinned by robust supporting strategies
- Develop Clinical Service Centres as fully functioning developed business units with full responsibility
- Re-align corporate services to support all of the above

Engaging with our partners and stakeholders

Our Trust strategy has not been developed in isolation. We have an important role to play within the local health economy and we have assessed local priorities and developed an external facing strategy that complements our plans for internal clinical provision.

Our three Clinical Commissioning Groups (Portsmouth, Fareham and Gosport, and South Eastern Hampshire) commission 80% of current activity within the Trust and we work in partnership to deliver three clear priorities for the region:

- Improving care for the frail and elderly by implementing an integrated approach
- Reviewing pathways and models of care for a range of elective services
- Financial stability for all partners across the health care system

We can best serve our local population by working collaboratively with partners across the local health and social care system to respond to the growing pressures and mitigate the impact of an increasingly ageing population.

Together we aim to drive a decline in emergency admissions and average length of stay through:

- Developing care pathways to reduce multiple handovers and offer a streamlined and targeted service – for example our diabetes service
- Reducing the need for hospital admissions for the frail and elderly, and those with long term conditions
- Supporting self-management and long term prevention of ill-health working closely with Public Health

Key areas of work for the organisation in 2015/16

We identified 7 key areas of focus for the organisation:

1. Financial sustainability

The current NHS economic climate necessitates significant savings both locally and nationally. This is at a time when everyone in the NHS is seeking continuing improvements in standards of patient care. We face the dual challenge of delivering high quality care whilst offering value for money and creating year on year surpluses to reinvest in patient care for our local communities.

The financial challenges we faced in 2014/15 continued into 2015/16 and we finished the year with a £23.5m deficit. This was certainly not where we wanted to be, but the Board was adamant that we would not compromise patient care for cost. This performance was unsatisfactory and materially adverse to the Trusts original plan for a £16m deficit.

The Trust has experienced significant Unscheduled Care pressures during the year and this has impacted on the delivery of the 2015/16 plan overall. The financial position has likewise been affected and expenditure increases, greater than the value of additional income generated and difficulties in delivering full anticipated efficiency savings, have been major contributors to this adverse financial performance.

Our External Auditors have issued a Section 30 report, under the Local Audit and Accountability Act 2014, reporting their view that we would not be able to achieve our breakeven duty over a rolling three year period. In order to satisfy itself that it is appropriate to adopt the 'going concern' basis, in preparing the 2015/16 financial statements, the Trust has applied the definition as set out in the Department of Health Group Manual for Accounts; which outlines the interpretation of International Accounting Standard 1 'Presentation of Financial Statements' as 'anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents'.

Our planning process for 2016/17 has taken account of the out-turn financial position from 2015/16, and with support from the Sustainability and Transformation Fund, aims to return the Trust to financial balance in the coming year. There are significant challenges contained within the plan including a 5.6% efficiency requirement of £32m.

The development of savings plans has been supported by a newly established Delivery Unit which will continue the development of plans for future years, monitor and drive in year delivery and connect the efficiency programme to our overall improvement agenda.

We are also committed to taking a leading role, working with all of our stakeholders across the local health

economy, to ensure the financial stability of the healthcare system so that we become less reactive to financial pressures and more able to control investment decisions.

2. Unscheduled care

Working with a range of partners we are implementing sustainable plans to provide sufficient capacity, and speed of access, to ensure that our patients receive high quality services in line with NHS constitutional standards. These plans have been captured as part of an Unscheduled Care Improvement Plan with key sections covering:

- Improved patient flow within the Emergency Department
- The redesign of the 'Medical Take Model' to ensure the timely assessment of medical patients
- Increased focus on the effective and timely turnaround of short-stay patients
- The transformation of the Acute Medical Unit to accommodate patients up to a 24 hour period
- An increase in the level of ambulatory care provision, preventing the need for an inpatient admission
- Improving the timeliness of ward-based discharges
- An increased focus on the Acute Frailty Pathway including early comprehensive interdisciplinary assessment
- Streamlined site operations to maximise patient flow

3. The development of a healthcare hub

We are working with a wide range of partners to ensure that the hospital trust is the focal point for acute care provision, reaching out to the boundaries of our catchment area to further develop our services in community locations.

This will include:

- The provision of more complex treatments covering a population of over 1 million
- Networking in 'hospital chains', expanding our work with other local acute providers to ensure a full range of high quality services is offered to the local population within our geographical area e.g. collaboration of maternity services between Portsmouth, Southampton, Isle of Wight, Winchester and Basingstoke
- Working with community partners and local authorities to ensure our patients can access high quality local rehabilitation services
- Providing enhanced levels of service, including diagnostics, in community hubs to support the delivery of new models of care
- Working closely with GP practices to ensure that long term conditions can be managed close to, and in, patients' own homes
- Collaborating with all NHS partners to play a proactive role in the prevention, and early detection, of illnesses and diseases

4. Digitalisation and inter-operability

In line with local and national aspirations we aim to become a paper free organisation by 2020. This will be achieved through the development and subsequent roll out of an extensive 'e-hospital' programme. This will replace many of our ageing IT systems giving maximum clinical efficiency and further improving patient care. Linked to 'e-hospital' is a focus on creating seamless two way transfers of information between all local health providers.

5. Standardisation and transformation

Many pathways of care including unscheduled, elective, diagnostic and cancer, have been reviewed and redesigned to ensure that our patients are treated in line with the best clinical and administrative practice. These revised pathways will be introduced across the whole organisation and in some cases across the wider health and social care system through a systemic transformation programme.

6. Seven day services

We will continue to increase the level of provision to ensure that all appropriate services are available to our patients seven days a week.

7. Research and innovation

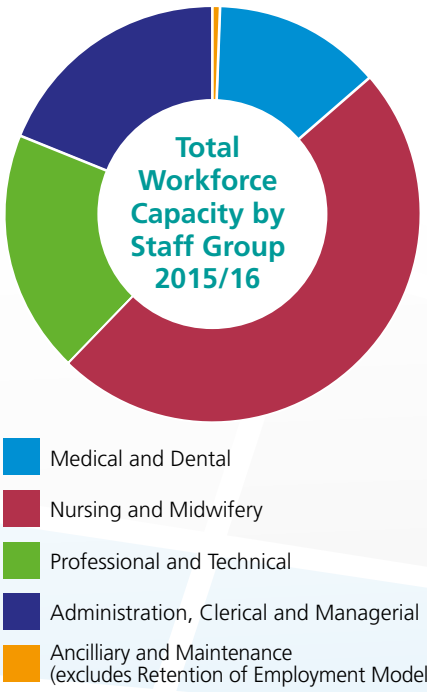
We will further build upon our significant reputation for our research and innovation. We are actively involved in the national agenda in this work and will continue to push the boundaries to improve the health and outcomes for the population we serve.

Investing in our skilled workforce

We employ around 6,400 people and we are the second largest employer in Portsmouth.

Recruiting and maintaining an effective workforce is a major priority and our strong partnerships with NHS Professionals, who provide our temporary workforce, Carillion and the Ministry of Defence helps us to achieve the goal of maintaining safe services for all of our patients.

In addition to our partnerships with other organisations, we have continued to recruit from abroad to fill key vacancies and maintain our workforce levels across all staff groups and departments.



Our total workforce capacity is made up of:

- **Nursing and Midwifery workforce - including our registered nursing workforce and nursing support staff**
- **Professional and technical workforce**
- **Administrative and clerical**
- **Medical and dental - including consultants and junior doctors.**

In addition, our temporary staffing accounts for five per cent of the total workforce establishment.

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

Investments have been made in 2015/16 to increase staffing levels. Increased non-elective activity has resulted in a further increase in nursing, technical and medical staff working in the organisation. This has been within the Emergency Department and medical specialties. Our partnership with NHS Professionals has given us support in meeting staffing requirements due to increased patient demand.

Progress has been made in delivering staff appraisals (81.6%) and essential skills training (87.1%). Much work has also taken place to improve staff satisfaction and this has been reflected in the national staff survey results.

A number of exit packages were agreed in the year as detailed in Note 10.4 of the Annual Accounts.

Equality, diversity and human rights

We are fully committed to employee equal opportunities and our equality and diversity policy is published on our website www.porthosp.nhs.uk.

The gender breakdown of our workforce includes:

Female	77%
Male	23%
Disability	4%
BME (Black and Minority Ethnicity)	13%

A gender breakdown of senior managers (Directors and all managers over band 8a) employed by the Trust shows that just over half are male.

Female	46%
Male	54%
Disability	3%
BME (Black and Minority Ethnicity)	4%

The Equality Act 2010 and Public Sector Equality Duty require that we provide services that are personal, fair and diverse. We want to be recognised as a leader in this, ensuring positive outcomes for everyone who comes into contact with us. This is not just about responding to our legal and regulatory requirements; we are also using this as a driver for change.

We have a sustainable, and evidence based, equality and diversity strategy called 'Everyone Counts' which helps us to integrate equality and diversity into our mainstream business. Progress is monitored and reviewed by the Equality Impact Group.

We have also launched our Equality Standard, a toolkit that aims to improve health outcomes for all; improve patient access and experience and empower, engage and support our staff through inclusive leadership.

Staff engagement and consultation

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

Listening into Action 2015

Recognising the critically important role of our staff in meeting the challenges we face, the Trust has continued to drive its organisational development strategy building on the success of the Listening into Action (LiA) staff engagement initiative.

The Trust's commitment to staff engagement is undoubtedly paying dividends and the largely positive results of the national NHS staff survey emphasises that our staff are able to see an improvement in the way the organisation is managed, and that they are able to enjoy a more enriched job experience.

Examples of some of the outcomes and initiatives which have taken place in the last year as a result of LiA engagement and consultation include:

- The introduction of an 'Activity Tracker' into Theatres to view where a patient is within the Theatres system. December 2015 saw 18% fewer cancellations than April 2015
- Introduced a new style monthly Team Brief which communicates the key priorities from our Trust Board to our staff
- Broadened the opportunities for Dementia awareness, training and assessment for staff
- Developed eSwap, a web based page to recycle equipment and items
- Added the 'Patients Choice' Award to our Best People recognition awards to give patients, their families and carers the opportunity to nominate individuals and teams for their amazing care
- Introduced a new staff eLearning package on Bullying and Harassment
- Following feedback from staff created 'Zero Tolerance' posters
- The Phlebotomy Team worked together to introduce a new uniform, making them more visible and easy to recognise on the wards

Throughout the coming year we will be exploring how staff can continue to make a difference to the experiences of patients, their relatives and carers.

The National NHS Staff Survey 2015

The Trust chose, again, to survey all staff in the 2015 survey. A total of 4,295 staff took the opportunity, which is the largest collection of staff feedback to date, representing a 59% response rate. This placed us in the highest 20% for acute trusts in England, and compares with a response rate of 54% in our 2014 survey.

The overall staff engagement score represents staff members' perceived ability to contribute to improvements at work, their willingness to recommend the organisation as a place to work or receive treatment, and the extent to which they feel motivated and engaged in their work.

This score when compared with all acute trusts has improved from being in the worst 20% in 2012 and 2013, average in 2014 and above average in 2015 with a scale summary score of 3.87 which is above the national average.

When considering improvements and deteriorations of acute Trusts, we ranked 21st of all 99 Trusts. Of the 20 Trusts ranking above Portsmouth, only 5 Trusts have higher overall in staff engagement scores.

Due to the number of changes made to the survey for 2015, only 22 of the 32 key findings are comparable to 2014 outcomes, and of these a number of the 2014 figures have been recalculated to enable a meaningful comparison which is statistically significant. Of the 22 key findings considered comparable:

- 8 show improvement
- 12 have remained unchanged
- 2 have deteriorated (however one is in the best 20% of acute trusts and the other is average)

The focus given to our staff engagement agenda has resulted in our workforce feeling more valued, more able to contribute to changes that affect them and a higher number recommending it as a place to work and receive treatment. It is pleasing to see the overall staff engagement level increase further during the last 12 months which provides the opportunity for us to continue to foster a culture of openness and transparency to promote staff led change and to provide a first class service for our patients.

It is crucial that we maintain this upward direction of travel; we continue to build on our successes and pay attention to those areas that are still in need of improvement. The survey provides evidence of a highly engaged but hard working, pressured workforce.

Working alongside our military personnel

The professional and highly regarded relationship between military doctors, nurses and allied health care professionals from the Defence Medical Group South and the Trust has continued to reap benefits.

Personnel from all three Armed Services are fully integrated within the Trust, working alongside their civilian counterparts, helping to treat and care for patients from the local and surrounding communities.

The Commanding Officer, Lieutenant Colonel Adam Shorrock, acts as the pivotal point of contact between the two organisations. He promotes cohesion and ensures that the relationship is mutually beneficial for all involved.

Military personnel work within the Trust in preparation to provide defence forces with highly capable clinically trained healthcare professionals that are able to deliver high quality clinical care in support of current and future operations.

In 2015 the focus for military personnel was Operation GRITROCK, Her Majesty's Government support to the Ebola crisis in Africa. Training and preparedness for future deployments around the world, including providing support to humanitarian missions will remain the priority in the future.

Military personnel pride themselves on supporting local and national charities, and have continued to raise funds for the Trust's Rocky Appeal, The Royal British Legion and Single Service Benevolent Funds to name but a few.

Improved participation and engagement

The Trust has worked with patients, families, carers, voluntary sector organisations and community groups to help us better understand what is most important to them when using our services.

A Patient Engagement Strategy Participation for Improvement has been developed with patients, families and carers and members of the local community. The strategy has changed the way we work with people to better understand peoples experience, by reaching out to our local community and using their expertise to identify issues and design solutions. The implementation is being led by our patients and carers, supported by the Trust Patient Experience Team.

We have actively involved people in service changes and developments, including way finding, the design of ward information boards and the development and delivery of an event to raise staff awareness of the needs of carers.

In 2015, nearly 55,000 patients provided us with feedback about their experience through the Friends and Family Tests. Whilst Patients reported a 95% satisfaction score we have continued to learn from patient feedback and where things could be further improved.

This feedback led to many small but significant changes being made including:

- New posters to show patients and visitors what each staff uniform means
- Purchase of more comfortable chairs for relative rooms
- Information for new patients
- Improved communication in out-patient clinics about waiting times

We have introduced wide ranging opportunities for people from the local community to help us identify the patient experience priorities for 2016/17. This includes face to face meetings with people from community groups including carers and Black and Minority Ethnic groups, attendance at community engagement events and the development of a simple web based survey.

A caring and charitable hospital

Portsmouth Hospitals Charity aims to serve our patients by:

- Providing additional facilities and equipment
- Supporting research and innovation in the development of services
- Providing education to patients and staff

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

charity supports 66 individual funds for different wards, departments or initiatives under its registered status as Portsmouth Hospitals Charity.

The charity is most grateful for the support it has received from patients, their friends and family; staff; businesses and a number of associated charities including Ickle Pickles, League of Friends, Hospital Radio and Sam's Haven.

We have worked hard over the last year to further develop our supporter focused website that explains about the charity and how it supports the wards and departments, shares patient and donor stories, and promotes the main events and activities being carried out to raise funds.

The charity is now active on social media. We have also introduced a supporter's newsletter Your Charity News and created a suite of leaflets to help introduce the charity to new donors and existing supporters.

We have also received fantastic corporate support from local businesses including Sainsbury's in Farlington who donated fresh flowers twice a week to patient reception areas, and Eaton Aerospace who supported the Paediatrics Department in the renovation of their outside play area, making us their chosen charity.

Many of the wards and departments have benefited from generous donations including:

- **Endoscopy Charitable Fund - Gosport League of Friends donated £82,000 for the new Endoscopy Suite at the Gosport War Memorial Hospital**
- **NICU Charitable Fund - Ickle Pickles Charity raised over £35,000 to purchase 4 Draeger monitors for high dependence babies within the Neonatal Intensive Care Unit**
- **Breast Care Charitable Fund - The Medical Records Team, and Football for Cancer, raised £4,000 to buy a tattoo machine to benefit patients who have under gone breast reconstructive surgery**
- **Paediatrics Charitable Fund - Received a £4,000 grant from The Car Finance Company towards the Paediatrics outside Play Area renovation project**

Fundraising for the Rocky Appeal, also comes under the umbrella of Portsmouth Hospitals Charity, raising funds for our state of the art Da Vinci Surgical Robot. This has continued to receive fantastic community support in the last year.

Individual donations have also continued to make a huge difference to our patient care. Parents Kelly and Antony had twins 11 weeks early and raised £2,675 for the Neonatal Intensive Care Charitable Fund. Antony says:

'If it wasn't for the Neonatal Intensive Care Unit here at QA, my babies wouldn't be recovering as well as they are. I am now organising a charity boxing event, as I would love to give something back. I am so grateful for the care my babies are receiving and would like to raise as much money as I can to help save other children's lives.'

Dan Kirk ran the Great South Run 2015 and raised £1,110 for the Cardiology Charitable Fund. He said:

'In January 2013 my mum suffered a heart attack and was taken to the Cardiology Department at QA Hospital. With the skill of the surgeons they saved her life and for that I am truly thankful, and would like to raise as much money as I can to show them how much I appreciate the work they do.'

Lee Doak trekked the Sahara Desert in November 2015 for the Diabetes Patient Charitable Fund and raised £2,786. He said:

'I'm a British soldier and on the 10th April 2015 I was told I had Type 1 Diabetes and would have to change my life. I wanted to prove that with good management and a little effort Type 1 Diabetes is an illness which can be managed and a normal life can be had. I also wanted to take part in the Sahara Challenge and raise money for the charity to say thank you to the brilliant diabetic nurses at QA as I'd like to help them, help people like me.'

4 Research and Innovation

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

The last twelve months have been busy and rewarding for the Research and Innovation team. We have won 2 prestigious national awards, the HSJ Value and Improvement award in the Use of Diagnostics and the HSJ award for Improving Care with Technology.

Research and Innovation continues to thrive within the Trust. There are 150 research staff working across all clinical specialties. Nearly 3,000 patients have taken part in a clinical research study this year. Our research income increases year on year and we have received over £4.5million for our research activity.

We continue to rank in the top 20% nationally for our research activity. Twelve of our clinical specialties are in the national top 10 rankings for recruitment including ageing; gastroenterology; critical care; haematology; hepatology and respiratory with the latter 3 nationally top of the rankings.

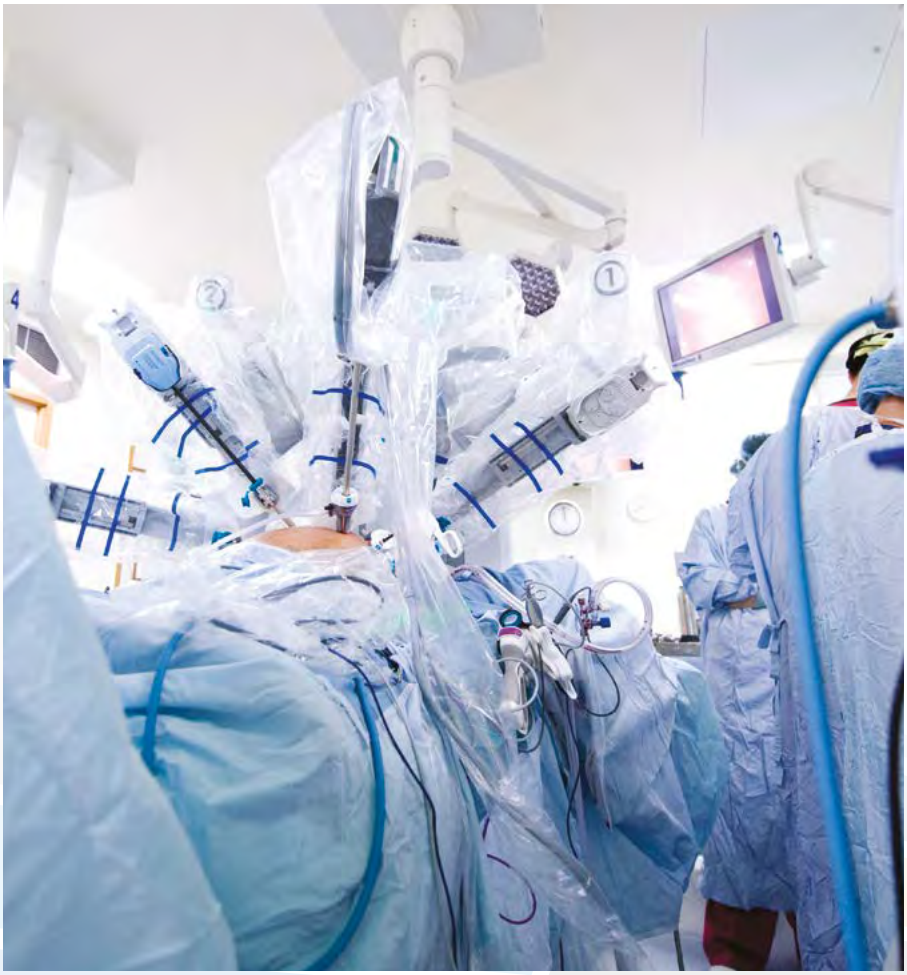
We ensure all of our health professionals make research part of their core business. We have also made research easier to do here in Portsmouth. We have an excellent Research and Innovation office that now designs and facilitates research for the benefit of our staff and patients. We also continue to develop clinical academic training pathways for nurses, midwives and junior doctors who are trained in the design and delivery of high quality research. In 2015/16 we supported 13 nurses and midwives to undertake a PhD whilst in clinical practice and 16 medical Fellows.

Headlines for our research and innovation throughout the last 12 months include:

- The Portsmouth Clinical Outcomes Research Group, established in 2013, uses clinical outcome data to demonstrate improvements in patient care using "VitalPAC". The Group continues to collaborate with the Fundamental Care in Hospital Research Group, NIHR CLAHRC Wessex, to research and publish aspects of patient safety. The Group were shortlisted for a BMJ Patient Safety Award in May and won the HSJ Improving Care with Technology award in November
- Our new service model called MISSION-Severe Asthma, funded by Wessex Academic Health Science Network, won the HSJ Value and Improvement award in the Use of Diagnostics category in September. MISSION Severe Asthma project uses a 'carousel clinic' model of assessment and care to improve diagnosis and treatment of uncontrolled asthma. It recognises the

benefits to be made in supporting self-care and enabling patients to manage their own condition. At the beginning of the sessions 64% of people who responded to a patient survey said that they felt confident or very confident in managing their asthma; at the end of the sessions this increased to 93%. Data from three participating surgeries also show a 24% reduction in oral steroid courses and a 25% reduction in non-routine GP appointments. Following a consultation from MISSION one patient said 'I actually feel I am now in complete control of my condition; it no longer worries me'

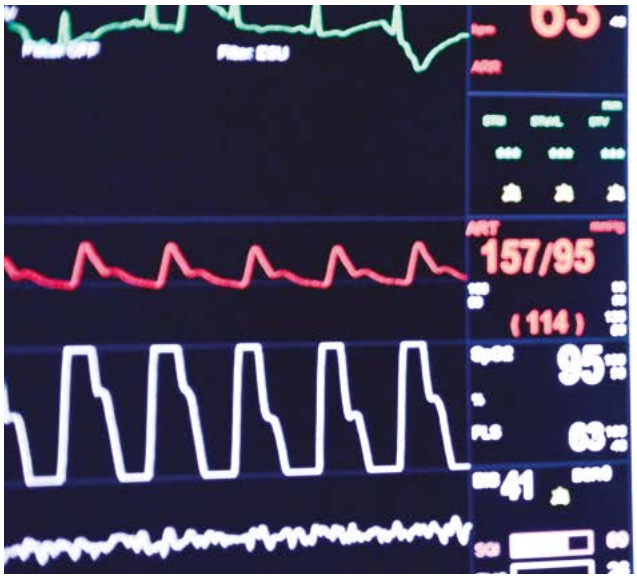
- Recognising the lack of treatment options for well phenotyped asthma patients the team recruited to a national randomised controlled trial (RCT). LASER is being led here in Portsmouth and is currently in follow up. This trial tests a new allergen reduction device for asthma patients. More can be found at www.lasertrial.co.uk
- The Research and Innovation annual conference held in May 2015 was well attended. Staff gave research presentations or presented their work in posters. Ashley Brooks, National Patient Champion gave an inspirational talk about the value of research in the NHS and the impact research has on the options for new treatments, drugs and services for our patients



5 Performance report - sustaining high quality services

We are monitored by the Care Quality Commission (CQC) against a range of targets and thresholds as published in the Operating Framework by both the CQC and the Trust Development Agency (TDA). Our trust board is provided with a monthly quality and performance report summarising quality, operational, finance and human resources performance which is discussed at public board meetings. A summary of performance against the key indicators and constitutional standards is published below.

	National Trust Development Agency Key Indicators & Constitutional Standards	Target	Trend	2015/16												Year to date
				A	M	J	J	A	S	O	N	D	J	F	M	
Responsive	% Incomplete Pathways < 18 weeks	92%		●	●	●	●	●	●	●	●	●	●	●	●	●
	Incomplete Patients waiting > 52 weeks	0		●	●	●	●	●	●	●	●	●	●	●	●	●
	Incomplete Patients waiting > 40 weeks	0		●	●	●	●	●	●	●	●	●	●	●	●	●
	Diagnostic waits: 6 weeks	99%		●	●	●	●	●	●	●	●	●	●	●	●	●
	Endoscopy waits: 6 weeks	99%		●	●	●	●	●	●	●	●	●	●	●	●	●
	4 hour arrival to admission/transfer/discharge	95%		●	●	●	●	●	●	●	●	●	●	●	●	●
	12 hour trolly waits	0		●	●	●	●	●	●	●	●	●	●	●	●	●
	All 2-week wait referrals	93%		●	●	●	●	●	●	●	●	●	●	●	●	●
	Breast symptomatic 2 week referrals	93%		●	●	●	●	●	●	●	●	●	●	●	●	●
	31 day diagnosis to treatment	96%		●	●	●	●	●	●	●	●	●	●	●	●	●
	31 day susequent cancers to treatment	94%		●	●	●	●	●	●	●	●	●	●	●	●	●
	31 day susequent anti-cancer drugs	98%		●	●	●	●	●	●	●	●	●	●	●	●	●
	31 day susequent radiotherapy	94%		●	●	●	●	●	●	●	●	●	●	●	●	●
	62 day referral to treatment	85%		●	●	●	●	●	●	●	●	●	●	●	●	●
	62 day screening to treatment	90%		●	●	●	●	●	●	●	●	●	●	●	●	●
	Cancer maximum wait to treatment 104 days	0		●	●	●	●	●	●	●	●	●	●	●	●	●
	Cancelled urgent operations	0		●	●	●	●	●	●	●	●	●	●	●	●	●
	Urgent operations cancelled fo a 2nd time	0		●	●	●	●	●	●	●	●	●	●	●	●	●
	Urgent operations: 28 day guarantee	0		●	●	●	●	●	●	●	●	●	●	●	●	●
	Total bed days blocked	N/A		●	●	●	●	●	●	●	●	●	●	●	●	●
	Delayed transfer of care	3.5%		●	●	●	●	●	●	●	●	●	●	●	●	●
	30 days emergency readmissions	N/A		●	●	●	●	●	●	●	●	●	●	●	●	●



During the past year the Trust continued to experience significant pressure across several integrated performance measures, with high levels of unscheduled care demand impacting on scheduled care delivery. Despite this challenging operating environment, the Trust delivered improvements across all NHS constitutional standards with the exception of the 4 hour A&E standard, thanks to the dedication and commitment of staff throughout the Trust.

The 4 hr standard has not been achieved; there were 10,300 A&E attendances (8%) more than the previous year. The Trust, working with community partners and supported by the national improvement team, has developed a robust recovery plan. Central to this is the safety of patients with incremental and sustained pathway enhancements to improve flow through the hospital and deliver performance of 90% by the end of 2016/17.

Cancer services continued to focus on reducing the backlog of patients waiting to be treated. Demand for cancer services continues to increase. Despite these challenges, careful management of the position by the multi-disciplinary cancer team meant that there have been improvements across all 8 of the key standards and the Trust will be in a position to deliver these sustainably going forward. 7 of the 8 standards have been delivered for the year as a whole. The 62 day standard has not been achieved. This has been driven by increased demand and a shortfall in capacity, which has been addressed, and the Trust has in place an improvement trajectory, supported by a robust improvement plan, to deliver sustainable performance from September 2016.

While Referral Time to Treat (RTT) delivery was impacted by high demand for unscheduled care the Trust achieved this national standard overall. The Trust took the decision during winter to reduce and cancel non-urgent elective appointments to ensure that emergency patients had access to the life-saving expertise of our clinical teams. This resulted in an increase in the waiting list for surgery and non-delivery of the planned reduction in over 35 week waits for treatment. This is not a situation we want to continue and we are reviewing options with our commissioners to ensure the bed capacity is in place to support the needs of all patients.

The Trust has made significant improvements to the delivery of the six week diagnostic standard which is a key component of delivery of the 18 week standard and delivered this despite increasing demand in 11 out of 12 months.

Our Emergency Department performance remained challenging with attendances higher than in previous years, particularly after 1900hrs. An increasing acuity and age profile further impacted on flow through the hospital. In addition, the number of patients medically fit for discharge increased significantly, to a high point of 190 patients staying longer in an acute hospital bed than they needed to.

We continued to work with partners to increase care at home, and in the community to support earlier discharge once a patient is medically fit, which is better for the patient's health and well-being. It also releases a bed for the next patient who is acutely unwell.

This metric continues to be our key performance priority to improve during 2016/17. An Unscheduled Care Improvement Plan has been developed, based on national best practice, to materially improve performance in this area and improve the overall patient experience in this particular pathway.

Key areas of focus going forwards include:

- Improved patient flow within the Emergency Department
- The redesign of the 'Medical Take Model' to ensure the timely assessment of medical patients
- Increased focus on the effective and timely turnaround of short-stay patients
- The transformation of the Acute Medical Unit to accommodate patients up to a 24 hour period
- An increase in the level of ambulatory care provision, preventing the need for an inpatient admission
- Improving the timeliness of ward-based discharges
- An increased focus on the Acute Frailty Pathway including early comprehensive interdisciplinary assessment
- Streamlined site operations to maximise patient flow

Key risks to the successful implementation of the Unscheduled Care Improvement Plan include a continuing increase in demand for Emergency Department services and the continued high level of medically fit for discharge patients in the hospital. These risks are regularly discussed with external partners to ensure appropriate risk mitigation strategies are put in place and continuously monitored.

We continue to monitor, measure and further develop our services. Our performance against targets is measured at a specialty level on a daily basis in the context of weekly internal trajectories and monthly external trajectories. These trajectories will be reviewed on a weekly basis at a performance meeting. Whilst the 18 week target is measured at Trust aggregate level, we are planning to achieve the target at specialty level through the development of action plans in specialties that have been traditionally more challenged.

Our cancer pathways will continue to be measured and reviewed on a daily basis across all specialties. This is particularly important due to the expected variation in referrals throughout the year and the need to flex capacity across a range of teams to ensure that patients are reviewed, assessed and treated in a timely manner. A particular focus, due to an identification of the risk of delays in pathway management, will be placed on the development of appropriate mechanisms to ensure the timely treatment of patients from hospitals that refer patients to us.

Other key input indicators (e.g. discharge numbers by ward and time of day) will also be measured and analysed on a daily basis. Trajectories have been calculated and agreed to deliver incremental and sustainable improvement throughout the year.

Principles for Remedy

To ensure that our vision and values are at the forefront of everything we do, openness, transparency and dealing with any issues that may arise in a confidential, timely, consistent, fair and appropriate manner is fundamental.

It is a right of employees, should they have any concerns about wrong doing at work, to be able to raise these concerns via the Trust's Whistle Blowing Policy. Any disclosure or 'whistle-blow' is handled in a confidential manner, taken seriously and investigated appropriately.

This year four issues were raised, three were investigated and appropriately resolved with no impact to patient care; and one allegation remains outstanding, subject to on-going investigation.

We have policies in place for handling complaints and a claims management process that adheres to the six principles of good practice outlined in the HM Treasury Guidance on Managing Public Money (October 2007) as well as Health Service Parliamentary Ombudsman and NHS Litigation Authority guidelines.

This ensures that an effective and timely investigation can be instigated and a response given to any claim, including allegations of clinical negligence, public liability or personal injury. This also helps to reduce the occurrence of incidents and events, which may give rise to future claims.

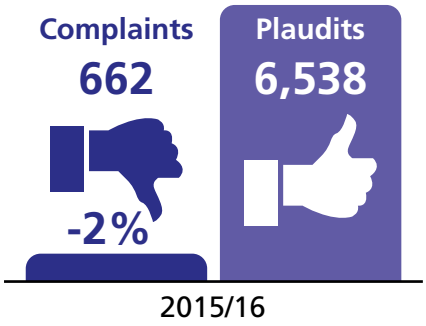
All of our staff working throughout the various departments and wards within the hospital are dedicated to finding new ways of improving our standards of care and making sure that patients, relatives and visitors all have a positive experience when they come to the hospital.

This is certainly appreciated given the number of plaudits and messages of thanks we receive every day from patients and visitors. However, we are also aware that things may go wrong from time to time and when it does we expect staff within the ten Clinical Service Centres to resolve things as quickly as possible.

The Patient Advice & Liaison Service (PALS) has been set up to make sure that people feel comfortable to share any concerns they may have in a supportive and helpful environment.

All of our services are focused on improving care and the patient experience. Whilst our services continue to receive many plaudits we fully recognise the need to respond quickly and effectively to feedback.

In the last year we were delighted to receive 6,538 plaudits. Our complaints reduced 2% on the previous year to a total of 662. We worked hard to increase awareness of PALS service and as a consequence saw a 27% increase in requests. This rose from 1,585 to 2,171 in 2015/16.



Health, safety and wellbeing

The numbers of reported staff incidents have seen a slight rise throughout 2015/16, increasing 12% on last year's figures.

Whilst we continue to strive for reductions in the overall numbers of staff incidents occurring it is clear that staff awareness and improved procedures have encouraged far better reporting, particularly relating to violence and aggression and needle stick incidents.

Alongside the management of staff safety we have seen an increase in the promotion and encouragement of good health across our workforce, with a number of successful health and wellbeing initiatives being held throughout the year.

We are well-prepared for any emergencies which might occur, either in the hospital or in the wider community. We need to be able to plan for, and be prepared to respond to, a wide range of incidents which could impact on health or patient care.

We have plans in place as a Category One responder for major incidents. Alongside policies and plans relating to major incidents, such as extreme weather, a major transport incident or an outbreak of infectious disease, we also have plans in place to ensure

business continuity. Our plans have been created in response to local and national risk registers and have been reviewed via table top exercises.

Throughout the year we have continued to keep our staff well-informed about departmental plans and roles in the event of a major incident and many have attended external and internal training.

Managing staff sickness

We are committed to the on-going health and wellbeing of our staff and we have HR policies and procedures in place to support staff and managers within the Trust.

The average staff sickness level for the year was 3.8% compared to 3.4% in the previous year. We have several measures in place to ensure that absence is managed appropriately and to ensure the fair and sensitive management of employees who are unable to fulfil their contractual duties due to ill health or disability.

Ensuring a sustainable future

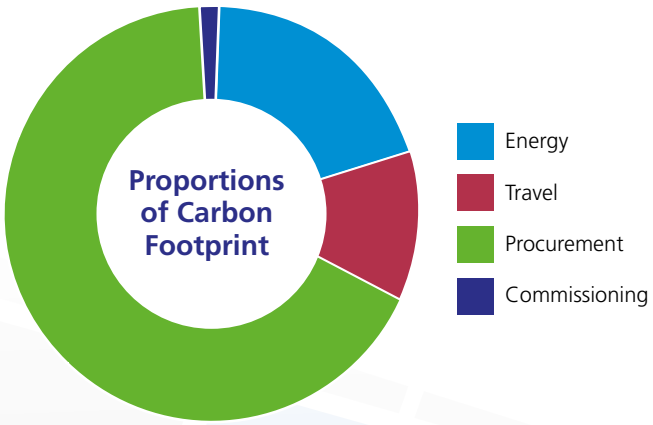
The Trust monitors its environmental performance against the targets set by the Department of Health for reducing our carbon footprint. We identify energy use, procurement and travel as our largest contributors to emissions.

The increasingly evident effect of climate change on UK weather patterns means we may need to adapt in response to extreme weather events. Climate change brings new challenges to our organisation, potentially affecting our estate and local public health and we are working on a plan for potential climate change risks affecting our local area. We are also updating our Sustainable Development Management Plan and a new Travel Plan.

NHS England has set a target of a 34% reduction in carbon footprint by 2020 and a 50% reduction by 2025. This is to back up the Government's Climate Change Act target of 80% reduction by 2050. We support this strategy and are working hard to achieve it. With the support of our partners we take the opportunity to promote carbon reduction to our staff, visitors and the general public.

Our Carbon Footprint

Using the latest modelling guidance provided by the Sustainable Development Unit of NHS England we calculate the Trust's carbon footprint as 125,966 tonnes of Carbon Dioxide equivalent (CO_2e). The graph shows a high-level breakdown of these emissions.

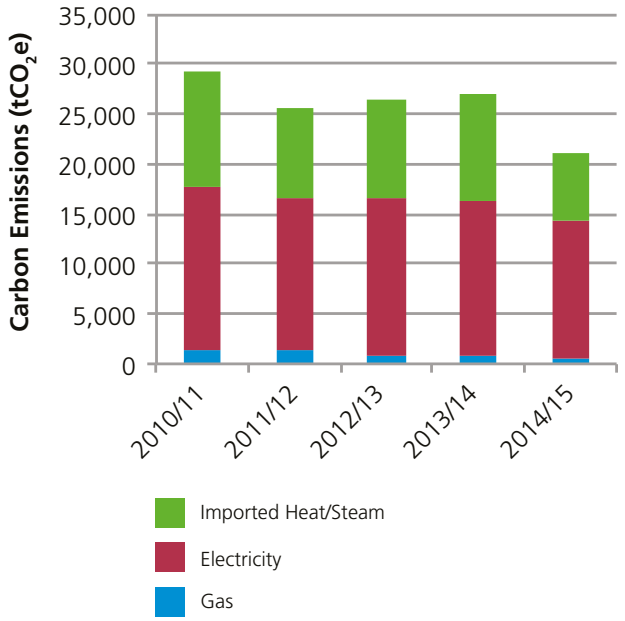


Energy

Since the baseline reporting year of 2007/8, the Trust has increased in size and is seeing more patients. However, our energy consumption continues to reduce;

Context info	2007/08	2012/13	2013/14	2014/15
Floor Space (m2)	134,869	189,125	183,689	159,809
Number of Staff (wte)	5940	6185	6276	6142
Total Patient Contacts	887,538	909,284	945,154	1,013,818

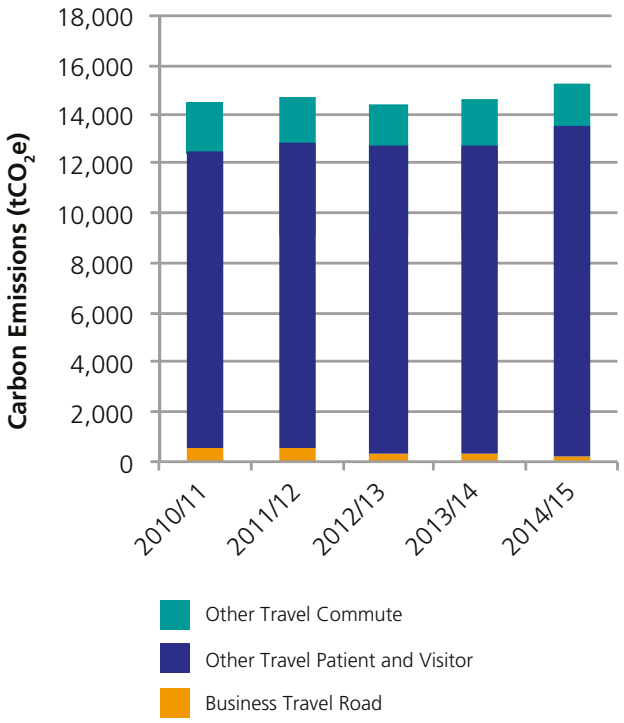
Energy Related Emissions



Travel

Our travel carbon footprint has remained largely unchanged with a slight increase attributable to our increase in patient activity. We continue to promote alternative means of commuting to our staff and provide facilities to support cycling and walking to work.

Travel Related Emissions



We have withdrawn from the CRC Energy Efficiency Scheme by virtue of the Government's simplification exercise. We remain compliant with the European Union Emissions Trading Scheme and the Energy Efficiency of Buildings Directive.

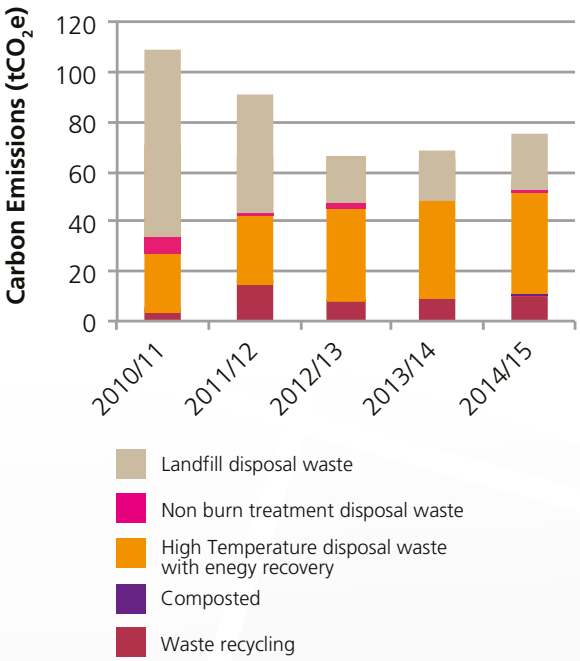
Working with our PFI Partner we have identified practical ways to reduce our energy consumption, identifying potential invest to save schemes as well as operational improvements. We are actively seeking funding for these schemes.

Our Information Technology service has exchanged most desktop PCs with "thin clients", giving better performance at lower electricity consumption. We continue to promote energy use reduction amongst our staff whilst at work and at home and have delivered briefings on procurement, transport and waste disposal.

Waste

Overall waste generation has increased and we are investigating the potential causes. Waste segregation and recycling schemes continue to be extended throughout the organisation and these will contribute to a significant carbon saving as well as financial benefits.

Waste Related Emissions

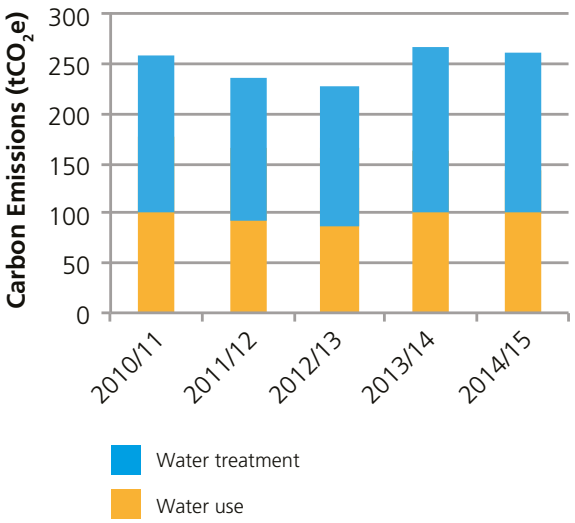


Waste segregation schemes include reclassification of clinical wastes allowing more appropriate methods of disposal with lower carbon intensity. Waste recycling schemes include cardboard baling and mixed waste segregation, which is currently deployed in non-clinical areas with a plan to extend to the whole organisation.

Water

Carbon emissions due to water consumption and waste water treatment have reduced.

Water Related Emissions

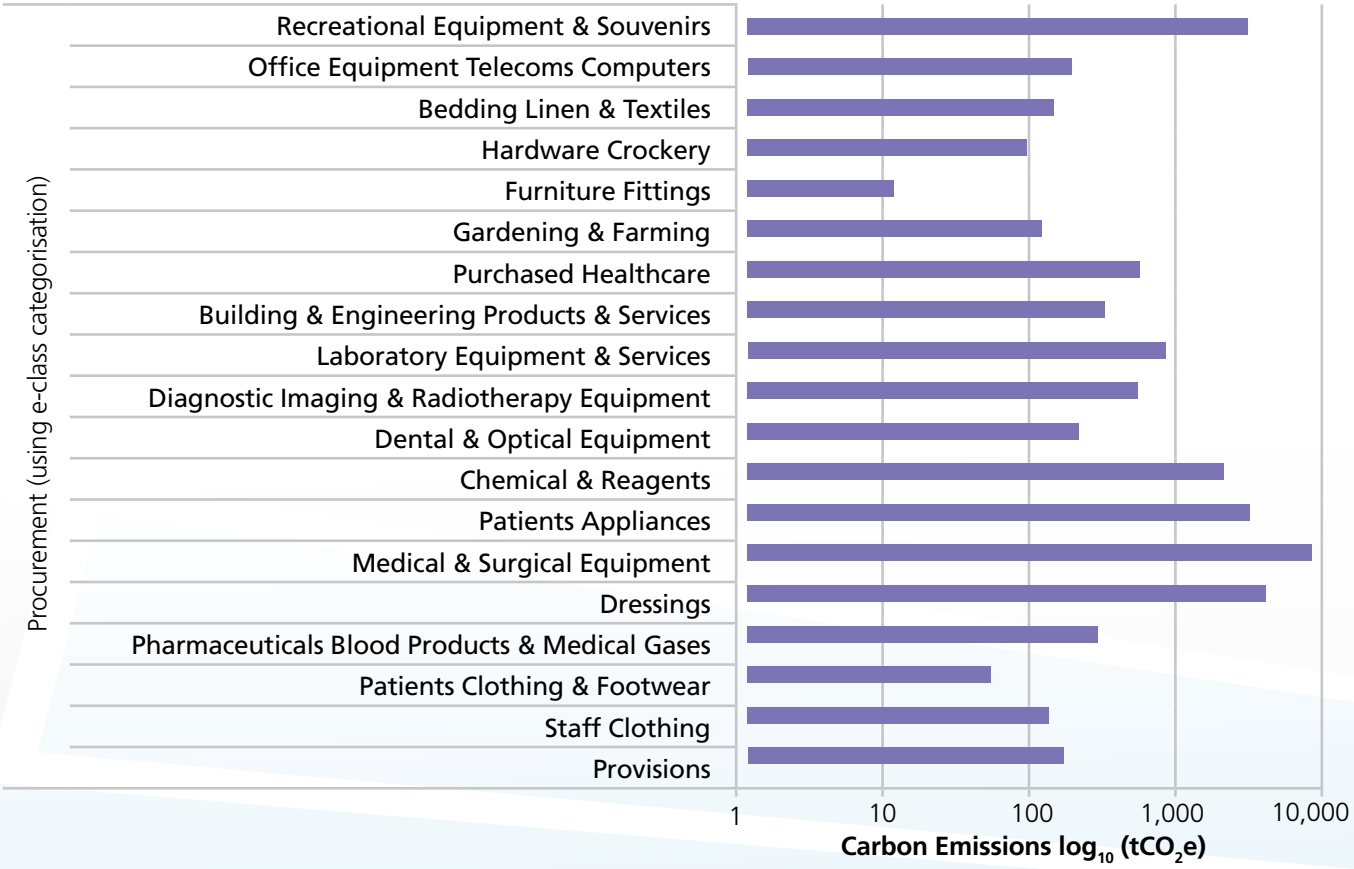


We are working with our PFI partners to reduce water wastage. Underground water leakage has been virtually eliminated.

Procurement

In seeking tenders for goods and services the Trust includes an assessment of the environmental and social aspects of the procurement. Our Procurement Service ensures that tenderers for goods and services demonstrate their commitment to sustainability thereby ensuring our supply chain carbon footprint is minimised. The latest guidance for reporting on procurement related emissions has been used to analyse our current procurement carbon footprint.

Procurement Related Emissions



6 Directors' accountability report

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 experienced the following externally-reportable serious incident in 2015/16.

Externally Reportable Incident

Date of incident (month)	Nature of incident	Nature of data involved	Number of data subjects potentially affected	Notification steps
August 2015	Safeguarding Alert form left in birthing room and found by person unconnected to the alert.	Name, unique identifying number, high risk confidential information	1	ICO reported – outcome no further action.
June 2015	Excel document containing approximately 8,000 patient details sent to incorrect recipient via secure, NHSMail e-mail	Name, unique identifying number and detailed clinical information	c. 8,000	ICO reported – outcome no further action.
March 2016	Referral letters for Portsmouth Dermatology sent to IOW Dermatology	Name, unique identifying number and detailed clinical information	<10	Reported to ICO externally – under investigation.

Lower Severity Incidents

Category	Breach Type	Total
A	Corruption or inability to recover electronic data	**0**
B	Disclosed in Error	**69**
C	Lost in Transit	**0**
D	Lost or stolen hardware	**0**
E	Lost or stolen paperwork	**5**
F	Non-secure Disposal – hardware	**0**
G	Non-secure Disposal – paperwork	**7**
H	Uploaded to website in error	**1**
I	Technical security failing (including hacking)	**0**
J	Unauthorised access/disclosure	**6**
K	Unsecure transport / storage	**13**

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 2015/16 was 75% compared to our 2014/15 score of 85%. Importantly, our submission is graded as 'Satisfactory' as the minimum expected level of compliance was achieved against all 45 Toolkit standards.

Freedom of Information

We received 546 Freedom of Information requests in 2015/16, a slight increase on 539 requests in 2014/15. 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.

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 group and staff. A further eight 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 Trust Board periodically to challenge and comment on Trust plans. It co-organises Trust Open Days and holds public constituency meetings throughout the year where Trust members can ask questions, give feedback and hear about new initiatives. These meetings give local people a chance to comment on the running of their hospital and for the Governors to follow up on this information.

Fareham and Gosport constituency

Lucy Docherty
David Gattrell
Richard Mackay
Mary Sheppard

Havant and East Hampshire constituency

Frances Bates (until April 2015)
Jocelyn Booth
Kate Bowskill
Roland Howes
Ernie Wells

Portsmouth City constituency

Sarah Edmonds
Tom Hart
Robin Lander-Brinkley
Lez Ward

Parent/Carer constituency

Pepe Chisenga (until November 2015)
Dr Robin Marsh

Staff Governors

Mr Anthony Evans
Jayne Jempson
Les Jones

Appointed Governors

- Stephen Arkle, University of Portsmouth
- Julia Barton - Fareham and Gosport CCG
- Cllr Gwen Blackett, Havant Borough Council
- Cllr Jennie Brent – Portsmouth City Council (from June 2015)
- Commodore Peter Buxton (from October 2014)
- Cllr Peter Edgar, Hampshire County Council
- Adel Resouly - South East Hants CCG
- Norman Robson – West Sussex

Portsmouth Hospitals' Trust Board

The Board comprises a Chairman, Non-Executive Directors and Executive Directors.

Portsmouth Hospitals' Trust Board is accountable for setting strategic direction, monitoring performance against local and nationally set objectives; ensuring high standards of performance are maintained and promoting links between Portsmouth Hospitals and the local community.

The Board has two mandatory committees whose membership is formed by Non-Executive Directors:

- **The Audit Committee provides an independent and objective review of our internal controls. Membership is currently held by Steve Erskine, Liz Conway and Mike Attenborough-Cox**
- **The Remuneration and Nominations Committee approves substantive appointments of Executive Directors and approves their remuneration, including any bonuses**

Chairman

Sir Ian Carruthers
Chairman from June 2014

In his 46 year NHS career, Sir Ian has overseen many major service changes and is a champion of change to deliver better outcomes for patients, staff and communities. He received a Knighthood in the 2003 New Year's Honours List for services to the NHS. Sir Ian has undertaken the role of Chief Executive at all levels in the NHS and, in March 2006 became Interim Chief Executive of the NHS and was responsible for running one of the largest organisations in the world, having 1.3 million employees and a budget in excess of £100 billion.

Sir Ian is currently Chancellor of the University of the West of England; Chair of the Healthcare UK Governance Board; Chair of 2020 Delivery Board; Chair of NHS Supply Chain Customer Board; Non-Executive Director of Bioquell plc.; Non-Executive Director of OR International; Non-Executive Director of Centric Health and acts as an independent advisor to NHS Chief Executives, NHS and private sector organisations.

Non-Executive Directors

Michael Attenborough-Cox joined the Trust Board in March 2015. A qualified accountant and internal auditor, Mike was a partner at Mazars LLP for 13 years. He has extensive experience of working within public sector organisations with previous roles including 12 years as an independent member of Hampshire Police Authority and three years as Chair and Non-Executive Director of the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust. He is Chair of the Joint Audit Committee of the Police and Crime Commissioner and Chief Constable for Hampshire, and a member of the Audit and Risk Committee of the Foreign and Commonwealth Office Services Department and the Royal Institute of Chartered Surveyors. He has recently been appointed chair of the Small Bodies Audit and Appointments Ltd and a member of the Local Audit Delivery Board.

Elizabeth Conway joined the Trust Board in October 2009 and has 30 years as a marketing specialist in the pharmaceutical and health care industry. Having an extensive range of operational and commercial business experience she has founded and developed two successful businesses specialising in Healthcare Communications.

Steve Erskine joined the Trust Board in May 2011. His background is in information technology, logistics and business development 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.

Mark Nellthorp 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.

Mr John Smith joined the Trust Board in March 2015. He was a Consultant Surgeon in Sheffield for 29 years but spent the last three in Edinburgh as President of the Royal College of Surgeons. At various times he chaired the Joint Committee on Higher Surgical Training; the Senate of Surgery and the Joint Committee on Inter-Collegiate Exams. He was a member of the Post-graduate Medical Education and Training Board and a Trustee of Diverse Abilities, a charity based in Dorset, dealing with severely disabled people. He was awarded CBE in the New Year's Honours 2008.

Alan Cole (left October 2015) – Deputy Chairman and Interim Chairman from January 2013 until June 2014. He joined the Board in 2006 and left in October 2015. He has held a number of senior financial positions and has wide experience of leading professional, multi-disciplinary, client-focused teams.

Portsmouth Hospitals' Trust Board

Executive Directors

Ursula Ward
Chief Executive

Ursula has held the Chief Executive post for 12 years. She was initially appointed to the Trust in August 1999 as Director of Nursing and Midwifery and was then appointed as Deputy Chief Executive in 2002. She has a clinical background, predominantly in Cardiology and Cancer care, as well as a strong background in research. She spent a number of years in general management before coming to Portsmouth.

She plays a significant role in bringing together the Military personnel into the NHS workforce, culminating in the establishment of the military hospital unit in the Trust. She was instrumental in reconfiguring services across the three original hospitals: Queen Alexandra in Cosham, St Mary's in Milton and Royal Haslar in Gosport. Following Treasury approval, she led the process that secured the building and commissioning of the new Queen Alexandra hospital as it is today.

She is passionate about patient safety and the patient experience, and continues to pursue strategies that improve the care for patients through targeted approaches to organisational development, with a particular emphasis on staff led change and leadership development.

Her responsibilities include leading, developing and delivering the organisation's strategy and objectives, ensuring that the health needs of the population are met.

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.

Cathy Stone
Director of Nursing

Before joining the Trust Cathy had been Director of Nursing at Western Sussex Hospitals Foundation Trust since 2009. She joined the Trust in 2015. A registered nurse and midwife, Cathy has a special interest in neonatology and participated in the national steering group which developed the first Advanced Neonatal Nurse Practitioner role in the country. In support of her clinical background, Cathy has an MSc in Healthcare Management and has previously held senior general manager positions in other Trusts.

Christopher Adcock (joined October 2015)
Finance Director.

Chris has worked in the NHS since 1997. He was Chief Financial Officer at Brighton and Sussex University Hospitals from 2009 to 2013, and Director of Finance for University Hospitals of North Midlands from 2013 before joining the Trust.

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.

Simon Jupp
Chief Operating Officer (from November 2014 until March 2015) now Director of Strategy.

Simon brings 20 years of NHS experience, 11 of which have been at Board Level. He spent five years as Chief Operating Officer at University Hospitals Southampton, then six as Director of Commissioning for NHS England (Wessex), formerly Hampshire PCT, focusing on Specialised Commissioning, Primary Care and Public Health.

Ed Donald
(joined in March 2015) Chief Operating Officer.

Ed was previously Chief Executive at Royal Berkshire NHS Foundation Trust. Other roles include Chief Operations Officer at Imperial College Healthcare NHS Trust, where he played a key part in the creation of the first Academic Health Science Centre in the NHS.

Richard Eley
(left October 2015) Interim Director of Finance.

Richard is a Chartered Accountant with over 20 years' experience of working as a Finance Director at Board level in health and University sectors.

Directors reports statements and disclosures

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

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

Surname	First Name	Job title	Interests (Y/N)	Details
Donald	Ed	Interim Chief Operating Officer	Yes	Ed Donald Consulting Ltd
Holmes	Simon	Medical Director	No	
Jupp	Simon	Director of Strategy	No	
Powell	Tim	Director of Workforce and Organisational Development	No	
Stone	Cathy	Director of Nursing	No	
Ward	Ursula	Chief Executive	No	
Adcock	Christopher	Director of Finance	No	
Eley	Richard	Interim Director of Finance (left October 2015)	-	
Attenborough-Cox	Michael	Non-Executive Director	Yes	Director of the Institute of Group Analysis
Carruthers	Ian	Chairman	Yes	NED - Bioquell NED OR International Chair - 2020 Delivery Chair - Healthcare UK Chair - NHS Supply Chain Customer Board Co-Chair - Prime Ministers Dementia Challenge Director - IJC Healthcare
Cole	Alan	Non-Executive Director (left October 2015)	No	
Conway	Elizabeth	Non-Executive Director	No	
Erskine	Steve	Non-Executive Director	No	
Nellthorp	Mark	Non-Executive Director	No	
Smith	John	Non-Executive Director	Yes	Trustee of Charity Diverse Abilities

Disclosure of Interests

- **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, former Non-Executive Director, is owner of Simply Green Garden Designs Ltd. The company has no business dealings with Portsmouth Hospitals NHS Trust.**

In addition to the 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 Clinic Ltd in 2015/16 was £131k.

Remuneration Policy

Remuneration for staff is set through nationally agreed terms and conditions as detailed in Agenda for Change, and the national contracts for Consultants and Junior Doctors. The Trust is compliant in its application of these policies. Remuneration for Executive Directors is overseen by the Remuneration Committee, the terms of reference for which are clearly set out on the Trust's website. Full details of the remuneration policy can be found on page 41.

Pension liabilities

We are an employer with staff entitled to membership of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales.

The scheme is accounted for as if it were a defined contribution scheme; further details can be found in the Trust's accounting policy at note 10.6 in the Trust's Annual Accounts.

Countering fraud

We have a zero tolerance of fraud and 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.

We publicise our policies and procedures on counter fraud on our website, www.porthosp.nhs.uk, and counter fraud awareness training is mandatory for all staff as part of their Trust induction.

Cost allocation/setting of charges for information

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

Prompt Payment Code

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

The Prompt Payment Code sets standards for payment and the Better Payment Practice code target set for all public sector bodies is set at 95%. We have achieved 93%.

Further details of performance against the Better Payment Practice Code can be found at Note 11 in the Annual Accounts.

Statutory Accounts

Annual Report 2015/16

The accounts of Portsmouth Hospitals NHS Trust for the year ended 31st March 2016 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 23rd May 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 2015/16 annual accounts for statutory work carried out by external audit is £81,000 exclusive of non-recoverable V.A.T. Of this sum, £60,750 has been charged to 2015/16 and the balance, £20,250, will be charged in 2016/17.

Financial Summary

The following financial information is a summary taken from the Trust's Annual Accounts shown on pages 56 to 96 of this report. The accounts are also available from the Director of Finance on 023 9228 6649 or at:

http://www.porthosp.nhs.uk/about-us/publications/publications-index.htm

Financial Performance in 2015/16

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

- **The Trust made a revenue deficit of £23.5m 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 2015/16 this was £2.2m.**
- **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, 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.**

Finance Director's Report

The Trust has ended the 2015/16 financial year with a reported deficit of £23.5m. This position consists of both the 'retained' deficit of £26.4m and the 'technical' adjustments (see above) as summarised below:

	£'000	£'000
Retained deficit for the year		(26,361)
IFRIC 12 adjustments (UK GAAP to IFRS)	2,481	
Impairments (Asset Revaluations)	(79)	
Adjustment in respect of donated asset reserve	482	2,884
Adjusted Retained Deficit		**(23,477)**

Further information can be found in the Financial Sustainability section on page 13.

Audit Committee

The Trust has an Audit Committee comprising three Non-Executive Directors and the committee membership during 2015/16 was:

- Steve Erskine - Non-Executive Director (Committee Chairman until December 2015)
- Mike Attenborough-Cox – Non-Executive Director (Committee Chairman from January 2016)
- Liz Conway – Non-Executive Director (from November 2015)
- Alan Cole – Non-Executive Director (until October 2015)

Representatives from External Audit, Internal Audit and Counter Fraud attend the Audit Committee along with the Director of Finance, Director of Corporate Affairs, Head of Financial Accounting and Head of Governance. 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 2015/16 comprised;

- Alan Cole - Non-Executive Director
- Mark Nellthorp - Non-Executive Director & Senior Independent Director
- Elizabeth Conway - Non-Executive Director
- Steve Erskine - Non-Executive Director
- Mike Attenborough-Cox – Non-Executive Director
- Dr John Smith – 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 2015/16

On pages 98-101 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 2015/16 was £185k-£190k, which was the Chief Executive and her salary was comparable with 2014/15. The Chief Executive's salary was 7.1 times (2014/15, 6.9 times) the median remuneration of the workforce which was £26,041 (2014/15, £26,822).

In 2015/16, no employees received remuneration in excess of the highest-paid director (2014/15, none).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

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.

'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 2016 and new 'off-payroll' engagements between 1 April 2015 and 31 March 2016 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 2016

	Number
Number of existing engagements as of 31 March 2015	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 2014 and 31 March 2015 > £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	4
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	4
Number for whom assurance has been requested	4
Of which:	
assurance has been received	4
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:

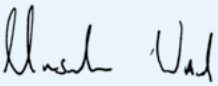
- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

- 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.

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

I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Date: 27th May 2016 Signed:  Chief Executive.

Statement of directors' responsibilities in respect of the accounts

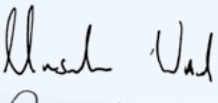
The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised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

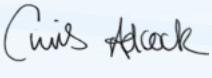
- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and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

Date: 27th May 2016 Signed:  Chief Executive.

Date: 27th May 2016 Signed:  Finance Director.

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

We have audited the financial statements of Portsmouth Hospitals NHS Trust for the year ended 31 March 2016 under the Local Audit and Accountability Act 2014. The financial statements comprise the Trust's Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1-44. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2015-16 Government Financial Reporting Manual (the 2015-16 FReM) as contained in the Department of Health Group Manual for Accounts 2015-16 and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

We have also audited the information in the Remuneration and Staff Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes;
- the table of pension benefits of senior managers and related narrative notes;
- the tables of exit packages and related notes;
- the analysis of staff numbers and related notes; and
- the table of pay multiples and related narrative notes.

This report is made solely to the Board of Directors of Portsmouth Hospitals NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Directors, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of Directors, the Accountable Officer and auditor

As explained more fully in the Statement of Directors' Responsibilities in respect of the Accounts, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards also require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

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

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

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

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the directors; and
- the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report and accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2015, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined

this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

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

Opinion on the financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of Portsmouth Hospitals NHS Trust as at 31 March 2016 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the National Health Service Act 2006 and the Accounts Directions issued thereunder.

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Accounts Direction made under the National Health Service Act 2006; and
- the other information published together with the audited financial statements in the annual report and accounts is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters:

- in our opinion the governance statement does not comply with the NHS Trust Development Authority's guidance; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

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

- Proper arrangements to secure economy, efficiency and effectiveness

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

Basis for qualified conclusion on reporting by exception

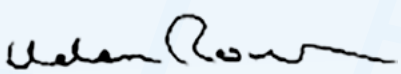
The Trust was set a deficit budget of £9.7 million for the year ended 31 March 2016, but reported a deficit of £23.5 million in its financial statements for the year then ended. The Trust has agreed to deliver a surplus of £1.2 million for 2016/17. This is dependent upon achieving a £32.3 million cost improvement plan, with £14.5 million support from the Sustainability and Transformation Fund. The Trust reported a cumulative breakeven position of £26.4 million as at 31 March 2016, which is the second year of cumulative deficit. This would result in a likely cumulative deficit, at the end of the three year breakeven recovery period, of £25.2 million, which would mean the Trust will breach its duty, under paragraph 2 (1) of Schedule 5 the National Health Service Act 2006, to break even.

Qualified conclusion on reporting by exception

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2015, with the exception of the matters reported in the basis for qualified conclusion paragraph above, we are satisfied that, in all significant respects, Portsmouth Hospitals NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

Certificate

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



Helen Thompson
for and on behalf of Ernst & Young LLP

Southampton
31 May 2016

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, 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 care needs of the population, but also to manage the risks associated with the achievement of the organisation's strategic objectives. To this end, the Trust has met regularly throughout the year with both the 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

Board Committee Structure

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

The Director of Corporate Affairs is the Trust Secretary and provides senior leadership in corporate governance. The Board approves an annual schedule of business in order to monitor which items the Board has received and to add additional items as required. Exception reports to the Board ensure that the Board considers the key issues and makes effective use of its time. The Trust Board met a total of 9 times during the year and Board papers are published on the Trust website.

Trust Board attendence record	30-Apr-15	28-May-15	29-Jun-15	30-Jul-15	24-Sep-15	29-Oct-15	03-Dec-15	04-Feb-16	03-Mar-16
Directors									
Ursula Ward	✓	✓	✓	✓	✓	✓	✓	✓	✓
Simon Holmes	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tim Powell	✓	✓	✓	✓	✓	✓	✓	✓	✓
Peter Mellor	✓	✓	✓	✓	✓	✓	✓	✓	✓
Simon Jupp	✓	✓	✓	✓	✓	✓	✓	✓	✓
Cathy Stone	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ed Donald	✓	✓	✓	✓	✓	✓	✓	✓	✓
Richard Eley	✓	✓	✓	✓	✓				
Chris Adcock						✓	✓	✓	✓
Non-Executive Directors									
Sir Ian Carruthers	✓	✓	✓	✓	✓	✓	✓	✓	✓
Alan Cole	✓	✓	✓	✗	✓	✓			
Elizabeth Conway	✓	✓	✓	✗	✓	✓	✓	✓	✓
Mark Nellthorp	✓	✓	✓	✓	✓	✓	✓	✓	✗
Steve Erskine	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr John Smith	✓	✓	✓	✓	✓	✓	✓	✓	✓
Michael Attenborough-Cox	✓	✓	✓	✓	✓	✗	✓	✗	✓

Attended ✓

Apologies given ✗

The Trust's Standing Orders, Standing Financial Instructions and Reservation and Delegation of Powers were updated in March 2016 to take account of changes to the Trust's governance arrangements and legislation. The Standing Orders were adhered to throughout the year and no suspensions were recorded.

Board Performance

Membership of the Trust Board consists of the Trust Chair, 5 independent Non-Executive Directors and 7 Executive Directors, of which 2 are non-voting. The Trust Board continually seeks to improve its effectiveness and regularly reviews its work streams and meeting agendas to ensure that it is strategically focussed. Work continued throughout 2015/16 on the wider development of the organisation with specific emphasis on how we engage with our staff in a way that supports continuous improvement of the services we provide.

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. The Chief Executive reviews the performance of Executive Directors. This latter review takes account of the Non-Executive Directors views of the effectiveness of the Executive team. Following the retirement of one of the Non-Executive Directors, (completion of second term of office), the designate Non-Executive Director became a substantive appointment. The terms of office of two other Non-Executive Directors were extended. A substantive Chief Operating Officer was appointed. A substantive Director of Finance was also appointed, replacing the interim Director of Finance. A comprehensive record of attendance at meetings of the Trust Board is maintained.

The Trust Board fully subscribes to the principles within the September 2014 Corporate Governance Code of accountability, transparency, probity and focus on sustainable success and the Nolan principles. Each Director of the Trust has passed the 'fit & proper person' test.

Board Committees

The Board has overall responsibility for the effectiveness of the governance framework and requires that each of its sub-committees has agreed terms of reference which describes the duties, responsibilities and accountabilities, and describes the process for assessing and monitoring effectiveness.

To underpin an effective governance framework, the Board was supported during 2015/16 by a robust committee structure; further review of this structure and all sub-Board committee terms of reference was undertaken in January 2016. The sub-committees are:

- Audit Committee (mandatory).
- Appointments and Remuneration Committee (mandatory).
- Governance and Quality Committee which is chaired by a Non-Executive director and ensures that there is continuous and measurable improvement in the quality of the services provided, and 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.
- Finance and Performance Committee which is chaired by a Non-Executive director.
- Risk Assurance Committee which is chaired by a Non-Executive-director. Following the Committee structure review, this committee which previously reported to the Governance and Quality Committee is now a formal sub-committee of the Board. This committee promotes effective risk management and maintains and monitors the Board Assurance Framework and the Risk Register. The Committee also promotes local level responsibility and accountability and challenges risk assessment, mitigation, risk assurance arrangements, and outcomes in any area of the Trust activity where robust controls are not evident, in order to raise standards and ensure continuous improvement.

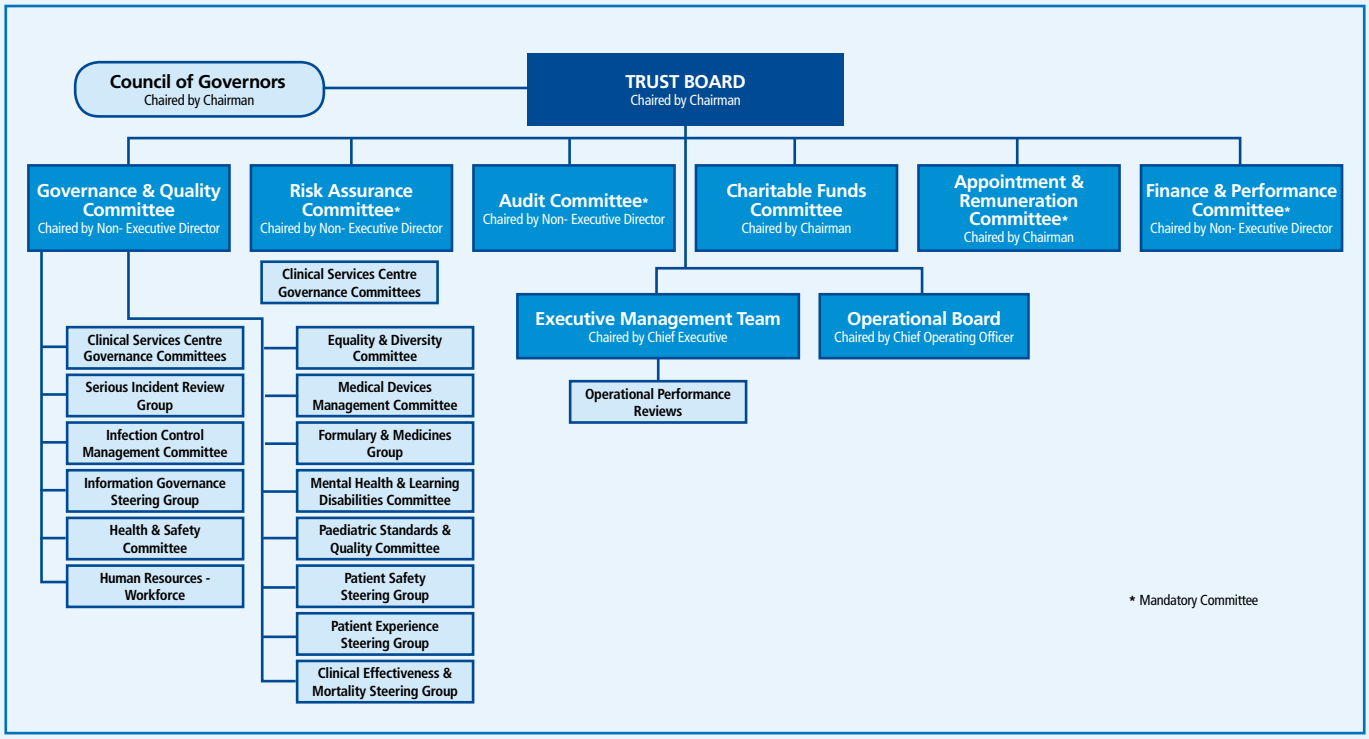
Attendance records are maintained for all the above committees and reviewed on a regular basis. The Trust proposes to take this robust structure forward into 2016/17.

The Audit Committee is the senior Board committee responsible for oversight and scrutiny of the Trust's systems of internal control and risk management. It ensures that there are effective internal audit arrangements in place that meet mandatory NHS Internal Audit Standards and provides independent assurance to the Board. The Committee reviews the work and findings of External Audit and maintains oversight of the Trust's Counter Fraud arrangements. Attendance through the year was in line with the requirements of the Terms of Reference. The Audit Committee met 7 times during 2015/16. It was chaired by a Non-Executive Director, who submits a regular report to the Trust Board. Items brought to the attention of the Board included:

- The Section 19 referral made by the External Auditors to the Secretary of State.
- Update on the governance arrangements relating to South of England Procurement Services and the assurance gained.
- The significant improvement noted since the previous audit in relation to the Internal Audit on recruitment.

- The risk related to the Mental Health liaison service and the on-going discussions with Commissioners. Risk noted on the Board Assurance Framework.
- An update on the Reference Costs Strategy produced following the Capita CHKS review on the Payment and Tariff Assurance Framework.
- Noted the Internal Audit relating to software licenses and the limited assurance conclusion. Discussions with the Director of Strategy regarding implementation of the recommendations. The Risk Assurance Committee are being provided with the assurance on progress against the recommendations.

There are other Committees and Groups with specific responsibility for various aspects of quality and risk management; as follows:



Governance committees continued to be developed and strengthened within 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 pathway of care for their patients.

There are clear reporting lines to the Trust Board from these sub board committees and a copy of the minutes are included in the Board reports. This allows Trust Board members to raise any issues regarding the work of these committees and provides the committee chairs with an opportunity to bring any issues they wish to the attention of the Trust Board.

Corporate Governance

Through its governance arrangements and the reviews undertaken by the Trust's Internal Auditors, and the construction of the Board Governance Memorandum, I am assured that the Trust complies with the HM Treasury/ Cabinet Office Corporate Governance Code and does not have any significant departures from the Code.

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 the automatic enrolment of all employed staff in to the NHS Pension scheme, 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. The Trust provides the NHS Pensions Agency with an annual assurance statement.

An Equality Standard compliance framework is in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with; of which the Trust received a National award from NHS Employers in regard to Equality Standard progress during 2015/16.

Carbon reduction measures have been identified, for example, energy usage and waste minimisation. Our Procurement Service ensures that tenders for goods and services demonstrate their commitment to sustainability.

The Sustainable Development Unit (SDU) publishes reporting guidance and we have updated our performance

reports in line with their template. We have taken an opportunity to withdraw from the CRC Energy Efficiency Scheme following the Governmental review and simplification of the scheme; we remain compliant with the European Union Emissions Trading Scheme and the Energy Efficiency of Buildings Directive.

The PFI contract is providing opportunities to improve the energy efficiency of the facilities during Life Cycle refurbishment works. Working with our PFI Partners, a series of potential schemes have been identified to reduce our energy consumption by a combination of "invest to save" and operational improvements. Some of these have already been implemented. For example; ward refurbishments now incorporate LED lighting. Others require investment of capital or personnel and we are exploring funding options to enable them to proceed.

We propose to commit further resources to promoting awareness among our staff on how they can reduce their carbon footprint due to energy, procurement, transport and waste disposal.

Improved waste segregation has resulted in significant carbon saving. Recycling continues to be rolled out to many areas.

Financial Governance

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

The duties and responsibilities of the Finance and Performance Committee include review of the Trust's in-year financial and performance management position and to scrutinise and approve, under delegated limits, the investment appraisal of capital and revenue development business cases and wider business development opportunities.

Quality Governance

The Director of Nursing has delegated responsibility for quality and safety, supported by the Medical Director. In addition, the Senior Management Team (Executive Directors and Clinical Service Centre Management Teams) are responsible for the general management of business on behalf of the Trust Board. There are monthly performance reviews with the Executive Team and each Clinical Service Centre (CSC) to monitor the delivery of all standards in line with the Trust Business Plan. Moving forward for 2016/17 these arrangements have been revised and will ensure even greater transparency and accountability for the delivery of the Business Plan. To strengthen the monitoring, oversight and challenge on quality, a quality pack has been developed which identifies key areas for increased scrutiny to inform the monthly Clinical Service Centre Performance Reviews with the Executive Team.

The Trust continues to report monthly to the Trust Board on quality metrics as part of the Integrated Performance Report. A detailed quarterly quality report is presented to the Governance and Quality Committee, with key exceptions escalated to the Board as required.

The annual clinical audit plan is linked to the Trust priorities and risks and is monitored by the Clinical Effectiveness Steering Group, which reports to the Governance and Quality Committee. The Audit Committee also have oversight of the delivery of the plan.

All serious incidents are reviewed by the Serious Incident Review Group prior to reporting to Commissioners and to other bodies in line with current reporting requirements. Root cause analysis is undertaken with monitored action plans.

The Trust has undertaken a comprehensive review of its incident reporting system, Datix, with the aim of improving the reporting culture and management of risk across the organisation. A revised Datix system is currently being implemented, which will support and improve the management of complaints, claims, risk and learning from these across the organisation and wider community. A Board workshop in January 2016 focussed on risk management, in particular risk appetite.

To ensure on-going provision of safe, high quality care and compliance with the Care Quality Commission fundamental standards, the Trust has implemented monthly themed Quality Care Reviews. This assurance is undertaken by a team of multi-disciplinary staff of all grades, including external stakeholders. These are supported by Front-line Peer Reviews and a ward accreditation scheme.

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 ' Delivering for Patients: Accountability Framework' 2015/16, NHS Constitution, and 'Everyone Counts, Planning for Patients' 2015/16. The Trust has continued to work towards delivering sustainable performance against these national priorities including Referral to Treatment (RTT), with the incomplete standard achieved at Trust Aggregate level in every month. There have been breaches of the 52 week standard due to administrative errors and the complete validation of the Patient Targeted List (PTL) has been undertaken to provide assurance that no further errors had occurred and all staff within the team are receiving remedial face to face RTT training. The Trust has an access data quality team in place

who audit compliance with Trust and national waiting list policy and undertake spot check audits to ensure that the RTT status is reflective of the overall patient pathway and clinical intension. They also undertake validation of pathways to an accurate reflection of the waiting time. This is supported by face to face and e-learning packages for RTT and Cancer Standards. In addition, diagnostics standard has been achieved in every month except December and 5 of the 8 key cancer standards were achieved for quarters 1, 2 and 3. The Emergency Department four hour standard has not been achieved and there have been breaches of the zero tolerance 12 hours trolley wait standard. There have been breaches of the zero tolerance 28 day rebook standard for non-clinical cancellations of procedures. Breaches of the standard have been due to significant emergency pressures leading to the cancellation of all routine surgery. The standard operating procedure for the management of patients cancelled on the day and those subject to the 28 day rule has been re-written and strengthened with clear escalation points and milestones. Patients at risk of breaching the standard are reviewed at the weekly assurance meeting. The C.Difficile and MRSA targets were achieved. There were no 'never events' reported in 2015/2016.

Quality Account

The Trust published its Quality Account in June 2015, which set out the priorities for 2015/16 and reflected on its achievements in 2014/15. Consultation with internal and external stakeholders is currently underway to inform the Quality Account which will be published in June 2016 and will be 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 a monthly and the Quality and Governance Committee on a quarterly basis to ensure regular sight of progress and assurance of actions being taken to address any shortfalls. An external review of the Quality Account was undertaken in June 2015 by external auditors – Ernst & Young LLP. The review found that the Trust has a system of internal control (or has processes in place) adequate to permit the preparation of the 2014/15 quality accounts in accordance with the Regulations made by the Secretary of State for Health (Health Act 2009) National Health Service Regulations 2010.

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.

In order for such an application to be successful, the Trust will need to have a Care Quality Commission rating of 'Good' or 'Outstanding'.

Stakeholders

The Trust's Patient and Public Engagement Strategy; participation for improvement 2015 – 2027, describes the multifaceted ways by which we engage with key stakeholders, including patients, families and carers and members of the local community. The strategy is based on the principles of meaningful participation which will move us towards the active involvement of local people in the design and improvement of the services we provide.

A new model of outreach has been implemented which makes the best use of established community groups across the health and social care community. This includes, HealthWatch Portsmouth and Hampshire, Carers Boards, Community Engagement Groups and specialist service user groups for people with mental ill health.

We promote equal access to all involvement and engagement activities including workshops, meetings and feedback methods by the use of a set of simple standards designed with community groups and leaders. These include the timing of events to allow people to use public transport passes, the avoidance of early morning events to give people with disabilities time to "get up and go" after medication and the provision of buddies in meetings where writing tasks are required.

A process for working with patients, carers and community representatives has been established to co-design solutions to the problems they have identified. Events have been held with people with physical disabilities about car parking; carers supporting people in hospital; patients, families and carers of people living with head, neck and thyroid cancer and frail older people and their families and carers.

Other engagement with Internal and external stakeholders includes:

- Council of Governors
- Participation in the annual staff survey
- Participation in the annual in-patient survey
- Our Listening into Action Programme which has resulted in a number of Big Conversations with staff from across the organisation
- Open meetings with the Chief Executive
- Chief Executive's weekly message
- Chief Executive's monthly team brief
- Trust open days
- Specialty open days
- Joint board meetings with Commissioners

Risk Assessment

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

- Identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives; and
- Evaluate the likelihood of those risks being realised and the impact should they be realised; and how to manage them most appropriately.

Risks continued to be identified throughout 2015/16, from a variety of sources, including:

- Internal and external reviews and inspections
- Internal and External Audit
- Risk assessments
- Care Quality Commission Fundamental Standards for 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.

The Risk Assurance Committee is Chaired by a Non-Executive Director, with Executive Director membership.

During the year 2015/16 the Trust has identified, 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 through the key committees responsible for quality and risk. At the close of the year the highest scoring risks remain concentrated around meeting the demand for unscheduled care and the potential for impact on the provision of scheduled care activity. This has been the subject of detailed internal and external scrutiny with extensive action plans in place to mitigate the risks to the Trust.

New and emerging risks identified during 2015/16 have included the challenges in relation to the lack of sufficiently qualified staff to review and report on every plain film x-ray, and lack of sufficient capacity to deliver activity.

Future major risks for the Trust relate to on-going compliance with the Care Quality Commission Fundamental Standards, particularly in relation to safety of patients within the Unscheduled Care Pathway. This risk is being addressed through a revised Urgent Care Improvement Plan which is monitored through the Systems Resilience Group.

In addition, a further clinical risk relates to provision of an ageless psychiatric liaison service. Funding discussions are currently underway between the Director of Finance and Commissioners. A project manager, funded by the CCG has been appointed to facilitate the project. This is monitored monthly through the contract review meetings between the Trust and Commissioners.

Delivery of the finance plan required by NHS Improvement carries significant risks:

- The plan assumes that the Trust secures the sustainability and transformation funding but has yet to agree the milestones and trajectories with Commissioners and NHS England.
- The Trust financial plans require an efficiency improvement of £32m which equates to 5.6% of Expenditure. Whilst progress on plans is well underway the plans are yet to reach a level of maturity to confirm delivery. The plans are also reliant on improvements in patient flow, in-particular unscheduled care which is not entirely contained within the Trust.
- The Trust's financial plans are predicated on the success of the unscheduled care improvement plan, which requires a system wide response. Improved discharges and the reduction of Delayed Transfers of Care and Medically Fit for Discharge are a critical factor.
- The Trust has yet to agree Indicative Activity plans with Commissioners that meet the constitutional standards. Therefore, there is a risk to delivery and additional costs of providing care at a premium rate.
- The final national tariffs and contracts have yet to be published and therefore, there is a risk that the assumptions underpinning the Trusts plans are incorrect.

Information Governance

The Director of Corporate Affairs is the nominated Senior Information Risk Officer (SIRO) who is responsible, along with the Medical Director as Caldicott Guardian, for ensuring there is a control system in place to maintain the security of information.

The Trust has an Information Governance Steering Group, chaired by the Information Governance Manager with representation from across the Trust, including the Senior Information Risk Owner and all CSCs. 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 2015/16 there were three incidents which required reporting to the Information Commissioner. One related to a list of patients emailed to the wrong recipient from Information Services. Another related to a safeguarding alert form left in a birthing room which was found by a person unconnected to the alert. The third related to out-patient letters being sent to St Mary's Hospital on the Isle of Wight instead of St Mary's Hospital, Portsmouth. The investigations were completed for the first two cases and the Information Commissioner has closed both cases with no further action. The third case has been investigated and a response sent to the Information Commissioner. The Trust is awaiting the outcome.

The Trust's Information Governance Toolkit submission for 2015/16 demonstrated 75% compliance, and attained "Satisfactory" by achieving the minimum level of expected compliance against all 45 standards. A full review of the assurance process for compliance with the Information Governance Toolkit will be undertaken in 2016/17 following an Information Governance Toolkit Internal Audit overall assurance assessment of limited assurance.

The risk and control framework

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

The Annual Plan is agreed by the Trust Board and reported to NHS England and the TDA within required timescales. Progress against the plan is monitored by the Board through the Trust Board Integrated Performance Report with detailed reports presented through the Board sub-groups e.g. quarterly quality report presented to Governance and Quality Committee.

Reporting of the cost improvement plans and the continued review of the impact on quality is completed on an agreed cycle no less frequently than monthly through the Delivery Group which is chaired by the Director of Finance; with the status of each risk statement reviewed and updated monthly. The Director of Nursing and Medical Director sign off all Quality Impact Assessments and a quarterly report is provided to the Risk Assurance Committee summarising changes to scheme risks and mitigating actions.

The Integrated Performance Report is a standing Board agenda item. The report summarises the Trust's performance against all the key quality, finance, compliance, and workforce targets, and also contains performance against the TDA Accountability Framework and NHS Constitution key standards.

The Trust has a Local Counter Fraud Specialist (LCFS) whose work is directed by an annual workplan agreed by the Audit Committee which is in line with the requirements of NHS Protect Standards for Providers. Work is conducted under 4 headings of Strategic Governance, Inform and Involve, Prevent and Deter and Hold to Account. The organisation was assessed by NHS Protect under these standards and identified areas of weakness were addressed by the formulation and implementation of an action plan. This included the arrangements for reporting and managing system weaknesses identified by the LCFS, which are now managed by the Director of Corporate Affairs. The LCFS has given presentations to groups of staff to inform them of the need to be particularly vigilant to the possibility of fraud as well as investigating potential frauds notified to the LCFS by the Trust, direct reporting or external reporting methods. A programme of fraud awareness is currently underway for all budget holders and key staff groups.

Risk Management

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.

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. All CSC risk registers are now stored centrally on the intranet to improve transparency and awareness of risks across the organisation.

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. This includes 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, affect the quality of service provision or which may adversely affect the Trust's profile or reputation. Risks contained within the Trust Risk Register are cross referenced to the strategic risks within the Board Assurance Framework if not directly replicated. Each risk has a responsible lead and monitoring committee.

The Trust Risk Register and Board Assurance Framework are reviewed regularly by the Risk Assurance Committee to ensure that both remain dynamic and interlinked processes that provide risk information and assurance to the Board. The Board review the Trust Risk Register on a bi-annual basis; this will be increased to quarterly for 2016/17.

As part of the Datix review and upgrade, the Risk Register module has been purchased and will be implemented during 2016/17. This will increase transparency of all organisational risks.

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 Fundamental 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. In November 2015 responsibility for the Board Assurance Framework was reassigned to the Director of Corporate Affairs to ensure that Trust Board has absolute ownership of the risks to achievement of the agreed strategic aims and agreed mitigating actions.

The Trust Board and the Risk Assurance Committee provides scrutiny of the Assurance Framework 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

Internal Audit

Following the completion of a tender exercise, the Trust's internal auditor changed on 1st August. The outgoing auditor reported on five audits and issued assurance ratings of full assurance on one, substantial assurance on two and limited assurance on two.

The new internal auditor, who uses a different assurance rating system, reported on nine audits and issued assurance ratings of reasonable assurance on five and limited assurance on four.

The limited assurance ratings relate to:

- Ward and Site Visits: eleven medium priority recommendations were made covering areas including security arrangements, workforce controls and administration around controlled drugs. No high priority recommendations were made, but given the number of medium priority recommendations this led to the limited assurance rating.
- Payment by Results and Ambulance Discharge Delays: one high priority recommendation was made relating to the accurate completion of discharge summaries and are available for the application of correct coding.
- Software Licensing: three urgent recommendations were made relating to software asset management framework and policy and the need for a review of software licenses currently in use.
- E-Rostering: four important recommendations were made relating to underachievement of non-financial benefits of e-Rostering, the need for training/refresher training and the need for informal and formal shift pattern review.
- Information Governance Toolkit: 3 important recommendations were made relating to a lack of on-going assurance through the Information Governance Steering Group, accountability of information governance standard leads and strengthening of evidence to support compliance.
- CIP Efficiency Savings Audit: the need to reinstate the Programme Management Office model and to hold regular work stream meetings for 2016/17 for all work streams.

Formal action plans have been agreed to address these significant control weaknesses in all areas and the Audit Committee is updated regularly on the progress of implementing the recommendations. There have been no common weaknesses identified through Internal Audit reviews.

The Head of Internal Audit's Opinion is based on the work undertaken in 2015/16. The overall opinion is reasonable.

The system of internal control has been in place in Portsmouth Hospitals NHS Trust for the year ending 31 March 2016 and up to the date of approval of the annual report and accounts.

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 (HoIA) is one of reasonable assurance (as per the draft HoIA opinion). Those 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.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, Audit Committee, Finance and Performance Committee, Governance and Quality Committee, Executive Management Committee, and Risk Assurance Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.

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

- 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 Specialist (LCFS), which is regularly reported to the Audit Committee.
- Care Quality Commission (CQC) Fundamental Standards of Quality and Safety self-assessment through the Quality Care Reviews.
- Publication of the Quality Accounts, following consultation with stakeholders.
- Announced and unannounced visits by the Care Quality Commission.
- Monthly reports of Serious Incidents to Trust Board.
- Monthly Quality Exception reports.
- Quarterly Quality reports: which provide amongst other matters 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.
- Monthly reports from key directors, including Finance, Nursing and the Chief Operating Officer.

An Internal Audit, designed to ensure that adequate and effective controls over the Risk Management and Assurance Framework process are in place commenced in December 2015. The final report in March 2016 demonstrated reasonable assurance and the agreed actions will be implemented.

Care Quality Commission

The Trust was inspected by the CQC on the 10th-13th February 2015, followed by two unannounced visits on 22nd February and 2nd March 2015. Overall, the Trust was rated as Requires Improvement and rated as 'Outstanding' for providing caring services and 'Good' for effective services. The major quality concerns related to the safety of patients within the Emergency Department and the Unscheduled Care pathway and resulted in a rating of 'inadequate' for safety domain of urgent and emergency services. Two warning notices were served on 4th March 2015 under safety, for 'care and welfare of patients' and 'assessing and monitoring the quality of service provision' in the Emergency Department. An unannounced focussed inspection to follow up on the warning notices served was undertaken on 25th April 2015 which resulted in the 'inadequate' rating improving to a rating of 'requires improvement'; and an overall core service rating of 'requires improvement'. A Trust-wide quality improvement plan was developed and has been implemented over the last year; with monthly reporting to Trust Board, Governance and Quality Committee, TDA, CQC and Commissioners.

The CQC subsequently inspected the Trust in February 2016 and identified on-going safety concerns relating to the Emergency Department for which the Trust has received an Enforcement Notice. The Enforcement Notice outlines four conditions:

1. The Registered Provider must ensure there is effective leadership of the emergency care pathway.
2. The Registered Provider must operate an effective escalation system which will ensure that every patient attending the Emergency Department at Queen Alexandra Hospital is triaged, assessed and streamlined by appropriately qualified staff as set out in the guidance issued by the College of Emergency Medicine and others in their Triage Position Statement April 2011.
3. The registered provider must ensure the large multi-occupancy ambulance known as the "Jumbulance" will not be permitted to be used on site at the Queen Alexandra Hospital.
4. The Registered Provider must provide CQC with daily monitoring information that is to be provided on a weekly basis and based on the provided list of metrics.

The Trust has worked with partners to further enhance the Urgent Care Improvement Plan which is monitored through the System Resilience Group.

Significant issues

The Trust has operated within a significantly challenged financial environment throughout 2015/16. The scale of financial challenge was increased from the planned deficit control total of £16.0m with the requirement to deliver a stretch target of £9.7m deficit which was communicated to the Trust in July 2015. Throughout the year it became increasingly clear that for a variety of reasons, including prolonged and extreme unscheduled care pressures and shortfalls in delivery of Cost Improvement Plans, that both the stretch target and original planned deficit would not be achieved. Financial reporting, budgetary control and decision making, as well as Cost Improvement Planning and delivery capacity have represented high profile risks during the financial year and improvements to all aspects of these areas of the Trust's control environment have been made during the latter half of the year, and will act to mitigate on-going levels of risk in this regard.

The Trust reported a forecast year end deficit of £23.6m deficit to the December Trust Board meeting following a detailed review of the financial position and remains on track to deliver this position.

The performance of the Emergency Department has remained challenged throughout 2015/16, with attendances remaining higher than previous years particularly after 1900hrs. An increasing acuity and age profile further impacted on flow through the hospital. In addition the number of patients medically fit for discharge increased significantly, to a high point of 190 patients that stayed longer in an acute hospital bed than they needed to. The Trust continued its work with partners to increase care at home and in the community to support earlier discharge once a patient is medically fit, which is better for the patient's health and well-being. It also releases a bed for the next patient who is acutely unwell.

While RTT delivery was impacted by high demand for unscheduled care the Trust achieved this national standard overall. The Trust made the decision during winter to reduce and cancel non-urgent elective appointments to ensure that emergency patients had access to the life-saving expertise of our clinical teams. This resulted in an increase in the waiting list for surgery and non-delivery of the planned reduction in over 35 week waits for treatment. This is not a situation we want to continue and we are reviewing options with our commissioners to ensure the bed capacity is in place to support the needs of all patients.

Annual Accounts

Statement of Comprehensive Income for year ended 31 March 2016

	NOTE	2015-16	2014-15
		£000s	£000s
Gross employee benefits	10.1	**(293,052)**	(270,339)
Other operating costs	8	**(218,021)**	(203,809)
Revenue from patient care activities	5	**452,553**	431,389
Other operating revenue	6	**52,019**	53,074
Operating surplus/(deficit)		**(6,501)**	10,315
Investment revenue	12	**53**	48
Other gains and (losses)	13	**(207)**	34
Finance costs	14	**(17,476)**	(16,776)
Surplus/(deficit) for the financial year		**(24,131)**	(6,379)
Public dividend capital dividends payable		**(2,230)**	(1,850)
Retained surplus/(deficit) for the year		**(26,361)**	(8,229)

Other Comprehensive Income

	2015-16	2014-15
	£000s	£000s
Impairments and reversals taken to the revaluation reserve	**(79)**	(102)
Net gain/(loss) on revaluation of property, plant & equipment	**31,056**	31,311
Total other comprehensive income	**30,977**	31,209
Total comprehensive income for the year*	**4,616**	22,980

Financial performance for the year

Retained surplus/(deficit) for the year	**(26,361)**	(8,229)
IFRIC 12 adjustment (including IFRIC 12 impairments) *	**2,481**	4,649
Impairments (excluding IFRIC 12 impairments) **	**(79)**	(102)
Adjustments in respect of donated gov't grant asset reserve elimination***	**482**	770
Adjusted retained surplus/(deficit)	**(23,477)**	(2,912)

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 94 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 83 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 63 for more details).

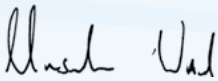
The notes on pages 60 to 96 form part of this account.

Statement of Financial Position as at 31 March 2016

	NOTE	31 March 2016 £000s	31 March 2015 £000s
Non-current assets:			
Property, plant and equipment	15	**362,219**	338,332
Intangible assets	16	**2,975**	2,541
Trade and other receivables		**4,953**	3,925
Total non-current assets		**370,147**	344,798
Current assets:			
Inventories	21	**13,032**	12,257
Trade and other receivables		**36,832**	37,176
Cash and cash equivalents	26	**2,716**	1,239
Sub-total current assets		**52,580**	50,672
Non-current assets held for sale	27	**0**	0
Total current assets		**52,580**	50,672
Total assets		**422,727**	395,470
Current liabilities			
Trade and other payables	28	**(50,941)**	(51,142)
Provisions	35	**(258)**	(519)
Borrowings	30	**(4,910)**	(5,119)
DH revenue support loan	30	**(260)**	(260)
DH capital loan	30	**(1,902)**	(1,892)
Total current liabilities		**(58,271)**	(58,932)
Net current assets/(liabilities)		**(5,691)**	(8,260)
Total assets less current liablilities		**364,456**	336,538
Non-current liabilities			
Provisions	35	**(1,881)**	(1,764)
Borrowings	30	**(235,041)**	(239,627)
DH revenue support loan	30	**(32,033)**	(1,040)
DH capital loan	30	**(4,480)**	(6,382)
Total non-current liabilities		**(273,435)**	(248,813)
Total assets employed:		**91,021**	87,725
FINANCED BY:			
Public Dividend Capital		**49,560**	50,880
Retained earnings		**(73,734)**	(47,633)
Revaluation reserve		**115,195**	84,478
Total Taxpayers' Equity:		**91,021**	87,725

The notes on pages 60 to 96 form part of this account.

The financial statements on pages 56 to 59 were approved by the Audit Committee, with delegated authority from the Board on 23 May 2016 and signed on its behalf by

Chief Executive:  Date: 27th May 2016

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2016

	Public Dividend capital	Retained earnings		Revaluation reserve		Other reserves	Total reserves
	£000s	£000s		£000s		£000s	£000s
Balance at 1 April 2015	**50,880**	**(47,633)**	**0**	**84,478**	**0**	**0**	**87,725**
Changes in taxpayers' equity for 2015-16							
Retained surplus/(deficit) for the year		(26,361)					(26,361)
Net gain / (loss) on revaluation of property, plant, equipment				31,056			31,056
Impairments and reversals				(79)			(79)
Transfers between reserves		260		(260)		0	0
Permanent PDC received - cash	27						27
Permanent PDC repaid in year	(1,347)						(1,347)
Net recognised revenue/(expense) for the year	**(1,320)**	**(26,101)**		**30,717**		**0**	**3,296**
Balance at 31 March 2016	**49,560**	**(73,734)**		**115,195**		**0**	**91,021**
Balance at 1 April 2014	**50,217**	**(40,423)**		**54,288**		**0**	**64,082**
Changes in taxpayers' equity for the year ended 31 March 2015							
Retained surplus/(deficit) for the year		(8,229)					(8,229)
Net gain / (loss) on revaluation of property, plant, equipment				31,311			31,311
Impairments and reversals				(102)			(102)
Transfers between reserves		1,019		(1,019)		0	0
New temporary and permanent PDC received - cash	7,163						7,163
New temporary and permanent PDC repaid in year	(6,500)						(6,500)
Net recognised revenue/(expense) for the year	**663**	**(7,210)**		**30,190**		**0**	**23,643**
Balance at 31 March 2015	**50,880**	**(47,633)**		**84,478**		**0**	**87,725**

Statement of Cash Flows for the Year ended 31 March 2016

	NOTE	2015-16 £000s	2014-15 £000s
Cash Flows from Operating Activities			
Operating surplus/(deficit)		**(6,501)**	10,315
Depreciation and amortisation	8	**15,787**	15,084
Impairments and reversals	17	**(79)**	(102)
Donated Assets received credited to revenue but non-cash	6	**(500)**	(175)
Interest paid		**(17,307)**	(16,766)
PDC Dividend (paid)/refunded		**(2,050)**	(1,808)
(Increase)/Decrease in Inventories		**(775)**	(294)
(Increase)/Decrease in Trade and Other Receivables		**(684)**	(9,434)
Increase/(Decrease) in Trade and Other Payables		**(1,136)**	8,760
Provisions utilised		**(400)**	(321)
Increase/(Decrease) in movement in non cash provisions		**87**	54
Net Cash Inflow/(Outflow) from Operating Activities		**(13,558)**	5,313
Cash Flows from Investing Activities			
Interest Received		**53**	48
(Payments) for Property, Plant and Equipment		**(7,960)**	(11,126)
(Payments) for Intangible Assets		**(1,195)**	(1,016)
Proceeds of disposal of assets held for sale (PPE)		**726**	89
Net Cash Inflow/(Outflow) from Investing Activities		**(8,376)**	(12,005)
Net Cash Inform / (outflow) before Financing		**(21,934)**	(6,692)
Cash Flows from Financing Activities			
Gross Temporary (2014/15 only) and Permanent PDC Received		**27**	7,163
Gross Temporary (2014/15 only) and Permanent PDC Repaid		**(1,347)**	(6,500)
Loans received from DH - New Capital Investment Loans		**0**	5,600
Loans received from DH - New Revenue Support Loans		**32,003**	1,300
Other Loans Received		**0**	0
Loans repaid to DH - Capital Investment Loans Repayment of Principal		**(1,892)**	(1,332)
Loans repaid to DH - Working Capital Loans/Revenue Support Loans		**(1,010)**	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(4,870)**	(5,644)
Capital grants and other capital receipts (excluding donated / government granted cash receipts)		**500**	175
Net Cash Inflow/(Outflow) from Financing Activities		**23,411**	762
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**1,477**	(5,930)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**1,239**	7,169
Cash and Cash Equivalents (and Bank Overdraft) at year end	26	**2,716**	1,239

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 Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2015-16 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 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 SOCI, and is disclosed separately from operating costs.

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

1.4 Charitable Funds

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

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

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

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.

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 a 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.

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.

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

Government grant funded assets are capitalised at their fair value on receipt, with a matching credit 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 of interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust's surplus/deficit.

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

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

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

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) Payment 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 at the time they are provided by the operator 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 1.37% for pensions and -1.55% (short term), -1% (medium term) and -0.8% (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

The Trust holds Financial Assets in the form of trade receivables which are recognised when the goods or services have been delivered.

1.26 Financial liabilities

The Trust holds Financial Liabilities in the form of trade payables, loans from the Department of Health and PFI and Finance Lease obligations. Financial liabilities are recognised when the Trust becomes party to the contractual provisions or, in the case of trade payables, when the goods or services have been received.

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

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

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

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

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

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

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

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

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 Trust does not have any associates.

1.34 Joint arrangements

Material entities over which the Trust has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture. The Trust does not have any joint arrangements.

1.35 Research and Development

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

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

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2015-16. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 Revenue for Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2017, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

2. Pooled budget

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 (£494.5m 98%) is derived from 'non-trading' healthcare. Of the total income, 2% (£10.1m) 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.

	Heaalthcare		Pharmacy Trading		Total	
	2015-16	2014-15	**2015-16**	2014-15	**2015-16**	2014-15
Income	**£000s**	£000s	**£000s**	£000s	**£000s**	£000s
External	**494,503**	473,724	**10,069**	10,739	**504,572**	484,463
Internal	**0**	0	**40,484**	39,951	**40,484**	39,951
Total Income	**494,503**	473,724	**50,553**	50,690	**545,056**	524,414
Expenditure						
Segment Costs	**481,238**	443,023	**49,451**	49,424	**530,689**	492,447
Common costs	**40,484**	39,951	**244**	245	**40,728**	40,196
Total Expenditure	**521,722**	482,974	**49,695**	49,669	**571,417**	532,643
Retained surplus/(deficit) for the year	**(27,219)**	(9,250)	**858**	1,021	**(26,361)**	(8,229)

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

	2015-16	2014-15
	£000s	£000s
NHS Trusts	**14**	5
NHS England	**105,679**	98,116
Clinical Commissioning Groups	**340,386**	328,926
Foundation Trusts	**12**	0
Department of Health	**12**	0
NHS Other (including Public Health England and Prop Co)	**633**	26
Additional income for delivery of healthcare services	**1,347**	0
Non-NHS:		
Private patients	**2,752**	2,395
Overseas patients (non-reciprocal)	**173**	363
Injury costs recovery	**897**	932
Other	**648**	626
Total Revenue from patient care activities	**452,553**	431,389

6. Other operating revenue

	2015-16 £000s	2014-15 £000s
Education, training and research	**18,192**	17,672
Charitable and other contributions to revenue expenditure -non- NHS	**229**	243
Receipt of donations for capital acquisitions - Charity	**500**	175
Non-patient care services to other bodies	**13,141**	13,738
Income generation (Other fees and charges)	**15,320**	16,722
Rental revenue from operating leases	**734**	1,668
Other revenue	**3,903**	2,856
Total Other Operating Revenue	**52,019**	53,074
Total operating revenue	**504,572**	484,463

7. Overseas Visitors Disclosure

	2015-16 £000	2014-15 £000s
Income recognised during 2015-16 (invoiced amounts and accruals)	**173**	363
Cash payments received in-year (re receivables at 31 March 2015)	**7**	16
Cash payments received in-year (iro invoices issued 2014-15)	**61**	151
Amounts added to provision for impairment of receivables (re receivables at 31 March 2014)	**34**	36
Amounts written off in-year (irrespective of year of recognition)	**18**	208

8. Operating expenses

	2015-16 £000s	2014-15 £000s
Services from other NHS Trusts	**819**	2,863
Services from CCGs/NHS England	**0**	60
Services from NHS Foundation Trusts	**5,533**	7,479
Total Services from NHS bodies*	**6,352**	10,402
Purchase of healthcare from non-NHS bodies	**9,732**	8,294
Trust Chair and Non-executive Directors	**60**	52
Supplies and services - clinical	**115,689**	104,971
Supplies and services - general	**2,260**	2,436
Consultancy services	**1,475**	1,809
Establishment	**4,373**	4,266
Transport	**513**	2,922
Service charges - ON-SOFP PFIs and other service concession arrangements	**28,503**	25,339
Business rates paid to local authorities	**2,891**	2,585
Premises	**8,423**	8,509
Hospitality	**12**	19
Insurance	**348**	382
Legal Fees	**318**	362
Impairments and Reversals of Receivables	**124**	399
Inventories write down	**0**	71
Depreciation	**15,026**	14,525
Amortisation	**761**	559
Impairments and reversals of property, plant and equipment	**(79)**	(102)
Audit fees	**125**	133
Clinical negligence	**18,073**	11,660
Education and Training	**1,448**	1,470
Change in Discount Rate	**65**	8
Other	**1,529**	2,738
Total Operating expenses (excluding employee benefits)	**218,021**	203,809
Employee Benefits		
Employee benefits excluding Board members	**291,927**	269,325
Board members	**1,125**	1,014
Total Employee Benefits	**293,052**	270,339
Total Operating Expenses	**511,073**	474,148

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

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 £657,500.

9.1. Portsmouth Hospitals NHS Trust as lessee

	Land £000s	Buildings £000s	Other £000s	2015-16 Total £000s	2014-15 £000s
Payments recognised as an expense					
Minimum lease payments				**1,487**	1,606
Total				**1,487**	1,606
Payable:					
No later than one year	491	591	353	**1,435**	1,378
Between one and five years	878	1,767	47	**2,692**	3,713
After five years	0	2,539	0	**2,539**	2,809
Total	**1,369**	**4,897**	**400**	**6,666**	7,900
Total future sublease payments expected to be received:				3,644	2,944

9.2. Portsmouth Hospitals NHS 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.

	2015-16 £000	2014-15 £000s
Recognised as revenue		
Rental revenue	734	1,668
Total	**734**	1,668
Receivable:		
No later than one year	642	662
Between one and five years	1,829	1,836
After five years	1,173	446
Total	**3,644**	2,944

10. Employee benefits and staff numbers

10.1 Employee benefits

	2015-16 Total	Permanently employed	Other
	£000s	£000s	£000s
Employee Benefits - Gross Expenditure			
Salaries and wages	**249,800**	217,631	32,169
Social security costs	**16,945**	16,945	0
Employer Contributions to NHS BSA - Pensions Division	**26,816**	26,816	0
Total employee benefits	**293,561**	**261,392**	**32,169**
Employee costs capitalised	**509**	509	0
Gross Employee Benefits excluding capitalised costs	**293,052**	**260,883**	**32,169**

Employee Benefits - Gross Expenditure 2014-15	Total	Permanently employed	Other
	£000s	£000s	£000s
Salaries and wages	229,958	203,064	26,894
Social security costs	15,958	15,958	0
Employer Contributions to NHS BSA - Pensions Division	24,743	24,743	0
TOTAL - including capitalised costs	270,659	243,765	26,894
Employee costs capitalised	320	320	0
Gross Employee Benefits excluding capitalised costs	270,339	243,445	26,894

10.2 Staff Numbers

	2015-16 Total	Permanently employed	Other	2014-15 Total
	Number	**Number**	**Number**	Number
Average Staff Numbers				
Medical and dental	**922**	878	44	905
Ambulance staff	**0**	0	0	0
Administration and estates	**1,216**	1,199	17	1,193
Healthcare assistants and other support staff	**0**	0	0	17
Nursing, midwifery and health visiting staff	**3,270**	2,951	319	3,120
Scientific, therapeutic and technical staff	**1,134**	1,106	28	1,090
Healthcare Science Staff	**197**	197	0	193
TOTAL	**6,739**	**6,331**	**408**	6,518
Of the above - staff engaged on capital projects	**21**	12	9	21

10.3 Staff Sickness absence and ill health retirements

	2015-16	2014-15
	Number	Number
Total Days Lost	**47,913**	45,605
Total Staff Years	**6,193**	5,614
Average working Days Lost	**7.74**	8.12

	2015-16	2014-15
	Number	Number
Number of persons retired early on ill health grounds	**8**	8

	£000s	£000s
Total additional pensions liabilities accrued in the year	**542**	349

10.4 Exit Packages agreed in 2015-16

2015-16

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of Departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£
Less than £10,000	0	0	33	89,742	33	89,742	0	0
£10,000-£25,000	0	0	0	0	0	0	0	0
£25,001-£50,000	0	0	0	0	0	0	0	0
£50,001-£100,000	0	0	0	0	0	0	0	0
£100,001-£150,000	0	0	0	0	0	0	0	0
£150,001-£200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	**0**	**0**	**33**	**89,742**	**33**	**89,742**	**0**	**0**

2014-15

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of Departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£
Less than £10,000	5	0	18	54,070	23	54,070	0	0
£10,000-£25,000	2	35,539	1	19,529	3	55,068	0	0
£25,001-£50,000	2	91,225	0	0	2	91,225	0	0
£50,001-£100,000	0	0	0	0	0	0	0	0
£100,001-£150,000	0	0	0	0	0	0	0	0
£150,001-£200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	**9**	**126,764**	**19**	**73,599**	**28**	**200,363**	**0**	**0**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pension 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 Pension Scheme. Ill-health retirement costs are met by the NHS Pension 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

	2015-16		2014-15	
	Agreements	**Total value of agreements**	Agreements	Total value of agreements
	Number	**£000s**	Number	£000s
Contractual payments in lieu of notice	**32**	**80**	19	74
Exit payments following Employment Tribunals or court orders	**1**	**10**	0	0
Total	**33**	**90**	**19**	**74**

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 package 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.

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.

10.6 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.
In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 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. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

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

11 Better Payment Practice Code

11.1 Measure of compliance

	2015-16 Number	2015-16 £000s	2014-15 Number	2014-15 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**100,733**	**254,808**	90,895	236,909
Total Non-NHS Trade Invoices Paid Within Target	**94,136**	**239,949**	84,336	221,157
Percentage of NHS Trade Invoices Paid Within Target	**93.45%**	**94.17%**	92.78%	93.35%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,587**	**15,076**	2,525	20,095
Total NHS Trade Invoices Paid Within Target	**2,073**	**11,830**	1,995	17,087
Percentage of NHS Trade Invoices Paid Within Target	**80.13%**	**78.47%**	79.01%	85.03%

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

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

	2015-16 £000s	2014-15 £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

	2015-16 £000s	2014-15 £000s
Interest revenue		
Bank interest	**53**	48
Total investment revenue	**53**	48

13 Other Gains and Losses

	2015-16 £000s	2014-15 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**(207)**	34
Total other gains and losses	**(207)**	34

14 Finance Costs

	2015-16 £000s	2014-15 £000s
Interest		
Interest on loans and overdrafts	**834**	91
Interest on obligations under PFI contracts:		
- main finance cost	**12,728**	12,998
- contingent finance cost	**3,745**	3,677
Total interest expense	**17,307**	16,766
Provisions - unwinding of discount	**169**	10
Total	**17,476**	16,776

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15.1 Property, plant and equipment

2015-16	Land	Building excluding dwellings	Dwellings
	£000's	£000's	£000's
Cost or valuation:			
At 1 April 2015	**23,950**	**274,632**	**3,050**
Additions of Assets Under Construction	0	0	0
Additions Purchased	0	3,234	45
Additions - Non Cash Donations (i.e. physical assets)	0	0	0
Disposals other than for sale	0	0	0
Upward revaluation/positive indexation	0	30,339	336
Impairments/reversals charged to reserves	0	(79)	0
At 31 March 2016	**23,950**	**308,126**	**3,431**
Depreciation			
At 1 April 2015	0	0	0
Disposals other than for sale	0	0	0
Upward revaluation/positive indexation	0	0	0
Impairments/reversals charged to operating expenses	0	(79)	0
Charged During the Year	0	7,083	113
At 31 March 2016	**0**	**7,004**	**113**
Net Book Value at 31 March 2016	**23,950**	**301,122**	**3,318**
Asset financing:			
Owned - Purchased	23,950	5,065	0
Owned - Donated	0	4,272	0
Held on finance lease	0	0	0
On-SOFP PFI contracts	0	291,785	3,318
Total at 31 March 2016	**23,950**	**301,122**	**3,318**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings
	£000's	£000's	£000's
At 1 April 2015	16,431	60,327	2,420
Movements (specify)	0	30,259	337
At 31 March 2016	**16,431**	**90,586**	**2,757**

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
0	**70,409**	**93**	**21,549**	**3,167**	**396,850**
0	0	0	0	0	**0**
0	3,029	0	1,983	0	**8,291**
0	464	0	36	0	**500**
0	(2,738)	(16)	(12)	0	**(2,766)**
0	888	1	0	44	**31,608**
0	0	0	0	0	**(79)**
0	**72,052**	**78**	**23,556**	**3,211**	**434,404**
0	43,544	91	13,636	1,247	**58,518**
0	(1,805)	(16)	(11)	0	**(1,832)**
0	534	1	0	17	**552**
0	0	0	0	0	**(79)**
0	5,611	0	1,989	230	**15,026**
0	**47,884**	**76**	**15,614**	**1,494**	**72,185**
0	**24,168**	**2**	**7,942**	**1,717**	**362,219**
0	20,734	2	7,888	1,717	**59,356**
0	2,219	0	54	0	**6,545**
0	1,215	0	0	0	**1,215**
0	0	0	0	0	**295,103**
0	**24,168**	**2**	**7,942**	**1,717**	**362,219**

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
0	4,964	11	16	309	**84,478**
0	354	0	0	27	**30,977**
0	**5,318**	**11**	**16**	**336**	**115,455**

15.2 Property, plant and equipment prior-year

2014-15	Land	Building excluding dwellings	Dwellings
	£000's	£000's	£000's
Cost or valuation:			
At 1 April 2014	23,865	249,753	2,752
Additions of Assets Under Construction	0	0	0
Additions Purchased	0	1,985	143
Additions - Non Cash Donations (i.e. Physical Assets)	0	0	0
Disposals other than for sale	0	0	0
Revaluation	85	30,370	287
Impairments/negative indexation charged to reserves	0	(102)	0
At 31 March 2015	**23,950**	**282,006**	**3,182**
Depreciation			
At 1 April 2014	0	0	0
Disposals other than for sale	0	0	0
Revaluation	0	0	0
Reversal of Impairments charged to operating expenses	0	(102)	0
Charged During the Year	0	7,476	132
At 31 March 2015	**0**	**7,374**	**132**
Net Book Value at 31 March 2015	**23,950**	**274,632**	**3,050**
Asset financing:			
Owned - Purchased	23,950	4,711	0
Owned - Donated	0	3,982	0
Held on finance lease	0	0	0
On-SOFP PFI contracts	0	265,939	3,050
Total at 31 March 2015	**23,950**	**274,632**	**3,050**

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
0	76,320	124	18,202	3,102	374,118
0	0	0	0	0	0
0	3,503	0	3,533	0	9,164
0	175	0	0	0	175
0	(10,727)	(32)	(186)	0	(10,945)
0	1,212	1	0	65	32,020
0	0	0	0	0	(102)
0	**70,483**	**93**	**21,549**	**3,167**	**404,430**
0	48,150	121	12,512	999	61,782
0	(10,672)	(32)	(186)	0	(10,890)
0	687	1	0	21	709
0	0	0	0	0	(102)
0	5,379	1	1,310	227	14,525
0	**43,544**	**91**	**13,636**	**1,247**	**66,024**
0	**26,939**	**2**	**7,913**	**1,920**	**338,406**
0	23,331	2	7,883	1,920	61,797
0	2,271	0	30	0	6,283
0	1,337	0	0	0	1,337
0	0	0	0	0	268,989
0	**26,939**	**2**	**7,913**	**1,920**	**338,406**

15.3. Property, plant and equipment

The donated assets were received from the Portsmouth Hospitals Charity.

All land and buildings have been restated to modern equivalent asset value based on a valuation carried out in March 2015 by the District Valuer from the Revenue and Customs Government Department.

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: between 5 and 10 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: between 10 and 15 years

Gross carrying amount of fully depreciated assets still in use is £26.2m

16 Intangible non-current assets

16.1 Intangible non-current assets

2015-16	IT - inhouse & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Total
	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2015	**0**	**6,029**	**0**	**0**	**0**	**6,029**
Additions Purchased	0	1,195	0	0	0	1,195
At 31 March 2016	0	7,224	0	0	0	7,224
Amortisation						
At 1 April 2015	**0**	**3,488**	**0**	**0**	**0**	**3,488**
Charged During the Year	0	761	0	0	0	761
At 31 March 2016	**0**	**4,249**	**0**	**0**	**0**	**4,249**
Net Book Value at 31 March 2016	**0**	**2,975**	**0**	**0**	**0**	**2,975**
Asset Financing: Net book value at 31 March 2016 comprises:						
Purchased	0	2,968	0	0	0	2,968
Donated	0	7	0	0	0	7
Total at 31 March 2016	**0**	**2,975**	**0**	**0**	**0**	**2,975**

16.2 Intangible non-current assets prior year

2014-15	T - inhouse & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Total
	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:						
At 1 April 2014	0	5,125	0	0	0	5,125
Additions - purchased	0	1,016	0	0	0	1,016
Disposals other than by sale	0	(112)	0	0	0	(112)
At 31 March 2015	0	6,029	0	0	0	6,029
Amortisation						
At 1 April 2014	0	3,041	0	0	0	3,041
Disposals other than by sale	0	(112)	0	0	0	(112)
Charged during the year	0	559	0	0	0	559
At 31 March 2015	0	3,488	0	0	0	3,488
Net book value at 31 March 2015	0	2,541	0	0	0	2,541
Net book value at 31 March 2015 comprises:						
Purchased	0	2,529	0	0	0	2,529
Donated	0	12	0	0	0	12
Total at 31 March 2015	0	2,541	0	0	0	2,541

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 2015-16

	2015-16 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Changes in market price *	**(79)**
Total charged to Annually Managed Expenditure/S0CI	**(79)**

* 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

The Trust has no contracted capital commitments at 31 March 2016 not otherwise included in these financial statements (£0 2014/15)

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 £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with Other Central Government Bodies	276	0	5,287	0
Balances with Local Authorities	120	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	158	0
Balances with NHS bodies inside the Departmental Group	13,412	0	8,524	36,513
Balances with Public Corporations and Trading Funds	0	0	1,182	0
Balances with Bodies External to Government	23,024	4,953	42,862	235,041
At 31 March 2016	**36,832**	**4,953**	**58,013**	**271,554**
prior period:				
Balances with Other Central Government Bodies	4,686	0`	2,880	0
Balances with Local Authorities	149	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	333	0
Balances with NHS bodies inside the Departmental Group	15,479	0	7,951	7,422
Balances with Public Corporations and Trading Funds	0	0	3,092	0
Balances with Bodies External to Government	16,862	3,925	44,231	239,627
At 31 March 2015	**37,176**	**3,925**	**58,487**	**247,049**

21 Inventories

	Drugs	Consumables	Total
	£000s	£000s	£000s
Balance at 1 April 2015	**5,624**	**6,633**	**12,257**
Additions	53,881	46,247	100,128
Inventories recognised as an expense in the period	(53,683)	(45,670)	(99,353)
Balance at 31 March 2016	**5,822**	**7,210**	**13,032**

22.1 Trade and other receivables

	Current		Non-current	
	31 March 2016	31 March 2015	**31 March 2016**	31 March 2015
	£000s	£000s	**£000s**	£000s
NHS receivables - revenue	**13,290**	15,321	**0**	0
Non-NHS receivables - revenue	**4,279**	3,038	**0**	0
Non-NHS prepayments and accrued income	**3,800**	5,867	**3,743**	2,651
Provision for the impairment of receivables	**(967)**	(880)	**0**	0
VAT	**4,386**	4,680	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**6,200**	4,084	**0**	0
Interest receivables	**2**	2	**0**	0
Other receivables	**5,842**	5,064	**1,210**	1,274
Total	**36,832**	37,176	**4,953**	3,925
Total current and non current	**41,785**	41,101		

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.

22.2 Receivables past their due date but not impaired

	31 March 2016	31 March 2015
	£000s	£000s
By up to three months	**4,266**	4,842
By three to six months	**936**	1,115
By more than six months	**922**	517
Total	**6,124**	6,474

22.3 Provision for impairment of receivables

	2015-16	2014-15
	£000s	£000s
Balance at 1 April 2015	**(880)**	(809)
Amount written off during the year	**37**	328
Amount recovered during the year	**64**	93
(Increase)/decrease in receivables impaired	**(188)**	(492)
Balance at 31 March 2016	**(967)**	(880)

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 current financial assets.

24.2 Other Financial Assets - Non Current

The Trust has no other non current financial assets.

25 Other current assets

The Trust has no other current assets.

26 Cash and Cash Equivalents

	31 March 2016	31 March 2015
	£000s	£000s
Opening balance	**1,239**	7,169
Net change in year	**1,477**	5,930
Closing balance	**2,716**	1,239
Made up of		
Cash with Government Banking Service	**2,649**	1,171
Commercial banks	**41**	39
Cash in hand	**26**	29
Cash and cash equivalents as in statement of financial position	**2,716**	1,239
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**2,716**	1,239

27 Non-current assets held for sale

The Trust does not have any non-current assets held for sale (£0 as at 31st March 2015).

28 Trade and other payables

	Current		Non-current	
	31 March 2016	31 March 2015	**31 March 2016**	31 March 2015
	£000s	£000s	**£000s**	£000s
NHS payables - revenue	**5,132**	5,118	**0**	0
Non-NHS payables - revenue	**2,740**	4,278	**0**	0
Non-NHS payables - capital	**2,392**	1,562	**0**	0
Non-NHS accruals and deferred income	**5,298**	5,456	**0**	0
Social security costs	**2,590**	2,519		
PDC Dividend payable to DH	**420**	200		
Accrued Interest on DH Loans	**5**			
Tax	**2,697**	361		
Other	**29,667**	31,648	**0**	0
Total	**50,941**	51,142	**0**	0
Total payables (current and non-current)	**50,941**	51,142		
Included above:				
outstanding Pension Contributions at the year end	**2,228**	0		

29 Other liabilities

The Trust has no other liabilities.

30 Borrowings

	Current		Non-current	
	31 March 2016	31 March 2015	**31 March 2016**	31 March 2015
	£000s	£000s	**£000s**	£000s
Loans from Department of Health	**2,162**	2,152	**36,513**	7,422
PFI liabilities:				
Main liability	**4,383**	4,747	**234,353**	238,736
Finance lease liabilities	**527**	446	**688**	891
Total	**7,072**	7,345	**271,554**	247,049
Total borrowings (current and non-current)	**278,626**	254,394		

Borrowings / Loans - repayment of principal falling due in:

	31 March 2016		
	DH	**Other**	**Total**
	£000s	£000s	**£000s**
0-1 Years	2,162	4,910	**7,072**
1 - 2 Years	32,073	6,346	**38,419**
2 - 5 Years	2,200	20,231	**22,431**
Over 5 Years	2,240	208,464	**210,704**
TOTAL	**38,675**	**239,951**	**278,626**

31 Other financial liabilities

The Trust has no 'Other Financial Liabilities'.

32 Deferred income

	Current		Non-current	
	31 March 2016	31 March 2015	**31 March 2016**	31 March 2015
	£000s	£000s	**£000s**	£000s
Opening balance at 1 April 2015	**303**	1,491	**0**	0
Deferred revenue addition	**0**	303	**0**	0
Transfer of deferred revenue	**0**	(1,491)	**0**	0
Current deferred Income at 31 March 2016	**303**	303	**0**	0
Total deferred income (current and non-current)	**303**	303		

33 Finance lease obligations as lessee

The finance lease obligations relate mainly to the da Vinci Surgical Robot and Microscopes. The Da Vinci lease started in 2013 and is a 5 year lease. The microscopes lease started in 2016 and is a 4 year lease.

Amounts payable under finance leases (Other)	**Minimum lease payments**		**Present value of minimum lease payments**	
	31 March 2016	31 March 2015	**31 March 2016**	31 March 2015
	£000s	£000s	**£000s**	£000s
Within one year	**527**	446	**527**	446
Between one and five years	**688**	891	**688**	891
After five years	**0**	0	**0**	0
Less future finance charges	**0**	0		
Minimum Lease Payments / Present value of minimum lease payments	**1,215**	1,337	**1,215**	1,337
Included in:				
Current borrowings			**527**	446
Non-current borrowings			**688**	891
			1,215	1,337

34 Finance lease receivables as lessor

The Trust has no finance leases as lessor.

35 Provisions

		Comprising:		
	Total	**Early Departure Costs***	**Legal Claims****	**Other*****
	£000s	**£000s**	**£000s**	**£000s**
Balance at 1 April 2015	**2,283**	1,882	111	290
Arising during the year	**93**	0	93	0
Utilised during the year	**(400)**	(99)	(17)	(284)
Reversed unused	**(71)**	(19)	(46)	(6)
Unwinding of discount	**169**	169	0	0
Change in discount rate	**65**	65	0	0
Balance at 31 March 2016	**2,139**	**1,998**	**141**	**0**
Expected Timing of Cash Flows:				
No Later than One Year	**258**	117	141	0
Later than One Year and not later than Five Years	**451**	451	0	0
Later than Five Years	**1,430**	1,430	0	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

As at 31 March 2016	294,496
As at 31 March 2015	165,780

* 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. The Trust left the carbon reduction scheme in 2015/16.

36 Contingencies

	31 March 2016	31 March 2015
	£000s	£000s
Contingent liabilities		
Legal Claims	**(60)**	(61)
Net value of contingent liabilities	**(60)**	(61)

* 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.

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

	2015-16	2014-15
	£000s	£000s
Service element of on SOFP PFI charged to operating expenses in year	**28,503**	25,339
Total	**28,503**	25,339

Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI

No Later than One Year	**28,973**	29,188
Later than One Year, No Later than Five Years	**115,892**	116,752
Later than Five Years	**572,217**	605,651
Total	**717,082**	751,591

Imputed "finance lease" obligations for on SOFP PFI contracts due

	2015-16	2014-15
	£000s	£000s
No Later than One Year	**16,863**	17,475
Later than One Year, No Later than Five Years	**72,891**	72,396
Later than Five Years	**333,537**	350,895
Subtotal	**423,291**	440,766
Less: Interest Element	**(184,555)**	(197,283)
Total	**238,736**	243,483

Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due	**2015-16**	2014-15
Analysed by when PFI payments are due	**£000s**	£000s
No Later than One Year	**4,383**	4,747
Later than One Year, No Later than Five Years	**25,888**	24,131
Later than Five Years	**208,465**	214,605
Total	**238,736**	243,483

Number of on SOFP PFI Contracts

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

38 Impact of IFRS treatment - current year

The information below is required by the Department of Heath for budget reconciliation purposes	2015-16 Income £000s	2015-16 Expenditure £000s	2014-15 Income £000s	2014-15 Expenditure £000s
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g PFI / LIFT)				
Depreciation charges		7,019		7,369
Interest Expense		12,728		16,675
Other Expenditure		32,248		25,338
Impact on PDC dividend payable		1,572		460
Total IFRS Expenditure (IFRIC12)	**0**	**53,567**	**0**	**49,842**
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)		51,086		45,193
Net IFRS change (IFRIC12)		**2,481**		**4,649**
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12				
Capital expenditure 2015-16		1,799		1,206
UK GAAP capital expenditure 2015-16 (Reversionary Interest)		3,655		6,281

	2015-16 Income/ Expenditure IFRIC 12 YTD £000s	2015-16 Income/ Expenditure ESA 10 YTD £000s
Revenue costs of IFRS12 compared with ESA10		
Depreciation charges	**7,019**	
Interest Expense	**12,728**	
Other Expenditure		
Service Charge	**28,429**	**51,086**
Contingent Rent	**3,745**	
Lifecycle	**74**	
Impact on PDC Dividend Payable	**1,572**	
Total Revenue Cost under IFRIC12 vs ESA10	**53,567**	**51,086**
Revenue Receivable from subleasing	**0**	**0**
Net Revenue Cost/(income) under IDRIC12 vs ESA10	**53,567**	**51,086**

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 Trust has with commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the 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 NHS TDA. 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 2016 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 Clinical Commissioning Groups, 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
Receivables - NHS	0	13,290	0	**13,290**
Receivables - non-NHS	0	7,282	0	**7,282**
Cash at bank and in hand	0	2,716	0	**2,716**
Total at 31 March 2016	**0**	**23,288**	**0**	**23,288**
Receivables - NHS	0	15,321	0	**15,321**
Receivables - non-NHS	0	5,404	0	**5,404**
Cash at bank and in hand	0	1,239	0	**1,239**
Total at 31 March 2015	**0**	**21,964**	**0**	**21,964**

39.3 Financial Liabilities

	At 'fair value through profit and loss'	Other	Total
			£000s
NHS payables	0	5,132	**5,132**
Non-NHS payables	0	39,646	**39,646**
Other borrowings	0	38,675	**38,675**
PFI & finance lease obligations	0	239,951	**239,951**
Total at 31 March 2016	**0**	**323,404**	**323,404**
NHS payables	0	5,118	5,118
Non-NHS payables	0	42,552	42,552
Other borrowings	0	9,574	9,574
PFI & finance lease obligations	0	244,820	244,820
Total at 31 March 2015	0	302,064	302,064

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 2016.

	Expenditure	Income	Payables	Receivables
	£000	£000	£000	£000
NHS Coastal West Sussex CCG	0	8,926	0	902
NHS England (Wessex Local Office)	0	12,061	0	222
NHS England (Wessex Commissioning Hub)	0	91,537	0	2,907
NHS Fareham and Gosport CCG	3	105,103	757	788
NHS Litigation Authority	18,378	0	4	0
NHS Portsmouth CCG	28	113,710	1,020	1,794
NHS South Eastern Hampshire CCG	1	94,907	540	692
NHS West Hampshire CCG	0	9,257	0	218
University Hospitals Southampton NHS Foundation Trust	1,432	7,554	868	2,041

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

42 Losses and special payments

The total number of losses cases in 2015-16 and their total value was as follows:

	Total Value of Cases	Total Number of Cases
	£s	
Losses	122,377	404
Special payments	106,010	126
Total losses and special payments	**228,387**	**530**

The total number of losses cases in 2014-15 and their total value was as follows:

	Total Value of Cases	Total Number of Cases
	£s	
Losses	402,771	363*
Special payments	109,376	109
Total losses and special payments	512,147	472

Details of cases individually over £300,000

There were no individual cases over £300,000

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 for those years.

43.1 Breakeven performance

	2006-07 £000s	2007-08 £000s	2008-09 £000s
Turnover	372,407	409,985	422,836
Retained surplus/(deficit) for the year	857	7,299	159
Adjustment for:			
Timing/non-cash impacting distortions:			
Pre FDL(97)24 agreements	0	0	0
2007/08 PPA (relating to 1997/98 to 2006/07)	(533)		
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0	
Adjustments for impairments			111
Adjustments for impact of policy change re donated/government grants assets			
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*			
Absorption accounting adjustment			
Other agreed adjustments	0	0	0
Break-even in-year position	324	7,299	270
Break-even cumulative position	1,910	9,209	9,479

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

	2006-07 %	2007-08 %	2008-09 %
Materiality test (I.e. is it equal to or less than 0.5%):			
Break-even in-year position as a percentage of turnover	0.09	1.78	0.06
Break-even cumulative position as a percentage of turnover	0.51	2.25	2.24

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.

2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s
432,167	446,161	440,231	451,906	469,094	484,463	**504,572**
(77,052)	6,254	1,779	4,025	2,802	(8,229)	**(26,361)**
0	0	0	0	0	0	**0**
60,097	(6,095)	(3,097)	0	(5,079)	(102)	**(79)**
		22	268	277	770	**482**
2,078	0	1,444	0	2,830	4,649	**2,481**
			0	0	0	**0**
0	0	0	0	0	0	**0**
(14,877)	159	148	4,293	830	(2,912)	**(23,477)**
(5,398)	(5,239)	(5,091)	(798)	32	(2,880)	**(26,357)**

2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-16 %
-3.44	0.04	0.03	0.95	0.18	-0.60	**-4.65**
-1.25	-1.17	-1.16	-0.18	0.01	-0.59	**-5.22**

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 based on the pre audited accounts 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.

	2015-16	2014-15
	£000s	£000s
External financing limit (EFL)	**21,764**	6,830
Cash flow financing	**21,934**	6,692
Finance leases taken out in the year	**323**	0
Other capital receipts	**(500)**	(175)
External financing requirement	**21,757**	6,517
Under/(over) spend against EFL	**7**	313

43.4 Capital resource limit

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

	2015-16	2014-15
	£000s	£000s
Gross capital expenditure	**9,985**	10,355
Less: book value of assets disposed of	**(837)**	(55)
Less: donations towards the acquisition of non-current assets	**(500)**	(175)
Charge against the capital resource limit	**8,648**	10,125
Capital resource limit	**8,728**	12,269
(Over)/underspend against the capital resource limit	**80**	2,144

43.5 Third party assets

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

	31 March 2016	31 March 2015
	£000s	£000s
Third party assets held by the Trust	**0**	0

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Remuneration Report

Salary and Pension entitlements of senior managers 2015/16

Name	Title	Start date/leaving date (where not in post for full year)	2015/16		
			Salary	Expenses Payments (Taxable)	Performance Pay and Bonuses
			(bands of £5,000) £000	(total to nearest £100)	(bands of £5,000)
Executive Directors in post at 31st March 2016					
Ursula Ward	Chief Executive		180-185	5,000	-
Simon Holmes	Medical Director		180-185 **	-	-
Adcock Chris	Director of Finance	From 12/10/2015	75-80	-	-
Simon Jupp (non voting)	Director of Strategy	From 01/10/2014	130-135	-	-
Cathy Stone	Director of Nursing	From 01/01/2015	120-125	-	-
Tim Powell (non voting)	Director of Workforce & Organisational Development		120-125	-	-
Ed Donald	Chief Operating Officer	From 01/02/2016	20-25	-	-
Executive Directors who left during the year					
Ben Lloyd	Director of Finance and Investment	Until 16/03/2015	-	-	-
Nicola Lucey	Acting Director of Nursing	Un til 31/12/2014	-	-	-
Cherry West	Chief Operating Officer	Until 31/07/2014	-	-	-
Richard Eley	Interim Director OF Finance	From 05/05/2015 to 13/10/2015	135-140	-	-
Ed Donald	Interim Chief Operating Officer	From 02/03/2015 to 31/01/2016	295-300	-	-
Non- Executive Directors in post at 31st March 2016					
Sir Ian Carruthers	Chairman	From 11/06/2014	20-25	3,500	-
Nellthorp Mark	Non- Executive Director		5-10	-	-
Conway Elizabeth	Non- Executive Director		5-10	-	-
Erskine Steve	Non- Executive Director		5-10	1,600	-
Michael Attenborough-Cox	Non- Executive Director	From 01/03/2015	5-10	1,700	-
John Smith	Non- Executive Director	From 01/03/2015	5-10	1,100	
Non- Executive Directors who left during the year					
Cole Alan	Non- Executive Director (Interim Chair 01/01/2013 to 15/06/2014)	Until 31/10/2015	0-5	400	-
Higenbottam Tim	Non- Executive Director	Until 30/06/2014	-	-	-

* 2014/15 "All Pension Related" benefits have been restated to reflect the guidance on calculation that came into effect in 2014/15 but was not actioned.

** Medical Director salary includes remuneration for work other than management responsibilities of £35k-£40k (2014/15 £35k-£40k)

			2014/15					
Long Term Performance Pay and Bonuses	All Pension Related Benefits	TOTAL	Salary	Expenses Payments (Taxable)	Performance Pay and Bonuses	Long Term Performance Pay and Bonuses	All Pension Related Benefits	TOTAL
(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000) £000	(total to nearest £100)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500) *	(bands of £5,000)
-	7.5-10	195-200	185-190	5,000			0	185-190
-	25-27.5	205-210	180-185**				10-12.5	190-195
-	62.5-65	140-145						
-	67.5-70	200-205	65-70				62.5-65	125-130
-	112.5-115	235-240	30-35				0	30-35
-	37.5-40	160-165	115-120				17.5-20	130-135
-	0	20-25						
-	-	-	150-155				27.5-30	175-180
-	-	-	75-80				292.5-295	355-370
-	-	-	40-45				7.5-10	45-50
-	-	135-140	0					
-	-	295-300						
-	-	25-30	15-20	3,300				
-	-	5-10	5-10					
-	-	5-10	5-10					
-	-	5-10	5-10	1,200				
-	-	5-10	0-5					
-	-	0-5	5-10	700				
-	-	-	0-5					

Salary and Pension entitlements of senior managers

B) Pension Benefits

Name	Title	Real increase in pension at retirement age (bands of £2500) £000	Real increase in pension lump sum at retirement age (bands of £2500) £000
Ursula Ward	Chief Executive	0-2.5	2.5-5
Simon Holmes	Medical Director	0-2.5	5-7.5
Chris Adcock	Director of Finance	0-2.5	0-2.5
Simon Jupp (non voting)	Chief Operating Officer	2.5-5	2.5-5
Cathy Stone	Director of Nursing	5-7.5	15-17.5
Tim Powell (non voting)	Director of Workforce & Organisational Development	2.5-5	0
Ed Donald	Chief Operating Officer	0	0

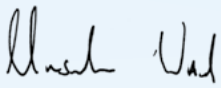
* The Trust has not made contributions to stakeholder pensions
** No lump sum is shown for employees who only have membership in the 2008 Section of the NHS Pension Scheme.

*** This represents the real increase since joining the Trust during the year

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

CASH EQUIVALENT TRANSFER VALUES
A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the members accrued benefits and any contingent spouse's pension payable from the scheme. CETV's are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

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

Chief Executive:  Date: 27th May 2016

Total accrued pension at age 60 at 31/03/2016 (bands of £5000) £000	Lump sum at pension age related to accrued pension 31/03/2016 (bands of £5000) £000	Cash equivalent transfer value 31/03/2016 £000	Cash equivalent transfer value 31/03/2015 £000	Real increase in cash equivalent transfer value (bands of £5000) £000	Employers Contribution to Stakeholder Pension* To nearest £100
65-70	195-200	1,292	1,234	40-45	0
75-80	230-235	1,615	1,536	60-65	0
35-40	100-105	545	501	15-20 ***	0
35-40	105-10	620	558	55-60	0
50-55	160-165	1077	941	120-125	0
10-15	0 **	133	100	30-35	0
0	0	0		0	0

A Patient's Story

John Louch

"I was helped throughout the whole thing by some fantastic staff at QA"

John Louch, cancer patient

John Louch, a successful car salesman aged 76 from Fareham, always had the gift of the gab, and relied largely on his friendly patter to establish his business.

However, fate dealt him a cruel blow in 2010 when a diagnosis of oesophageal cancer led to the removal of his voice box.

Following treatment here at Queen Alexandra Hospital he soon regained the ability to speak by learning to use a special valve, and now he is using that voice to help raise awareness of head and neck cancer.

John says "I knew something was wrong in early 2010. My speech had changed dramatically for no apparent reason. I had several examinations and tests, but nothing was found, and I was at the end of my tether."

It was then revealed that Mr Louch had oesophageal cancer with a small tumour found hidden behind his voice box, which had made it almost impossible to detect.

He explained "As soon as I had that diagnosis things started moving very quickly. I was given only weeks to live, so time was of the essence."

John had a total laryngectomy where the cancer and all of his voice box was removed. Surgeons cut a hole in his throat, and inserted a special valve, or voice prosthesis. This allowed him to make sounds, by pushing air from his lungs through the valve and up into his mouth.

John continues "I got the hang of it quite quickly. It was so important to me that I learnt to speak again. I was helped throughout the whole thing by some fantastic staff at QA, especially Vanessa Young, who is Macmillan Senior Head and Neck Clinical Nurse Specialist."

His wife Ann comments "John's always been a real talker, and I'm really proud of how he has coped with everything. He has a very big personality, and he refuses to let things get him down, although it is a lot to go through. I'm so proud of him."

A Patient's Story

Taliya Anyia-Dawkins

"It's great to see her doing the things which she could only watch others do before"

Sabrina Dawkins, Mum

Despite being born without a left hand, eight-year-old Taliya Anyia-Dawkins is able to take part in all of the same activities as her school friends, thanks to the incredible work done at Portsmouth Enablement Centre, in St Mary's Community Health Campus.

Taliya, from Gosport, was over the moon to receive a special custom-made 'gymnastics hand' by the centre, which means she is now able to do cartwheels and handstands in comfort.

The hand is slightly longer than her normal prosthetic, which makes her much more balanced when she is taking part in sports.

Her mum, Sabrina Dawkins, said "She loves gymnastics and she's really good at it. It's great to see her doing the things which she could only watch others do before.

"She's also now taking up athletics – there's no stopping her! It's lovely to see her enjoying herself and being so active. "It's not always easy for her, especially being at school and noticing that she's different to the other children. She finds a way to do most of the things that everyone else does. We're lucky that we live so close to the Enablement Centre.

"They have been really good with Taliya and are always thinking of her needs.

"She is very much involved in the creation of her prosthesis and she will be asked about her likes and dislikes, her favourite colours and her hobbies. All of this is used by the experts when they are creating her hands. She is seen by her prosthetist and by an occupational therapist, who suggests different ways for her to do certain things, which is often really helpful. It has built up her confidence a lot and I am really proud of her."

Portsmouth Enablement Centre changed its name in 2015 from Disablement Services Centre, to better reflect the work which is carried out in the centre, and the attitude of its users.

The centre, which is one of only 40 such centres across the UK, helps thousands of adults and children across the South of England.

Chantel Ostler, Amputee Specialist Physiotherapist at the centre, said "This was something which our users felt very strongly about. We wanted our name to reflect our philosophy here, and our focus is firmly on enablement, and empowering people."

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

This annual report is available to view at **www.porthosp.nhs.uk**

If you require this document in another language, large print or another format, i.e. audiotape, please contact the Patient Advice and Liaison Service on Freephone 0800 917 6039.

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