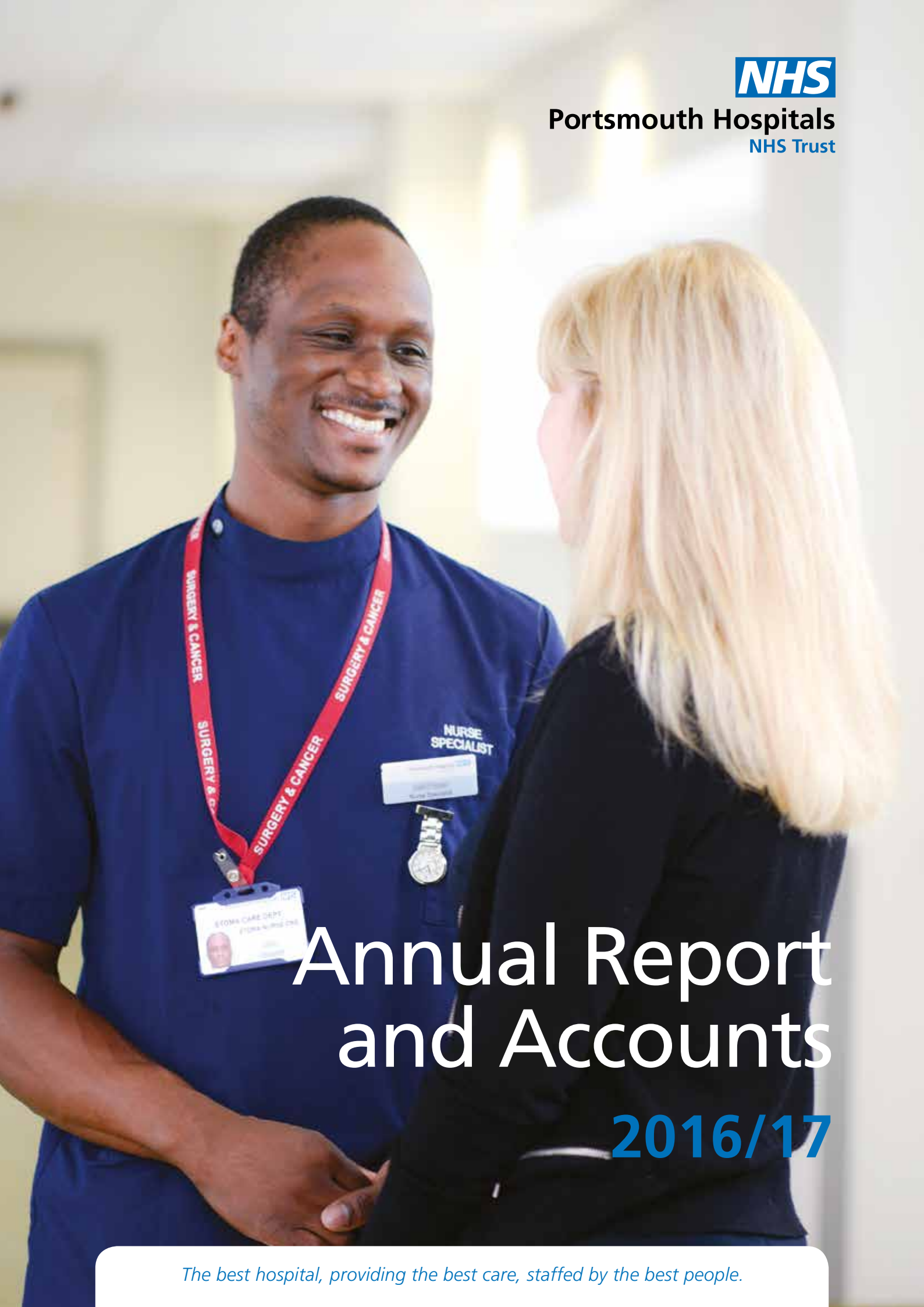

NHS
Portsmouth Hospitals
NHS Trust

Annual Report and Accounts

2016/17

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

A Patient's Story

> "It was so special to receive such a high level of care and attention at the MISSION clinic. It really is a first class project."
>
> **Kate,** patient

Eighty-two-year-old Kate Dawson-Taylor, from Fareham, was one of the patients involved in the MISSION COPD project. Kate, who climbs her stairs for fun in a bid to clock up steps on her new Fitbit, said taking part in the project has given her a new lease of life.

MISSION-COPD proactively identifies patients with undiagnosed or high-risk COPD from selected local GP registers. The team then conduct an assessment of disease control, quality of life and triggers in the practice surgery, followed if necessary by evaluation in hospital by a specialist COPD team.

"The whole Saturday morning was dedicated to a group of 10 of us and our lungs," said Kate. "I hadn't had my asthma treatment changed in 25 years so it was really eye-opening to be put through lots of different tests and procedures to see how my respiratory health really was. The results of the initial tests prompted Professor Chauhan to change my medication. The two new inhalers he prescribed me are really working very well and are keeping my condition nice and steady."

Kate attended a follow-up clinic a few months later at Queen Alexandra Hospital where the efficacy of her new medication was checked. She was also advised to undergo an x-ray of her lungs.

"The x-ray showed I had scarring on my lungs so I went on to have a CT scan and bronchoscopy," said Kate. "I was terrified I had cancer. So when the results came back all clear I was very, very happy. I knew I had a clean bill of health as far as my lungs were concerned. So here I am, at the age of 82, knowing that everything physically possible has been done to check my lungs are as healthy as possible, and that's as a result of the MISSION clinic. It is something I will be eternally grateful for and something I hope many others will benefit from.

"Being given a clean bill of health at my age has made me feel totally different about where I am in my life and it's given me a determination to be healthier in all aspects. The whole MISSION team are full of empathy – they smile, they know the right gentle words to say at the right time, and they care. We live in the days now where you almost feel as though you have to apologise for going to see the GP. It was so special to receive such a high level of care and attention at the MISSION clinic; it really is a first class project."

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1 Introduction from the Chairman and Chief Executive

This last year has continued to be very challenging for NHS colleagues across the country. The trials and tribulations of the NHS are well documented and yet despite the growing pressure on our services our staff continued to be outstanding, making a difference to people at a time when they have needed it most. There is a lot that remains unresolved in our hospital, and our urgent care pressures remain, but with the commitment and resilience of our staff we remain as confident and determined as ever that we can continue to improve the services we provide to our patients.

2016/17 has been a year of considerable financial challenge for the Trust. The Trust was set a control total target of £1.2m surplus for the year based on an expectation that the stretch target year end deficit of £9.7m had been achieved in 2015/16. As the Trust had ended the previous year with a deficit of £23.5m, this resulted in a cost improvement target for 2016/17 of £32m, almost 6% of turnover.

We are proud to continue to host military colleagues from all three services in the hospital. The mutual relationship between Defence Medical Group (South) and the Trust remains as important as ever. Under the command of Lieutenant Colonel Adam Shorrock the military medical personnel, which encompass Consultant Doctors, Specialist and Generalist Nurses and Allied Healthcare Professionals, provides a capable and flexible workforce which works to support the priorities of the Trust. We were also delighted to continue to play a role supporting military reservists.

Despite the relentless pressures throughout the year we have continued to win many awards for our work. We were recognised at the Sport and Physical Activity Awards, along with a select number of other public sector organisations for our work on staff health and well-being. Despite the title this was not about producing a workforce capable of running marathons or swimming the Channel, but was recognition of a workforce capable of delivering better outcomes for our patients, a workforce who values the need to look after themselves in order to look after their patients, and a workforce who recognises that looking after each other is really important. This means supporting one another and working collaboratively across teams.

Of course this is not the only award we have won. There are almost too many to mention whether it be The News Best of Health awards, the Shine Awards, and of course our own Best People Awards. We can be proud of so many of our colleagues who have been recognised, and of course everyone who has supported them.

Looking ahead we continue to explore opportunities to ensure the local NHS and social care services work together as a team, becoming stronger in our common purpose to deliver better care and outcomes for a much wider population than just Portsmouth, Fareham, Gosport and SE Hampshire. Working in collaboration with our partners on the Isle of Wight, and Southampton, and potentially further afield, we aspire to deliver better care and sustainable services for our patients going forward.

This is not a merger or a takeover, simply a way by which we can work as a larger team, share resource at a time when it is at a premium, and deliver better services for the benefit of all of our patients. Importantly this work will be led by clinical leaders from all organisations to ensure that changes really do deliver better outcomes for patients as we move forward. This is an exciting opportunity without which would see us struggle to keep up with demand over the years ahead.

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

Sir Ian Carruthers
Chairman

Tim Powell
Interim Chief Executive

2 One year, numerous achievements – our year in review

There have been many achievements and successes in 2016/7. A summary of our highlights includes:

April

- Our Learning and Development team was awarded a Quality Mark
- Our already successful 'My Birthplace' app was launched throughout the Wessex region

May

- We were ranked as one of CHKS' top 40 hospital trusts in the UK, for an impressive eleventh time. The Top Hospitals Award is judged on the evaluation of over 20 performance indicators including safety, clinical effectiveness, data quality, patient experience and quality of care
- Our hospital catering team achieved a five star rating in food hygiene standards for the fifth year in a row. The team has never received anything less than top results
- Our Acute Pain Service celebrated its 20th birthday
- Excellent standards in our Anaesthesia Department were rewarded as colleagues received Anaesthesia Clinical Services Accreditation (ACSA). They are only the tenth national team to receive this

June

- Positive results are published in our annual inpatient survey. The survey asked for the views of adults who had stayed overnight as an inpatient and what they thought about aspects of the care and treatment they had received

July

- We won a prestigious HSJ Patient Safety Award for Improving Safety in Medicines Management. The successful MISSION-COPD team worked in collaboration with the Wessex Academic Health Science Network

August

- We scored highly in the Patient-led Assessment of the Care Environment (PLACE), an annual mandatory inspection
- Portsmouth patients scooped an impressive haul of 14 medals at the Westfield Health British Transplant Games. Andrew Dibsdall, Bob Jolliffe, Tim Jenkins, Keith Cooper, Tracey Sinclair, Dave Eldridge, Richard Twose and Jeremy Clifton picked up four gold medals, six silver medals and four bronze medals between them

September

- Whilst raising funds for our Paediatric and Maternity Departments Robert Knott from Gosport achieved a world record for the most weight deadlifted in 24 hours. A team of 35 people lifted an incredible 880,000kg in 12 hours 30 minutes breaking the world record of 750,000kg

October

- A local initiative entitled 'Diabetes pregnancy care – achieving similar outcomes to non-diabetes related pregnancies' was highly placed within the Quality in Care (QiC) Diabetes 2016 National Awards
- Claire Jeffries, lead clinical specialist physiotherapist for hydrotherapy and rheumatology, and the Specialist AS Team received Patients' Choice Awards from the National Ankylosing Spondylitis Society (NASS)
- The Stop the Red Clocks Project was shortlisted for a prestigious Nursing Times Award in the Patient Safety Improvement category
- We held our annual Best People awards celebrating our staff

November

- Our Rheumatology team received the National Rheumatoid Arthritis Society (NRAS) Healthcare Champions Award
- Teams and individuals are celebrated at the News Best of Health Awards
- MISSION-Asthma and COPD, in collaboration with Wessex Academic Health Science Network, scoop another prestigious HSJ award for Primary Care Innovation
- Triplets born at QA Hospital in 2014, who were 17 weeks premature and weighing just 2lb 14.34oz combined were awarded a Guinness world record for the lightest and earliest trio ever born in the world
- Our neonatal intensive care unit (NICU) becomes the second only unit in the UK to gain accreditation for its family-centred care under the Bliss Baby Charter

December

- Anna Robinson, Lymphoma Care Co-ordinator, won the Lymphoma Association's 'Beacon of Hope' award for her kindness and support towards patients
- Our Frailty and Interface Team (FIT) celebrated one year of service

January

- Our Vascular Assessment Unit achieved IQIPS Accreditation from the Royal College of Physicians
- The Care Quality Commission upgrades their assessment of the unscheduled care pathway following a positive inspection
- Six Band 5 staff nurses were awarded certificates by Cathy Stone, Director of Nursing, for successfully passing a new leadership course to prepare them for future roles

February

- Our maternity team launched a new website 'Maternal Emotional Wellbeing Matters Portsmouth' to help women deal with Perinatal Mental Health
- Portsmouth LiverChat! group was launched for patients to meet others with an autoimmune liver condition, for friendship, support and information

March

- We were rated in the top 20 per cent of acute hospital trusts in the national NHS Staff Survey
- The Haematology and Oncology Day Unit was awarded a Macmillan Quality Environment Mark (MQEM) for delivering high standards of care to people affected by cancer

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 ensuite wards.

The current hospital was first opened by Princess Alexandra in 1980 and 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 of 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 142,000 patients each year. We also see over 567,000 outpatients and carry out over 53,000 day case operations. Our maternity services deliver around 5,800 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 with the national agenda in these fields.

Providing the best care across South East Hampshire

We are organised into ten Clinical Service Centres (CSCs)

- Clinical Support
- Emergency Medicine
- Head and Neck
- Medicine
- Medicine for Older People, Rehabilitation and Stroke
- Renal and Transplantation
- Cancer and Surgery
- Theatres, Anaesthetics and Critical Care
- Trauma, Orthopaedics, Rheumatology and Pain
- Women and Children.

These centres are both 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 contrasted 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 reablement 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

Private Patients

The demand for the services delivered from the Harbour Suite private patients service continues to grow and delivers an increasing 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.

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

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

Challenges within our operating environment

The hospital continued to be 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.
In the last year we saw:

73,000 planned admissions to hospital

142,000 emergency department attendances

567,000 outpatients appointments

5,800 births in our maternity units

54,000 emergency admissions

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 our community is atypical:

- **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.

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 its 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 for April to February and every standard was achieved for March.

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. We are therefore disappointed that five 'Never Events' were experienced in this last year. None of the events resulted in moderate or severe harm or death for the patient involved, but they are unacceptable instances which have been fully investigated with action plans put in place to ensure such incidents do not recur.

Date of incident	Nature of incident
April 2016	Retained foreign object after surgery.
June 2016	Insulin overdose administered with incorrect device.
December 2016	Retained foreign object after surgery.
December 2016	Wrong site procedure where the patient was administered a steroid injection in the incorrect joint of the intended finger.
March 2017	Wrong site surgical procedure

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 7 out of 12 months and have made improvements to the Referral to Treatment waiting time standard over the last six months. 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 MRSA bloodstream infection, MSSA bloodstream infection and C.difficile.

This year we have purchased an additional two hydrogen peroxide fogging machines to add to our fleet. Prudent antimicrobial prescribing is a priority, and this year the Trust took part in a European Point Prevalence audit of antimicrobial usage and healthcare associated infection.

During 2016/17, we had 33 cases of hospital attributed C.difficile infections against a target of 40. This means that our performance positively exceeds our target by 17.5%. Our performance with MRSA bloodstream infections also met the target, with zero avoidable cases against a target of zero avoidable cases. The Trust did however have one unavoidable case attributed to it in October.

MSSA bloodstream infections, although not subject to NHS England trajectories, are closely monitored by the Trust. A number of interventions have been put in place to reduce the risk of these infections, and cases have reduced in response to these measures.

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 organisational priorities to ensure that we deliver our vision. These are:

Deliver safe, high quality patient centered care:

- Reducing level of Hospital Standardise Mortality Ratio (HSMR)
- Increasing Safety Thermometer of harm-free care:
  - Improved timeliness of identification and treatment for sepsis in emergency departments and admission areas
  - Minimising the number of hospital acquired grade 3 and 4 pressure ulcers
  - Reducing level of medication incidents

Continually improve the patient experience

- Ensure patient experience is not compromised through limited capacity (including ambulance holds and patient moves)
- Achieve quality and safety metrics as outlined in the Urgent Care Improvement Plan
- Achieve positive patient experience through full engagement with families, carers and patients
- Maintenance of compliance with CQC regulations

Ensure delivery of the national constitutional standards:

- Achieve the A&E 4 hour performance target
- Meet the required Referral To Treatment waiting time
- Cancer pathway targets are met
- Achieve the diagnostic procedure wait target
- Reduction in delayed transfers of care
- Meet the SAFER target for the percentage of patients discharged by midday seven days a week

Create a healthy organisational culture where staff report they are well led and have high levels of satisfaction working in the trust:

- National Staff Survey results place the Trust in the top 20% for staff engagement
- National Staff Survey results show an improvement in the number of staff reporting bullying and harassment
- Achievement of the race equality standard
- Demonstrate an improvement in the CQC rating for the 'well led' domain for leadership and culture
- Develop strategies to ensure hard to recruit to roles are filled
- Deliver the workforce cost improvement programme

Achieve financial health and sustainability:

- Delivery of income and expenditure control total
- Delivery of cost improvement programme
- Management of cash within agreed limits
- Management of capital resources within limits in line with business plan objectives

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

Working in partnership to deliver health and care for our communities

Our Trust strategy has not been developed in isolation. We have an important role to play within the local health economy and we are a key player in the delivery plan of the Hampshire and Isle of Wight Health and Care System Sustainability and Transformation Plan (STP). This recognises the challenges we face, our vision for Hampshire and the Isle of Wight and the action we are taking to address our challenges and deliver our vision.

This sets out the details of our six core delivery programmes and our four enabling programmes - the priority work that partners in the health and care system are undertaking together to transform outcomes, improve satisfaction of patients and communities and deliver financial sustainability.

Each programme has senior clinical and managerial leadership, detailed programme plans underpinned by robust analysis, clear delivery milestones and consensus about the priorities and approach to delivery.

Delivering our plan will result in tangible benefits and improvements for local people and communities:

Investing in prevention and supporting people to look after their own health	We are implementing a series of evidence based solutions focused on primary & secondary prevention and behaviour change, supported by technology. This will improve healthy life expectancy, improve cancer survival rates, and reduce dependency on health and care services. Tackling obesity in childhood and improving life choices will deliver long term benefits.
Strengthening and investing in primary and community care	We are implementing the GP Forward View in HIOW. GP practices are collaborating and working at scale to deliver access for urgent needs across an extended 7 day period. Services operating within the currently fragmented out of hospital system are coming together to deliver a single, coordinated extended primary care team for local populations. More specialist care is being delivered in primary care settings. New models of integrated care for children are being delivered across our system.
Simplifying the urgent and emergency care system	We are simplifying the urgent and emergency care system, making it more accessible to patients. As a result we will consistently deliver the A&E and ambulance standards. We are improving patient flow, ensuring that best practice is implemented in every locality without delay, and investing in home based care capacity. This will mean that Delayed Transfers of Care are lower than the national 3.5% requirement
Improving the quality of hospital services	Acute hospital providers are working as an Alliance to reconfigure unsustainable acute services to improve outcomes and optimise the delivery for the population in Southern Hampshire and on the Isle of Wight. Supporting services will be reviewed to ensure that provision is efficient and cost effective. We will determine the best option for a sustainable configuration of acute services in North & Mid Hampshire and work together to deliver the agreed option. We are implementing the national recommendations, including those in maternity services to improve outcomes and reduce variations in practice.
Making tangible improvements to mental health services	We are making tangible improvements to mental health services for children and adults, and services for people with learning disabilities. We are committed to valuing mental and physical health equally to ensure that support for mental health is embedded holistically across the system and not seen in isolation in order to achieve parity of esteem. The four HIOW Trusts providing mental health services (Southern Health FT, Solent NHST, Sussex Partnership FT and IoW NHST), commissioners, local authorities, third sector organisations and people who use services, are working together in an Alliance to deliver a shared model of care with standardised pathways and enact the Five Year Forward View for Mental Health.
Creating a financially sustainable health system for the future	As we transform services to improve patient experience and outcomes, we are also reducing overall system costs and avoiding future cost pressures from unmitigated growth in demand. We are striving for top quartile efficiency and productivity in all sectors. We are adapting financial flows and contracting and payment mechanisms to align outcomes, metrics and financial incentives to support optimum patient outcomes, improved decision making and financial stability. Through a combination of efficiency savings and transformation set out in this plan, and using £60m of the STP fund, we will deliver at least a break even position by 2020/21. We are working to identify a further £60m of savings to deliver our surplus requirements.

These plans are underpinned by a new way of working between NHS providers and commissioners and social care, with shared responsibility for delivery and partnership. Going forward we will:

- Manage our workforce as one Hampshire and Isle of Wight system
- Invest, together, in digital technology
- Use a joint leadership and organisational development programme to create the culture necessary for success
- Run a robust project management programme with clear governance systems

Implementation of the STP will improve both the physical and mental health and wellbeing of our local population and lead to a clinically and financially sustainable health and care system.

Investing in our skilled workforce

We employ around 6,480 people and we are the 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 the following staff groups;

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


NHS

In addition to our substantive workforce capacity, our temporary staffing accounts for 7.6% of the total workforce establishment. This is a 2.6% increase in comparison to this time last year.

Some investments have been made in 2016/17 to increase substantive staffing levels across the Trust. The Trust's effort has targeted 'hard to recruit'/high-cost agency areas, with an aim to reduce our reliance on temporary workforce bringing our total pay bill to more affordable levels. In addition, our partnership with NHS Professionals has given us support in meeting staffing requirements for an increased patient demand.

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

Progress has been made in delivering staff appraisals (83.4%), this is a minor increase in comparison to this time last year and similarly, our essential skills training has risen and currently stands at (89.4%). Much work has also taken place to improve staff satisfaction and this has been reflected in the national staff survey results.

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	80%
Male	20%
Disability	5%
BME (Black and Minority Ethnicity)	12%

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

Female	48%
Male	52%
Disability	4%
BME (Black and Minority Ethnicity)	13%

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 also use our Equality Standard Toolkit 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 regular 'all staff message' from the Chief Executive, a monthly Team Brief, staff magazine, staff surveys and various social media platforms.

Recognising the critically important role of 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.

Examples of some of the outcomes and initiatives which have taken place in the last year as a result of staff led change include:

- Improving care for young people, wherever they are in hospital - The outcomes of this LiA conversation included an increased awareness of young people's needs through additional training, a young people's intranet hub for clinicians and an improvement to outpatient environments specifically for young people
- 'Passport to manage' and 'licence to lead' – The development and implementation of a comprehensive management development framework to equip managers with the right management and leadership skills to undertake their role successfully. Raising capability and reducing variation in practice will impact on the ability of our trust to provide high quality patient care
- The 'wear it well' campaign was developed by the Listening into Action Professional Image 2 Team to incorporate the principles of inspiring confidence and a positive self-image
- The 2015 National Staff Survey, and our own local survey, identified unacceptable levels of bullying and harassment. A staff-led change group was commissioned to deliver a campaign to provide guidance, support and confidential reporting for managers and staff. More staff and managers are now aware of the specifics of preventing workplace bullying and harassment. Reporting and subsequent action taken has increased
- 'IdeasPort' receives and progresses innovation and ideas from staff with the aim of improving processes and services for patients, their families and carers.
- Employee wellbeing through resilience workshops - to improve staff wellbeing through the development of tools and techniques to build their own, and their team's, resilience. Delivered by highly trained facilitators with counseling, psychotherapy and mental health skills there are many benefits including improving staff wellbeing and performance at work and positive effects on the patient experience
- A Listening into Action event focusing on Safety Learning Events and incident reporting resulted in the 'Learning from Incidents' campaign. Following this work the 2015 National Staff Survey showed an increase in staff perception of the fairness and effectiveness of procedures for reporting errors, near misses and incidents (we were in the best 20% of acute trusts) and an increase in staff reporting errors, near misses or incidents

The National NHS Staff Survey 2016

The NHS Staff Survey is recognised as an important way of ensuring that the views of staff working in the NHS informs local improvements and national assessments of quality, safety, and delivery of the NHS Constitution. The results of this annual survey are also used by NHS England to support national assessments of quality and safety, and the Care Quality Commission uses the results to inform its Intelligent Monitoring work to help to decide who, where and what to inspect.

We chose to survey all of our staff in 2016, as we have in previous years. A total of 3,949 staff took the opportunity to complete and return a survey, a 58% response rate. This places us in the highest 20% for acute trusts in England and compares with a response rate of 59% in the 2015 survey.

The survey report is structured around nine themes:

- Appraisals and support for development
- Equality and Diversity
- Errors and incidents
- Health and wellbeing
- Working patterns
- Job satisfaction
- Managers
- Patient care and experience
- Violence, harassment and bullying

The detailed content of the report has been presented in the form of Key Findings (KFs) and contains 32 KFs, all of which are comparable with the 2015 survey. When comparing the Key Findings to the 2015 survey:

- 1 showed improvement
- 28 remained unchanged
- 3 deteriorated (however of these, one KF is better than average when compared to all acute trusts)

Of the 32 Key Findings (KFs) when measured against all acute trusts in England:

- 12 are in the best 20%
- 7 are above average
- 7 are average
- 3 are below average and 3 are in the worst 20%

Top ranking scores:

- More staff are satisfied with flexible working opportunities
- There is good communication between senior management and staff
- There is recognition and value of staff by managers and the organisation
- The percentage of staff working extra hours is low
- There is support from immediate managers
- There is organisation and management interest in, and action on, health and wellbeing

Bottom ranking scores:

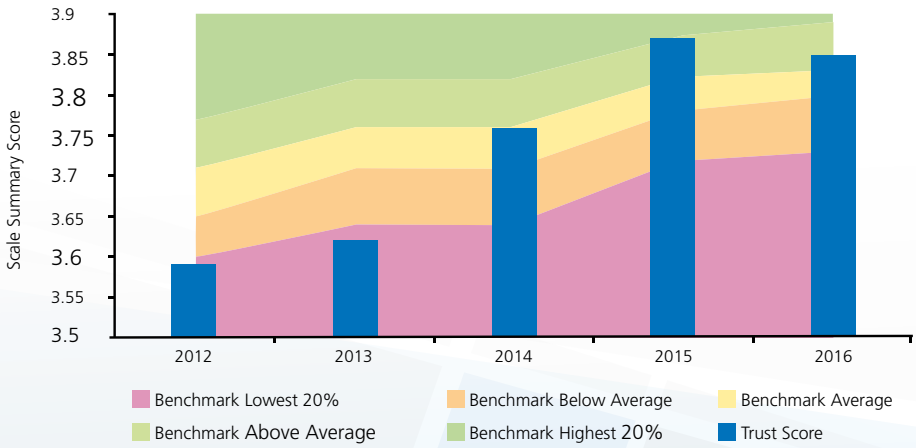
- Staff recommendation as a place to work or receive treatment
- Staff experiencing bullying or harassment or abuse from patients, relatives/public
- Staff witnessing potentially harmful errors, near misses or incidents
- Staff attending work despite feeling unwell because they felt pressure from their manager, colleague or themselves
- Staff reporting most recent experience of harassment, bullying or abuse
- Staff experiencing physical violence from staff

The overall staff engagement score when compared with all acute trusts has remained at 'above average'. From ranking in the worst 20% in 2012 and 2013, average in 2014 and above average in 2015 with a scale summary score of 3.85 (a slight decline of 0.03 from 2015).

It is pleasing to see the overall staff engagement level maintain over the last 12 months during a time of unsettling change, unprecedented activity and external scrutiny. Continuing staff engagement provides the opportunity 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.

This will be further built upon during the coming year to ensure that we not only maintain our 12 KFs in the top 20% of all acute trusts, but also aspire to be in the top 20% for overall staff engagement. It is crucial that to 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 pressured workforce.

National Staff Survey - 2012 to 2016
Overall Engaagement Score compared to Acute Trusts



Working alongside our military personnel

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

Under the command of Lieutenant Colonel Adam Shorrock the military medical personnel, which encompass Consultant Doctors, Specialist and Generalist Nurses and Allied Healthcare Professionals, provide a capable and flexible workforce which works to support the priorities of the Trust. In doing this the MoD clinicians maintain and develop their clinical skills that will be used to provide medical support to the Royal Navy, Army and Royal Air Force wherever they may be deployed world-wide.

Although high profile operations such as those in Afghanistan have been scaled back, the Unit regularly deploys personnel in support of humanitarian operations as well as holding staff who are ready to deploy at short-notice in support of unforeseen requirements.

During this last year military personnel have also taken an increasing number of leadership roles within the Trust including the appointment of Colonel Neil Mackenzie and Commander Barrie Dekker as Chiefs of Service, further ensuring the flow of best practice between the NHS and MoD. The success of the partnership lies in the quality of the personnel and the quality of the placements available to them and we look forward to the relationship continuing for the foreseeable future.

Improved participation and engagement

Developing a better understanding of what matters most to our patients, families and carers is essential to us. To achieve this we have worked closely with our local community to put in place a wide variety of opportunities for people to let us know how we are doing and to contribute to improving the overall patient experience.

Over the last year we have improved the ways people can provide feedback, to ensure that every patient can tell us how they feel about their care and treatment.

The NHS Friends and Family Test (FFT) ensures that all patients have the opportunity to provide feedback about their experience. This simple and confidential tool has helped us go from strength to strength, developing a better understanding of what matters most. We gather over 5,000 responses each month, with many ratings supported by additional written comments.

Care is rated using a satisfaction score out of 100%, and every patient has the opportunity to express concern by not recommending the hospital. This information helps us understand how we are doing in comparison to other similar hospitals.

Case study: Mental Health Champions Programme

Patients with specialist mental health needs, and their families and carers, have told us that they do not always have a positive experience of care in our hospital. We had tried lots of different ways of helping staff improve their understanding and develop better skills but this has not worked long term. Something had to change. So, we asked the experts by experience, people living with enduring mental ill health, what was most important to them and what we could do differently

They said:

"We don't need you to be experts in mental health but sometimes your attitudes towards us is not positive, your behaviour tells us you are not confident in caring for us and your skills are sometimes lacking"

"You need to see past my mental health issues and see me…."

Together we designed and delivered a 5 day programme to help staff develop greater skills in supporting patients with specialist mental health needs.

A caring and charitable hospital

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

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

The charity supports 62 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 are delighted to have also received the support of Aidan's Activity Fund in the last year.

We are continuously promoting the charity within the local community, sharing 'good news' stories about the amazing fundraising that supporters and our staff have undertaken, and the positive results that impact on our patients here within the Trust.

We have received fantastic corporate support from local businesses including Sainsbury's in Farlington, and Sainsbury's in Commercial Road who donated fresh flowers twice a week to patient reception areas. They have also donated fresh fruit and vegetables on a monthly basis for our 'Cardiac Rehab Education Session', and chose the Children's Bubble Fund as their 'charity of the year'.

Eaton Aerospace continues to support us as their 'charity of the year', in addition to Marks & Spencer's in Gunwharf Quays and energy supplier SSE.

We are also lucky enough to have received regular donations and support from many local Waitrose stores through their 'Community Matters Scheme'. Their Waterlooville store donated £614 to our Renal Department.

Many other wards and departments have benefited from generous donations including:

- Children's Bubble Charitable Fund – Staff, patients and family members raised £30,484 through a number of events and donations to purchase a Blood Gas Analyzer for the Children's Assessment Unit (CAU).
- Head & Neck Charitable Fund – The Golf Preservation Society raised £15,000 during the year to refresh the unit's quiet room and helped fund suction units; nebulisers; boogie boards; wheelchairs and high-low couches.
- Cancer Services Charitable Fund - The Collins family raised £2,161 to help purchase two beds for relatives on the Oncology ward, helping family members to stay overnight with their loved one.
- Cancer Services Charitable Fund - The Fewings family raised £2,680 in memory of their loved one, purchasing a Qubit 3 Machine for the research lab, aiding special tests in patient's DNA samples.

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.

Neil Gray, who ran the London Marathon raising £1,105 for the Rocky Appeal, said "My friend Terry had the misfortune of being told he had cancer of the oesophagus earlier in the year. After receiving surgery aided by the Da Vinci Robot, and experiencing great care from hospital staff, Terry was able to receive treatment which has given him some more time with his family and friends."

Individual donations and community group led fundraising have also continued to make a huge difference to our patient care:

- College Chambers, Southampton raised an incredible £5,104 for the Renal department.

Dan Nother, Renal patient and Barrister at College Chambers said "two years ago I suddenly had a very rare disease called GBM which had the effect of almost completely removing my kidney function. The treatment I have received in QA, both in Renal and ICU was absolutely excellent and all of the staff were completely brilliant and lovely. I am lucky that I have made a better than expected recovery and I am now feeling pretty healthy, I go running and am back at work full time."

- Elisabeth Yaxley and family raised £4,222 for a new Optiflow machine in the Paediatrics department. Her son Noah was born with chromosome deletion 1Q44, which means he has a low immune system that leaves him vulnerable to infections. Elisabeth organised a charity fun weekend.

She said "The Paediatrics Team are brilliant with Noah. He has been on the Optiflow machine before and I know that is what they need. I just want to do anything I can to help give something back."

4 Research and Innovation

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

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

In the last year we have seen a 41% increase in the number of patients taking part in studies – from 3,668 patients in 2015/16 to 5,165 patients in 2016/17. We have also achieved a 1% increase in the number of studies we are able to offer to patients – from 330 in 2015/16 to 332 in 2016/17.

Our research recruitment is ranked in the top five of acute trusts nationally and we continue to rank in the top 10% for our research activity. Seven of our clinical specialties are in the national top three rankings for recruitment including Haematology, Surgery, Gastroenterology, Hepatology, Respiratory, Stroke and Primary Care with a further 11 specialties in the top 10 of the national rankings - Cancer, Ophthalmology, Cardiology, Dermatology, Diabetes, Health Services and Delivery Research, Dementias and Neurodegeneration, Critical Care, Musculoskeletal Disorders, Children, Reproductive Health and Childbirth.

Our research - changing practice and saving lives

Aged 36-years-old, Reverend Jim Thomas took part in a clinical trial for his severe eczema testing the efficacy of a new biologic drug. He said "My eczema was life-altering for me. It massively affected my life, but a month into the new treatment my skin was completely clear. It was amazing! You wouldn't even know I had eczema now. Taking part in research has completely transformed my life for the better."

When the parents of seven-year-old Rosie-May Murphy-White were approached about enrolling their daughter in a trial looking at the best way to treat a certain type of bacteria which can often occur in the lungs of Cystic Fibrosis patients, they jumped at the chance. Mum Tiffany said "We need a cure and an effective way to keep these bugs away, so I wanted to make sure we did what we could to help the doctors find this out. Research will help find the best way to treat my little girl."

Our patients are regularly the first-in-the-world to have the opportunity to trial new treatments, and even more are first in the UK.

At the end of last year our gastroenterology research team published results of a study in

which they found the over-the-counter medicine used to treat colic in babies, known as Infacol, helps improve the chances of detecting gullet and stomach cancer earlier during endoscopy. Professor Pradeep Bhandari, lead researcher for the study, said: "The study data has clearly demonstrated the advantage of giving the drink before the endoscopy. We are introducing this into our routine practice at QA Hospital and are now encouraging other centres to do so."

The last 12 months also brought increased opportunities for heart attack patients. Since February 2016 patients have been offered the opportunity to take part in a high-profile clinical trial which could potentially change the future of heart attack treatment. The £1.3m British Heart Foundation-funded clinical trial is investigating whether the simple technique of inflating and deflating a blood pressure cuff on the patient's arm during a heart attack can help reduce the damage to the heart and help recovery.

Ali Dana, Consultant Cardiologist and Principal Investigator for the trial at QA, said: "This is a very exciting and high profile study for us to be a part of. If this treatment is found to work our patients may see significant benefits from this simple intervention."

Our research is award-winning

The multi-award winning MISSION projects stem from Professor Chauhan, Director of Research and Innovation, and have been funded through various sources, including the Wessex Academic Health Science Network, pharmaceutical companies and NHS England.

These projects have included patients with asthma, COPD and undifferentiated breathlessness, and centre on a multidisciplinary secondary care team working with primary care to improve the diagnosis and management of respiratory disease. This has had a significant impact on hospital admissions, patient outcomes and experience, and is undergoing constant review and scaling-up through quality improvement processes and focused research.

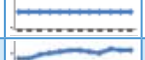
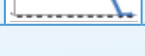
The current project, MISSION ABC, encompasses a variety of commercial partners and includes electronic respiratory management apps, diagnostic devices and educational tools, and is expected to show even greater impact on patient outcomes and NHS costs.

At the end of last year MISSION-Asthma and COPD were crowned winners of the Primary Care Innovation category at the prestigious HSJ Awards. Results from the asthma scheme included a 67% cut in emergency department visits, while the follow-up COPD project, supported by a grant from the Health Foundation, slashed such visits by 97%.

Professor Chauhan said "It is clear that these projects have improved, and potentially saved, many lives locally. The team's hard work and dedication has yet again been commended by national experts and this will only encourage us to do even more."

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 NHS Improvement (NHSI). 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.

	Key Indicators	Target	Trend	2016/17											
				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 subsequent cancers to treatment	94%		●	●	●	●	●	●	●	●	●	●	●	●
	31 day subsequent anti-cancer drugs	98%		●	●	●	●	●	●	●	●	●	●	●	●
	31 day subsequent 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 for 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. 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 95% by the end of 2017/18.

Cancer services continued to focus on reducing the backlog of patients waiting to be treated. Demand for cancer services continues to increase, recruitment during the year has lead to improved capacity and performance. Continued 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 and 5 of the 8 standards have been delivered for the year as a whole. All of the cancer standards were delivered in March. The 62 day standard has been achieved for quarter 4. 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 going forward.

The Referral Time to Treatment (RTT) delivery was impacted by high demand for unscheduled care and increased demand which the Trust did not have the capacity to meet and did not achieve the standard from June. 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 that sufficient bed capacity is in place to support the needs of all patients. Robust management of patient pathways and focused additional resources have enabled the Trust to start to address some of the underlying capacity issues and performance has improved month on month since December.

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 has delivered this despite increasing demand in 7 out of 12 months.

Our Emergency Department performance remained challenging with increasing acuity and age profile further impacting on flow through the hospital. In addition the number of patients medically fit for discharge increased significantly throughout the year, despite a range of initiatives, supported by partners, to reduce this. During quarter 3 and quarter 4, the numbers of Medically Fit For Discharge patients reached more than 200 – 285 at its highest.

We continue 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 2017/18. 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 to reduce length of stay and bed occupancy
- 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 an 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.

All breaches of the four hour target will be reviewed for the proceeding 24 hours with associated actions being taken to mitigate against the potential for identified trends to continue. Other key input indicators (e.g. discharge numbers by ward and time of day) are also measured and analysed on a daily basis. Trajectories have been calculated and agreed to deliver incremental and sustainable improvement throughout the year.

Financial Performance

The Trust finished the year with a £17.6m deficit, against a control total target of £1.2m surplus.

The Trust made investments during 2016/17 as part of its Unscheduled Care Improvement Plan with the expectation that this, and the work across the system, would reduce the pressure the Trust was increasingly facing and that this would support the delivery of material productivity gains and income generating activity and reduce the reliance on unfunded extra capacity and premium rate costs associated with temporary workforce requirements. During Quarter 2 of the financial year, further steps were taken and plans articulated to mitigate developing and on-going cost pressures, budgetary overspends, and shortfalls in the development of sufficient CIPs to cover the full costs being incurred across the Trust. This was reported to the Board and Finance Committee at regular intervals throughout the year as part of a detailed year end forecast review document.

As a result of the increasing pressures in relation to unscheduled care the Trust Board formally advised NHS Improvement as part of the Q3 reporting submissions that the year-end control total would not be achieved and this would result in a loss of Sustainability and Transformation funding (STF) to the Trust for the second half of the year. This, combined with the adverse financial performance as set out above meant that the Trust's best case out-turn position was revised to a £16.1m deficit forecast, although this position carried approximately £3m of income risk in relation to the Trust's main activity contracts, partly the result of commissioner affordability and partly the result of significant cancellations of activity and the increased requirement for out-sourcing to provide capacity for demand for services in some instances.

The Trust also acted to establish a recovery programme in the form of that operated through the NHS Improvement Financial Improvement Plan methodology. Phase 1 of this plan was completed by the end of March 2017 and presented at a Trust Board workshop in quarter 1 of 2017/18 as a consolidated report with clear recommendations and a management action plan.

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 the right of employees in the Trust, if 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.

The Trust has also appointed a 'Speak Up Guardian'. This is an independent person for staff to talk to and raise concerns about their working life including any concerns about bullying and harassment. This new role is an independent post within the trust reporting to the Chief Executive and Chair.

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

The Trust has 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 the Parliamentary and Health Service Ombudsman, and NHS Litigation Authority guidelines.

This ensures that an effective and timely investigation can be carried out and a decision made about 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.

Each day our Trust staff work hard to provide a high standard of care throughout all departments and wards within the hospital. They are also dedicated to finding new ways of seeking the views of people who use our services as this offers an opportunity to review procedures and make any changes necessary which will improve our standards of care and make sure that patients, relatives and visitors all have a positive experience when they come to the hospital.

The Patient Advice & Liaison Service (PALS) is available Monday to Friday, from 9am to 5pm, and provides advice and support to people who have concerns about their own care or that of a friend or family member. PALS has a drop in office in the hospital, a free phone telephone number and a dedicated e-mail address so that support is easily accessible. However, we acknowledge that sometimes things do not always go as well as we expect, and when this happens

staff will make every effort to resolve things as quickly as possible. We fully recognise the need to respond quickly and if necessary to try to rebuild people's confidence in our services.

Over the last year, PALS has recruited a number of volunteers to help and befriend people in hospital. This has proved to be very successful, particularly in helping us make sure that patients have a smooth and safe transition from hospital back to the comfort of their home environment. The volunteers spend time with patients in the Discharge Lounge and inpatient areas, having a friendly chat and making sure that arrangements have been made to support them at home if necessary.

From the feedback we receive, it is encouraging that, in the vast majority of cases, people have had a positive experience and this is demonstrated by the large number of plaudits and messages of thanks that we receive each day from patients and visitors.

In the last year we were delighted to receive 7,346 plaudits. Our formal complaints increased 7% on the previous year to a total of 692. The number of people seeking advice from PALS has continued to increase and as a consequence we saw a massive 200% increase in contacts. This rose from 2171 in 2015/16 to 6755 in 2016/17 with the majority of issues being resolved within five working days.

Health, safety and wellbeing

We are fully committed to supporting and improving the health, safety and wellbeing of all our employees throughout the organisation. We have a dedicated wellbeing centre for our staff and a fully integrated service accessible to them.

This past year has seen a number of developments including improvements to the incident reporting system, which has encouraged better reporting of staff incidents and has enabled a more targeted approach for accident and incident investigation.

The introduction of a new staff Health and Wellbeing CQUIN has targeted key areas for development such as the flu vaccination programme. It has also included support for staff with musculoskeletal disorders and the management of work related stress. All have well developed action plans and have seen excellent progress in the last 12 months.

We are also proud that an increased availability, and uptake, of physical activity schemes has resulted in the Trust being awarded silver accreditation at the Sport and Physical Activity at Work Awards 2016.

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 3.9% compared to 3.8% 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.

Average working days lost were 8.

Ensuring a sustainable future

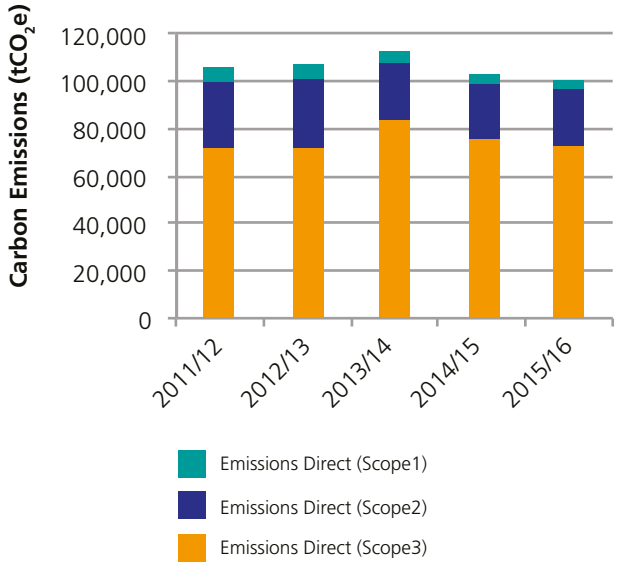
The Trust monitors its environmental performance against the targets set by the Department of Health for reducing our carbon footprint. We identify energy use, procurement and travel as our largest contributors to emissions.

NHS England has set a target of a 34% reduction in carbon footprint by 2020 and a 50% reduction by 2025. This supports the Government's Climate Change Act target of 80% reduction by 2050. We support this strategy and aspire to meet these targets. 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

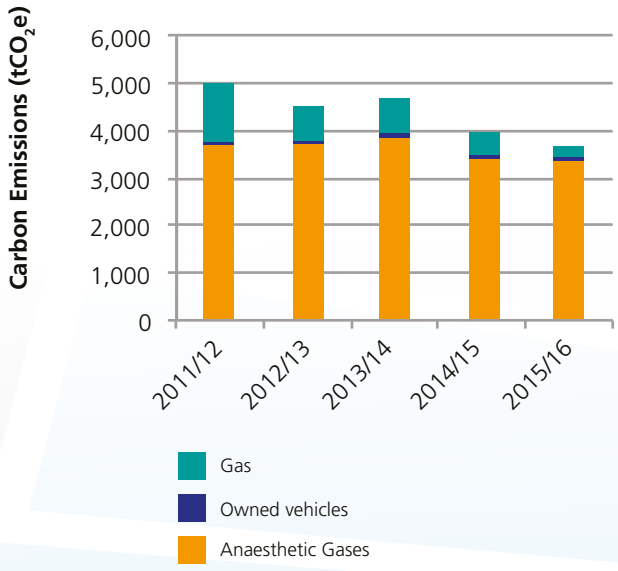
Using the latest modelling guidance provided by the Sustainable Development Unit of NHS England we calculate the Trust's carbon footprint as 100,205 tonnes of Carbon Dioxide equivalent (CO2e) A slight reduction on previous years. The graph below shows a high-level breakdown of these emissions

Total Carbon Emissions

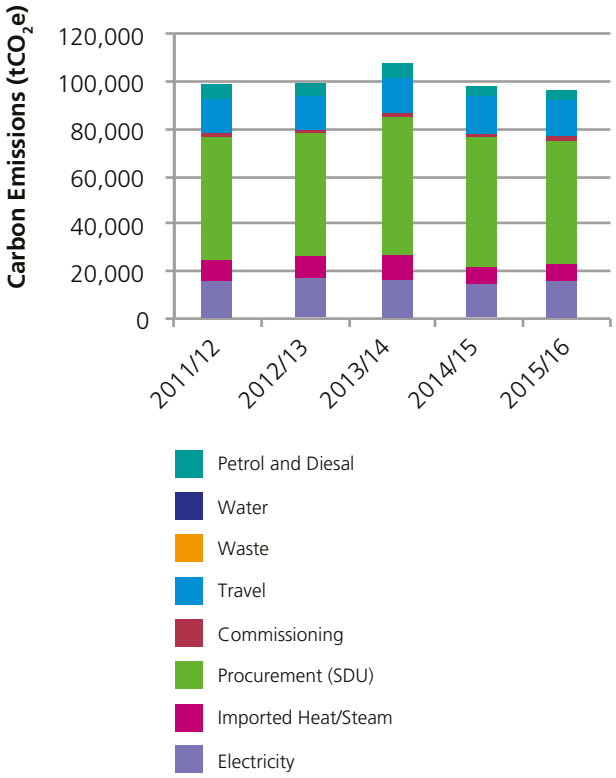


Direct and indirect carbon emissions are illustrated in the following graphs:

Direct (Scope 1) Emissions



Indirect (Scope 2&3) Emissions



Working with our PFI Partner we have identified practical ways to improve efficiency in our energy consumption, identifying potential invest to save schemes as well as operational improvements. The Lord Carter Report into Operational Productivity and Performance in the NHS, published in 2016, identified potential for significant savings in energy costs and recommended investment in energy saving technologies. We are preparing schemes in readiness for funding announcements.

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.

We can do more to reduce our carbon footprint and have identified and allocated additional resources to work towards the mandatory targets.

6 Directors' accountability report

The confidentiality and security of information regarding both patients and staff, is maintained through our governance and control 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 a breach of personal data is graded and the more serious incidents must be reported to the Department of Health and the Information Commissioner's Office (ICO).

We experienced six externally-reportable serious incidents in 2016/17. One incident was downgraded and therefore withdrawn. The remaining five were reported using the ICO's Incident Reporting Tool.

Externally Reportable Incident

Date of incident (month)	Nature of incident	Nature of data involved	Number of data subjects potentially affected	Notification steps
July 2016	Ex staff member using round robin email addresses for personal use	Personal email address	100+	Reported externally to the ICO – recommendations x2 but no further action
August 2016	Locum doctor disposed of handover sheets in public recycling bin	PID and clinical information	94	Reported to the ICO – x2 recommendations but no further action
September 2016	Maternity Hand Held notes given to wrong patient and taken home	PID and detailed clinical information	1	Reported to ICO – no further action
October 2016	External contractor had malware attack resulting in the loss of staff data	Name, Date of birth, National Insurance number, radiation dose	1865	Reported to ICO – DH and NHS Digital investigating
January 2017	General information sent to a cohort of patients using the 'To' function and not the 'Bcc' function	Name, hospital number, personal email address	230	Reported to the ICO – no further action

Lower Severity Incidents

Category	Breach Type	Total
A	Corruption or inability to recover electronic data	**0**
B	Disclosed in Error	**118**
C	Lost in Transit	**3**
D	Lost or stolen hardware	**0**
E	Lost or stolen paperwork	**13**
F	Non-secure Disposal – hardware	**0**
G	Non-secure Disposal – paperwork	**6**
H	Uploaded to website in error	**0**
I	Technical security failing (including hacking)	**0**
J	Unauthorised access/ disclosure	**5**
K	Unsecure transport / storage	**12**
L	Misdirected FAX/Email/ Printer	**19**

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 2016/17 was 68% compared to our 2015/16 score of 75%. 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 696 Freedom of Information requests in 2016/17, a 127% increase on 547 requests in 2015/16. We embrace our duty of openness and have made full or partial disclosure of information in approximately 99.5%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. Our compliance with issuing a response within 20 working days is currently at 72%.

Council of Governors

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

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 – (left July 2016)
David Gattrell
Richard Mackay
Mary Sheppard

Havant and East Hampshire constituency

Frances Bates (from November 2016)
Jocelyn Booth
Kate Bowskill – (left June 2016)
Roland Howes
Ernie Wells

Portsmouth City constituency

Sarah Edmonds
Tom Hart (left November 2016)
Ken Thompson (from December 2016)
Robin Lander-Brinkley
Lez Ward

Parent/Carer constituency

Dr Robin Marsh

Staff Governors

Mr Anthony Evans (left December 2016)
Jayne Jempson
Les Jones

Appointed Governors

- Stephen Arkle, University of Portsmouth (left July 2016)
- Richard Thelwell, University of Portsmouth (from August 2016)
- Julia Barton - Fareham and Gosport CCG
- Councillor Gwen Blackett, Havant Borough Council
- Councillor Jennie Brent, Portsmouth City Council (left June 2016)
- Councillor Luke Stubbs, Portsmouth City Council (from November 2016)
- Surgeon Commodore Peter Buxton
- Councillor Peter Edgar, Hampshire County Council
- Adel Resouly - South East Hampshire CCG
- Norman Robson – representing 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. Current members are 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 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 experience 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 Deputy Chairman. He 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. He is the Senior Independent Director, chair of the Governance & Quality committee and chair of the Charitable Funds committee.

Mr John Smith (until March 2017) 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. He is a Trustee/ Director of Diverse Abilities, a charity based in Poole, caring for severely disabled people. He was awarded a CBE in the New Year's Honours 2008.

Portsmouth Hospitals' Trust Board

Executive Directors

Tim Powell
Interim Chief Executive
(from May 2016)

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

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
Director of Finance

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.

Rob Haigh
Director of Unscheduled Care
(from July 2016)

Rob is accountable for all aspects of unscheduled care, including delivery of the agreed Urgent Care Improvement Plan. Although employed by the Trust, he works in collaboration with Partners across the system to ensure the best experience for all patients on an emergency care pathway. Rob assumes line management of Emergency Medicine, AMU and MOPRS CSC's. The remaining CSC's are also accountable to Rob for delivery of their unscheduled care responsibilities. Rob was previously Chief of Medicine and Deputy Medical director at Western Sussex Hospitals NHS Foundation Trust.

Rebecca Kopecek
Interim Director of Workforce and Organisational Development (from May 2016).

Rebecca has worked in the NHS since 1989 and joined the Trust in December 2002 with a wide range of HR experience. She has previously held senior workforce manager positions in other Trusts, including Acute, Community, Mental Health, Health Authority and Primary Care Trusts.

Sheila Roberts
Interim Chief Operating Officer (from February 2017)

Sheila started her NHS career in 1986 working as a clerical officer in Farnborough Hospital in Kent. She then moved on to work in a number of mental health, specialist and acute hospitals in London and the South East. In 2002 Sheila was asked to join an executive team tasked with turnaround for the Royal United Hospital in Bath. A number of interim senior management posts followed. She worked as Director of Operations and Chief Operating Officer in Royal Bolton Hospitals, St Helens and Knowsley Foundation Trust, East Midlands Ambulance Trust and the Royal National Orthopaedic Hospital in Stanmore, London. More recently Sheila has been working with the Portsmouth and South East Hampshire Health System as Chief Delivery Officer.

Ed Donald
Chief Operating Officer to December 2016 and Executive Director from January 2017.

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.

Simon Jupp
Director of Strategy and Executive Director to December 2016 (from January 2017 seconded to Solent NHS Trust).

Simon brings over 20 years of NHS experience, 13 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.

Ursula Ward
Preceding Chief Executive (left the Trust December 2016)

Ursula held the Chief Executive post for 12 years. She was initially appointed in August 1999 as Director of Nursing and Midwifery and then Chief Executive in 2004.

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
Adcock	Christopher	Director of Finance	No	
Donald	Ed	Chief Operating Officer and Executive Director from February 2017	Yes	Ed Donald Consulting Ltd
Haigh	Rob	Director of Unscheduled Care	No	
Holmes	Simon	Medical Director	No	
Jupp	Simon	Director of Strategy and seconded Executive Director from January 2017	No	
Powell	Tim	Chief Executive	No	
Roberts	Sheila	Interim Chief Operating Officer	Yes	Director - Dusek Associates Ltd
Stone	Cathy	Director of Nursing	No	
Ward	Ursula	Chief Executive (left Trust)	No	
Attenborough-Cox	Michael	Non-Executive Director	Yes	Non-Executive Director and Chair of Small Audits and Appointments Limited
Carruthers	Ian	Chairman	Yes	NED - Bioquell NED - OR International NED – Centric Health Chair - 2020 Delivery Chancellor of the University of the West of England Chair - NHS Supply Chain Customer Board Director - IJC Healthcare
Conway	Elizabeth	Non-Executive Director	Yes	Director - Northlands House Management Ltd
Erskine	Steve	Non-Executive Director	No	
Nellthorp	Mark	Non-Executive Director	No	
Smith	John	Non-Executive Director	Yes	Consultant in Medico Legal Practice Trustee/Director for Diverse Abilities, for severely disabled individuals, based in Poole

Disclosure of Interests

- Ed Donald, a Director, is a Director of Ed Donald Consulting Limited. This organisation had no business dealings with Portsmouth Hospitals NHS Trust in 2016/17.
- Sheila Roberts, a Director, is a Director of Dusek Associates Limited. This organisation had no business dealings with Portsmouth Hospitals NHS Trust in 2016/17.
- Mike Attenborough-Cox a Non-Executive Director, is a Non-Executive Director and chair of Small Audits and Appointments Ltd. This organisation had no business dealings with Portsmouth Hospitals NHS Trust in 2016/17.
- Elizabeth Conway a Non-Executive Director, is a Director of Northlands House (Management) Ltd. This organisation had no business dealings with Portsmouth Hospitals NHS Trust in 2016/17.
- John Smith a Non-Executive Director, is a Consultant in Medico Legal Practice. He is a Trustee/Director of Diverse Abilities, a charity based in Poole caring for severely disabled people of all ages. This organisation had no business dealings with Portsmouth Hospitals NHS Trust in 2016/17.

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. 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 10.3 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 94%.

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

Statutory Accounts

Annual Report 2016/17

The accounts of Portsmouth Hospitals NHS Trust for the year ended 31st March 2017 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 Board, at a meeting on the 1st June and have been audited. The auditor's certificate is unqualified and is incorporated in the annual report.

External Auditor

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

The audit fee for the 2016/17 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 2016/17 and the balance, £20,250, will be charged in 2017/18.

Financial Summary

The following financial information is a summary taken from the Trust's Annual Accounts shown on pages 60 to 98 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 2016/17

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

- **The Trust made a revenue deficit of £17.6m 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 2016/17 this was £2.1m.**
- **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 2016/17 financial year with a reported deficit of £17.6m. This position consists of both the 'retained' deficit of £20.9m and the 'technical' adjustments (see above) as summarised below:

	£'000	£'000
Retained deficit for the year		(20,853)
IFRIC 12 adjustments (UK GAAP to IFRS)	2,367	
Impairment Reversals	(18)	
Adjustment in respect of donated asset reserve	859	3,208
Adjusted Retained Deficit		**(17,645)**

Further information can be found in the Financial Performance section on page 26.

The cumulative break-even position of the Trust is a deficit of £44m. This is the second consecutive year the Trust has failed to meet it's statutory cumulative break-even duty. The External Auditor has issued a report to the Secretary of State for Health under section 30(2) under the Local Audit and Accountability Act 2014 in respect of this. The Trust has a statutory responsibility to achieve cumulative break-even and will continue to discuss with NHS Improvement colleagues to agree a timescale for this.

The financial control total set for the Trust for 2016/17 was a highly challenging target in the context of the performance and finance related challenges encountered during the previous financial year. The £1.2m surplus requirement was based on the expectation that the Trust would achieve its year end forecast stretch target for 2015/16 of £9.7m deficit. The actual 2015/16 year end deficit of £23.5m deficit meant that the actual income and expenditure run rate position for the Trust entering the 2016/17 financial year was materially worse than required, and therefore the 2016/17 financial improvement requirement was consequentially greater as a result.

The Trust's financial plan was connected to the performance and service improvements sought through the unscheduled care plans both internally and across the wider health system. Significant elements of expenditure which have contributed to the Trust's deteriorating financial position are tied up with the provision of extra and unfunded capacity, both within the Hospital and in the Community, as a result of the pressures associated with unscheduled care services.

The continued use of this capacity, and other investments required to support the delivery of safe services, materially impacted on financial performance in 2016/17.

The Trust has held open and constructive discussions with Commissioners throughout the year and this has resulted in material changes to the contractual form for services being agreed for 2017/18. This new contract builds on this good work and will enable alignment of incentives, risk and responsibility going forward consistent with the challenges faced, and objectives shared across the system.

Audit Committee

The Trust has an Audit Committee comprising three Non-Executive Directors and the committee membership during 2016/17 was:

- **Mike Attenborough-Cox – Non-executive Director (Committee Chair)**
- **Steve Erskine - Non-executive Director**
- **Liz Conway – Non-executive Director**

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 2016/17 comprised;

- 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.

The Trust complies with NHSI regulations in terms of approving salaries that are greater than £142,500.

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 2016/17

On pages 100-102 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 2016/17 was £185k-£190k, which was the Medical Director and his salary was comparable with 2015/2016. The Medical Director's salary was 7.7 times (2015/16, 7.1 times) the median remuneration of the workforce which was £24,304 (2015/16, £26,041).

In 2016/17, no employees received remuneration in excess of the highest-paid director (2015/16, 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.

Staff Costs

	Total £000	Permanently Employed £000	Other Agency/ Contract £000	Other Excluding Agency/Contract £000
Salaries & Wages	256,283	221,397	34,330	556
Social Security Costs	21,843	21,843		
NHS Pensions Scheme	27,337	27,337		
Termination Benefits	37	37		
Total Including Capitalised Costs	**305,500**	**270,614**	**34,330**	**556**
Capitalised Costs	577	577	0	0
Total Excluding Capitalised Costs	**304,923**	**270,037**	**34,330**	**556**

Average Staff Numbers

	Total	Permanently Employed	Other
Medical and Dental	942	875	67
Administration and Estates	1,221	1,206	15
Nursing, Midwifery and Health Visiting Staff	3,376	2,972	404
Scientific, Therapeutic and Technical Staff	1,200	1,169	31
Healthcare Science Staff	167	167	0
Total	6,906	6,389	517
Staff Engaged on Capital Projects	12	12	0

Exit Packages

The Trust made no compulsory redundancies in the year.
Other exit packages are shown below:

	Number of cases	£
Less than £10,000	11	19,514
£10,000 - £25,000	1	17,500
Total	**12**	**37,014**

Analysis of Other Exit Packages

	Number of cases	£
Contractual Payments in Lieu of Notice	11	20
Exit payments following Employment Tribunal or Court Order	1	18
Total	**12**	**38**

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 2017 and new 'off-payroll' engagements between 1 April 2016 and 31 March 2017 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 2017

	Number
Number of existing engagements as of 31 March 2017	2
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	1
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	1

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 2016 and 31 March 2017 > £220 per day and over 6 months

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	0
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	0
Number for whom assurance has been requested	0
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 NHS Improvement 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 NHS Improvement.

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: 1 June 2017 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:

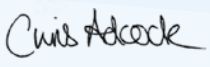
- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and 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: 1 June 2017 Signed:  Chief Executive.

Date: 1 June 2017 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 2017 under the Local Audit and Accountability Act 2014. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 45. 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 2016-17 Government Financial Reporting Manual (the 2016-17 FReM) as contained in the Department of Health Group Accounting Manual 2016-17 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 costs 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 2016, 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 2017.

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 2017 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 Improvement's guidance; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

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

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

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

On 25 May 2017 we referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014. The statutory accounts indicate the Trust has a cumulative deficit at 31 March 2017 of £44.142 million over the three year period from 1 April 2014 to 31 March 2017, and therefore has not met it's rolling breakeven duty.

- Proper arrangements to secure economy, efficiency and effectiveness.

We report to you, if we are not satisfied that the Trust has 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 surplus budget of £1.2 million for the year ended 31 March 2017, but reported a deficit of £17.785 million in its financial statements for the year then ended. The Trust reported a cumulative breakeven deficit of £44.1 million as at 31 March 2017, which is the third year of cumulative deficit. The Trust has therefore breached its duty, under paragraph 2 (1) of Schedule 5 of the National Health Service Act 2006, to break even.

For 2017/18, the Trust has agreed to deliver a surplus of £9.66 million. This is dependent upon achieving £34.6 million of cost improvement plans, with £13.4 million support from the Sustainability and Transformation Fund. This represents a significant challenge for the Trust given the financial outturn for 2016/17.

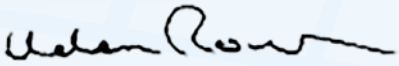
These issues are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

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 2016, 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 2017.

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 1 June 2017

Governance Statement

Scope of responsibility

The Trust 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 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 priorities. To this end, the Trust has met regularly throughout the year with both the Local Commissioning Groups and NHS Improvement 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 the local population to achieve the best possible health outcomes, live healthy lives and have access to a choice of high quality services where and when 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 Trust Board approves an annual schedule of business to which it will add additional items as required. Exception reports to the Trust Board will ensure that it considers key issues and makes effective use of its time. The Trust Board met, on a formal basis, a total of 9 times during the year and Board papers are published on the Trust website.

The Trust's Standing Orders, Standing Financial Instructions and Reservation and Delegation of Powers were recently reviewed to ensure that they reflect any changes to the Trust's governance arrangements and changes through legislation.

Board Performance

Membership of the Trust Board consists of the Trust Chair, 5 independent Non-Executive Directors and 8 Executive Directors, of which 3 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 2016/17 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 the Chief Executive, the Director of Workforce and Organisational Development was asked to fill the role on an interim basis and his deputy was appointed as the interim Director of Workforce and Organisational Development. In January 2017, the Director of Strategy was seconded to Solent NHS

Trust and in February 2017 an Interim Chief Operating Officer was appointed to free up the substantive post-holder so that there could be a focus on strategy. Two of the Non-Executive Directors retired in March and their replacements will take office early in the new financial year. 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 2016/17 by a robust committee structure; review of this structure and all sub-Board committee terms of reference are undertaken on an annual basis. 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 and is 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. Trust Board attendance is noted below.

Trust Board attendence record

	06-May-16	02-June-16	07-June-16	01-Sept-16	06-Oct-16	03-Nov-16	01-Dec-16	02-Feb-17	02-March-17	06-Apr-17
Directors										
Ursula Ward	✗									
Tim Powell	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗
Peter Mellor	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓
Simon Holmes	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Simon Jupp	◆	✓	✓	✓	✓	✓	✓			
Cathy Stone	✓	✓	✓	✓	✗	✓	✓	✓	✓	
Ed Donald	✓	✗	✓	✓	✓	✗	✓	✓	✓	✓
Chris Adcock	✓	✓	✓	✓	✓	✓	✓	✓*	✓	✓
Rebecca Kopecek		✗	✓	✓	✓	✓	✓	✓	✓	✓
Rob Haigh				✗	✓	✓	✓	✓	✗	✓
Shella Roberts									✓	✓
Non-Executive Directors										
Sir Ian Carruthers	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓
Elizabeth Conway	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓
Mark Nellthorp	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓
Steve Erskine	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Dr John Smith	✓	✓	✗	✗	✗	✓	✓	✗	✗	
Michael Attenborough-Cox	✓	✓	✓	✓	✓	✗	✗	✓	✓	✗

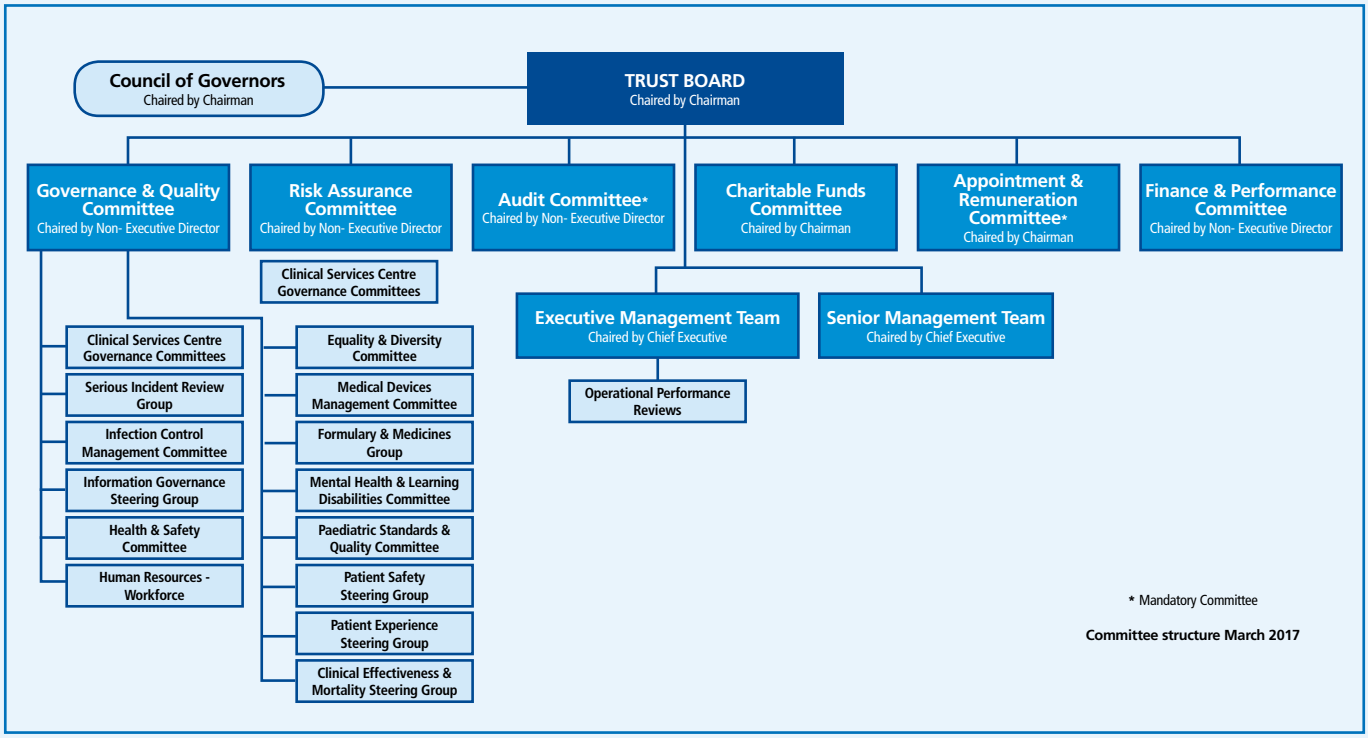
Attended ✓ Apologies given ✗ Absent on Trust ◆ Part attendance *

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 5 times during 2016/17. 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 draft External Audit Annual Results Report and the Head of Internal Audit Opinion for 2015/16.
- That Internal Audit had identified a gap in that the Trust has no IT strategy and there is not one person responsible for determining the overall IT strategy.
- The Internal Audit report on Patient Records which was given a 'Limited Assurance' rating.
- The Internal Audit report on e-Rostering which was given a 'Limited Assurance' rating.
- Both Internal and External Audit highlighted that having had no up to date BAF for over half the year will impact on their judgement when forming their opinions and the level of assurance they can take.

- The regular non-attendance by members of various committees and the need to review membership to ensure they are still valid.
- The Audit Panel report recommending the appointment of Ernst & Young as the Trust's External Auditor from 2017/18.

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



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, employer's 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.

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 our performance reports are in line with their template. We have withdrawn 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 provides 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 continue to promote 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 SFI Breach reporting is being expanded to include staff establishment breaches and details of managers who have failed to return their staff nominal roll confirmations. 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. These arrangements were revised for 2016/17 to 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 was developed which identifies key areas for increased scrutiny to inform the reviews. The performance reviews were halted in quarter 4 in order that a robust format for 2017/18 could be agreed and these are re-commencing in quarter 1 of 2017/18.

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.

The process for sign off for all serious incidents was strengthened to ensure Executive agreement of the final report prior to sending to the CCG for closure. Following CSC Management Team sign off of the investigation report, there is now a final Executive sign off panel. This panel is comprised of an Executive Director, Deputy Director of Nursing, Associate Director of Quality and Governance, Head of Risk Management, Head of Patient Safety and the Head of Legal Services as required. This has increased the level of scrutiny over the investigative process and quality of the reports including identified recommendations and supporting actions. All action plans are reviewed by the Serious Incident Review Group to ensure closure and to identify key themes and shared learning for the organisation.

The Trust completed 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 has been implemented, which will support and improve the management of complaints, claims, risk and learning from these, as well as incidents, across the organisation and wider community. There has been a significant increase in the number of reported incidents since the upgrade and this is reflected in the improved reporting to the NRLS. The latest figures show that the Trust has shown a marked improvement in position, moving from the bottom 5% up to the middle 50% of acute non-specialist Trusts.

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 Integrated Performance Report has been received by the Trust Board and is considered in detail each month. It is reviewed by the Finance and Performance Committee and consists of detailed reports on quality, operations, finance and workforce. The report provides the Board with assurance of the Trust's performance against National priorities set out for the NHS by NHS Improvement (NHSI) and NHS England (NHSE). The Trust continues to strive to reach sustainable improvement in its performance against these priorities, including the Referral to Treatment (RTT) target. This has been a challenging year for the Trust and the RTT incomplete standard has not been achieved since June 2016. With robust recovery plans in place, improved performance has been delivered in Quarter 4.

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 as appropriate. Further advice to gain assurance has also been sought from NHS Improvement. 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, the 6 week diagnostic standard has been achieved for 7 out of 12 months. Five of the eight key cancer standards were achieved in every quarter. The Breast Symptomatic 2 week standard was achieved in 3 out of the 4 quarters. 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 was re-written in 2016 and strengthened with clear escalation points and milestones. This is being followed robustly by the CSC teams. Patients at risk of breaching the standard are reviewed at the weekly assurance meeting.

There were 5 'never events' reported in 2016/2017. These related to incorrect administration of insulin, 2 incidents of retained foreign bodies following surgery and 2 incidents of wrong site surgery/surgical intervention. Following investigation, there were no common themes or process issues identified and no long term harm caused to patients.

The Emergency Department four hour standard has not been achieved and there have been 284 breaches of the zero tolerance 12 hour trolley wait standard. Work has been done to reduce the number of minors breaches considerably. The predominant reason for breaches relates to poor flow through the hospital caused by a high number of patients who are deemed medically fit remaining in the hospital.

Quality Account

The Trust published its Quality Account in June 2016, which set out the priorities for 2016/17 and reflected on its achievements in 2015/16. Consultation with internal and external stakeholders is currently underway to inform the Quality Account which will be published in June 2017 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, with an overarching Trust priority relating to vulnerable patients.

To provide assurance on the accuracy and data quality of the Quality Account, data submissions must be accompanied by a data validation form signed by both the data owner and their line manager. The majority of quality metrics are reported to the Board on a monthly basis and the Quality and Governance Committee on a quarterly basis. This ensures regular oversight of progress and assurance of actions being taken to address any shortfalls. An external review of the Quality Account was undertaken in June 2016 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 2015/16 quality accounts in accordance with the Regulations made by the Secretary of State for Health (Health Act 2009) National Health Service Regulations 2010.

Stakeholders

The Trust continues to develop the scope and scale of our patient, family, carer and community engagement and involvement. Our engagement strategy, "Participation for Improvement" has been successfully implemented; supported by the Trust Patient Family and Carer Collaborative. This group, led by a lay chair includes recent patients, family carers, people from the local community and HealthWatch Portsmouth and Hampshire. Amongst other things members act as advisers for policy and guideline development, receive external reports and make recommendations for action and help in the delivery of training events.

We have effectively introduced processes by which stakeholders are involved in the identification of areas for improvement and partnership working to design the solutions to these issues. This has included:

- **Users of Older People's Mental Health Liaison service who helped clinical staff identify what was most important to them when they were acutely physically unwell.**
- **A communications workshop designed three standards which have now been published and included in clinical documentation.**
- **'My Anticoagulation: what matters to me' as part of a quality improvement (QI) project to improve the quality and consistency of patient education when starting anticoagulant medication used to prevent or treat blood clots, also known as thrombosis.**

Our partnership approach has been recognised by leaders in the field of family carers:

"When I visited QA, I was very struck by the sense of a team spirit, with staff at all levels working in partnership with carers. I was equally struck by talking to the carers themselves (and the head of the local carers' centre)

and hearing their views about how positive they now felt about the value and support given to carers in acute hospital settings. I also noted the important creation of good relationships with agencies outside, like the local authority and wider community. Perhaps best of all, there was a real sense of integrated and strategic planning and the continuous collection of evidence about 'what works' ".

Comment from Dame Philippa Russell, Vice President, Carers UK

This year we have also significantly increased the number of stakeholders involved in the quality monitoring of our services. Members of the local community, as well as current and recent patients, family members and carers, routinely participate in our internal monitoring systems. People work alongside clinical staff, to review the quality of care provided to patients and seek the views of patients of their personal experiences during their stay.

Risk Assessment

TThe 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 2016/17, 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, Safety Learning Events and claims.**
- **Alerts received from the Central Alert System.**
- **Consultation with staff and patients.**
- **Mandatory/statutory targets.**
- **Service reviews.**

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

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

During the year 2016/17, 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 2016/17 have been associated with the on-going pressures exerted by the unscheduled care challenges; including the location of patients to inappropriate care spaces and patients outlied from their speciality footprint. Additionally, the risk relating to increased numbers of medically optimised patients awaiting discharge has impacted both on timely care for patients and achievement of national targets.

The establishment of the Sustainability and Transformation Fund (STF) for 2016/17 influenced or changed the risk environment in relation to finance in the following ways:

i) A year end financial control total was set by NHSI based on the year end forecast for 2015/16 at month 6 (September). This therefore set a £9.7m deficit as the baseline for calculation of the control total whereas the actual out-turn deficit was £23.5m. As a result, the Trust's cost improvement requirement was materially higher than both the level inferred in the calculation of the control total and the level specified in the national tariff and funding settlements.

ii) The Trust's cash support requirements were expected to be met through receipt of STF on a quarterly basis. Failure to achieve the levers of performance would therefore have an impact on income and expenditure performance and the cash flow forecast and would require a separate solution to be negotiated.

iii) The risk associated with the STF replaces the risks of fines and penalties associated with the national standard contract terms and conditions.

The other key financial risks identified for 2016/17 were:

i) Income and Expenditure performance – achieving the levels of income specified in the plan within budgets and expenditure limits contained in the plan, and the capability of the organisation to manage to budget.

ii) Delivery of Cost Improvement Plans – specifically in the context of the continuing unscheduled care pressures, and achieving the benefits articulated by the Trust's Unscheduled Care Improvement Plan.

iii) Management of cash within agreed limits – as mentioned above, within the context of restrictions resulting from uncertainty in relation to the Trust's loan application and maximised Interim Revolving Working Capital Facility.

iv) Management of capital resources – due to significant demands on the capital programme within the restrictions of the Trust's Capital Resource Limit (CRL), an inability to raise additional funds and material cash pressures in year.

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/A&E Delivery Board.

The clinical risk presented in the 2015/16 statement relating to provision of an ageless psychiatric liaison service has been predominantly mitigated. A Mental Health Liaison Team is now operational 7 days per week and provides a service for the Emergency Department and all in-patients with the recruitment of an additional Consultant Psychiatrist in February 2017. The service specification is currently under review for final agreement between the Trust and the service provider.

The key risks identified for 2016/17 continue into 2017/18 although there have been a number of developments in relation to the control environment and management actions which are designed to provide mitigations to these risks. These issues are reported regularly to the Finance and Performance Committee, the Risk Assurance Committee and the Trust Board.

Specific items of note include:

i) NHSI have advised the Trust of a new mechanism for calculating the Trust's Capital Resource Limit (CRL) for 2017/18 and beyond. This materially impacts on the Trust's future capital availability and in 2017/18 reduces available resources by approximately 50%. The Trust has material challenges ahead in terms of equipment replacement, important estate issues and critical IT investments. Resolving the CRL with NHSI is an essential component in the management of these matters.

ii) The Trust is planning to enter into an Aligned Incentives Contract (AIC) with commissioners for 2017/18. This creates a basis for change and improved services, but system wide change in planning, delivery, risk management and mindset is crucial to maximising the benefits of these changes. The AIC and system financial framework will require the Trust and system partners to take specific responsibility for the management of financial risk in line with plans and also to share the financial risk associated with unmitigated or unidentified savings targets pending the full identification of schemes to enable savings to be fully transacted. In addition, ensuring activity and performance related plans are deliverable within the contract values agreed changes the perception, management and responsibility for financial risk from that present through a Payment By Results contract.

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

- **The plan assumes that the Trust secures the sustainability and transformation funding**
- **The Trust financial plans require an efficiency improvement of £34.6m which equates to 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 significant improvements in unscheduled care, 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 Board agreed that the Trust should seek to negotiate an Aligned Incentives Contract with the three main commissioners. Substantial process has been made but the negotiations continue.**

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 Officer 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 2016/17 there were 5 incidents which required reporting to the Information Commissioner's Office (ICO). One incident was withdrawn as downgraded. The other 4 incidents were unrelated and 3 have been closed by the ICO with no further action. The remaining incident is being investigated by NHS Digital as this related to an external breach of IT security which has affected numerous

organisations. A further incident was externally reported to the ICO regarding the Trust which was closed with no further action.

The Trust's Information Governance Toolkit submission for 2016/17 demonstrated 68% compliance, and attained "Satisfactory" by achieving the minimum level of expected compliance against all 45 standards. The Trust undertook a full review of the assurance process for compliance with the Information Governance Toolkit following an Information Governance Toolkit Internal Audit overall assurance assessment of limited assurance in 2015/16. The repeat audit in 2016/17 overall assessment was of reasonable 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.

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

The Annual Plan is agreed by the Trust Board and reported to NHS England and NHS Improvement 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. The Finance and Performance Committee specifically reviews finance and operational performance against the annual plan.

Reporting of the cost improvement plans is prepared by the Delivery Unit in conjunction with the financial management department. Meetings are held with CSCs and CIP work stream leads no less frequently than monthly to review the development of plans and supporting documentation and delivery against those plans. Reporting against CIP plans is via the Executive Steering Group chaired by the Chief Executive and from there to the Finance and Performance Committee. 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 arrangements for reporting and managing any system weaknesses that are identified by the LCFS 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 exists 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 recorded on the Datix web management system and reviewed at least quarterly, to aid monitoring of the implementation of action plans necessary for mitigation. The transfer of risk registers to the Datix web management system has allowed for further transparency and awareness of risks across the organisation.

Any risk that cannot be managed at 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 organisational priorities 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. 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 Risk Assurance Committee provide exceptions to the Trust Board via the Chair who is a Non-Executive Director.

Assurance Framework

The Board Assurance Framework was significantly refreshed during the year to reflect the organisational priorities that were identified by the Board and the revised version has been a regular Board agenda item since October 2016. However, concern has been expressed by both the Risk Assurance and Audit Committee that the Assurance Framework is focussed on organisational, rather than strategic, objectives and that it was not presented regularly to the Trust Board throughout the year. These concerns were also reflected in a recent Internal Audit of the Board Assurance Framework which provided only limited assurance. All of the recommendations from the Audit report have been accepted and the different concerns will be addressed.

Internal Audit

The Internal Auditor issued sixteen audit reports in 2016/17. A further four reviews were conducted that were not audits and therefore no opinion was given. Of the sixteen reports issued, three were rated 'Substantial Assurance', ten 'Reasonable Assurance' and one 'Limited Assurance'. Two were given a split opinion of 'Limited/ Reasonable'.

The limited assurance ratings related to:

- **Cyber Security: One urgent, three important and two routine recommendations were made. The urgent recommendation related to the lack of a Threat Vulnerability Management System being in place. A Business Case is to be prepared for the purchase of a system and will follow the usual route of the Business Case Review Group and Trust Board. The Internal Auditor will link with the IT in support of the case.**
- **Bed Blocking: The opinion of 'Limited/ Reasonable' reflected the auditor's opinion that the process and controls in place to manage bed blocking were reasonable overall, there were factors, including those beyond the Trust's direct control that restrict the process and controls adequacy to address the problem of a significant number of beds being blocked.**
- **Board Assurance and Risk Framework: Three urgent and three important recommendations were made. The Board Assurance element of this audit was rated limited assurance due to the lack of review by the Board and Risk Assurance Committee for seven months of the year.**

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 2016/17. The overall opinion is Reasonable Assurance.

The system of internal control has been in place in Portsmouth Hospitals NHS Trust for the year ending 31 March 2017 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. Are we happy this has provided an adequate level of assurance?
- 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, is carried out each year. This provides me with an objective opinion of the effectiveness of our risk management and internal controls and any agreed actions will be implemented.

Care Quality Commission

The inspection by the CQC in February 2016 resulted in the Trust receiving an Enforcement Notice due to on-going safety concerns relating to the Emergency Department.

The CQC undertook an unannounced inspection of the Trust on the 29th and 30th September 2016; during this inspection the CQC found that significant improvements in patient safety had been made and proposed to remove the conditions.

Following the inspections in September, the Trust received requirement notices for which an action plan to address the issues was developed. This plan has subsequently been reported, monthly, to Trust Board.

The final report from the September inspections was published by the CQC on the 1st February 2017. The Trust was required to provide a detailed action plan, which included actions not originally contained within the requirement notices, in the CQC template, by the 27th February; this deadline was achieved.

The CQC undertook further unannounced inspections on the 16th and 17th February, returning again on the 28th February.

As a result of these inspections, on the 3rd March, the CQC imposed four conditions on the Trust:

1. The Registered Provider of the Acute Medical Unit, at the Queen Alexandra Hospital, must ensure that beds only remain open in respect of which the required level of staffing can be provided. The Registered Provider must ensure that beds are opened for patient use, and closed to patient use if care and treatment at the appropriate level can no longer be provided for patients on the Acute Medical Unit.
2. The registered provider must ensure that the GP triage referral area has in place, and operates effectively a clearly defined standard operating procedure for crowding and escalation for patient safety concerns. This includes having clearly defined trigger points for escalation of crowding and safety concerns in the GP triage referral area.
3. The Registered Provider must ensure that there are a sufficient number (based on demand) of suitably qualified, competent, skilled and experienced clinical staff placed in the corridor/waiting area, of the Acute Medical Unit entrance and GP triage referral area. The Registered Provider must ensure that staffing is flexed appropriately to meet the acuity and dependency of patients waiting to be seen, treated or admitted to the hospital, so as to ensure their safety.
4. The Registered Provider must, as soon as is reasonably practicable, and in any event by 12pm on 6 March 2017, describe the system the Registered Provider is operating in the Acute Medical Unit at Queen Alexandra Hospital, which incorporates the GP triage referral area and escalation area, so as to comply with the above conditions. The trust must send the Care Quality Commission an update every two weeks in this respect from the week commencing 13 March 2017 at 3pm.

The Trust has formulated a comprehensive action plan to address the concerns raised.

Significant issues

2016/17 has been a year of considerable financial challenge for the Trust. The Trust was set a control total surplus target of £1.2m surplus for the year based on an expectation that the stretch target year end deficit of £9.7m had been achieved in 2015/16. As the Trust had ended the previous year with a deficit of £23.6m, this resulted in a cost improvement target for 2016/17 of £32m, almost 6% of turnover.

The Trust made investments during 2016/17 as part of its Unscheduled Care Improvement Plan with the expectation that this, and the work across the system would reduce the pressure the Trust was increasingly facing and that this would support the delivery of material productivity gains and income generating activity and reduce the reliance on unfunded extra capacity and premium rate costs associated with temporary workforce requirements. During Quarter 2 of the financial year, further steps were taken and plans articulated to mitigate developing and on-going cost pressures, budgetary overspends, and shortfalls in the development of sufficient CIPs to cover the full costs being incurred across the Trust and this was reported to the Board and Finance Committee at regular intervals throughout the year as part of a detailed year end forecast review document.

As a result of the increasing pressures in relation to unscheduled care the Trust Board formally advised NHS Improvement as part of the Q3 reporting submissions that the year-end control total would not be achieved and this would result in a loss of Sustainability and Transformation funding (STF) to the Trust for the second half of the year. This, combined with the adverse financial performance as set out above meant that the Trust's best case out-turn position was revised to a £16.1m deficit forecast, although this position carried approximately £3m of income risk in relation to the Trust's main activity contracts, partly the result of commissioner affordability and partly the result of significant cancellations of activity and the increased requirement for out-sourcing to provide capacity for demand for services in some instances.

The Trust also acted to establish a recovery programme in the form of that operated through the NHS Improvement Financial Improvement Plan methodology. Phase 1 of this plan was completed by the end of March 2017 and will be presented at the Trust Board workshop on 27 April 2017 as a consolidated report with clear recommendations and a management action plan.

The Emergency Department has had a challenging year for performance. Attendances remain high in the department and the increasing acuity of patients attending and a rise in frail elderly patients has impacted on the flow through the hospital. The numbers of patients who are medically fit for discharge but remain in hospital has continued to rise to around 250 patients remaining in an acute bed longer than they need to. The Trust has introduced a multi-agency Integrated Discharge Service working with all partners to manage the more complex discharges together.

Referral time to treat (RTT) delivery has been adversely impacted by high demand for unscheduled care and senior workforce gaps mid-year. As requested by NHSi, the Trust cancelled all routine orthopaedic elective activity requiring an overnight stay, throughout the winter period, focussing on day case procedures only. This has further impacted on the Trust's ability to deliver the RTT standard. A detailed recovery plan and revised trajectories were agreed with commissioners and regulators and improvement has been seen in key areas. Recruitment to the senior workforce gaps has been successful. The waiting list size has reduced overall, although a significant reduction in patients waiting greater than 35 weeks has not delivered to the degree that we had planned. We are working in collaboration with our commissioners to ensure that our demand and capacity requirements are aligned to support the needs of all patients.

The unexpected resignation of the Chief Executive during the year, coupled with the planned retirement of other Trust Board members late in 2016/17 and the early part of 2017/18 will urgently need to be addressed to ensure effective Trust leadership. NHS Improvement is actively supporting different targeted recruitment drives, which are either underway, or have just completed, which are anticipated to resolve this issue.

Accountable Officer: Tim Powell

Organisation: Portsmouth Hospitals NHS Trust

Signature: 

Date: 1 June 2017

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Annual Accounts

Statement of Comprehensive Income for year ended 31 March 2017

	NOTE	2016-17	2015-16
		£000s	£000s
Gross employee benefits	10.1	**(304,923)**	(293,052)
Other operating costs	8	**(226,398)**	(218,021)
Revenue from patient care activities	5	**471,427**	452,553
Other operating revenue	6	**58,955**	52,019
Operating surplus/(deficit)		**(939)**	(6,501)
Investment revenue	12	**38**	53
Other gains and (losses)	13	**(8)**	207
Finance costs	14	**(17,854)**	(17,476)
Surplus/(deficit) for the financial year		**(18,763)**	(24,131)
Public dividend capital dividends payable		**(2,090)**	(2,230)
Retained surplus/(deficit) for the year		**(20,853)**	(26,361)

Other Comprehensive Income

	2016-17	2015-16
	£000s	£000s
Impairments and reversals taken to the revaluation reserve	**(18)**	(79)
Net gain/(loss) on revaluation of property, plant & equipment	**7,977**	31,056
Total other comprehensive income	**(12,894)**	4,616

Financial performance for the year

Retained surplus/(deficit) for the year	**(20,853)**	(26,361)
IFRIC 12 adjustment (including IFRIC 12 impairments) *	**2,367**	2,481
Impairments (excluding IFRIC 12 impairments) **	**(18)**	(79)
Adjustments in respect of donated gov't grant asset reserve elimination***	**859**	482
Adjusted retained surplus/(deficit)	**(17,645)**	(23,477)

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 44.1 on page 96 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 18 on page 85 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 67 for more details).

The notes on pages 64 to 98 form part of this account.

Statement of Financial Position as at 31 March 2017

	NOTE	31 March 2017 £000s	31 March 2016 £000s
Non-current assets:			
Property, plant and equipment	16	**363,452**	362,145
Intangible assets	17	**2,408**	2,975
Trade and other receivables	22.1	**7,413**	4,953
Total non-current assets		**373,273**	370,073
Current assets:			
Inventories	21	**13,866**	13,032
Trade and other receivables	22.1	**33,845**	36,832
Cash and cash equivalents	26	**5,207**	2,716
Sub-total current assets		**52,918**	52,580
Non-current assets held for sale	27	**0**	0
Total current assets		**52,918**	52,580
Total assets		**426,191**	422,653
Current liabilities			
Trade and other payables	28	**(51,669)**	(50,941)
Provisions	35	**(220)**	(258)
Borrowings	30	**(6,511)**	(4,836)
DH revenue support loan	30	**(260)**	(260)
DH capital loan	30	**(560)**	(1,902)
Total current liabilities		**(59,220)**	(58,197)
Net current assets/(liabilities)		**(6,302)**	(5,617)
Total assets less current liablilities		**366,971**	364,456
Non-current liabilities			
Provisions	35	**(1,971)**	(1,881)
Borrowings	30	**(229,355)**	(235,041)
DH revenue support loan	30	**(52,251)**	(32,033)
DH capital loan	30	**(3,920)**	(4,480)
Total non-current liabilities		**(287,497)**	(273,435)
Total assets employed:		**79,474**	91,021
FINANCED BY:			
Public Dividend Capital		**50,907**	49,560
Retained earnings		**(94,527)**	(73,734)
Revaluation reserve		**123,094**	115,195
Total Taxpayers' Equity:		**79,474**	91,021

The notes on pages 64 to 98 form part of this account.

The financial statements on pages 60 to 98 were approved by the Trust Board on 1st June 2017 and signed on its behalf by

Chief Executive:  Date: 1 June 2017

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2017

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	**49,560**	**(73,734)**	**115,195**	**0**	**91,021**
Changes in taxpayers' equity for year ended 31 March 2017					
Retained surplus/(deficit) for the year		(20,853)			(20,853)
Net gain / (loss) on revaluation of property, plant, equipment			7,977		7,977
Impairments and reversals			(18)		(18)
Transfers between reserves		60	(60)	0	0
Temporary and permanent PDC received - cash	3,902				3,902
Temporary and permanent PDC repaid in year	(2,555)				(2,555)
Net recognised revenue/(expense) for the year	1,347	**(20,793)**	**7,899**	**0**	**(11,547)**
Balance at 31 March 2017	**50,907**	**(94,527)**	**123,094**	**0**	**79,474**
Balance at 1 April 2015	**50,880**	**(47,633)**	**84,478**	**0**	**87,725**
Changes in taxpayers' equity for the year ended 31 March 2016					
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
New PDC received - cash	27				27
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**

Statement of Cash Flows for the Year ended 31 March 2017

	NOTE	2016-17 £000s	2015-16 £000s
Cash Flows from Operating Activities			
Operating surplus/(deficit)		**(939)**	(6,501)
Depreciation and amortisation	8	**17,436**	15,787
Impairments and reversals	18	**(18)**	(79)
Donated Assets received credited to revenue but non-cash	6	**(158)**	(500)
(Increase)/Decrease in Inventories		**(834)**	(775)
(Increase)/Decrease in Trade and Other Receivables		**527**	(684)
Increase/(Decrease) in Trade and Other Payables		**994**	(1,136)
Provisions utilised		**(182)**	(400)
Increase/(Decrease) in movement in non cash provisions		**165**	87
Net Cash Inflow/(Outflow) from Operating Activities		**16,991**	5,799
Cash Flows from Investing Activities			
Interest Received		**38**	53
(Payments) for Property, Plant and Equipment		**(8,655)**	(7,960)
(Payments) for Intangible Assets		**(507)**	(1,195)
Proceeds of disposal of assets held for sale (PPE)		**13**	726
Net Cash Inflow/(Outflow) from Investing Activities		**(9,111)**	(8,376)
Net Cash Inform / (outflow) before Financing		**7,880**	(2,577)
Cash Flows from Financing Activities			
Gross Temporary and Permanent PDC Received		**3,902**	27
Gross Temporary and Permanent PDC Repaid		**(2,555)**	(1,347)
Loans received from DH - New Revenue Support Loans		**21,310**	32,003
Loans repaid to DH - Capital Investment Loans Repayment of Principal		**(1,902)**	(1,892)
Loans repaid to DH - Working Capital Loans/Revenue Support Loans		**(1,092)**	(1,010)
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(4,910)**	(4,870)
Interest paid		**(17,785)**	(17,307)
PDC Dividend (paid)/refunded		**(2,515)**	(2,050)
Capital grants and other capital receipts (excluding donated / government granted cash receipts)		**158**	500
Net Cash Inflow/(Outflow) from Financing Activities		**(5,389)**	4,054
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**2,491**	1,477
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**2,716**	1,239
Cash and Cash Equivalents (and Bank Overdraft) at year end	26	**5,207**	2,716

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 Accounting Manual (GAM) 2016-17, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 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 GAM 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.

Going Concern

These accounts have been prepared on a going concern basis, in accordance with the definition as set out in section 4 of the GAM which outlines the FReM interpretation of IAS1 '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'.

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 NHS 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 NHS trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

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 Pension Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The schemes 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, the schemes are accounted for as though they were defined contribution schemes: the cost to the NHS body of participating in a 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 NHS 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 either
- the item cost at least £5,000; or
- Collectively, a number of items have a total 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.
- 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. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations of property, plant and equipment 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. Current values in existing use are determined as follows:

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

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 and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

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

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 cost. Software that is integral to the operation 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; and
- 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 current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. 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, assets under construction or development, and assets held for sale are not depreciated/amortised.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, on a straight line basis over their estimated useful lives. 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 the shorter of the lease term and the estimated useful lives.
At each financial year-end, the NHS trust checks whether there is any indication that its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of such an impairment, 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 at the financial year end. 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 are 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 current value in existing use, if they will be held for their service potential, or otherwise at 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 treated in the same way as 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 current value in existing use, if they will be held for their service potential, or otherwise at 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 or, if lower, at the present value of the minimum lease payments, in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value in existing use.

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 initial 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 accrual 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 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-outcost 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.

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.24% (2015-16: positive 1.37%) in real terms. All other provisions are subject to three separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A short term rate of negative 2.70% (2015-16: negative 1.55%) for expected cash flows up to and including 5 years
- A medium term rate of negative 1.95% (2015-16: negative 1.00%) for expected cash flows over 5 years up to and including 10 years
- A long term rate of negative 0.80% (2015-16: negative 0.80%) for expected cash flows over 10 years.

All percentages are in real terms.

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. The Trust does not have any CRC allowances.

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 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 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 the Trust not been bearing its 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. 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 2016-17.

- 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 from Contracts with Customers - 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 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.

1.37 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value. The Trust has not made any gifts.

2. Pooled budgets

The Trust does not have any pooled budget arrangements.

3. Operating segments

The Trust has identified two operating segments relating to the provision of healthcare and pharmacy trading. The vast majority of the Trust's income (£520.4m 98%) is derived from 'non-trading' healthcare. Of the total income, 2% (£9.8m) 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	
	2016-17	2015-16	**2016-17**	2015-16	**2016-17**	2015-16
Income	**£000s**	£000s	**£000s**	£000s	**£000s**	£000s
External	**520,393**	494,503	**9,838**	10,069	**530,231**	504,572
Internal	**0**	0	**40,163**	40,484	**40,163**	40,484
Total Income	**520,393**	494,503	**50,001**	50,553	**570,394**	545,056
Expenditure						
Segment Costs	**502,260**	481,238	**48,520**	49,451	**550,780**	530,689
Common costs	**40,163**	40,484	**339**	244	**40,502**	40,728
Total Expenditure	**542,423**	521,722	**48,859**	49,695	**591,282**	571,417
Retained surplus/(deficit) for the year	**(22,030)**	(27,219)	**1,142**	858	**(20,888)**	(26,361)

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

	2016-17	2015-16
	£000s	£000s
NHS Trusts	**60**	14
NHS England	**111,413**	105,679
Clinical Commissioning Groups	**355,410**	340,386
Foundation Trusts	**20**	12
Department of Health	**0**	12
NHS Other (including Public Health England and Prop Co)	**0**	633
Additional income for delivery of healthcare services	**0**	1,347
Non-NHS:		
Private patients	**3,273**	2,752
Overseas patients (non-reciprocal)	**284**	173
Injury costs recovery	**339**	897
Other Non-NHS patient care income	**628**	648
Total Revenue from patient care activities	**471,427**	452,553

6. Other operating revenue

	2016-17 £000s	2015-16 £000s
Education, training and research	**19,172**	18,192
Charitable and other contributions to revenue expenditure -non- NHS	**219**	229
Receipt of charitable donations for capital acquisitions	**158**	500
Non-patient care services to other bodies	**13,315**	13,141
Sustainability & Transformation Fund Income	**6,996**	
Income generation (Other fees and charges)	**14,003**	15,320
Rental revenue from operating leases	**1,807**	734
Other revenue	**3,285**	3,903
Total Other Operating Revenue	**58,955**	52,019
Total operating revenue	**530,382**	504,572

7. Overseas Visitors Disclosure

	2016-17 £000s	2015-16 £000s
Income recognised during 2016-17 (invoiced amounts and accruals)	**284**	173
Cash payments received in-year (re receivables at 31 March 2016)	**7**	7
Cash payments received in-year (iro invoices issued 2016-17)	**74**	61
Amounts added to provision for impairment of receivables (re receivables at 31 March 2016)	**108**	34
Amounts written off in-year (irrespective of year of recognition)	**57**	18

8. Operating expenses

	2016-17 £000s	2015-16 £000s
Services from other NHS Trusts	**1,212**	819
Services from CCGs/NHS England	**266**	0
Services from NHS Foundation Trusts	**4,334**	5,533
Total Services from NHS bodies*	**5,812**	6,352
Purchase of healthcare from non-NHS bodies	**12,929**	9,732
Trust Chair and Non-executive Directors	**57**	60
Supplies and services - clinical	**117,441**	115,689
Supplies and services - general	**2,123**	2,260
Consultancy services	**2,751**	1,475
Establishment	**3,910**	4,373
Transport	**537**	513
Service charges - ON-SOFP PFIs and other service concession arrangements	**25,843**	28,503
Business rates paid to local authorities	**3,396**	2,891
Premises	**10,463**	8,423
Hospitality	**9**	12
Insurance	**375**	348
Legal Fees	**423**	318
Impairments and Reversals of Receivables	**104**	124
Depreciation	**16,359**	15,026
Amortisation	**1,077**	761
Impairments and reversals of property, plant and equipment	**(18)**	(79)
Internal Audit Fees **	**67**	0
Audit fees	**109**	125
Clinical negligence	**20,111**	18,073
Education and Training	**1,574**	1,448
Change in Discount Rate	**147**	65
Other	**799**	1,529
Total Operating expenses (excluding employee benefits)	**226,398**	218,021
Employee Benefits		
Employee benefits excluding Board members	**303,573**	291,927
Board members	**1,350**	1,125
Total Employee Benefits	**304,923**	293,052
Total Operating Expenses	**531,321**	511,073

*Services from NHS bodies does not include expenditure which falls into a category below
** Internal audit fees were not reported separately in 2015/16 - the value for 2015/16 was £70k

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 £148,000.
- Fort Southwick office buildings and car parks - used for off site car parking and administration, the lease period is for 10 years (expires 2019) and has an annual value of £640,000.

9.1. Portsmouth Hospitals NHS Trust as lessee

	Land £000s	Buildings £000s	Other £000s	2016-17 Total £000s	2015-16 £000s
Payments recognised as an expense					
Minimum lease payments				**1,371**	1,487
Total				**1,371**	1,487
Payable:					
No later than one year	491	572	195	**1,258**	1,435
Between one and five years	487	1,470	70	**2,027**	2,692
After five years	0	2,264	0	**2,264**	2,539
Total	**978**	**4,306**	**265**	**5,549**	6,666
Total future sublease payments expected to be received:				2,706	3,644

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 Unit to Alliance.

	2016-17 £000s	2015-16 £000s
Recognised as revenue		
Rental revenue	1,807	734
Total	**1,807**	734
Receivable:		
No later than one year	1,803	642
Between one and five years	2,705	1,829
After five years	1,042	1,173
Total	**5,550**	3,644

10. Employee benefits

10.1 Employee benefits

	2016-17 Total £000s	2015-16 Other £000s
Employee Benefits - Gross Expenditure		
Salaries and wages	**256,283**	249,710
Social security costs	**21,843**	16,945
Employer Contributions to NHS BSA - Pensions Division	**27,337**	26,816
Termination benefits *	**37**	90
Total employee benefits	**305,500**	293,561
Employee costs capitalised	**577**	509
Gross Employee Benefits excluding capitalised costs	**304,923**	293,052

*Termination benefits were not shown separately in the 2015-16 accounts

10.2. Retirements due to ill-health

	2016-17 Number	2015-16 Number
Number of persons retired early on ill health grounds	3	8
	£000s	£000s
Total additional pensions liabilities accrued in the year	**153**	542

10.3. 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 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 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.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

11 Better Payment Practice Code

11.1 Measure of compliance

	2016-17 Number	2016-17 £000s	2015-16 Number	2015-16 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**101,316**	**251,585**	100,733	254,808
Total Non-NHS Trade Invoices Paid Within Target	**95,490**	**231,674**	94,136	239,949
Percentage of Non-NHS Trade Invoices Paid Within Target	**94.25%**	**92.09%**	93.45%	94.17%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,546**	**13,983**	2,587	15,076
Total NHS Trade Invoices Paid Within Target	**2,130**	**11,801**	2,073	11,830
Percentage of NHS Trade Invoices Paid Within Target	**83.66%**	**84.40%**	80.13%	78.47%

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

	2016-17 £000s	2015-16 £000s
Amounts included in finance costs from claims made under this legislation	**8**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**8**	**0**

12 Investment Revenue

	2016-17 £000s	2015-16 £000s
Interest revenue		
Bank interest	**38**	53
Total investment revenue	**38**	53

13 Other Gains and Losses

	2016-17 £000s	2015-16 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**(8)**	(207)
Total other gains and losses	**(8)**	(207)

14 Finance Costs

	2016-17 £000s	2015-16 £000s
Interest		
Interest on loans and overdrafts	**1,420**	834
Interest on obligations under PFI contracts:		
- main finance cost	**12,480**	12,728
- contingent finance cost	**3,877**	3,745
Interest on late payment of commercial debt	**8**	0
Total interest expense	**17,785**	17,307
Other finance costs	**0**	0
Provisions - unwinding of discount	**69**	169
Total	**17,854**	17,476

15. Finance Costs

15.1. Other auditor remuneration

	2016-17	2015-16
	£000s	£000s
Other auditor remuneration paid to the external auditor:	0	0
Total	0	0

15.2. Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2016/17 or 2015/16.

16.1 Property, Plant and Equipment 2016/17

201-17	Land	Building excluding dwellings	Dwellings
	£000's	£000's	£000's
Cost or valuation:			
At 1 April 2016	**23,950**	**301,122**	**3,318**
Additions Purchased	0	4,355	210
Additions - Non Cash Donations (i.e. physical assets)	0	0	0
Disposals other than for sale	0	0	0
Revaluation	479	7,047	81
Impairments/reversals charged to reserves	0	(18)	0
At 31 March 2017	**24,429**	**312,506**	**3,609**
Depreciation			
At 1 April 2016	0	0	0
Disposals other than for sale	0	0	0
Revaluation	0	0	0
Impairments/reversals charged to operating expenses	0	(18)	0
Charged During the Year	0	8,050	131
At 31 March 2017	**0**	**8,032**	**131**
Net Book Value at 31 March 2017	**24,429**	**304,474**	**3,478**
Asset financing:			
Owned - Purchased	24,429	5,013	3,478
Owned - Donated	0	4,211	0
Held on finance lease	0	0	0
On-SOFP PFI contracts	0	295,250	0
Total at 31 March 2017	**24,429**	**304,474**	**3,478**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings
	£000's	£000's	£000's
At 1 April 2016	16,431	90,586	2,757
Movements	479	7,029	81
At 31 March 2017	**16,910**	**97,615**	**2,838**

Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
£000's	£000's	£000's	£000's	£000's
71,978	**78**	**23,556**	**3,211**	**427,213**
3,029	0	1,958	0	**9,552**
146	0	12	0	**158**
(765)	0	(77)	0	**(842)**
975	1	0	48	**8,631**
0	0	0	0	**(18)**
75,363	**79**	**25,449**	**3,259**	**444,694**
47,884	76	15,614	1,494	**65,068**
(744)	0	(77)	0	**(821)**
631	1	0	22	**654**
0	0	0	0	**(18)**
5,646	1	2,298	233	**16,359**
53,417	**78**	**17,835**	**1,749**	**81,242**
21,946	**1**	**7,614**	**1,510**	**363,452**
18,434	1	7,567	1,510	**60,432**
1,935	0	47	0	**6,193**
1,577	0	0	0	**1,577**
0	0	0	0	**295,250**
21,946	**1**	**7,614**	**1,510**	**363,452**

Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
£000's	£000's	£000's	£000's	£000's
5,059	10	16	336	**115,195**
284	0	0	26	**7,899**
5,343	**10**	**16**	**362**	**123,094**

16.2. Property, plant and equipment prior-year

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 Purchased	0	3,234	45
Additions - Non Cash Donations (i.e. Physical Assets)	0	0	0
Disposals other than for sale	0	0	0
Revaluation	0	30,339	336
Impairments/reversals charged to operating expenses	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
Revaluation	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**

Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
£000's	£000's	£000's	£000's	£000's
70,409	**93**	**21,549**	**3,167**	**396,850**
3,029	0	1,983	0	8,291
464	0	36	0	500
(2,738)	(16)	(12)	0	(2,766)
888	1	0	44	31,608
0	0	0	0	(79)
72,052	**78**	**23,556**	**3,211**	**434,404**
43,544	91	13,636	1,247	**58,518**
(1,805)	(16)	(11)	0	(1,832)
534	1	0	17	552
0	0	0	0	(79)
5,611	0	1,989	230	15,026
47,884	**76**	**15,614**	**1,494**	**72,185**
24,168	**2**	**7,942**	**1,717**	**362,219**
20,734	2	7,888	1,717	59,356
2,219	0	54	0	6,545
1,215	0	0	0	1,215
0	0	0	0	295,103
24,168	**2**	**7,942**	**1,717**	**362,219**

16.3. Property, plant and equipment additional information

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 £34.2m

17. Intangible non-current assets

17.1. Intangible non-current assets current year

2016-17	IT - inhouse & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Intangible Assets Under Construction	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2016	**0**	**7,224**	**0**	**0**	**0**	**0**	**7,224**
Additions Purchased	0	510	0	0	0	0	510
At 31 March 2017	0	7,734	0	0	0	0	7,734
Amortisation							
At 1 April 2016	**0**	**4,249**	**0**	**0**	**0**		**4,249**
Charged During the Year	0	1,077	0	0	0		1,077
At 31 March 2017	**0**	**5,326**	**0**	**0**	**0**	**0**	**5,326**
Net Book Value at 31 March 2017	**0**	**2,408**	**0**	**0**	**0**	**0**	**2,408**
Asset Financing: Net book value at 31 March 2017 comprises:							
Purchased	0	2,405	0	0	0	0	2,405
Donated	0	3	0	0	0	0	3
Total at 31 March 2017	**0**	**2,408**	**0**	**0**	**0**	**0**	**2,408**
Revaluation reserve balance for intangible non-current assets							
At 1 April 2016	**0**	0	**0**	**0**	**0**	0	0
Movements (specify)	**0**	0	**0**	**0**	**0**	0	0
At 31 March 2017	**0**	0	**0**	**0**	**0**	0	0

17.2. Intangible non-current assets prior year

2015-16	T - inhouse & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Intangible Assets Under Construction	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:							
At 1 April 2015	0	6,029	0	0	0	0	6,029
Additions - purchased	0	1,195	0	0	0	0	1,195
At 31 March 2016	0	7,224	0	0	0	0	7,224
Amortisation							
At 1 April 2015	0	3,488	0	0	0	0	3,488
Charged during the year	0	761	0	0	0	0	761
At 31 March 2016	0	4,249	0	0	0	0	4,249
Net book value at 31 March 2016	0	2,975	0	0	0	0	2,975
Net book value at 31 March 2016 comprises:							
Purchased	0	2968	0	0	0	0	2,968
Donated	0	7	0	0	0	0	7
Total at 31 March 2016	0	2,975	0	0	0	0	2,975

17.3. 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.

18. Analysis of impairments and reversals recognised in 2016-17

	2016-17 Total £000s	2015-16 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI		
Changes in market price *	(18)	(79)
Total charged to Annually Managed Expenditure/S0CI	**(18)**	(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.

19 Investment property

The Trust does not hold any investment property.

20 Commitments

20.1 Capital commitments

The Trust has no contracted capital commitments at 31 March 2017 not otherwise included in these financial statements (£0 2015/16)

20.2 Other financial commitments

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

21 Inventories

	Drugs	Consumables	Total
	£000s	£000s	£000s
Balance at 1 April 2016	**5,822**	**7,210**	**13,032**
Additions	55,268	46,587	101,855
Inventories recognised as an expense in the period	(54,964)	(46,057)	(101,021)
Balance at 31 March 2017	**6,126**	**7,740**	**13,866**

22.1 Trade and other receivables

	Current		Non-current	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	£000s	£000s	**£000s**	£000s
NHS receivables - revenue	**14,118**	13,290	**0**	0
Non-NHS receivables - revenue	**4,208**	4,279	**0**	0
Non-NHS prepayments and accrued income	**0**	3,800	**6,284**	3,743
PDC Dividend prepaid to DH	**5**	0	**0**	0
Provision for the impairment of receivables	**(1,028)**	(967)	**0**	0
VAT	**2,981**	4,386	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income excluding PFI lifecycle	**7,066**	6,200	**0**	0
Interest receivables	**1**	2	**0**	0
Operating lease receivables	**0**	0	**1,129**	1,210
Other receivables	**6,494**	5,842	**0**	0
Total	**33,845**	36,832	**7,413**	4,953
Total current and non current	**41,258**	41,785		
Included in NHS receivables are prepaid pension contributions:	**0**			

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

22.2 Receivables past their due date but not impaired

	31 March 2017	31 March 2016
	£000s	£000s
By up to three months	**3,157**	4,266
By three to six months	**1,137**	936
By more than six months	**839**	922
Total	**5,133**	6,124

22.3 Provision for impairment of receivables

	2016-17	2015-16
	£000s	£000s
Balance at 1 April 2016	**(967)**	(880)
Amount written off during the year	**43**	37
Amount recovered during the year	**70**	64
(Increase)/decrease in receivables impaired	**(174)**	(188)
Balance at 31 March 2017	**(1,028)**	(967)

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. Other financial assets

The Trust has no other current or non-current financial assets.

25 Other current assets

The Trust has no other current assets.

26 Cash and Cash Equivalents

	31 March 2017	31 March 2016
	£000s	£000s
Opening balance	**2,716**	1,239
Net change in year	**2,491**	1,477
Closing balance	**5,207**	2,716
Made up of		
Cash with Government Banking Service	**5,148**	2,649
Commercial banks	**42**	41
Cash in hand	**17**	26
Cash and cash equivalents as in statement of financial position	**5,207**	2,716
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**5,207**	2,716
Patients' money held by the Trust, not included above	**0**	0

27 Non-current assets held for sale

The Trust does not have any non-current assets held for sale (£0 as at 31st March 2016).

28 Trade and other payables

	Current		Non-current	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	£000s	£000s	**£000s**	£000s
NHS payables - revenue	**6,377**	5,132	**0**	0
Non-NHS payables - revenue	**3,059**	2,740	**0**	0
Non-NHS payables - capital	**2,626**	2,392	**0**	0
Non-NHS accruals and deferred income	**2,581**	5,298	**0**	0
Social security costs	**3,147**	2,590		
PDC Dividend payable to DH	**0**	420		
Accrued Interest on DH Loans	**14**	5		
Tax	**2,716**	2,697		
Other	**31,149**	29,667	**0**	0
Total	**51,669**	50,941	**0**	0
Total payables (current and non-current)	**51,669**	50,941		
Included above:				
Outstanding Pension Contributions at the year end	**2,253**	2,228		

29 Other liabilities

The Trust has no other liabilities.

30 Borrowings

	Current		Non-current	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	£000s	£000s	**£000s**	£000s
Loans from Department of Health	**820**	2,162	**56,171**	36,513
PFI liabilities - Main liability	**5,819**	4,383	**228,534**	234,353
Finance lease liabilities	**692**	453	**821**	688
Total	**7,331**	6,998	**285,526**	271,554
Total borrowings (current and non-current)	**292,857**	278,552		

Borrowings / Loans - repayment of principal falling due in:

	31 March 2017		
	DH	**Other**	**Total**
	£000s	£000s	**£000s**
0 - 1 Years	820	6,511	**7,331**
1 - 2 Years	820	7,125	**7,945**
2 - 5 Years	53,671	21,033	**74,704**
Over 5 Years	1,680	201,197	**202,877**
TOTAL	**56,991**	**235,866**	**292,857**

31 Other financial liabilities

The Trust has no 'Other Financial Liabilities'.

32 Deferred income

	Current		Non-current	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	£000s	£000s	**£000s**	£000s
Opening balance at 1 April 2016	**303**	303	**0**	0
Deferred revenue addition	**0**	0	**0**	0
Transfer of deferred revenue	**0**	0	**0**	0
Current deferred Income at 31 March 2017	**303**	303	**0**	0
Total deferred income (current and non-current)	**303**	303		

33 Finance lease obligations as lessee

The finance lease obligations relate to the Da Vinci Surgical Robot, Microscopes and other miscellaneous scopes. 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. The scopes lease started in 2017 and is a 5 year lease.

Amounts payable under finance leases (Other)	**Minimum lease payments**		**Present value of minimum lease payments**	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	£000s	£000s	**£000s**	£000s
Within one year	**692**	527	**692**	527
Between one and five years	**821**	688	**821**	688
Minimum Lease Payments / Present value of minimum lease payments	**1,513**	1,215	**1,513**	1,215
Included in:				
Current borrowings			**692**	0
Non-current borrowings			**821**	0
			1,513	0

34 Finance lease receivables as lessor

The Trust has no finance leases as lessor.

35 Provisions

		Comprising:	
	Total	**Early Departure Costs***	**Legal Claims****
	£000s	**£000s**	**£000s**
Balance at 1 April 2016	**2,139**	1,998	141
Arising during the year	**77**	0	77
Utilised during the year	**(182)**	(111)	(71)
Reversed unused	**(59)**	(22)	(37)
Unwinding of discount	**69**	69	0
Change in discount rate	**147**	147	0
Balance at 31 March 2017	**2,191**	**2,081**	**110**
Expected Timing of Cash Flows:			
No Later than One Year	**220**	110	110
Later than One Year and not later than Five Years	**440**	440	0
Later than Five Years	**1,531**	1,531	0

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

As at 31 March 2017	389,023
As at 31 March 2016	294,496

* 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.

36 Contingencies

	31 March 2017	31 March 2016
	£000s	£000s
Contingent liabilities		
Legal Claims	**(47)**	(60)
Net value of contingent liabilities	**(47)**	(60)

37 Analysis of charitable fund reserves

	31 March 2017	31 March 2016
	£000s	£000s
As per note 1.32 Portsmouth Hospitals Charity has not been consolidated with the Trust accounts.		
Restricted / Endowment Funds	1,169	1,323
Non-Restricted Funds	44	175
	1,213	1,498

Non-restricted funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.
Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

38. 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

	2016-17	2015-16
	£000s	£000s
Service element of on SOFP PFI charged to operating expenses in year	**25,843**	28,503
Total	**25,843**	28,503

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

No Later than One Year	**26,543**	28,973
Later than One Year, No Later than Five Years	**106,172**	115,892
Later than Five Years	**497,681**	572,217
Total	**630,396**	717,082

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

	2016-17	2015-16
	£000s	£000s
No Later than One Year	**18,069**	16,863
Later than One Year, No Later than Five Years	**72,986**	72,891
Later than Five Years	**315,373**	333,537
Subtotal	**406,428**	423,291
Less: Interest Element	**(172,075)**	(184,555)
Total	**234,353**	238,736

Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due	**2016-17**	2015-16
Analysed by when PFI payments are due	**£000s**	£000s
No Later than One Year	**5,819**	4,383
Later than One Year, No Later than Five Years	**27,337**	25,888
Later than Five Years	**201,197**	208,465
Total	**234,353**	238,736

Number of on SOFP PFI Contracts

Total Number of on PFI contracts	**1**

39. Impact of IFRS treatment - current year

The information below is required by the Department of Heath for budget reconciliation purposes	2016-17 Income £000s	2016-17 Expenditure £000s	2015-16 Income £000s	2015-16 Expenditure £000s
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g PFI / LIFT)				
Depreciation charges		**7,984**		7,019
Interest Expense		**12,480**		12,728
Other Expenditure		**29,720**		32,248
Impact on PDC dividend payable		**2,256**		1,572
Total IFRS Expenditure (IFRIC12)	**0**	**52,440**	**0**	**53,567**
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)		**50,073**		51,086
Net IFRS change (IFRIC12)		**2,367**		**2,481**
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12				
Capital expenditure 2015-16		3,973		1,799
UK GAAP capital expenditure 2015-16 (Reversionary Interest)		3,786		3,655

	2016-17 Income/ Expenditure IFRIC 12 YTD £000s	2016-17 Income/ Expenditure ESA 10 YTD £000s	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	**7,984**		7,019	
Interest Expense	**12,480**		12,728	
Other Expenditure				
Service Charge	**25,480**	**50,073**	28,429	51,086
Contingent Rent	**3,877**		3,745	
Lifecycle	**363**		74	
Impact on PDC Dividend Payable	**2,256**		1,572	
Total Revenue Cost under IFRIC12 vs ESA10	**52,440**	**50,073**	53,567	51,086
Revenue Receivable from subleasing	**0**	**0**	0	0
Net Revenue Cost/(income) under IDRIC12 vs ESA10	**52,440**	**50,073**	53,567	51,086

40. Financial Instruments

40.1. Financial risk management

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

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

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 NHS Improvement. 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.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

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 2017 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with primary care organisations, 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		14,118		**14,118**
Receivables - non-NHS		8,390		**8,390**
Cash at bank and in hand		5,207		**5,207**
Total at 31 March 2017	**0**	**27,715**	**0**	**27,715**
Receivables - NHS		13,290		13,290
Receivables - non-NHS		7,282		7,282
Cash at bank and in hand		2,716		2,716
Total at 31 March 2016	**0**	**23,288**	**0**	23,288

40.3. Financial Liabilities

	At 'fair value through profit and loss'	Other	Total
			£000s
NHS payables		6,377	**6,377**
Non-NHS payables		38,950	**38,950**
Other borrowings		56,991	**56,991**
PFI & finance lease obligations		235,866	**235,866**
Total at 31 March 2017	**0**	**338,184**	**338,184**
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

41 Events after the end of the reporting period

There are no material events to report.

42 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 Department of Health Ministers, Portsmouth Hospitals NHS Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the Trust.

The Department of Health is regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as parent Department. Entities are listed below where the cumulative value of transactions exceed £5 million. Total Expenditure and Income for the year is shown, together with amounts payable to and amounts receivable from the related party as at 31st March 2017.

	Expenditure	Income	Payables	Receivables
	£000	£000	£000	£000
NHS Coastal West Sussex CCG	0	9,458	0	409
NHS England (Wessex Local Office)	0	13,357	0	245
NHS England (Wessex Commissioning Hub)	0	95,728	0	3,697
NHS Fareham and Gosport CCG	183	109,462	833	1,180
NHS Litigation Authority	20,445	0	0	0
NHS Portsmouth CCG	1	117,729	1,109	1,592
NHS South Eastern Hampshire CCG	80	99,039	705	1,038
NHS West Hampshire CCG	0	9,752	0	221
University Hospitals Southampton NHS Foundation Trust	1,409	7,007	722	1,052

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.

43. Losses and special payments

The total number of losses cases in 2016-17 and their total value was as follows:

	Total Value of Cases	Total Number of Cases
	£s	
Losses	183,418	501
Special payments	119,138	87
Total losses and special payments and gifts	**302,556**	**588**

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

Details of cases individually over £300,000

There were no individual cases over £300,000

44. 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.

44.1. Breakeven performance

	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s
Turnover	372,407	409,985	422,836	432,167
Retained surplus/(deficit) for the year	857	7,299	159	(77,052)
Adjustment for:				
Timing/non-cash impacting distortions:				
Prior Period Adjustments	(533)	0	0	0
Adjustments for impairments	0	0	111	60,097
Adjustments for impact of policy change re donated/government grants assets				
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*				2,078
Break-even in-year position	324	7,299	270	(14,877)
Break-even cumulative position	1,910	9,209	9,479	(5,398)

* 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 %	2009-10 %
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	-3.44
Break-even cumulative position as a percentage of turnover	0.51	2.25	2.24	-1.25

The amounts in the above tables in respect of financial years 2006/07 to 2008/09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.

2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s	2016-17 £000s
446,161	440,231	451,906	469,094	484,463	**504,572**	**530,382**
6,254	1,779	4,025	2,802	(8,229)	**(26,361)**	**(20,853)**
0	0	0	0	0	**0**	**0**
(6,095)	(3,097)	0	(5,079)	(102)	**(79)**	**(18)**
	22	268	277	770	**482**	**859**
0	1,444	0	2,830	4,649	**2,481**	**2,367**
159	148	4,293	830	(2,912)	**(23,477)**	**(17,645)**
(5,239)	(5,091)	(798)	32	(2,880)	**(26,357)**	**(44,002)**

2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-16 %	2016-17 %
0.04	0.03	0.95	0.18	-0.60	-4.65	**-3.33**
-1.17	-1.16	-0.18	0.01	-0.59	-5.22	**-8.30**

44.2. 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%.

44.3. External financing

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

	2016-17	2015-16
	£000s	£000s
External financing limit (EFL)	**19,122**	21,764
Cash flow financing	**12,420**	21,934
Finance leases taken out in the year	**825**	323
Other capital receipts	**(158)**	(500)
External financing requirement	**13,087**	21,757
Under/(over) spend against EFL	**6,035**	7

The undershoot on the EFL was due to the requirement to carry forward £4.1m of capital cash and lower than anticipated new finance leases taken out in the year.

44.4. Capital resource limit

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

	2016-17	2015-16
	£000s	£000s
Gross capital expenditure	**10,222**	9,985
Less: book value of assets disposed of	**(21)**	(837)
Less: donations towards the acquisition of non-current assets	**(158)**	(500)
Charge against the capital resource limit	**10,043**	8,648
Capital resource limit	**14,245**	8,728
(Over)/underspend against the capital resource limit	**4,202**	80

45. 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 2017	31 March 2016
	£000s	£000s
Third party assets held by the Trust	**0**	0

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Remuneration Report

Salary and Pension entitlements of senior managers 2016/17

Name	Title	Start date/leaving date (where not in post for full year)	2016/17		
			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 2017					
Tim Powell	Director of Workforce & Organisational Development until 26/05/16; Interim Chief Executive from 27/05/16	Change in year - see Title	145-150	-	-
Simon Holmes	Medical Director		185-190 *	-	-
Chris Adcock	Director of Finance	From 12/10/2015	160-165	-	-
Cathy Stone	Director of Nursing	From 01/01/2015 to 31/03/2017	120-125	-	-
Rob Haigh	Director of Unscheduled Care	From 18/07/2016	145-150 **	800	-
Rebecca Kopecek	Interim Director of Workforce and Organisational Development	From 27/05/2016	80-85	-	-
Sheila Roberts	Interim Chief Operating Officer	From 06/02/2017	60-65	-	-
Executive Directors who left during the year					
Ursula Ward	Chief Executive until 26/05/16; Preceding Chief Executive until 20/12/2016	Until 20/12/2016	130-135	3,600	-
Simon Jupp	Director of Strategy until 02/01/17; Executive Director on secondment to Solent NHS Trust from 03/01/17	Change in year - see Title	130-135	-	-
Ed Donald	Chief Operating Officer until 02/01/17; Executive Director	Change in year - see Title	145-150	-	-
Richard Eley	Interim Director OF Finance	From 05/05/2015 to 13/10/2015	-	-	-
Ed Donald	Interim Chief Operating Officer	From 02/03/2015 to 31/01/2016	-	-	-
Non- Executive Directors in post at 31st March 2017					
Sir Ian Carruthers	Chairman		20-25	3,000	-
Mark Nellthorp	Non- Executive Director		05-10	-	-
Elizabeth Conway	Non- Executive Director		05-10	300	-
Steve Erskine	Non- Executive Director	Until 31/03/2017	05-10	1,800	-
Michael Attenborough-Cox	Non- Executive Director		05-10	1,300	-
Non- Executive Directors who left during the year					
Alan Cole	Non- Executive Director	Until 31/10/2015	-	-	-
John Smith	Non- Executive Director	Until 24/03/2017	05-10	1,400	-

* Medical Director salary includes remuneration for work other than management responsibilities of £35k-£40k (2015/16 £35k-£40k)
** Director of Unscheduled Care includes remuneration for work other than management responsibilities of £30k-35k

			2015/16					
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)
-	70-72.5	220-225	120-125	-	-	-	37.5-40	160-165
-	90-92.5	275-280	180-185 *	-	-	-	25-27.5	205-210
-	17.5-20	180-185	75-80	-	-	-	62.5-65	140-145
-	2.5-5	125-130	120-125	-	-	-	112.5-115	235-240
-	10-12.5	160-162.5						
-	132.5-135	215-220						
-	-	60-65						
-	0-2.5	130-135	180-185	5,000	-	-	7.5-10	195-200
-	7.5-10	140-145	130-135	-	-	-	67.5-70	200-205
-	-	145-150	20-25	-	-	-	-	20-25
-	-	-	135-140	-	-	-	-	135-140
-	-	-	295-300	-	-	-	-	295-300
-	-	25-30	20-25	3,500	-	-	-	25-30
-	-	5-10	5-10	-	-	-	-	5-10
-	-	5-10	5-10	-	-	-	-	5-10
-	-	5-10	5-10	1,600	-	-	-	5-10
-	-	5-10	5-10	1,700	-	-	-	5-10
-	-	-	0-5	400	-	-	-	0-5
-	-	5-10	5-10	1,100	-	-	-	-

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
Tim Powell	Interim Chief Executive	2.5-5	0-2.5
Simon Holmes	Medical Director	5-10	15-20
Chris Adcock	Director of Finance	0-2.5	0-2.5
Cathy Stone	Director of Nursing	0-2.5	2.5-5
Rob Haigh	Director of Unscheduled Care	0-2.5	0-2.5
Rebecca Kopecek	Interim Director of Workforce & Organisational Development	5-10	10-15
Sheila Roberts	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.

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

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

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

Chief Executive:  Date: 1 June 2017

	Total accrued pension at age 60 at 31/03/2017 (bands of £5000) £000	Lump sum at pension age related to accrued pension 31/03/2017 (bands of £5000) £000	Cash equivalent transfer value 31/03/2017 £000	Cash equivalent transfer value 31/03/2016 £000	Real increase in cash equivalent transfer value (bands of £5000) £000	Employers Contribution to Stakeholder Pension* To nearest £100
	15-20	0 **	189	133	50-55	0
	80-85	245-250	1,796	1,615	160-165	0
	40-45	100-105	728	545	175-180	0
	55-60	165-170	1,139	1,077	45-50	0
	90-95	175-180	1,550	1,492	25-30	0
	20-25	60-65	378	257	100-105	0
	0	0	0	0	0	0

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