Annual report and accounts 2017 – 2018

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WELCOME

2017/18 was a year of significant change for Portsmouth Hospitals NHS Trust, particularly with regard to its senior leadership. The new Chief Executive was appointed in July 2017 and a new Chairman was appointed in November 2017. In addition, a number of new Non-Executive and Executive Directors, all of whom bring experience and expertise joined the Trust Board. We have introduced new reporting and risk management arrangements, and developed revised corporate governance arrangements ready for implementation in the coming year.

Our staff have continued to be a loyal and dedicated workforce, many of whom are drawn from our local communities, and who are very passionate about their patients and very proud of what they do. We have faced operational challenges in many areas of the Trust throughout the year but our staff have remained committed to meeting those challenges and providing the best patient care possible. As a result we have developed some excellent services during 2017/18 including:

- Labour Line telephone service in maternity
- Frailty Unit
- Digital appointment letters

Our staff have taken great pride in delivering them.

We are also proud of our collaborative working to deliver the very best for our patients. Our relationship with the Ministry of Defence, in the form of Defence Medical Group (South) remains as important as ever and we have seen a number of military colleagues taking on leadership roles within the Trust. Our working relationships with our local and national commissioners and other partners across the health and social care economy in Hampshire and Portsmouth have developed and improved, to the benefit of all concerned and particularly our shared patients and service users. In addition, 2017/18 saw the first use in this area of a new contract to ensure better alignment of service delivery and performance across acute, community and primary care, and we look forward to developing this approach further in the coming year.

In common with a number of hospitals we have used Carillion PLC to provide some facilities management services at the hospital. Following Carillion's insolvency in early 2018, we were able to continue to operate business as usual, and our patients and staff will have noticed little difference in the way we work. We are extremely grateful to the former Carillion staff, who remain with us under a new contractor, for their dedication to the Trust, its patients and staff, and for their professionalism during times of uncertainty during the last year.

Since we took up post as Chief Executive and Chairman we have faced some significant challenges, but at all times we have remained focused on trying to do what is right for our patients and our staff. Their health and wellbeing is crucial to all members of the Board, and we are committed to listening and responding. We have made real improvements in our staff engagement and we recently welcomed Professor Michael West to the Trust to open our first leadership summit and support the launch of our new cultural change programme. We have a collective passion about the importance of defining an organisation's culture and in particular the role of compassionate leadership in the delivery of safe and compassionate patient care.

The Trust's financial position during 2017/18 has been a concern to the Board, the Trust's regulatory and other stakeholders. The Trust was set a control total target of £9.7m surplus for the year, but in January 2018 issued a revised financial forecast for the year showing a deficit of £36.8m which reflected the review and assessment work carried out during the

latter part of 2017, with the support of NHS Improvement (NHSI). We are pleased to report that this revised forecast has been achieved.

We have engaged with our regulators throughout 2017/18. Although it was a great disappointment to us that the Care Quality Commission (CQC) found the services we provided to be at times not of the quality our patients, service users and their families deserve, we have acknowledged the concerns expressed in full and taken action to address them. We have also worked with NHS Improvement to enhance our management of the Trust and are grateful to them for the support provided.

There is a huge amount of hard work going on within the Trust and we are focused on the future, learning from our mistakes and working together to harness the talent and ambition of our staff for the benefit of our patients.

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

Melloney Poole OBE
Chairman

Mark Cubbon
Chief Executive

A PATIENT'S STORY

"We've been through so much"

Huan, kidney transplant patient

The journey for Nicole started when she decided she wanted to be an altruistic kidney donor, she would be one of just a few in the UK who choose to donate their kidney to complete strangers. Nicole made a call to QA Hospital "Once I commit myself to something there is no going back. I met Jenny Frank my Live Donor Coordinator at the hospital, and she scheduled meetings and tests with just about everyone. Before I knew it, I was deemed healthy enough and ready enough to donate". The only thing Nicole needed was a recipient for her kidney.

For 49 year old Huan, her journey in life was becoming increasingly difficult. She had come to the UK from China and was getting her PH.D in Education at the University of Portsmouth, and her kidneys were failing "I had polycystic kidney disease for a long time. The end result is that you have kidney failure, but that usually only happens to people who are older. I was in my forties and no one, especially me, expected me to be so sick and so quickly"

Huan's husband Anthony wanted to donate his kidney but he didn't have the correct blood type. She went on dialysis and things looked bleak, especially as two potential kidney donations fell through. Then came the call that all kidney recipients dream of, there was a healthy kidney available and it was a match.

Nicole had found her recipient and Huan her donor. Huan had the surgery and says "As soon as I woke up I could not believe how much better I felt"

Huan wanted to reach out to her anonymous donor, and she wrote a letter to her explaining how grateful she was. A few days later she heard back from Nicole and the two women began corresponding, eventually deciding to meet. From the very beginning the two women hit it off and a genuine friendship began.

"Normally we see each other once a week if we can. We certainly talk a couple of times a week." Nicole says, and the pair cannot imagine life without the other. Nicole even attended Huan's graduation ceremony

"We've been through so much," Huan says. "And Nicky has such a sense of humour. She even named her kidneys. I have Grace and hers is called Alice. So when she calls she always asks about Grace and when I call her I ask after Alice. And so far they both are doing so well!"

CHAPTER 1 – PERFORMANCE REPORT

OVERVIEW

ABOUT THE TRUST

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

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

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

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

Carillion went into Compulsory Liquidation on 15th January 2018. The Hospital Company and The Trust enacted their contingency plans to ensure continued delivery of the facilities management services and are negotiating the appointment of a replacement contractor. Thanks to the continuous attendance and dedication of the Carillion staff, there was no effect on patient care or Trust business.

Although we are not a University Hospital allied to a medical school, we are a major provider of under-graduate and post-graduate education working with three universities - Southampton, Portsmouth and Bournemouth. We have a significant reputation for our research and innovation and are actively involved with the national agenda in these fields. Some of our patients are regularly the first-in-the-world to have the opportunity to trial new treatments, and even more are first in the UK.

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

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

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

- St Mary's Hospital - midwifery, dermatology and disablement services.

- Gosport War Memorial Hospital - a range of services including the Blake Maternity Unit, Minor Injuries Unit and diagnostics.
- Petersfield Community Hospital - the Grange Maternity Unit.

Working alongside our military personnel

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

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

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 at readiness 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.

Private Patients

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

However, the performance of the private patients unit was adversely affected by the management of winter occupancy issues which resulted in some beds in the Harbour Suite being used as escalation beds for some months.

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

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

A caring and charitable hospital

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

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

The charity is grateful for the support it has received from patients, their friends and family, staff, businesses, Trusts and a number of associated charities including Ickle Pickles, League of Friends and Aiden's Activities over the last year.

The charity continued to work hard over the last year to develop relationships with supporters, businesses and community groups within the local area.

We are hugely grateful to all who support us and recognise the hard work our staff do to benefit our patients and local community. We have received wonderful support from so many including, Sainsbury's Waterlooville, who chose the Paediatrics Emergency Department as their 'charity of the year'. They raised a fantastic £6,033 through various activities, including a Supermarket Sweep event held in their store, in store collections and book sales. This contributed to the department achieving its target of £10,000 to purchase an interactive floor for the Children's Assessment Unit. Wave 105 also granted £3,800 towards this project.

QA Hospital's League of Friends granted £15,000 towards the Rocky Appeal's Da Vinci Robot.

Business Building Networking group have chosen the Neurology Department as one of their chosen charities. Offering the charity free weekly networking and support from many small local businesses that also support Portsmouth Hospitals Charity, with sponsorship, expertise, advise and fundraising; this has been a positive experience and has enabled the charity to build positive and lasting relationships with local companies.

Research and Innovation

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

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

We have increased our research activity significantly in the last year, offering more patients access to better care, services and treatments. Last year we were ranked by the National Institute for Health Research as being in the top 10 acute trusts nationally reporting the biggest increase in research activity. In the last year we have seen a 10% increase in the number of patients taking part in studies, from 5,791 patients in 2016/17 to 6,368 patients in 2017/18.

Our research recruitment is currently ranked 7th among large acute trusts national, 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 - Surgery, Dermatology, Ophthalmology, Gastroenterology, Respiratory, Critical Care and Children. A further 11 specialities in the top 10 of the national rankings - Cardiology, Diabetes, Genetics, Hepatology, Injuries and emergency, Cancer, Neurological disorders, Ageing, Cancer, Primary Care and Renal.

ORGANISATIONAL STRUCTURE

Providing the best care across Portsmouth and South East Hampshire

We are currently 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 clinically led and managed.

DID YOU KNOW?

Our Emergency Department saw in excess of 144,500 patients.

We dealt with over 59,600 emergency admissions.

We had over 67,700 planned admissions.

We saw over 516,500 outpatients and carried out over 57,000 day case operations.

5,679 babies were born at our hospital.

Our services were delivered by approximately 6,400 employees and over 600 volunteers.

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.

The Trust's strategy is being refreshed during 2018/19.

Working in partnership to deliver health and care for our communities

We have an important role to play within the local health economy and we are a key player in the Hampshire and Isle of Wight Sustainability Partnership (STP) and the Portsmouth and South East Hampshire Local Delivery System, through which the priorities in the STP will be delivered for our local population.

Commissioners and providers across health and care in Portsmouth and South East Hampshire have been working together over the last 12 months through the Local Delivery System to develop an accountable care system partnership and greater integrated and collective working.

Part of this work has been the development of an improvement plan for Portsmouth and South East Hampshire. This is a collective plan to improve health and care outcomes, operational performance and service quality for the residents of Portsmouth and South East Hampshire, and to manage within the available budget. This plan has been developed with the involvement of all governing bodies of local organisations.

The plan describes the priority actions we are taking as a partnership to deliver our vision. The plan focuses around four key programmes of service transformation and improvement with a single system plan:

- Urgent and Emergency Care - To improve urgent care access and performance, reduce demand, reduce harm, and manage clinical variation, enabling the system to meet A&E and Delayed Transfers of Care targets.
- New Models of Out of Hospital Care - To prevent ill health, increase early intervention and build the strong, sustainable primary and community care services required to proactively manage the needs of the population at home and the community.

- Elective demand and capacity - To improve how we manage demand for elective care, and to redesign how we provide elective care, ensuring demand and capacity are in balance to enable constitutional targets to be met.
- Mental Health - To improve the quality of and access to mental health care for adults and children.

The implementation of the single system improvement plan will be led by the Accountable Officers of the statutory bodies in Portsmouth and South East Hampshire. A Senior Responsible Officer (SRO) has been designated to lead each of the four Service Improvement Programmes. The Portsmouth and South East Hampshire Accountable Care Board will provide strategic leadership to the Portsmouth and South East Hampshire Local Delivery System.

CARE QUALITY COMMISSION

Registration under the Health and Social Care Act 2008 (Regulated Activity) Regulations 2009 and the Care Quality Commission (Registration) Regulations 2009. During 2013/14 all NHS healthcare providers were required by law to register with the Care Quality Commission (CQC) and declare compliance against 28 regulations.

Of these, 16 regulations relate to quality and safety of care received by patients. Following inspection, any areas of non-compliance are responded to with an action plan, which is reviewed and monitored by the CQC. Registration can be issued with 'no condition' or 'with conditions'.

The Trust was subject to a full CQC inspection in February and May 2015, following which the Trust was rated as 'Requires Improvement'; however, care was rated across the organisation as 'Outstanding'.

The Trust has subsequently been subject to various inspections by the CQC which resulted in the following Conditions being placed upon the Trust registration:

- Section 31 (AMU) issued 3rd March 2017 following inspection 28th February 2017.
  The Notice related to ensuring sufficient staffing levels and skill mix in AMU and the GP triage referral area to meet the needs of patients, and to ensure appropriate Standing Operating Procedures are in place.

- Section 31 (Mental Health) issued 12th May 2017 following inspection 10th and 11th May 2017.
  The Notice related to ensuring suitably qualified and competent staff in the Emergency Decision Unit to provide safe, good quality care to patients with Mental Health Problems. That appropriate risk assessments and treatment plans are completed for patients presenting to the ED. Ensuring the identification and oversight of vulnerable patients across the organisation and that Deprivation of Liberty Safeguards and the Mental Capacity Act are being applied appropriately.

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

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

The Trust has worked with Commissioners, NHSI and other partners to deliver an improvement programme.

KEY ISSUES AND RISKS

Please refer to the Annual Governance Statement 2017/18 from page 36 of this document.

ADOPTION OF GOING CONCERN

The Trust prepares its accounts as a going concern. Full information can be found at note 1.1.2 within the financial statements section of this report.

YEAR AT A GLANCE

April 2017

- The Haematology and Oncology Day Unit was awarded a Macmillan Quality Environment Mark for delivering high standards of care to people affected by cancer.
- A 24-hour telephone support service 'Labour line', was launched for women who think they may be in labour or their waters have broken.
- As part of #PHTPerfectWeek the Trust was encouraging patients to Get up, Get Dressed and Keep Moving.

May 2017

- We were acknowledged as one of CHKS' 40 top hospital trusts in the UK for the twelfth time with their 2017 Top Hospitals Program Award.
- Membership Engagement Services awarded the Trust the prestigious 'Engagement Champion of the Year' Award in recognition of the Trust's commitment to involve its local community in the design, delivery and monitoring of its services.

June 2017

- Children's Bubbles Fund donation wall. New donation recognition wall in the Paediatrics Unit, with over £61,000 of donations.

July 2017

- New Chief Executive Officer, Mark Cubbon, commences in post.
- Portsmouth Hospitals welcomes Royal College of Midwives for the formal signing of the Caring For You Charter.

August 2017

- Chief Executive Officer publishes 100 day plan.
- The Trust scored above the national average in five categories in the 2017 Patient-Led Assessment of the Care Environment (PLACE) system survey.

September 2017

- The Voluntary Services Team at QAH awarded a special commendation at the Excellence in Voluntary Services Awards – National Association of Voluntary Services Management 2017.

October 2017

- Portsmouth's Fracture Liaison Service celebrates service at the Houses of Parliament Portsmouth MP, Penny Mordaunt, joined staff from Portsmouth Hospitals at Westminster on Thursday 26 October to celebrate the care provided by the Trauma and Orthopaedics team in Portsmouth.
- Quality Improvement Plan published 31st October setting out our approach to delivering sustainable quality improvements for our patients and our staff
- We are one of four Trusts in the country to roll out digital appointment letters which allows patients to receive and respond to their appointment letters digitally using their smartphones.
- A comic book created by diabetes experts in Portsmouth and Southampton to help young patients' understanding of their diabetes diagnosis was recognised nationally for its success.

November 2017

- Melloney Poole OBE, appointed as Trust Chairman.
- Best people awards.

- Chief Executive completes first 100 days.
- New Frailty Unit opened on G4 to support patients to be seen, assessed, treated and discharged rather than being admitted.

December 2017

- We received an overwhelming response to our Christmas present appeal with over 5,000 gifts donated for those patients who would be in hospital over Christmas. Such generosity was hugely appreciated by both staff and patients.
- IDEAs conference held; our first patient experience and engagement event. Over 80 patients, local staff from health and social care teams, and members of the local community joined us to share our journey to improve experience and increase engagement. Speakers included people with a learning disability, community representatives, the Mental Health Human Library and the Head of Patient Experience from NHSI. Feedback was very positive.

January 2018

- The cardiology team went live in the operating theatre, broadcasting to a national audience #BCISACI.
- Dr Joanna Walker, Consultant Paediatrician, was awarded a Member of the Most Excellent Order of the British Empire (MBE).

February 2018

- Relaunch of the Black Asian Minority Ethnic Network. More than 60 staff attended an exciting and informative morning at which three nationally renowned speakers talked about the importance of networks in ensuring inclusivity at Portsmouth, the Workforce Race Equality Standard and personal stories.
- We held our first Patient Safety and Quality Conference which included external speakers. We heard from staff across the organisation talking about the many initiatives they are taking forward focusing on patient safety and quality improvement.
- We pledged to help ex-service individuals back into employment and careers within the public services.

March 2018

- Clinicians and staff from paediatrics worked with ODP students and staff from the University of Portsmouth to provide a 'surgery familiarisation' event for children and families.
- First leadership summit with Professor Michael West.

STATEMENT FROM CHIEF EXECUTIVE OFFICER ON ORGANISATIONAL PERFORMANCE

During 2017/18 The Trust has continued to face challenges across a number of performance measures. The challenges facing the NHS have been well documented, especially over the winter period, and the local picture compares with the national position.

This context has been challenging for our staff who continue to strive to deliver the best care possible. In that context, it is excellent that the feedback from patients remains positive about the care they have received as evidenced in the Family and Friends test feedback across all services the Trust provides.

The Trust has not met the four hour operational standard to treat, transfer or discharge patients within four hours. Whilst recognised as a national issue, it is with regret that we know people have waited longer than we would have wanted during the year. We are implementing an urgent care improvement plan, central to which is the safety of patients to sustain improvements to flow through the hospital to deliver improvements in the performance for patients. Our local population

has a high percentage of patients over 65 and together with increasing acuity has adversely impacted the flow of patients through the hospital. We continue to sustain delays in discharge for those deemed medically fit and in recognition of this the Trust continues to work with partners to focus on patients with extended delays, supporting safe discharge of these patients and also to review opportunities to increase capacity ahead of next winter.

The demand for unscheduled care has also affected our ability to treat routine elective patients, and waiting times at the Trust have grown; however, it is important to stress that the Trust has continued to treat urgent patients and has significantly improved delivery of cancer care and achieved all of the eight key cancer standards in February and March.

While striving to improve the quality and performance of the care we deliver, the need to provide value for money is also an important objective for NHS organisations. The Trust was unable to meet the control total of £9.7m surplus set in 2017/18; however, in November the Trust board agreed a revised position for the year of a £36.8m deficit and delivered that with an outturn of £31.8M deficit. Clinical and managerial staff worked together to identify how cost reductions could be made while maintaining patient safety and improvement programmes totalling £19.1m (3.6% of operating expenditure) were delivered.

The importance of positive patient feedback can never be underestimated and users of our services continue to report high levels of satisfaction for the work our staff do. I would like to recognise and thank the staff for their continued commitment, professionalism and compassion that makes this Trust the organisation that it is.

PERFORMANCE SUMMARY

All of our performance activities can be found in full within the monthly Trust Board reports found at Trust Board papers.

Performance against Trust standards for quality of care can be found in the Trust's Quality Account found also on the Trust website at Trust publications.

PERFORMANCE ANALYSIS

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

PERFORMANCE

A summary of performance against the key indicators and constitutional standards is published below.

National Trust Development Agency Key Indicators	Target	Trend	17/18 A	M	J	J	A	S	O	N	D	J	F	M	Change from last mth
% Incomplete Pathways < 18 wks	92%		90.4%	91.4%	91.5%	91.5%	91.1%	90.8%	90.4%	89.9%	88.3%	87.1%	86.1%	86.1%	↓
Incomplete Patients waiting >52 wks	0		0	1	0	0	0	1	3	1	1	0	0	1	↑
Incomplete Patients waiting >40 wks	0		63	59	30	34	54	77	88	73	95	83	103	166	↑
Diagnostic waits < 6 wks	99%		99.0%	99.2%	99.1%	93.1%	98.0%	99.1%	99.8%	99.4%	99.0%	98.7%	99.3%	98.6%	↓
Endoscopy waits < 6 wks	99%		97.2%	96.2%	97.5%	98.0%	97.1%	98.5%	98.6%	99.8%	98.0%	90.3%	98.3%	97.9%	↓
4 hr arrival to admission/transfer/discharge	95%		79.1%	75.0%	81.6%	78.6%	74.0%	77.1%	76.4%	77.0%	69.7%	70.8%	71.7%	71.0%	↓
12 hr Trolley waits	0		58	38	9	0	5	32	6	2	52	73	21	11	↓
All 2-week wait referrals	93%		96.8%	96.9%	97.4%	97.0%	97.9%	97.2%	96.6%	95.7%	95.9%	95.0%	96.5%	95.0%	↓
Breast symptomatic 2-week wait referrals	93%		95.9%	97.4%	94.8%	97.2%	93.2%	100%	97.1%	95.1%	93.2%	93.1%	94.4%	96.5%	↑
31-day diagnosis to treatment	96%		98.6%	99.0%	99.4%	98.2%	97.0%	98.0%	99.4%	98.5%	100.0%	98.7%	99.2%	99.7%	↑
31-day subsequent cancers to treatment	94%		93.0%	98.2%	100%	96.9%	100%	96.5%	94.1%	94.8%	100.0%	94.9%	97.7%	100%	↑
31-day subsequent anti-cancer drugs	98%		100%	100%	100%	100%	100%	100%	99%	100%	100%	99%	100%	99%	↑
31-day subsequent radiotherapy	94%		100%	98.8%	97.5%	99.0%	96.2%	95.5%	96.7%	100%	96.6%	95.7%	97.1%	99.3%	↑
62-day referral to treatment	85%		86.5%	88.1%	82.0%	79.7%	79.4%	83.5%	81.7%	80.0%	82.1%	81.4%	85.2%	85.6%	↑
62-day screening to treatment	90%		94.1%	84.8%	90.5%	71%	93.5%	90.5%	90%	95.7%	95.5%	92.7%	100.0%	94%	↓
Cancer maximum wait to treatment 104 days	0		5	4	4	11	12	6	8	8	0	6	3	3	→
Cancelled urgent operations	0		4	5	3	4	4	4	3	0	4	7	4	3	↑
Urgent Operations cancelled for a 2nd time	0		0	0	0	0	0	0	0	0	0	0	0	0	→
Cancelled operations: 28-day guarantee	0		0	0	0	0	0	0	0	0	5	6	2	5	↑
Total bed days blocked	N/A		1866	2358	2294	2689	2437	2067	2039	1862	1509	1611	1599	0	↑
Delayed Transfers of Care	3.5%		6.9%	8.7%	8.0%	10.4%	9.1%	8.6%	7.6%	8.2%	5.6%	5.2%	7.0%	4.6%	↑
30 days emergency readmissions	N/A		7.3%	6.4%	6.6%	7.1%	7.1%	6.8%	7.1%	6.9%	7.6%	6.6%	6.8%	0.0%	↑

During the past year we continued to experience significant pressure across several performance measures, with high levels of unscheduled care demand impacting on scheduled care delivery which has impacted on delivery of both referrals to treatment standards and 6 week diagnostic standard. Despite this challenging operating environment, the Trust delivered improvements to delivery of the cancer standards, thanks to the dedication and commitment of staff throughout the Trust.

The 4 hour 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.

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 we will be in a position to deliver these sustainably going forward. 7 of the 8 standards have been delivered for the year as a whole, whilst all of the cancer standards were delivered in February and there has been improvement in performance against the 62 day standard which was delivered in February and March. This has been supported by a robust improvement plan which has led to pathway redesign, reducing delays for patients.

The Referral 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 we have not achieved the standard. We 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 included switching an orthopaedic ward to elderly care. In January there was a national directive to suspend all non-urgent treatments in recognition of the national increase in demand for emergency care and increase in influenza admissions which were highest in Hampshire and Isle of Wight. Inevitably, this resulted in an increase in the waiting list for surgery and not 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 with our commissioners options to ensure that bed capacity is in place to support the needs of all patients, particularly focusing on ensuring that patients do not come to harm due to extended waiting times .

We made significant improvements to the delivery of the six week diagnostic standard which is key component of delivery of the 18 week standard and delivered this in 8 out of the 12 months, despite both increasing demand and focus on prioritising inpatients during unscheduled care pressures and use of the endoscopy unit as an additional escalation area.

Our Emergency Department performance remained challenging, reflecting the increase in the number of older people and their increasing acuity 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 our partners, to reduce it. It has remained, on average, at 243 patients.

We continue to work with partners to increase both care at home, and in the community to support the earlier discharge of medically fit patients, 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 2018/19. An Unscheduled Care Improvement Plan has also been developed, based on national best practice, to materially improve performance in this area as well as the overall patient experience in this area.

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 speciality level through the development of action plans in specialities 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 being measured and analysed on a daily basis.

A SAFE HOSPITAL – MEASURING OUR PERFORMANCE

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

We always aim 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 seven 'Never Events' were experienced in this last year. Four of the events resulted in no or low harm for the patient whilst three were categorised as moderate harm. Regardless of the level of harm, this is unacceptable, and all have been fully investigated, with action plans put in place to ensure that lessons are learnt and such incidents do not recur.

Date of incident	Nature of incident
August 2017	Wrong site procedure (low harm).
October 2017	Retained foreign object after surgery (moderate harm). Guide wire left in Central Venous Catheter (low harm).
November 2017	Retained foreign object post forceps delivery with episiotomy (moderate harm).
December 2017	Wrong site procedure (low harm).
January 2018	Incorrect implant (stent) placed in biliary tree (moderate harm).
February 2018	Patient mask attached to medical air instead of oxygen (low harm).

The Hospital Standardised Mortality Ratio (HSMR) of 108.2 (January 2017 – December 2017) and SHMI (Summary Hospital-level Mortality Indicator) of 109.13 (July 2016 – June 2017) 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 and falls.

A SAFE HOSPITAL - INFECTION PREVENTION

Our aim is to provide our patients with safe and effective care in a clean and safe hospital. We have continued our hard work to reduce the transmission of Healthcare Associated Infections wherever possible. Whilst we continue to focus on more traditional infections, like MRSA and C.Difficile, we have also had to turn our attention to newer infections like E. coli blood stream infections. These infections tend to occur in frail elderly patients who may have a history of urinary tract problems, including infections. In 2016/17 a national benchmarking exercise by Public Health England identified the Trust as having a very high rate of these infections. We are pleased to say that work undertaken in 2017/18 has resulted in a 24% decrease in the number of infections, making us one of the few acute Trusts to successfully reduce E.coli blood stream infections.

The winter of 2017/18 saw a surge in the number of flu cases at the Trust. For a few weeks in December and January, we had the highest number of flu cases in the country. This made life very busy for our staff and put additional pressures on our Emergency Department. Fortunately staff were well protected, with over 70% of our staff receiving the flu vaccine. This year the flu vaccine was also offered to long stay inpatients and immunosuppressed outpatients who were felt to be more vulnerable to catching the flu.

Prudent antimicrobial prescribing remains a priority and once again we were reassured to receive a positive report after taking part in a European Point Prevalence audit designed to benchmark our use of antibiotics. This means that our patients are receiving optimal treatment against all kinds of infections, including the serious life threatening infections in our critical care units.

The focus on frequent and appropriate hand hygiene has been one of our main goals this year aimed at protecting patients, staff and visitors from healthcare associated infections. While we have done much hand hygiene training and audits in clinical areas, we have also engaged with the general public in Trust open days, as well as out-reach visits to schools and health care establishments in the community, to spread the message that 'Clean Hands Save Lives'.

IMPROVED PARTICIPATION AND ENGAGEMENT

Our aim is to continuously improve the experience of patients, families and carers who use our services. To achieve this we need to continue to improve the way we engage with, include and involve people. Over the last 2 years, we have successfully developed a most vibrant participation and engagement community.

The Patient, Family and Carer Collaborative, the lay led group which leads our engagement and involvement work, now includes current and recent patients, carers, primary care patient participation group members, HealthWatch Portsmouth and Hampshire and special interest groups. The group have, amongst many activities:

- Been actively involved in the review of the Trust Quality Improvement Plan and a number of operational policies.
- Supported the quality monitoring of our services by participating in care quality review visits.
- Advised on the development of a specification for the purchase of a new IT programme.
- Participated in learning and development programmes for staff from a wide range of professional and support staff.

We have now set our sights on taking the work of our collaborative further, the aim being to develop our members as quality improvement facilitators, as part of the Portsmouth Quality Improvement Academy programme.

Case Study 1

The Patient, Family and Carer Collaborative led the design and delivery of the first Trust experience and engagement conference. Recognised at a local and national level as a great example of how to engage and involve patients, families and carers, the conference was designed in response to requests for information about how we have effectively involved local people from all walks of life.

Feedback from community representative who attended…

"First of all, Sheila and I would like to thank you all for a brilliant day at Fort Nelson yesterday. Please pass our thanks to Sarah. Although we had to leave just after 1.15, due to other urgent commitments coming up, we had a wonderful morning season which we will never forget. The speakers, organisation, friendliness, positive presentations on the NHS as well as the great refreshments, made the whole conference a great success. Please tell Sarah that it should become an annual event. We still have our questionnaires which we will complete and return to you asap. Once again please thank everyone for a great day. Finally could you send us your Chief Executive's e mail as we want to let him know how brilliant you all were."

NHS CHOICES

The NHS Choices website affords an opportunity for patients, families and carers who have accessed our services to provide valuable feedback about their experience. This is used in combination with a wide range of other sources of patient experience feedback to help us continually improve the quality of our services and act on any concerns or complaints.

NHS Choices allows patients to award hospitals a rating out of five stars and by the end of 2017/18, the Trust had an overall 4.5 star rating.

FREEDOM OF INFORMATION

We received 665 Freedom of Information requests in 2017/18, a slight decrease on 696 requests in 2016/17. We continue to embrace our duty of openness and have made a full or partial disclosure of information in approximately 83% of requests. The remainder includes non-disclosure due to legal exemption, the request for information being cancelled, information not held or information already published. Our compliance with issuing a response within 20 working days is currently at 85%, up from 72% in 2016/17.

CUSTOMER CARE

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.

Every day our staff work hard to provide a high standard of care throughout all of the 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.

Despite challenging times, staff throughout the Trust continue to work hard every day to provide a high standard of care for all patients. We recognise that things may not go as well as hoped every day therefore we are committed to ensuring that people feel confident and reassured in raising concerns as it is important to learn from their experience and where improvements may be required.

The Trust provides an effective support service (Patient Advice & Liaison Service i.e. PALS) which is available Monday to Friday, from 9am to 5pm, and offers advice and support for people who have concerns about their own care or that of a 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. PALS aim to resolve any difficulties with the staff involved as quickly as possible and to try to rebuild people's confidence in our services.

Over the last year, we have recruited more PALS Volunteers who are doing an excellent job of helping us make sure that patients have a smooth and safe transition from hospital back to the comfort of their home environment. The volunteers supported over 1,000 inpatients over the last year, spending time in the Discharge Lounge, as well as other inpatient areas, just having a friendly chat and making sure that arrangements are in place to support patients when they get home from hospital if necessary.

It is reassuring that the majority of feedback gathered by our Volunteers show that in most cases people have had a positive experience of our services, and this is reinforced by the large number of plaudits and messages of thanks that we continue to receive from our patients and visitors.

In the last year we were delighted to receive a 35% increase in plaudits (5,928) from our patients, relatives and visitors. Our formal complaints reduced by 11% on the previous year to a total of 614. The number of people seeking advice from PALS also saw a 17% reduction at 5,614, with the majority of issues being resolved within 5 working days.

ENSURING A SUSTAINABLE FUTURE

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 estimated carbon footprint has further reduced to 96,000 tonnes of Carbon Dioxide equivalent (CO_2e) [100,000 tCO_2e last year].

The Lord Carter Report into Operational Productivity and Performance in the NHS, published in 2016, identified potential for significant savings in energy related emissions and costs and recommended investment in energy saving technologies. We will work with our new FM Service Provider to establish opportunities to improve efficiency in our energy consumption, identifying potential invest to save schemes as well as operational improvements.

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

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE

As a Category One Responder under the Civil Contingencies Act 2004, we are required to work closely with other Category One Responders such as health partners, the Emergency Services, Local Authorities and Voluntary Agencies to enable us to respond to a wide range of incidents that could impact on health or patient care.

We do this through the Hampshire and Isle of Wight Local Resilience Forum and the Local Health Resilience Partnership, which is attended by the Trust's Accountable Emergency Officer (AEO) and Emergency Preparedness, Resilience and Response (EPRR) Officer.

As well as generic incident respond plans we have plans in place specifically designed to manage different types of incident such as adverse weather, pandemic flu and fuel shortage. Ensuring these plans readiness is essential and we exercise our plans internally and with partners. Later on this year the Trust will be holding a full live play exercise of our Incident Response Plan, something we are required to do every 3 years.

Each year NHS England (NHSE) assesses us for assurance against the EPRR core standards which details the minimum levels of preparedness we should have in place. In 2017, NHSE concluded that the EPRR assurance assessment was 'substantial' and acknowledged the work we had undertaken in year.

FINANCIAL PERFORMANCE

The Financial Statements are shown from page 63 of this report. The accounts are also available from the Director of Finance on 023 9228 6649 or at: http://www.porthosp.nhs.uk/about-us/publications/publications-index.htm.

Performance against the key targets are shown below.

Performance Area	Objective	Outcome
Income and Expenditure	Meet control total of £9.7m surplus, including STF funding Meet control total of £3.8m deficit excluding STF funding	Not achieved - Deficit for the year was £31.8m, including STF funding. Not achieved - Deficit for the year was £38.4m, excluding STF Funding
External Financing Limit (this is the maximum amount the Trust can raise cash through financing outside of the NHS)	Managing within the cash limit agreed with the Department of Health	Achieved
Capital resource limit (this is the maximum amount the Trust can spend on fixed assets)	Managing capital expenditure within the capital resource limit agreed with the Department of Health	Achieved
Capital Cost Absorption Rate	Making at least 3.5% return on the trust's net relevant assets	Achieved return of 3.5%
Cost Improvement Programme	Deliver identified efficiency schemes	Not achieved – delivered £19.0m against a target of £34.6m

Signed:

Mark Cubbon, Chief Executive
Date: 24/05/18

CHAPTER 2 – ACCOUNTABILITY REPORT

CORPORATE GOVERNANCE REPORT

DIRECTORS' ACCOUNTABILITY REPORT

The Trust Board is responsible for the leadership, management and governance of the organisation and setting the strategic direction. It also has a role in ensuring high standards are maintained.

All of the Trust's Non-Executive Directors, including the Chair, are appointed by NHSI for a fixed term, following open invitations among members of the local community. The Trust Board's formal membership is supplemented, where appropriate, by the local appointment of Associate Non-Executive Directors, who bring skills and experience particularly sought by the Trust Board to enhance its range and depth of expertise. Gary Hay was appointed as an Associate Non-Executive Director in December 2017.

The NHS and Trust recruitment guidance and policies are followed in these appointments, including open competition and the involvement of an independent external assessor. The Chief Executive is appointed by the Chair and Non-Executive Directors. The Executive Directors are recruited by a panel usually led by the Chief Executive.

The NHS Very Senior Manager Pay Framework has been adopted by the Remuneration Committee as guidance regarding pay for the executive team. Full details can be found in the Remuneration Report on page 54 of this report.

PORTSMOUTH HOSPITALS NHS TRUST BOARD

The Trust Board comprises a Chair, Non-Executive Directors and Executive Directors.

The 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 the Trust 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. Members of the Committee during 2017/18 were Mike Attenborough-Cox, David Parfitt, Jon Watson, Christine Slaymaker, Greg Brown and Gary Hay.
- The Remuneration and Nominations Committee approves substantive appointments of Executive Directors and approves their remuneration, including any bonuses. The membership of the Committee is comprised of all Non-Executive Directors.

Non-Executive Directors

Melloney Poole OBE joined the Trust Board in May 2017 and was appointed as Chair on 1st November 2017. Since June 2015, she has been the Head of the Armed Forces Covenant Fund and the other grant programmes funded by LIBOR fines which directly support the delivery of the Armed Forces Covenant across the UK. Melloney is a corporate, charity and public administrative law solicitor with 25 years of private sector commercial and corporate experience before becoming the Head of the Legal Department for the Big Lottery Fund in 2003. She developed the combined legal service department which now supports all the legal and governance matters for the Arts Council England, the Heritage Lottery Fund and the Big Lottery Fund. In addition, Melloney had a

parallel career as a Non- Executive Director in the NHS, serving on the boards of three NHS Trusts including leading one Trust through the Monitor process, and is the Vice Chair of the Health Foundation. She has also been a volunteer and fundraiser for various charities and a magistrate on the Preston bench. Melloney was awarded an OBE in the 2010 New Year Honours list for legal and governance services.

Christine Slaymaker CBE joined the Trust Board in May 2017. Prior to this she was Chief Executive of Farnborough College of Technology, rated 'Outstanding' for Quality and Financial Health. She is a Business graduate and has held Non-Executive positions for a number of organisations including Farnborough Aerospace Consortium, Treloar School and College, a Royal Engineers charity and the Enterprise M3 Local Enterprise Partnership. Christine was awarded a CBE in the Queen's Birthday Honours List in June 2014. She is from the Portsmouth area and still lives locally.

David Parfitt joined the Trust Board in May 2017. He is a chartered accountant, with broad commercial experience in a number of complex customer orientated businesses undergoing significant change, including the Granada Group, TSB Group and Lloyds Banking Group where he was the Risk, Control and Accounting Director of its retail banking business. In addition, he has direct experience of the NHS, firstly as a Non-Executive Director of NHS Luton and NHS Bedfordshire Primary Care Trusts and then as a Lay Member (audit and governance) of NHS Luton Clinical Commissioning Group. He is also a Non-Executive Director of Sussex Community NHS Foundation Trust; Chair of the Chichester Greyfriars Housing Association and a Board member/Trustee at The Brendoncare Foundation.

Gary Hay has been a solicitor for more than 25 years, most of which was spent acting for public sector bodies including the NHS, police, fire and local government. He has acted as trusted legal adviser to many NHS Trusts across the country, advising on employment law issues at a senior level. He is a recognised public speaker and is particularly known for his work around Equality & Diversity. During his time in private practice, Gary sat on the boards of two firms for a combined total of 14 years. At Capsticks solicitors, as well as helping to shape and deliver an ambitious strategy for growth, he was responsible for a number of key initiatives, including expansion into new geographies, developing new markets and establishing an HR consultancy service. Gary recently set up his own consultancy, Law2Business, focussed on training and coaching for lawyers. He is also Chair of the Helen Arkell Dyslexia Charity. Gary is an Associate Non-Executive Director of the Board.

Brigadier (Retired) Jonathan Forbes Watson MBE MA (known as Jon) was educated at Winchester College and Christ Church College, Oxford, where he read Philosophy, Politics and Economics. After graduation he joined the Army and was commissioned into the Devonshire and Dorset Regiment. During a 30 year career he served in Great Britain, Northern Ireland, Kenya, Germany, Bosnia, Canada, Sierra Leone, Iraq and Afghanistan. He left the Army in 2012 and is now CEO of Veterans Outreach Support, a Portsmouth based charity that provides welfare, wellbeing, peer mentoring and mental health support to ex-service personnel from all three services and the merchant marine. Jon is a Fellow of the Chartered Management Institute and in his spare time enjoys cycling, running and swimming

Sir Ian Carruthers – Chairman from June 2014 (until June 2017)
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 is an independent advisor to NHS Chief Executives, NHS and private sector organisations.

Mark Nellthorp – Interim Chair (until November 2017), 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.

Michael Attenborough-Cox (until October 2017) 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 in 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 was appointed chair of the Small Bodies Audit and Appointments Ltd and a member of the Local Audit Delivery Board.

Elizabeth Conway (until April 2017) joined the Trust Board in October 2009 and is 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.

Greg Brown joined the board in December 2017 and left in March 2018.

Executive Directors

Mark Cubbon – Chief Executive (from July 2017)
Mark first qualified as a nurse before moving into general and senior management roles within the NHS. He has worked at senior Director level at a number of high profile London Hospital Trusts, including Deputy Chief Executive Officer at Moorfields Eye Hospital. He also held the role of Managing Director at Whipps Cross, and in the newly merged Barts Health NHS Trust he became their Executive Director for Delivery. Before taking up the post of Chief Executive at Portsmouth Hospitals NHS Trust Mark held the role of Regional Chief Operating Officer for the Midlands and East at NHSI.

John Knighton – Medical Director (from June 2017)
John spent three years gaining General Medicine experience before training in Intensive Care Medicine and Anaesthesia in the South West and Wessex. He spent a year as a Visiting Instructor at the University of Michigan Hospital before taking a post in Intensive Care Medicine & Anaesthesia at Portsmouth Hospitals Trust at the start of 2000. He led the design of the state of the art Critical Care facilities, and was one of the clinical team leading on design for the whole hospital. He was Clinical Director for the Department of Critical Care from 2010 – 2016, during which it was rated as "Outstanding" by the CQC, Chief of Service for CHAT, and an Associate Medical Director. He has been a CQC Specialist Advisor for Acute Hospital inspections, and has had a long held passion for improving patient safety and quality of services, championing an open and learning culture of strong multi-disciplinary team working.

Theresa Murphy – Chief Nurse (from January 2018)
Theresa qualified in general nursing in 1987 and then went on to specialise in neuroscience, and critical care nursing, having held key clinical and managerial posts in both teaching and general hospitals. She joined Portsmouth Hospitals NHS Trust in September 2017. Theresa was awarded the Florence Nightingale leadership scholarship for 2012, and is an Honorary Professor for the City of London University, and has an LLB. Theresa holds Board level responsibility for nursing, governance and risk management, infection prevention and control, safeguarding people, patient experience and engagement.

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

Chris Adcock – 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 in October 2015.

Tim Powell – Interim Chief Executive (until July 2017) and Director of Workforce and Organisational Development (from July 2017)
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 the role of Chief Executive in May 2016. He was previously Director for Human Resources and Organisational Development at the London Development Agency, delivering economic development and regeneration priorities for the capital, including preparations for the London 2012 Olympics. Before this he spent five years as HR Director at Transport for London following 17 years at Royal Mail Plc.

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

Penny Emerit – Director of Strategy and Performance
Penny joined the Trust in January 2018 from NHSI having held senior leadership roles across the wider health system in London and the South. Penny's role as Delivery and Improvement Director for NHS Improvement involved oversight of the provider organisations across Hampshire and Isle of Wight and Dorset. Before joining NHS Improvement (and formerly NHS Trust Development Authority) Penny was the Area Director for South London at NHS England, Director of Delivery at the South East London PCT Cluster and held a number of roles at NHS London Strategic Health Authority, latterly supporting the implementation of the Healthcare for London programme. Penny joined the NHS as a Management Trainee and holds an Economics degree and Post Graduate Diploma in Healthcare Management.

Lois Howell – Director of Integrated Governance
Lois joined the Trust in April 2018 as Director of Integrated Governance. Lois is a solicitor by background and has many years' experience in governance and regulatory roles. She worked in local government before joining the NHS in 2007, and has also spent time as a consultant in governance and regulation, supporting clients across the public and private sectors.

Simon Holmes - Medical Director (until June 2017)
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 Medical Director for Central South Coast Cancer Network in 2007. Simon became Medical Director in August 2010.

Nicola Ryley – Interim Director of Nursing (until August 2017)
Nicola joined the Trust from her post as Executive Director of Nursing at Northern Devon Healthcare NHS Trust. She was appointed, on an interim basis, specifically to provide professional leadership to nursing and to promote the delivery safe, effective, patient-centred care to all who use our services. Nicola has extensive experience of acute, community, mental health/learning disability, primary care and prison service sectors. Holding nursing registrations for both adults and children, Nicola has an earned doctorate in clinical leadership, is an honorary professor and holds an honorary senior lecturer role.

Rob Haigh – Director of Unscheduled Care (until October 2017)
Rob was 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 had 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 (until July 2017)
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 (until September 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 (until September 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.

Peter Mellor – Director of Corporate Affairs (until February 2018)
Peter joined the Trust, in a full-time capacity, in November 2006 having been a Non-Executive Director since 1996. Hitherto he had been the principal and owner of many successful businesses locally. He has been a Magistrate in Portsmouth for 31 years.

BOARD EFFECTIVENESS

All Executive Directors and Non-Executive Directors have annual appraisals and performance development plans. They also undertake a self-assessment in line with fit and proper persons requirement (FPPR) and in line with NHSI quality governance framework. No issues or concerns have been raised. The board has regular structured development sessions and a programme of collective and individual development work is in development for 2018/19. The Board Committee structure is set out in the Annual Governance Statement on page 40 of this report.

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 a 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

- David Gattrell
- Richard Mackay
- Mary Sheppard

Havant and East Hampshire constituency

- Frances Bates
- Jocelyn Booth
- Roland Howes
- Ernie Wells

Portsmouth City constituency

- Sarah Edmonds
- Ken Thompson
- Robin Lander-Brinkley
- Lez Ward

Parent/Carer constituency

- Dr Robin Marsh

Staff Governors

- Jayne Jempson
- Les Jones

Appointed Governors

- Richard Thelwell, University of Portsmouth
- Councillor Luke Stubbs, Portsmouth City Council
- Cdre Inga Kennedy
- Councillor Peter Edgar, Hampshire County Council
- Adel Resouly - South East Hants CCG
- Norman Robson – representing West Sussex
- Elizabeth Kerwood – Fareham and Gosport CCG

AUDIT COMMITTEE

The Trust has an Audit Committee comprising of Non-Executive Directors. The committee membership during 2017/18 was:

- Mike Attenborough-Cox – Non-Executive Director (Committee Chair to 31 October 2017).
- David Parfitt – Non-Executive Director (Committee Chair from January 2018).
- Jon Watson – Non-Executive Director (from December 2017)
- Christine Slaymaker – Non-Executive Director (from May 2017).
- Greg Brown – Non-Executive Director (from December 2017).
- Gary Hay – Non-Executive Director (from February 2018 to March 2018).

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.

REGISTER OF INTEREST

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

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

Surname	First Name	Job title	Interests (Y/N)	Details
Adcock	Chris	Director of Finance	No	
Bytheway	Paul	Chief Operating Officer	Yes	Member of Priory Group of St John Ambulance
Cubbon	Mark	Chief Executive	Yes	NHS Elect Advisory Board since October 2017
Donald	Ed	Chief Operating Officer and Executive Director from February 2017	Yes	Ed Donald Consulting Ltd
Emerit	Penny	Director of Strategy and Performance	No	
Haigh	Rob	Director of Unscheduled Care	No	
Holmes	Simon	Medical Director	No	
Howell	Lois	Interim Director of Governance	Yes	Director, Howell Christie Ltd
Knighton	John	Medical Director	No	
Kopecek	Rebecca	Interim Director of Workforce and Organisational Development	No	
McKinney	Emma	Director of Communications and Engagement	No	
Mellor	Peter	Director of Corporate Affairs	No	
Murphy	Theresa	Chief Nurse	No	
Powell	Tim	Director of Workforce and Organisational Development	No	
Roberts	Sheila	Interim Chief Operating Officer	Yes	Director - Dusek Associates Ltd
Ryley	Nicola	Interim Director of Nursing	No	
Stone	Cathy	Director of Nursing	No	
Attenborough -Cox	Michael	Non-Executive Director	Yes	Non-Executive Director and Chair of Small Audits and Appointments Limited
Brown	Greg	Non-Executive Director	Yes	Voluntary Board member of Chichester Greyfriars Housing Association.

Surname	First Name	Job title	Interests (Y/N)	Details
Carruthers	Ian	Chairman	Yes	NED – Bioquell Plc
				NED - OR International Ltd
				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	
Hay	Gary	Non-Executive Director	Yes	Chair of the Helen Arkell Dyslexia Charity
Nellthorp	Mark	Non-Executive Director	No	
Parfitt	David	Non-Executive Director	Yes	Non-Executive Director, Sussex Community NHS Foundation Trust
				Chairman, Chichester Greyfriars Housing Association
				Trustee, The Brendoncare Foundation
Poole	Melloney	Chair	Yes	Chief Executive of the Armed Forces Covenant Fund Trust and Vice Chair of the Health Foundation
Slaymaker	Christine	Non-Executive Director	Yes	Trustee and Governor of Lord Mayor Treloar School and College
				Mentor for the Senior team at Prospects College of Advanced Technology in Basildon, Essex.
Watson	Jon	Non-Executive Director	Yes	Chief Executive Officer, Veterans' Outreach Support (registered charity)

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 2017/18.
- Sheila Roberts, a Director, is a Director of Dusek Associates Limited. This organisation has no business dealings with Portsmouth Hospitals NHS Trust in 2017/18.
- Lois Howell, a Director, is a Director of Howell Christie Limited. This organisation provided consultancy services to the Trust in 2017/18, prior to Ms Howell's appointment as a Director on 2nd January 2018. The transactions with Howell Christie Limited totalled £43,200 in 2017/18. There have been no business dealings with Howell Christie Limited since 1st January 2018.
- Sir Ian Carruthers, Chairman, is the Chair of 2020 Delivery Ltd. This company provided consultancy services to the Trust during the year. The transactions with 2020 Delivery Ltd totalled £598,985.
- Sir Ian Carruthers, Chairman, is the Chancellor of the University of the West of England. The Trust had transactions totalling £400 with this organisation in 2017/18.

COUNTER-FRAUD

The Local Counter Fraud Service (LCFS) was provided by the Hampshire and Isle of Wight Fraud and Security Management Service who provide a specialist service for a fixed cost, underpinned by a risk sharing agreement. The budget is agreed at the start of the financial year and the appropriate level

of resource was always made available to meet the fluctuating demands of the service. The Trust has an accredited, nominated LCFS specialist who reported directly to the Director of Finance and provided a risk assessed plan of work which was agreed and reviewed throughout the year. There is a programme of fraud awareness work, including an Anti-Fraud, Bribery and Corruption Policy, leaflets posters, newsletter and face to face fraud training and drop in sessions. The Trust receives all local and national fraud alerts and prevention notices and have been risk assessed in key areas including procurement and invoicing. All investigation work is conducted in accordance with relevant legislation. The annual Self Review Tool was rated as green in all four generic areas.

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.

INFORMATION GOVERNANCE

The confidentiality and security of information regarding both patients, staff and the Trust, 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).

As reported in the Annual Governance Statement, page 50, we experienced seven externally-reportable serious incidents in 2017/18 and these were reported using the ICO's Incident Reporting Tool.

Signed:
Mark Cubbon, Chief Executive
Date: 24/05/18

ANNUAL GOVERNANCE STATEMENT

1. SCOPE OF RESPONSIBILITY

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Trust Accountable Officer Memorandum*.

2. THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

3. CAPACITY TO HANDLE RISK

It has been acknowledged during 2017/18 that the Trust's risk management processes (as described below) require review and revision. Significant work has been undertaken to improve the identification, assessment, recording and management of strategic and operational risk, and this work will continue during 2018/19.

During 2017/18, the Board Assurance Framework was refined to enable better oversight of:

- risks to the delivery of the Trust's organisational objectives, and,
- the assurance available to demonstrate the effective management of those risks

The revised Board Assurance Framework was presented to the Board for the first time in October 2017 and at appropriate intervals thereafter. It is to be presented to the Board on a quarterly basis during 2018/19. The Board Assurance Framework is also, now used more effectively in day to day operational management of the Trust, for example, it is reviewed and taken into account by the Executive Management Team and Senior Management Team on a regular basis. Since January 2018 all meetings of the Trust Board conclude with a consideration of whether of the matters discussed during the meeting should be added to the Board Assurance Framework. The Board Assurance Framework has also been used more effectively during 2017/18 to plan for 2018/19, for example the Internal Audit Plan is much more closely aligned with risks on the Board Assurance Framework.

Work required to improve the management of operational risk is currently underway, although the Trust Board did receive and adopt a Corporate Risk Register for the first time in more than a year in February 2018. The Corporate Risk Register presented to the Board reflected a comprehensive review of all risks scoring 16 or more on operational risk registers to ensure that they were accurately described and scored, up to date and where appropriate, drew together linked issues and risks from across the Trust.

Committee responsibility for risk management has been reviewed during 2017/18, and it

was concluded that the Risk Assurance Committee did not operate effectively to provide the required level of assurance. Consequently, from the beginning of 2018/19 the new Quality and Performance Committee will be responsible for overseeing the quality of risk management activities at both the Clinical Service Centre (CSC) and corporate function levels. A new Risk Management Strategy, which takes account of the proposed organisational restructure and the revised arrangements for Committee oversight of risk management, will be proposed to the Board for adoption in July 2018.

Executive leadership for both operational and strategic risk has been in the portfolio of the Director of Integrated Governance since January 2018. For the earlier part of 2017/18, operational risk was led at Executive level by the Director of Nursing and strategic risk by the Director of Corporate Affairs.

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

4. THE RISK AND CONTROL FRAMEWORK

4.1.1 RISK MANAGEMENT

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

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

Risks continued to be identified throughout 2017/18, 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 was chaired during 2017/18 by a Non-Executive Director, with Executive Director membership.

During the year 2017/18, we identified a number of risks rated 16 and above; that is, risks which pose a serious threat to the 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 and financial sustainablity. This has been the subject of detailed internal and external scrutiny with extensive action plans in place to mitigate the risks to the Trust. A report concerning those risks was presented directly to the Board in February 2018.

New and emerging risks identified during 2017/18 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 accommodated outside their speciality footprint. Additionally, the risk relating to increased numbers of medically fit for discharge patients awaiting discharge has impacted both on timely care for patients and the achievement of national targets.

The key financial risks identified in 2017/18 were:

I. Income and Expenditure performance – achieving the levels of income and expenditure specified in the budget as well as the overall 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 – specifically accessing interim deficit financing from the Department of Health of £35.8m in the year.
IV. Management of capital resources – due to significant demands on the capital programme which is restricted to 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 CQC Fundamental Standards, particularly in relation to safety of patients within the Unscheduled Care Pathway. This risk is being addressed through a revised Urgent Care Improvement Plan which is monitored through the Systems Resilience Group/A&E Delivery Board.

The key risks identified for 2017/18 are expected to continue into 2018/19 although there have been a number of developments in relation to the control environment and management actions which are designed to provide mitigate those risks.

4.1.2 RISK MANAGEMENT IN PRACTICE

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

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

4.1.3 RISK MANAGEMENT RESPONSIBILITY

Risk management is a corporate responsibility and, therefore, the Trust Board has the ultimate responsibility for ensuring that effective processes are in place. The Board is committed to the continuous development of a framework that manages risks in a structured and focused way, in order to protect the Trust from 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, as Chief Executive, retain overall accountability for the management of risk, I have delegated various aspects of that management to designated Directors, and from 2 January 2018, specifically to the Director of Integrated Governance. However, elements of responsibility also lie with our employees and the structure of the organisation ensures there is adequate capacity to fulfil these responsibilities.

4.1.4 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 were 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. During 2017/18 the Risk Assurance Committee provided exceptions to the Trust Board through the Committee Chair, who was a Non-Executive Director.

5. THE TRUST BOARD

5.1.1 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.

Until 28 February 2018, the Director of Corporate Affairs was the Trust Secretary and provided senior leadership in corporate governance. This role has been fulfilled by the Director of Integrated Governance since 1 March 2018. 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 10 times during the year and Board papers are published on the Trust website.

The Trust's Standing Orders, Standing Financial Instructions and Reservation and Delegation of Powers were reviewed during 2017/18 to ensure that they reflect any changes to the Trust's governance arrangements and changes through legislation. Further review will be required in early 2018/19 to provide for revisions to the Board's committee structure and the proposed re-organisation of clinical teams

5.1.2 BOARD PERFORMANCE

During 2017/18, membership of the Trust Board changed considerably. By the end of 2017/18 and going into 2018/19, the membership of the Trust Board consists of the Trust Chair, five independent Non-Executive Directors (plus one independent Associate Non-Executive Director) and nine Executive Directors, including the Chief Executive Officer. Four of the Executive Directors are non-voting (Director of Human Resources and Organisational Development, Director of Strategy and Performance, Director of Communications and Engagement, Director of Integrated Governance).

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. At the February 2018 meeting of the Board a revised Board Committee structure was adopted for 2018/19 to help to ensure the more effective working of the Board. In addition, work continued throughout 2017/18 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 Chair 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 previous Chief Executive, the Director of Workforce and Organisational Development was asked to fill the role of Chief Executive Officer on an interim basis and his deputy was appointed as the interim Director of Workforce and Organisational Development. A substantive appointment to the role of Chief Executive Officer was made at he end of July 2017, and the Director of Workforce and Organisational Development returned to his original post. Three new Executive Director roles were created and filled in late 2017 to early 2018: Director of Communication and Engagement, Director of Strategy and

Performance and the Director of Integrated Governance. The Director of Corporate Affairs retired in February 2018. A comprehensive record of attendance at meetings of the Trust Board is maintained and is set out below.

Trust Board attendance record

	06-Apr-17	04-May-17	01-Jun-17	06-Jul-17	01-Sep-17	05-Oct-17	02-Nov-17	07-Dec-17	01-Feb-18	01-Mar-18
Directors										
Mark Cubbon					✓	✓	✓	✓	✓	✓
Tim Powell	x	✓	✓	✓	✓	✓	✓	✓	✓	✓
John Knighton				x	✓	✓	✓	✓	✓	✓
Chris Adcock	✓	✓	✓	x	✓	✓	✓	✓	✓	✓
Theresa Murphy					✓	✓	✓	✓	✓	✓
Paul Bytheway						✓	✓	✓	✓	✓
Emma McKinney								✓	✓	✓
Lois Howell								✓	✓	✓
Penny Emerit									✓	✓
Peter Mellor	✓	✓	✓	✓	✓	✓	✓	✓	x	
Rob Haigh	✓	✓	✓	✓	✓	x				
Sheila Roberts	✓	✓	✓	✓	✓					
Nicola Ryley			✓	✓						
Ed Donald	✓	✓	✓	✓						
Rebecca Kopecek	✓	✓	x	✓						
Simon Holmes	✓	✓	✓							
Non-Executive Directors										
Melloney Poole		✓	x	✓	✓	✓	✓	✓	✓	✓
Christine Slaymaker			✓	✓	✓	✓	✓	✓	✓	✓
David Parfitt			✓	✓	✓	✓	✓	✓	✓	✓
Gary Hay									✓	✓
Greg Brown									✓	✓
Jon Watson									✓	✓
Mark Nellthorp	✓	✓	✓	✓	✓	✓	✓			
Michael Attenborough-Cox	x	✓	✓	x	✓	x				
Sir Ian Carruthers	✓	✓	✓							
Elizabeth Conway	✓									

Attended	✓
Apologies given	x
Absent on Trust business	♦

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.

5.1.3 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 2017/18 by the committee structure described below. Review of this structure and all sub-Board committee terms of reference are reviewed annually. A revised committee structure will be introduced during 2018/19. The sub-committees in place during 2017/18 were:

- Audit Committee (mandatory).
- Appointments and Remuneration Committee (mandatory).

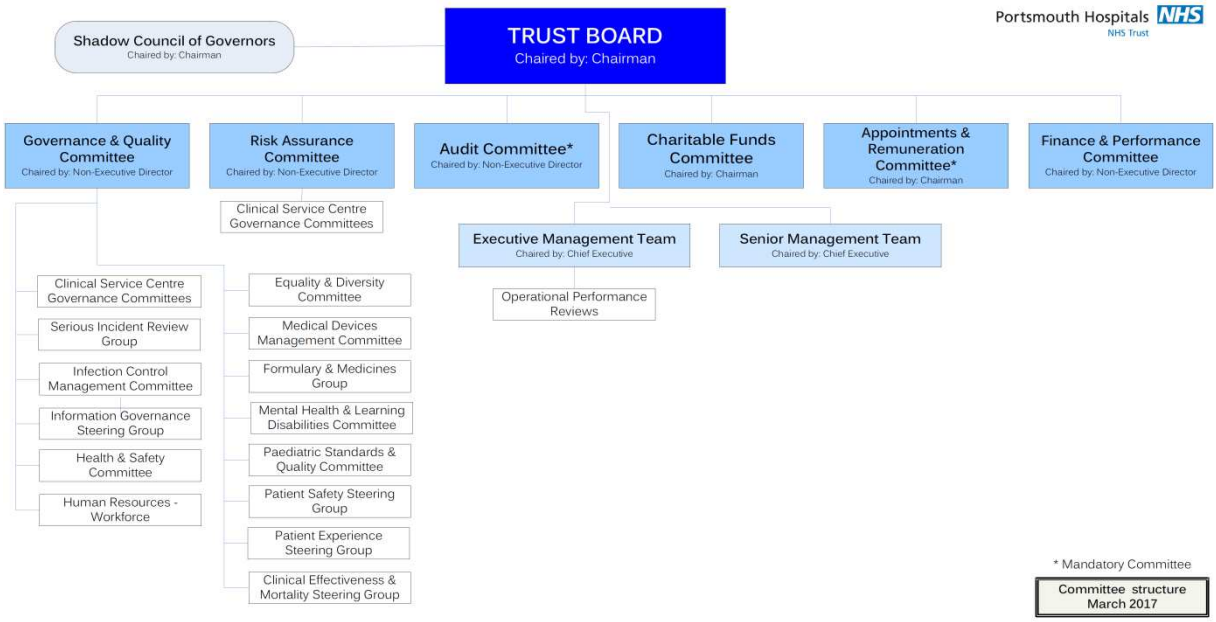
- Governance and Quality Committee which is chaired by a Non-Executive Director and ensures there is continuous and measurable improvement in the quality of the services provided, and that the Trust Board receives assurances that the risks associated with its activities are managed appropriately. The Committee also monitors the implementation of the Trust's Quality Improvement Strategy, as well as monitoring 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, promotes effective risk management and maintains and monitors the Board Assurance Framework and the Risk Register. The Committee also promotes local level responsibility and accountability and challenges risk assessment, mitigation, risk assurance arrangements, and outcomes in any area of the Trust activity where robust controls are not evident, in order to raise standards and ensure continuous improvement.

Attendance records are maintained for all the above committees and reviewed on a regular basis.

The 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 five times during 2017/18. 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:

- Concern that the Board Assurance Framework was not providing effective assurance (the BAF has subsequently been revised)
- The report issued by the External Auditor to the Secretary of State under Section 30 (2) of the Local Audit and Accountability Act 2014 informing of the failure by the Trust to meet it's statutory duty to break even over a three year period.

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



The Committee structure outlined above will undergo further revision during 2018/19.

6. GOVERNANCE ARRANGEMENTS

6.1.1 QUALITY GOVERNANCE

During 2017/18 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.

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 was presented to the Governance and Quality Committee throughout 2017/18, with key issues 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 has 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 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.

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, which comprises of detailed reports on quality, operations, finance and workforce, was reported monthly to the Trust Board and considered in detail, with elements of it reviewed by the Finance and Performance Committee. The report provides the Board with assurance of the Trust's performance against National priorities, set out for the NHS by NHSI and NHS England (NHSE), and local priorities. The Trust continues to strive to reach sustainable improvement in its performance against these priorities, including the Referral to Treatment (RTT) target.

6.1.2 CARE QUALITY COMMISSION

The inspection by the CQC in February 2017 resulted in the Trust receiving an Enforcement Notice in March 2017 due to the concern than patients who use services will or may be exposed to the risk of harm. This Notice comprised six conditions:

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. There is no internationally agreed and widely used definition of crowding. Markers of crowding or escalation might include, but are not exclusive to:
    - Prolonged Ambulance offload times (e.g. more than 15 minutes).
    - Long waits for patients to be assessed by clinicians (e.g. over 1 hour).
    - Occupancy of available chairs greater than 100%.
    - Use of the corridor area by patients (e.g. more than 5 or more trolleys/ beds)
    - Delays between request for a bed and that bed being made available (e.g. over 1 hour).
    - High proportion of patients in the AMU waiting area awaiting placement on an appropriate inpatient ward.
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 CQC undertook a responsive focused inspection of the corporate and leadership functions of the Trust in May 2017, inspecting the key question of 'well led'. The inspection resulted in the Trust receiving an Enforcement Notice in May 2017 due to the concern than patients who use services within the emergency medical pathway of the Queen Alexandra Hospital will or may be exposed to the risk of harm. This Notice comprised six conditions:

1. The Registered Provider must deploy sufficient numbers of suitably qualified and competent staff in the emergency decision unit in the emergency department to provide safe, good quality care to patients with mental health problems along with all other patient. Staffing levels and skill mix must take into account the acuity of all patients in the department at any given time.
2. The Registered Provider must ensure all patients presenting to the emergency department with mental health problems receive a full assessment of all risks assessment and corresponding risk management plan/care plan. This risk assessment and plan must include, but is not exclusive to, the following:
   - Assessment of risks across a broad range of mental health issues and the identification of any specific risks for the individual patient and others in the department (patients, carers, staff, members of the public) and any safeguarding concerns.
   - The environmental risks to the patient and mitigating actions
   - Robust immediate risk management/care plan documenting the appropriate frequency of observation, specific intervention (care and treatment) required to meet the patient's needs and escalation plans should the patient's condition deteriorate.
   - An identified time and date for review specific to the individual patient's needs.
3. The Registered Provider must identify, monitor and observe detained and / or high risk patients with mental health concerns or vulnerable safeguarding issues across the hospital and must have oversight of the location of these identified and plan of care of patients at all times.
4. The Registered Provider must ensure that there are clearly identified leads for mental health provision within the emergency department and acute medical unit at all management levels. The Registered Provider must also ensure that there is executive level leadership that has accountability for mental health care, safeguarding and Deprivation of Liberty Safeguards within the hospital.
5. The Registered Provider must ensure that Deprivation of Liberty Safeguards are applied as per the requirements of Mental Capacity Act, 2005, prior to depriving a person of their liberty.
6. The Registered Provider must immediately take action to ensure patients are safe. As a minimum, deploying sufficient, suitably qualified and competent staff and completing robust risk assessments, plans and delivering the identified care and treatment for patients presenting with mental health issues. Then, as soon as reasonably practicable, and in any event by 12pm on Monday 15 May 2017, describe the actions the Provider will take to meet the requirements of this notice and the timescales in which it will implement the required actions to

comply with the conditions set out in this notice. The Registered Provider must demonstrate that they are assured that such care is actually being delivered. The trust must send the Care Quality Commission an update weekly in this respect from the week commencing 22 May 2017.

The CQC undertook an unannounced inspection at the Queen Alexandra Hospital site in July 2017 to review specific aspects of the care provided by the diagnostic imaging department. The inspection resulted in the Trust receiving an Enforcement Notice in July 2017 due to concern that patients in receipt of the regulated activity of diagnostic and screening procedures will or may be exposed to the risk of harm. This Notice comprised four conditions:

1. The Registered Provider must take evidenced based appropriate steps to resolve the backlog of radiology reporting using appropriately trained members of staff. This must include a clinical review, audit and prioritisation of the current backlog of unreported images, (including those taken before January 2017); assess impact of harm to patients, and apply Duty of Candour to any patient adversely affected.
2. The Registered Provider must ensure that they have robust processes to ensure any images taken are reported and risk assessed in line with Trust policy.
3. The Registered Provider must submit their evidenced based decision-making on how the backlog will be addressed to the Commission by the 21 August 2017.
4. From 6 September 2017, and on the Wednesday of each week after, the Registered Provider must report to the Care Quality Commission, NHS Improvement and the NHS England Local Area Team:
    - The total number of images remaining in the backlog (including unreported images pre-January 2017) shown by year of image taken.
    - The current trajectory date of when the backlog (including unreported images pre-January 2017) will be cleared.
    - The proportion of patients waiting less than the trusts KPI for x-rays, CT and MRI.
    - The average waiting time (in days and hours) for a reported plain film (excluding GP requests).
    - The average waiting time (in days and hours) for chest and abdominal films (excluding GP requests).
    - Number of plain film requests (excluding GP requests).
    - Longest waiting time for a reported radiology plain film request.

The CQC issued the Trust with a Warning Notice under Section 29a of the Health and Social Care Act 2008 in July 2017 in relation to the inspections undertaken in February and May 2017. The Notice was issued to ensure significant improvements were made to the quality of health care provided within the Trust.

The Trust published a Quality Improvement Plan on 31 October 2017 to address the areas for improvement noted by the inspectors. A Quality Improvement Assurance Group (QIAG) was established to provide monitoring and oversight on the delivery of the plan. A high level dashboard with key performance indicators has been developed to measure the impact of delivery of the actions within the plan. Progress on implementing the Plan was regularly reported to the Board.

As a result of the enforcement notices in place, the Trust must declare itself as not fully compliant with the registration requirements of the Care Quality Commission.

7. NHS PENSION SCHEME GOVERNANCE

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions, and payments into the scheme are in accordance with the Scheme rules, and that 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.

8. EQUALITY, DIVERSITY AND HUMAN RIGHTS

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

We are in the process of developing our new 5 year Inclusion, Equality and Diversity 2018-2023 strategy which has four key priorities; Ethnicity, Disability Sexual Orientation and Transgender.

The Trust is relaunching the BAME staff network in 2018 and is making plans with staff for disability and LGBT+ networks to ensure the views and opinions of staff with a protected characteristic are heard and acted upon.

A recent visit from Dr Habib Naqvi, Head of Policy, from Workforce Race Equality Standard (WRES), gave the organisation assurance that the commitment the Trust is giving to the important WRES agenda was robust.

Analysis of our workforce includes:

Female	78%
Male	22%
Disability	5%
BME (Black and Minority Ethnicity)	22%

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	49%
Male	51%
Disability	4%
BME (Black and Minority Ethnicity)	19%

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 want to enable all our staff to be fully involved in the Trust's work, to protect them from unfair treatment and ensure each individual can reach their potential. We have developed a set of Equality Standards which aim to embed inclusion, equality and diversity throughout the organisation and continue to identify innovative ways to promote an inclusive workplace culture for all our staff.

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 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. The Equality Standard is designed to mainstream inclusion, equality and diversity in everything we do and offer incremental recognition of improvement with three levels of award: bronze, silver and gold.

Control measures are in place to ensure that all of the organisation's obligations under equality, diversity and human rights legislation are complied with.

9. CARBON REDUCTION

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

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

10. REVIEW OF ECONOMY, EFFICIENCY AND EFFECTIVENESS OF THE USE OF RESOURCES

The main mechanisms via which the Trust monitors its economy, efficiency and the effectiveness of its use of resources are its corporate governance and financial governance arrangements.

11. 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.

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.

12. 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.

The Trust plans to undertake a formal assessment of its use of resources by quarter 2 of 2018/19.

13. INFORMATION GOVERNANCE

The Director of Corporate Affairs was the nominated Senior Information Risk Officer (SIRO) 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 Director of Integrated Governance assumed the role of SIRO following the retirement of the Director of Corporate Affairs.

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 through the Trust's incident reporting mechanisms and Risk Registers and during 2017/18 there were five incidents which required reporting to the Information Commissioner's Office (ICO). One incident was withdrawn when downgraded. The other four incidents were unrelated and three 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 a number of organisations. A further incident was externally reported to the ICO regarding the Trust and was closed with no further action.

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

The Trust's Information Governance Toolkit submission for 2017/18 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 reasonable assurance in 2016/17. The repeat audit in 2017/18, resulted in an overall assessment of limited assurance. All concerns regarding evidence in support of the IG Toolkit submission were addressed in advance of the submission of the data to NHS Digital.

14. INFORMATION GOVERNANCE INCIDENTS

The confidentiality and security of information regarding patients, staff and the Trust, 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 seven externally-reportable serious incidents in 2017/18 and these were reported using the ICO's Incident Reporting Tool.

Externally Reportable Incidents

Date of incident	Nature of incident	Nature of data involved	Number of data subjects potentially affected	Notification steps
07/04/2017	Maternity client given wrong set of hand held notes following her appointment	Personal demographics and detailed clinical information	1	ICO response – does not meet criteria for formal enforcement
30/06/2017	Nursing handover sheet found on public street by a member of PHT staff	Name and detailed clinical information	31	ICO response – does not meet criteria for formal enforcement
07/08/2017	Maternity delivery summary filed in the wrong hand held notes	Personal demographics and detailed clinical information	1	ICO response – does not meet criteria for formal enforcement
09/11/2017	Patient records belonging to PHT patients found in a public place	Personal demographics, limited clinical information and photograph	25	ICO response – does not meet criteria for formal enforcement
20/11/2017	Paper reports of breast screening results sent to the wrong GP.	Personal demographics and screening results	111	*Awaiting response from ICO*
21/12/2017	Employee of PHT disclosed confidential information about a patient to a third party who worked with the patient	Name and limited clinical information	1	*Awaiting response from ICO*
14/03/2018	Radiographer in CT scanning accessed patient's details and sent patient an unsolicited and inappropriate text message	Name and telephone number	1	*Awaiting response from ICO*

15. QUALITY ACCOUNT

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

The Trust published its Quality Account in June 2017, which set out the priorities for 2017/18 and reflected on its achievements in 2016/17. Consultation with internal stakeholders and the Patient Collaborative is currently underway to inform the Quality Account which will be

published in June 2018 and will be available on the Trust website. This will set out the priorities for the coming year and will include patient safety, patient experience and clinical effectiveness indicators.

To provide assurance on the accuracy and data quality of the Quality Account, data submissions must be accompanied by a data validation form signed by both the data owner and their line manager. 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 2017 by external auditors – Ernst & Young LLP. This concluded that the Quality Account was prepared in line with the criteria set out in the Regulations.

16. REVIEW OF EFFECTIVENESS OF RISK MANAGEMENT AND INTERNAL CONTROL

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the Executive Directors and senior managers within the organisation who have responsibility for the development and maintenance of the system of internal control. My review is also informed by comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, Audit Committee, Finance and 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.
- Announced and unannounced visits by the Care Quality Commission.
- Monthly reports of Serious Incidents to Trust Board.
- Monthly Quality Exception reports.
- Quarterly Quality reports: which provide amongst other matters aggregated information on complaints, claims and incidents, patient experience, patient safety and clinical effectiveness.
- Health and Safety reports.
- Monthly review of the Board Assurance Framework.

- Monthly reports from key directors, including Finance, Nursing and the Chief Operating Officer.

An Internal Audit, designed to ensure that adequate and effective controls over the Risk Management and Assurance Framework process are in place, 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.

Whilst the overall Head of Internal Audit Opinion is Limited Assurance that there is a generally sound system of internal control, the acceptance of, and management responses to the recommendations made in internal audit reports gives me assurance that plans are in place to address the issues raised.

17. SIGNIFICANT INTERNAL CONTROL ISSUES

2017/18 has been a year of considerable financial and operational challenge for the Trust, and internal controls to address these will be strengthened in the coming year.

Key amongst the actions taken to strengthen internal control are those included in, or arising from corporate governance review conducted during the latter half of 2017/18. Key resulting actions include:

i. Review and planned revision of the Trust's organisational structure (consultation launched in March 2018; outcome to be implemented from July 2018)
ii. Revision of the accountability framework, used to hold operational teams to account for delivery of organisational, constitutional and contractual obligations, and the effective management of associated risks
iii. Revision of the Board's committee structure – planned during 2017/18 and effective from 1 April 2018. Further work will be undertaken during 2018/19
iv. Review, revision and refinement of the Integrated Performance Report – first revisions in place from February 2018; further refinements to continue throughout 2018/19
v. Review of all risks on the operational risk register scoring 16 or above, and presentation directly to the Board of a corporate risk register – to continue on a quarterly basis during 2018/19
vi. Review, revision and refinement of the Board Assurance Framework – first version of the revised content and format presented to the Board in October 2017. Further work to refine the format, its presentation and operational use will continue during 2018
vii. Improved alignment of the Internal Audit plan to the Board Assurance Framework
viii. Review of financial governance arrangements, in line with the outcome and recommendations of and NHSI investigation
ix. Revision of the Trust's financial forecast for 2017/18, and implementation of an associated Cost Improvement Programme to ensure delivery of the revised forecast

18. CONCLUSION

The Trust has identified the internal control issues identified at paragraph 8, i – ix above, and has plans in place to address this, most of which have already commenced their implementation to ensure that the statement of internal control for 2018/19 is unqualified.

Accountable Officer:	Mark Cubbon
Organisation:	Portsmouth Hospitals NHS Trust
Signature:	
Date	**24/05/18**

REMUNERATION AND STAFF REPORT

INVESTING IN OUR STAFF AND WORKFORCE

The Trust believes that a highly-skilled, motivated and engaged workforce is essential to ensuring delivery of high quality integrated care for the population we serve. The Trust has a track record of promoting workforce diversity and engagement, shared values and behaviours and continuous development and learning among its workforce. We employ around 6,400 full time equivalents and we are the largest employer in Portsmouth.

REMUNERATION COMMITTEE

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 is comprised of all Non-Executive members of the Board at any given time.

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.

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.

REMUNERATION TABLES

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

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 9 in the Trust's Annual Accounts.

RESOURCING

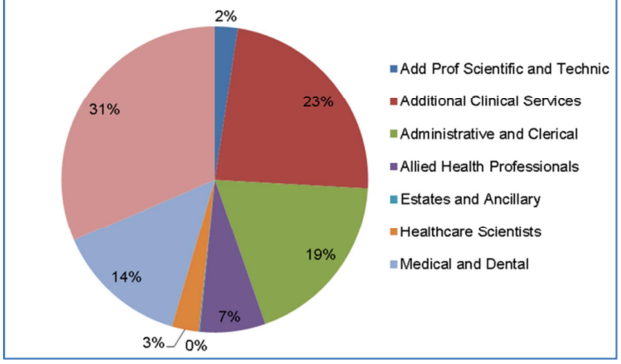
Recruiting and maintaining an effective workforce is a major priority and our strong partnerships with NHS Professionals, who provide our temporary workforce, Carillion and the Ministry of Defence helps us to achieve the goal of maintaining safe services for all of our patients.

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.

Table one details our total workforce capacity which 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.

Table one: 2017/18 Workforce Capacity by Staff Group



In addition to our substantive workforce capacity, our temporary staffing accounts for 8.3% of the total workforce establishment. This is 0.7% increase in comparison to this time last year.

Some investments have been made in 2017/18 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.

HEALTH, SAFETY AND WELLBEING

We are fully committed to supporting and improving the Health, Safety and Wellbeing of all our employees throughout the organisation with a fully integrated Health, Safety and Wellbeing Service onsite and the provision of a bespoke Wellbeing Centre, providing a range of support and activities for staff..

Key Health and Safety activities over this year have included a full Trust wide audit of Sharps disposal, increased sharps awareness training and improved reporting of incidents.

Progress in the Health and Wellbeing CQUIN continues. Over the year we have increased the provision for stress awareness and resilience training, fast tracked 216 staff members through physiotherapy and 72.3% of frontline staff were vaccinated against seasonal FLU.

In February 2018 the Trust Health, Safety & Wellbeing Advisor was appointed to the role of Freedom to Speak up Guardian.

RAISING STAFF CONCERNS

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

It is a right of employees 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's Freedom to Speak Up (FTSU) Guardian continues to help staff raise concerns in a confidential supporting and anonymised manner, signposting appropriately. 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 role is an independent post within the Trust reporting to the Chief Executive and Chair. FTSU Advocates have been recruited during 2017 and are in place from all Clinical Service Centres and Corporate Functions to support the Guardian role.

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

FAIR PAY POLICY

On pages 115 and 116 of this report are tables relating to the details of salary, allowances and pension benefits of the executive directors of the Trust.

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in the organisation and the median remuneration of the Trust's 'substantive' workforce.

The banded remuneration of the highest paid director in the Trust in the financial year 2017/18 was £160k-£165k, which was the Interim Chief Executive/Director of Workforce & Organisation Development and his salary was comparable with 2016/17 (taking into account part year office of Interim Chief Executive). The salary was 8.03 times (2016/17, 7.7 times) the median remuneration of the workforce which was £20,549 (2016/17, £24,304).

In 2017/18, no employees received remuneration in excess of the highest-paid director (2016/17, none).

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

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 3.7% of the workforce 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 9.

STAFF NUMBERS AND COSTS

Staff costs

	Permanent	Other	2017/18 Total	2016/17 Total
	£000	£000	£000	£000
Salaries and wages	225,791	1,959	**227,750**	221,953
Social security costs	22,423	-	**22,423**	21,843
Apprenticeship levy*	1,148	-	**1,148**	-
Employer's contributions to NHS pensions	27,953	-	**27,953**	27,337
Pension cost - other	-	-	**-**	-
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	-	-	**-**	37
Temporary staff		41,519	**41,519**	34,330
Total gross staff costs	**277,315**	**43,478**	**320,793**	**305,500**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**277,315**	**43,478**	**320,793**	**305,500**
Of which				
Costs capitalised as part of assets	764	-	**764**	577

* This is the gross amount paid to HM Revenue & Customs in respect of the apprenticeship levy

Average number of employees (WTE basis)

	Permanent	Other	2017/18 Total	2016/17 Total
	Number	Number	Number	Number
Medical and dental	913	82	**995**	942
Ambulance staff	-	-	**-**	-
Administration and estates	1,215	12	**1,227**	1,221
Healthcare assistants and other support staff	-	-	**-**	-
Nursing, midwifery and health visiting staff	3,038	451	**3,489**	3,376
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	1,154	32	**1,186**	1,200
Healthcare science staff	199	4	**203**	167
Social care staff	-	-	**-**	-
Other	-	-	**-**	-
Total average numbers	**6,519**	**581**	**7,100**	**6,906**
Of which:				
Number of employees (WTE) engaged on capital projects	-	-	**-**	12

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.

Essentially, Listening into Action is about:

- engaging all the right people around delivering better outcomes for our patients, our staff and our trust,
- aligning ideas, effort and expertise behind the patient experience, safety and quality of care,
- overcoming widespread challenges around staff engagement and morale,
- developing confidence and capability of our leaders to 'lead through engagement'
- collaborating across the usual boundaries, and
- engendering a sense of collective ownership and pride.

Listening into Action complements other important projects taking place at the trust, including the Continuous Improvement Programme. In fact, the change methodologies, systems and experience staff develop and gain through this programme will in many cases be used to help achieve changes which are identified by Listening into Action.

Staff appraisals currently record at 78.5% of the workforce. Staff appraisals have continued to be under the 85% target on a monthly basis and the Organisational Development team have supported managers with delivering new appraisal paperwork at frequent 'Passport To Manage' training sessions. Our essential skills training has decreased and currently stands at 89.3%.

THE NATIONAL NHS STAFF SURVEY 2017

The results are used by NHS England to support national assessments of quality and safety. The CQC use the results to inform their Intelligent Monitoring work to help to decide who, where and what to inspect. The NHS Staff Survey is recognised as an important way of ensuring that the views of staff working in the NHS inform local improvements and input in to local and national assessments of quality, safety, and delivery of the NHS Constitution.

The Trust decided to survey all staff in 2017, as in previous years. A total of, 4210 staff took the opportunity to complete and return the survey, representing a 59% response rate which is in the highest 20% for acute trusts in England and compares with a response rate of 58% in the 2016 survey. The survey report has been 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 2016 survey.

When comparing the Key Findings to the 2016 survey:

- 2 show improvement
- 22 have remained unchanged
- 8 have deteriorated (however of these, one KF is better than average and 4 are average when compared to all acute trusts)

Top ranking scores:

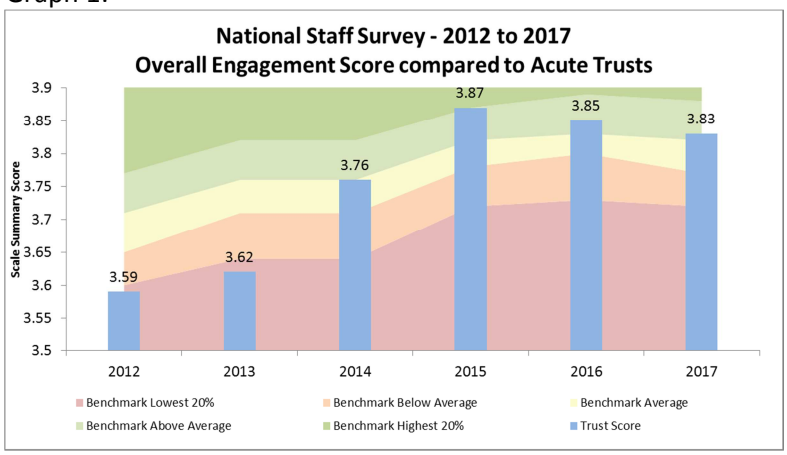
- The percentage of staff working extra hours is low
- Less staff feel unwell due to work related stress
- There is support from immediate managers
- More staff believe that the trust provides equal opportunities for career progression or promotion
- There is good communication between senior management and staff

Bottom ranking scores:

- Staff witnessing potentially harmful errors, near misses or incidents
- Staff experiencing physical violence from patients, relatives or the public
- Staff experiencing bullying or harassment or abuse from patients, relatives/public
- Staff experiencing discrimination at work
- Staff attending work despite feeling unwell because they felt pressure from their manager, colleague or themselves

The overall staff engagement score, when compared with all acute trusts, has remained at 'above average' with a scale summary score of 3.83, which is a slight decline of 0.02 from 2016. This is a pleasing position when considering the challenging year operationally and changes to the senior leadership team. The Trusts overall engagement score as a bench mark against all acute trusts since 2012 can be seen in Graph 1 below.

Graph 1:



The focus given to supporting staff to raise and respond to concerns, management and leadership development and staff health and well-being has resulted in more of our workforce feeling that they are able to report any experience of harassment, bullying or abuse. In addition, feel supported by their immediate managers, experience good communication between senior managers and staff and has resulted in less staff feeling unwell due to work related stress.

Our response rate was in the highest 20 per cent of acute trusts in England and, although our scores have declined slightly in some areas from 2016, we still remain significantly above average when

compared with other Trusts across the country. This is a great achievement considering the instability and challenges faced by the organisation over the past 12 months. 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.

We have already begun working on the key issues that were raised by this survey through commissioning an external independent review to help us to better understand the issues of bullying and harassment that staff have raised and identifying what actions we can take to address this. We have also appointed a new Freedom to Speak Up Guardian, along with 17 advocates who have attended the national training programme.

We officially launched our culture change programme on the 14 March 2018 at our first Leadership Summit with Professor Michael West, Head of Thought Leadership at the Kings Fund as the key note speaker. The programme is based on best practice, research and evidence and a national toolkit which focuses on developing compassionate cultures for high quality patient care. Improving our culture will take some time and has the full commitment of the Board. Adopting this programme in our organisation during the coming years will ensure that we not only maintain but improve upon 10 KFs being in the top 20% of all acute trusts and aspire to be in the top 20% for overall staff engagement.

To deliver this, we must also continue to build on our successes and pay much attention to those areas that are still in need of improvement. The survey results provide evidence of an engaged but highly pressured and exhausted workforce.

Over the coming 12 months we plan to take action to improve in the areas detailed as bottom ranking scores and where staff experience has declined. We will analyse the staff survey data at a granular level to identify the specific speciality, department or ward where staff experience has declined the most Once identified a bespoke intervention will be designed in collaboration with the management team of the area and implemented with appropriate resource. The quarterly Staff Friends and Family Test (Pulse Survey) will be used to monitor progress.

VOLUNTEERS

The Trust has a vibrant volunteer community, with over 600 volunteers ranging in age from 16 – 92 years!

Our volunteer's roles include hospital guides to help patients and visitors navigate their way around the hospital, meal time assistants who help our patients eat and drink at meal times and administrative roles to support our staff. In addition, we have developed new and exciting roles, which support the development, design and delivery of quality improvements in our services. Volunteers are now established members of our quality review teams, visiting wards and departments to look at care from a patient perspective. Some volunteers, who have long term health conditions, teach on multi-professional programmes, supporting our aim of putting the patient voice at the centre of everything we do. This has brought fresh eyes to the experience of care and helped us make small but significant changes to the way we provide care and treatment.

Terry's Story

Terry is a recovering alcoholic and was the catalyst for this whole programme. Terry plays the guitar and writes and sings his own songs. He is now our lead volunteer facilitator for patient surveys, undertaking face to face surveys with patients and families. He is an active participant in our co-design workshops and is leading the evaluation of our "Shhhh" – noise at night project.

We have also expanded the opportunities for volunteering, moving away from a traditional approach of a dedicated amount of time each week to encourage those who have are not able to make that regular commitment. To complement the change in type of opportunities available we

have also worked to ensure our volunteer community more fairly represents our hospital community.

We have had a significant increase in the number of younger people volunteering, many of whom wish to go into the health care professions, helping us grow our workforce for the future. In September 2017, the Voluntary Services Team were awarded a special commendation at the Excellence in Voluntary Services Awards – National Association of Voluntary Services Management 2017, for our "Safe and Supported Programme"- the panel said the programme was developed for vulnerable people who would not normally consider volunteering in the hospital. "Leading the way in changing the stereotypical view of who can volunteer". We now have a number of members of the local community with a range of specialist needs on the programme ranging from dyslexia, Asperger's Syndrome, cerebral palsy and enduring mental ill health. Our ambition is to grow these opportunities over the next year.

EXPENDITURE ON CONSULTANCY

The Trust spent a total of £2.6m on external consultancy in the year.

OFF-PAYROLL ENGAGEMENTS

Off-payroll Engagements over six months and over £245 per day as at 31st March 2018

Number of existing arrangements as at 31st March 2018	2
Of which the number that have existed:	
For less than one year at the time of reporting	2

New off-payroll Engagements over six months and over £245 per day

Number of new engagements, or those that reached six months in duration between 1 April 2017 and 31 March 2018	2
Of which:	
Number assessed as being covered by IR35	1
Number assessed as not being covered by IR35	1
Number engaged directly (through PSC contracted to department) and are on the departmental payroll	1
Number of engagements re-assessed for consistency/assurance purposes during the year.	0
Number of engagements that saw a change to IR35 status following the consistency review	0

EXIT PACKAGES

Reporting of compensation schemes - exit packages 2017/18

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
Less than £10,000	-	18	**18**
£10,001 - £25,000	-	2	**2**
Total number of exit packages by type	**-**	**20**	**20**
Total resource cost (£)	£0	£88,000	**£88,000**

Exit packages: other (non-compulsory) departure payments

	2017/18	
	Payments agreed	Total value of agreements
	Number	£000
Contractual payments in lieu of notice	20	88
Exit payments following Employment Tribunals or court orders	-	-
Total	**20**	**88**
Of which:		
Non-contractual payments requiring HM Treasury approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-

CHAPTER 3 – FINANCIAL STATEMENTS

ANNUAL ACCOUNTS 2017/18

The accounts of Portsmouth Hospitals NHS Trust for the year ended 31 March 2018 have been prepared in accordance with the financial records maintained by the Trust and the accounting standards and policies for the NHS laid down by the Secretary of State with the approval of the Treasury.

The accounts were approved by the Audit Committee, with delegated authority from the Board, at a meeting on the 24th May 2018 and have been audited. The auditor's report is unqualified and is incorporated in the annual report.

EXTERNAL AUDITOR

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

The audit fee for the 2017/18 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 2017/18 and the balance, £20,250, will be charged in 2018/19.

Statement of the chief executive's responsibilities as the accountable officer of the trust

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

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

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

Signed: Chief Executive

Date: 24/05/18

Statement of directors' responsibilities in respect of the accounts

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

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

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

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

By order of the Board

Date: 24/05/18 .....Chief Executive

Date: 24/05/18 .....Finance Director

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

Opinion

We have audited the financial statements of Portsmouth Hospitals NHS Trust for the year ended 31 March 2018 under the Local Audit and Accountability Act 2014. The financial statements comprise the Trust's Statement of Comprehensive Income, the Trust's Statement of Financial Position, the Trust's Statement of Changes in Taxpayers' Equity, the Trust's Statement of Cash Flows and the related notes 1 to 51. 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 2017-18 HM Treasury's Financial Reporting Manual (the 2017-18 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2017/18 and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

In our opinion the financial statements:

- give a true and fair view of the financial position of Portsmouth Hospitals NHS Trust as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the National Health Service Act 2006 and the Accounts Directions issued thereunder.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report below. We are independent of the trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's (C&AG) AGN01 and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Use of our report

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

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the directors use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters prescribed by the Health Services Act 2006

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

Matters on which we are required to report by exception

We 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.
- Proper arrangements to secure economy, efficiency and effectiveness.

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 8 May 2018 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 2018 of £74.703 million over the three year period from 1 April 2015 to 31 March 2018, and therefore has not met its rolling breakeven duty.

Proper arrangements to secure economy, efficiency and effectiveness

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

Basis for qualified conclusion on reporting by exception

The Trust set a surplus budget of £9.203 million for the year ended 31 March 2018, but reported a deficit of £31.773 million in its financial statements for the year then ended. While this deficit is significant, it shows better performance than the revised forecast outturn agreed with NHS Improvement in November 2017 of £36.8 million and represents achievement of the first milestone in the Trust's recovery plan. The Trust reported a cumulative breakeven deficit of £74.703 million as at 31 March 2018, which is the fourth 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.
Significant changes have been made to the Trust's Executive and Non-Executive teams, governance arrangements and reporting and accountability structures since the appointment of a new Chief Executive in year. These changes have been made to address the previously identified weaknesses relating to accountability for finance, lack of engagement with finance across the Trust, and the Board's focus on operational rather than strategic information. These improvements therefore demonstrate improved decision making and support the Trusts ability to deploy resources in a sustainable manner. However, the new arrangements are being embedded, but are not yet delivering significant demonstrable improvements in operational or financial performance.
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 (Except for)

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in August 2017, 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 2018.

Responsibilities of the Directors and Accountable Officer

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. In preparing the financial statements, the Accountable Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accountable Officer either intends to cease operations, or have no realistic alternative but to do so.

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

Auditor's responsibility for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in August 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The 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 2018.

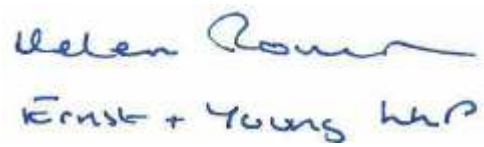
We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in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

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

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

Certificate

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



Helen Thompson
For & on behalf of Ernst & Young LLP
Southampton
29 May 2018

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

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	483,719	471,427
Other operating income	4	59,350	58,955
Operating expenses	6, 8	(555,307)	(531,321)
Operating surplus/(deficit) from continuing operations		**(12,238)**	**(939)**
Finance income	11	55	38
Finance expenses	12	(18,844)	(17,854)
PDC dividends payable		(1,367)	(2,090)
Net finance costs		**(20,156)**	**(19,906)**
Other gains / (losses)	13	(107)	(8)
Surplus / (deficit) for the year		**(32,501)**	**(20,853)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(40)	(18)
Revaluations	18	11,631	7,977
Total comprehensive income / (expense) for the period		**(20,910)**	**(12,894)**
Adjusted financial performance			
Surplus / (deficit) for the year		(32,501)	(20,853)
Add back all I&E Impairments/(Reversals)		(40)	(18)
IFRIC 12 adjustment *		-	2,367
Remove capital donations/grants I&E impact		768	859
Adjusted financial performance - surplus/(deficit)		**(31,773)**	**(17,645)**

* The IFRIC 12 adjustement is not included in the adjusted financial performance from 2017/18. It is shown and explained at note 50 of the accounts

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	15	2,233	2,408
Property, plant and equipment	16	368,991	363,378
Trade and other receivables	24	5,532	7,413
Total non-current assets		**376,756**	**373,199**
Current assets			
Inventories	23	14,340	13,866
Trade and other receivables	24	48,419	33,845
Cash and cash equivalents	27	1,104	5,207
Total current assets		**63,863**	**52,918**
Current liabilities			
Trade and other payables	28	(57,384)	(51,192)
Borrowings	31	(7,946)	(7,257)
Provisions	33	(311)	(220)
Other liabilities	30	(655)	(477)
Total current liabilities		**(66,296)**	**(59,146)**
Total assets less current liabilities		**374,323**	**366,971**
Non-current liabilities			
Borrowings	31	(313,415)	(285,526)
Provisions	33	(1,823)	(1,971)
Total non-current liabilities		**(315,238)**	**(287,497)**
Total assets employed		**59,085**	**79,474**
Financed by			
Public dividend capital		51,428	50,907
Revaluation reserve		134,456	123,094
Income and expenditure reserve		(126,799)	(94,527)
Total taxpayers' equity		**59,085**	**79,474**

The notes on pages 74 to 114 form part of these accounts.

Signed by 

Name Mark Cubbon

Position Chief Executive

Date 24/05/2018

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

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

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**49,560**	**115,195**	**(73,734)**	**91,021**
Surplus/(deficit) for the year	-	-	(20,853)	**(20,853)**
Other transfers between reserves	-	(60)	60	**-**
Impairments	-	(18)	-	**(18)**
Revaluations	-	7,977	-	**7,977**
Public dividend capital received	3,902	-	-	**3,902**
Public dividend capital repaid	(2,555)	-	-	**(2,555)**
Taxpayers' equity at 31 March 2017	**50,907**	**123,094**	**(94,527)**	**79,474**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(12,238)	(939)
Non-cash income and expense:			
Depreciation and amortisation	6.1	18,077	17,436
Net impairments	7	(40)	(18)
Income recognised in respect of capital donations	4	(248)	(158)
(Increase) / decrease in receivables and other assets		(12,022)	527
(Increase) / decrease in inventories		(474)	(834)
Increase / (decrease) in payables and other liabilties		4,292	994
Increase / (decrease) in provisions		29	(17)
Net cash generated from / (used in) operating activities		**(2,624)**	**16,991**
Cash flows from investing activities			
Interest received		52	38
Purchase of intangible assets		(959)	(507)
Purchase of property, plant, equipment and investment property		(9,596)	(8,655)
Sales of property, plant, equipment and investment property		63	13
Net cash generated from / (used in) investing activities		**(10,440)**	**(9,111)**
Cash flows from financing activities			
Public dividend capital received		521	3,902
Public dividend capital repaid		-	(2,555)
Movement on loans from the Department of Health and Social Care		35,014	18,316
Other capital receipts		-	158
Capital element of finance lease rental payments		(617)	(527)
Capital element of PFI, LIFT and other service concession payments		(5,819)	(4,383)
Interest paid on PFI, LIFT and other service concession obligations		(17,123)	(16,357)
Other interest paid		(1,685)	(1,428)
PDC dividend (paid) / refunded		(1,330)	(2,515)
Net cash generated from / (used in) financing activities		**8,961**	**(5,389)**
Increase / (decrease) in cash and cash equivalents		**(4,103)**	**2,491**
Cash and cash equivalents at 1 April - brought forward		**5,207**	**2,716**
Cash and cash equivalents at 31 March	27.1	**1,104**	**5,207**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting convention

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

Note 1.1.2 Going concern

These accounts have been prepared on a going concern basis, in accordance with the definition as set out in section 4 of the GAM which outlines the interpretation of IAS1 'Presentation of Financial Statements' as 'anticipated continuation of the provision of a service in the future, as evidenced by the inclusion of financial provision for that service in published documents'.

The Board has formally reviewed this in view of a cumulative deficit position and planned deficit for 2018/19.

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

The Trust has analysed drivers of the deficit and set out a remedial action plan to recover the trust's financial position over a three year period which was presented to NHS Improvement in November 2017. This is being developed into a medium term financial strategy for the Trust, in three elements: stabilisation, recovery and transformation. The financial strategy will support the overall Trust strategy.

The Trust is also a lead partner within the emerging Portsmouth and South East Hampshire system partnership. An initial system financial framework has been agreed and work has begun on wider system financial planning and recovery to secure financial sustainability in the longer term.

These factors, together with the two year signed contracts in place for 2018/19 with the main commissioners, a 2018/19 budget which is not reliant on accessing the Sustainability & Transformation Fund and a cash forecast for the next twelve months all support the adoption of the going concern concept.

Note 1.2 Critical judgements in applying accounting policies

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

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

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

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

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

Land & Property Valuation. The Trust is required to show its land and property at fair value in its statement of financial position (see notes 1.7 and 1.8).

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

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

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

Note 1.2.1 Sources of estimation uncertainty

There are ongoing discussion in respect of the settlement of ongoing negotiations with Carillion on the PFI commercial arrangements. Settlement had been reached in December at meetings mediated by the Department of Health Private Finance Unit. The legal documentation was being drawn up at the time of the liquidation of Carillion in Janaury. However, the Trust is confident that a robust assessment has been made of the £3.3m benefit of the settlement that has been accounted for in the accounts.

Note 1.3 Interests in other entities

The Trust does not have any interests in other entities.

Note 1.4 Income

Income 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 income for the trust is contracts with commissioners in respect of health care services and education in come from Health Education England. At the year end, the trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

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

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

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

Note 1.5 Expenditure on employee benefits

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

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

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

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

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition
Property, plant and equipment is capitalised where:

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

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

Note 1.7.2 Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. Revaluaitons 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 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 item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

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

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

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

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

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

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

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

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

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

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

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

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

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs 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.

Note 1.7.6 Useful economic lives of property, plant and equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	10	73
Dwellings	25	26
Plant & machinery	5	15
Transport equipment	7	7
Information technology	5	10
Furniture & fittings	15	15

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets

Note 1.8.1 Recognition

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

Internally generated intangible assets

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

Expenditure on research is not capitalised.

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

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

Software

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

Note 1.8.2 Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

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

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

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

Note 1.8.3 Useful economic lives of intangible assets
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	**Max life Years**
Information technology	3	5
Development expenditure	3	5
Websites	3	5
Software licences	3	5
Licences & trademarks	3	5
Patents	3	5
Other (purchased)	3	5
Goodwill	3	5

Note 1.9 Inventories
Inventories are valued at the lower of cost and net realisable value using the first-in first-outcost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Note 1.10 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the trust’s cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.11 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement
Financial assets are categorised as fair value through income and expenditure or loans and receivables.

Financial liabilities are classified as "fair value through income and expenditure" or as "other financial liabilities".

Financial assets and financial liabilities at "fair value through income and expenditure"
Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets
At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

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

Note 1.12.1 The trust as lessee

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

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

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

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

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

Note 1.12.2 The trust as lessor
Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the trust net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trusts' net investment outstanding in respect of the leases.

Operating leases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.13 Provisions

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

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the trust is disclosed at note 33.2 but is not recognised in the trust's accounts.

Non-clinical risk pooling
The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.14 Contingencies
Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 34 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 34, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

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

Note 1.15 Public dividend capital

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

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

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

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

Note 1.16 Value added tax

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

Note 1.17 Third party assets

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

Note 1.18 Losses and special payments

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

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

Note 1.19 Gifts

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

Note 1.20 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.21 Standards, amendments and interpretations in issue but not yet effective or adopted

The DH GAM does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 and IFRS 17 still subject to HM Treasury consideration.

● IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
● IFRS 15 Revenue 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.
● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
● IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018.
● IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

Note 1.22 Subsidiaries

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

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

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

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

Note 2 Operating Segments

The Trust has identified two operating segments relating to the provision of healthcare and pharmacy trading. The vast majority of the Trust's income (£533.4m 98%) is derived from 'non-trading' healthcare. Of the total income, 2% (£9.6m) is generated from the sale of drugs externally to the NHS and private sector. In addition to selling drugs externally, Pharmacy Trading sell drugs internally on a full cost basis.

	Healthcare		Pharmacy Trading		Total	
	2017-18	2016-17	**2017-18**	2016-17	**2017-18**	2016-17
	£000's	£000's	**£000's**	£000's	**£000's**	£000's
Income						
External	**533,427**	520,393	**9,642**	9,838	**543,069**	530,231
Internal	**0**	0	**41,099**	40,163	**41,099**	40,163
Total Income	**533,427**	520,393	**50,741**	50,001	**584,168**	570,394
Expenditure						
Segment costs	**525,982**	502,260	**49,261**	48,520	**575,243**	550,780
Common costs	**41,099**	40,163	**328**	339	**41,427**	40,502
Total Expenditure	**567,081**	542,423	**49,589**	48,859	**616,670**	591,282
Retained surplus/(deficit) for the year	-33,654	-22,030	1,152	1,142	-32,502	-20,888

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	2017/18 £000	2016/17 £000
Acute services		
Elective income	84,306	85,817
Non elective income	141,124	131,655
First outpatient income	43,562	42,344
Follow up outpatient income	36,222	39,059
A & E income	17,837	16,322
High cost drugs income from commissioners (excluding pass-through costs)	46,289	43,210
Other NHS clinical income	106,143	108,772
All services		
Private patient income	3,064	3,273
Other clinical income	5,172	975
Total income from activities	**483,719**	**471,427**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18 £000	2016/17 £000
NHS England	120,537	111,413
Clinical commissioning groups	358,610	355,410
Other NHS providers	288	80
Non-NHS: private patients	3,064	3,273
Non-NHS: overseas patients (chargeable to patient)	392	284
NHS injury scheme	576	339
Non NHS: other	252	628
Total income from activities	**483,719**	**471,427**

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

	2017/18	2016/17
	£000	£000
Income recognised this year	392	284
Cash payments received in-year	231	81
Amounts added to provision for impairment of receivables	93	108
Amounts written off in-year	58	57

Note 4 Other operating income

	2017/18	2016/17
	£000	£000
Research and development	1,805	1,540
Education and training	19,594	19,172
Receipt of capital grants and donations	248	158
Charitable and other contributions to expenditure	98	219
Non-patient care services to other bodies	12,912	13,315
Sustainability and transformation fund income	6,636	6,996
Rental revenue from operating leases	1,731	1,807
Other income *	16,326	15,748
Total other operating income	**59,350**	**58,955**

* Other income includes £9.6m Pharmacy Sales and £3.1m of other income generation schemes

Note 5 Fees and charges

	2017/18	2016/17
	£000	£000
Income	-	-
Full cost	-	-
Surplus / (deficit)	**-**	**-**

Note 6.1 Operating expenses *

	2017/18	2016/17
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	3,287	5,812
Purchase of healthcare from non-NHS and non-DHSC bodies	16,044	12,929
Staff and executive directors costs	316,527	304,923
Remuneration of non-executive directors	66	57
Supplies and services - clinical (excluding drugs costs)	54,149	54,539
Supplies and services - general	2,031	2,123
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	68,289	62,902
Inventories written down	243	-
Consultancy costs	2,611	2,751
Establishment	4,002	3,910
Premises	11,091	12,488
Transport (including patient travel)	576	537
Depreciation on property, plant and equipment	16,943	16,359
Amortisation on intangible assets	1,134	1,077
Net impairments	(40)	(18)
Increase/(decrease) in provision for impairment of receivables	(144)	104
Change in provisions discount rate(s)	20	147
Audit fees payable to the external auditor		
audit services- statutory audit	110	109
other auditor remuneration (external auditor only)	-	-
Internal audit costs	70	67
Clinical negligence	22,181	20,111
Legal fees	392	423
Insurance	294	375
Research and development	3,502	-
Education and training	1,426	1,574
Rentals under operating leases	1,440	1,371
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	27,674	25,843
Hospitality	6	9
Other	1,383	799
Total	**555,307**	**531,321**

* The classification of some lines of expenditure have changed for 2017/18. 2016/17 comparators have been updated as appropriate.

Note 6.2 Other auditor remuneration

There has been no other auditor remuneration.

Note 6.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2017/18 or 2016/17.

Note 7 Impairment of assets

	2017/18	2016/17
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	(40)	(18)
Other	-	-
Total net impairments charged to operating surplus / deficit	**(40)**	**(18)**
Impairments charged to the revaluation reserve	40	18
Total net impairments	**-**	**-**

Note 8 Employee benefits

	2017/18	2016/17
	Total	Total
	£000	£000
Salaries and wages	227,750	221,953
Social security costs	22,423	21,843
Apprenticeship levy	1,148	-
Employer's contributions to NHS pensions	27,953	27,337
Pension cost - other	-	-
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	-	37
Temporary staff (including agency)	41,519	34,330
Total gross staff costs	**320,793**	**305,500**
Recoveries in respect of seconded staff	**-**	-
Total staff costs	**320,793**	**305,500**
Of which		
Costs capitalised as part of assets	764	577

Note 8.1 Retirements due to ill-health

During 2017/18 there were 2 early retirements from the Trust agreed on the grounds of ill-health (3 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £85k (£153k in 2016/17).

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

Note 9 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The 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 employee and employer representatives as deemed appropriate.

Note 10 Operating leases

Note 10.1 Portsmouth Hospitals NHS Trust as a lessor

This note discloses income generated in operating lease agreements where Portsmouth Hospitals NHS Trust is the lessor.

This mainly relates to the sub-leases of the Rehab Building to Solent NHS Trust, the Quad Building to University of Southampton, the Gym Building and Fort Southwick Building 3 to NHS Property Services Ltd and the PET Scanner Unit to Alliance.

	2017/18	2016/17
	£000	£000
Operating lease revenue		
Minimum lease receipts	1,731	1,807
Contingent rent	-	-
Other	-	-
Total	**1,731**	**1,807**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	1,492	1,803
- later than one year and not later than five years;	1,308	2,705
- later than five years.	602	1,042
Total	**3,402**	**5,550**

Note 10.2 Portsmouth Hospitals NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Portsmouth Hospitals NHS Trust is the lessee.

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

- Railway Triangle lease - used for Pharmacy Manufacture, the lease period is for 30 years (expires 2036) and has an annual lease value of £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 £491,000.

	2017/18	2016/17
	£000	£000
Operating lease expense		
Minimum lease payments	1,440	1,371
Total	**1,440**	**1,371**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease payments due:		
- not later than one year;	1,440	1,258
- later than one year and not later than five years;	3,098	2,027
- later than five years.	2,264	2,264
Total	**6,802**	**5,549**
Future minimum sublease payments to be received	-	-

Note 11 Finance income

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

	2017/18	2016/17
	£000	£000
Interest on bank accounts	55	38
Other finance income	-	-
Total	**55**	**38**

Note 12.1 Finance expenditure

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

	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	1,791	1,420
Interest on late payment of commercial debt	16	8
Main finance costs on PFI and LIFT schemes obligations	12,251	12,480
Contingent finance costs on PFI and LIFT scheme obligations	4,872	3,877
Total interest expense	**18,930**	**17,785**
Unwinding of discount on provisions	(86)	69
Other finance costs	-	-
Total finance costs	**18,844**	**17,854**

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

	2017/18	2016/17
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	16	8

Note 13 Other gains / (losses)

	2017/18	2016/17
	£000	£000
Gains on disposal of assets	32	8
Losses on disposal of assets	(139)	(16)
Total gains / (losses) on disposal of assets	(107)	(8)
Gains / (losses) on foreign exchange	-	-
Fair value gains / (losses) on investment properties	-	-
Fair value gains / (losses) on financial assets / investments	-	-
Fair value gains / (losses) on financial liabilities	-	-
Recycling gains / (losses) on disposal of available-for-sale financial investments	-	-
Total other gains / (losses)	**(107)**	**(8)**

Note 14 Discontinued operations

There are no discontinued operations.

Note 15.1 Intangible assets - 2017/18

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

Note 15.2 Intangible assets - 2016/17

	Software licences	Other (purchased)	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2016 - brought forward	**7,224**	**-**	**7,224**
Additions	510	-	**510**
Valuation / gross cost at 31 March 2017	**7,734**	**-**	**7,734**
Amortisation at 1 April 2016 - brought forward	**4,249**	**-**	**4,249**
Provided during the year	**1,077**	**-**	**1,077**
Amortisation at 31 March 2017	**5,326**	**-**	**5,326**
Net book value at 31 March 2017	**2,408**	**-**	**2,408**
Net book value at 1 April 2016	**2,975**	**-**	**2,975**

Note 16.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**24,429**	**312,506**	**3,609**	**-**	**75,289**	**79**	**25,449**	**3,259**	**444,620**
Additions	-	4,715	-	-	4,564	-	1,816	-	**11,095**
Impairments	-	(40)	-	-	-	-	-	-	**(40)**
Revaluations	896	10,676	(290)	-	1,056	1	-	53	**12,392**
Disposals / derecognition	-	-	-	-	(2,438)	-	(8)	-	**(2,446)**
Valuation/gross cost at 31 March 2018	**25,325**	**327,857**	**3,319**	**-**	**78,471**	**80**	**27,257**	**3,312**	**465,621**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**8,032**	**131**	**-**	**53,417**	**77**	**17,835**	**1,750**	**81,242**
Provided during the year	**-**	**8,336**	**139**	**-**	**5,705**	**1**	**2,525**	**237**	**16,943**
Reversals of impairments	-	(40)	-	-	-	-	-	-	**(40)**
Revaluations	-	-	-	-	732	1	-	28	**761**
Disposals / derecognition	-	-	-	-	(2,268)	-	(8)	-	**(2,276)**
Accumulated depreciation at 31 March 2018	**-**	**16,328**	**270**	**-**	**57,586**	**79**	**20,352**	**2,015**	**96,630**
Net book value at 31 March 2018	**25,325**	**311,529**	**3,049**	**-**	**20,885**	**1**	**6,905**	**1,297**	**368,991**
Net book value at 1 April 2017	**24,429**	**304,474**	**3,478**	**-**	**21,872**	**2**	**7,614**	**1,509**	**363,378**

Note 16.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**23,950**	**301,122**	**3,318**	**-**	**71,978**	**78**	**23,556**	**3,211**	**427,213**
Prior period adjustments	-	-	-	-	(74)	-	-	-	**(74)**
Valuation / gross cost at 1 April 2016 - restated	**23,950**	**301,122**	**3,318**	**-**	**71,904**	**78**	**23,556**	**3,211**	**427,139**
Additions	-	4,355	210	-	3,175	-	1,970	-	**9,710**
Impairments	-	(18)	-	-	-	-	-	-	**(18)**
Revaluations	479	7,047	81	-	975	1	-	48	**8,631**
Disposals / derecognition	-	-	-	-	(765)	-	(77)	-	**(842)**
Valuation/gross cost at 31 March 2017	**24,429**	**312,506**	**3,609**	**-**	**75,289**	**79**	**25,449**	**3,259**	**444,620**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**-**	**-**	**-**	**47,884**	**76**	**15,614**	**1,494**	**65,068**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2016 - restated	**-**	**-**	**-**	**-**	**47,884**	**76**	**15,614**	**1,494**	**65,068**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Provided during the year	**-**	**8,050**	**131**	**-**	**5,646**	**1**	**2,298**	**233**	**16,359**
Reversals of impairments	-	(18)	-	-	-	-	-	-	**(18)**
Revaluations	-	-	-	-	631	-	-	23	**654**
Disposals/ derecognition	-	-	-	-	(744)	-	(77)	-	**(821)**
Accumulated depreciation at 31 March 2017	**-**	**8,032**	**131**	**-**	**53,417**	**77**	**17,835**	**1,750**	**81,242**
Net book value at 31 March 2017	**24,429**	**304,474**	**3,478**	**-**	**21,872**	**2**	**7,614**	**1,509**	**363,378**
Net book value at 1 April 2016	**23,950**	**301,122**	**3,318**	**-**	**24,020**	**2**	**7,942**	**1,717**	**362,071**

Note 16.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	25,325	4,611	3,049	-	18,195	1	6,873	1,297	**59,351**
Finance leased	-	-	-	-	949	-	-	-	**949**
On-SoFP PFI contracts and other service concession arrangements	-	302,563	-	-	-	-	-	-	**302,563**
Owned - donated	-	4,355	-	-	1,741	-	32	-	**6,128**
NBV total at 31 March 2018	**25,325**	**311,529**	**3,049**	**-**	**20,885**	**1**	**6,905**	**1,297**	**368,991**

Note 16.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017									
Owned - purchased	24,429	5,013	3,478	-	18,360	2	7,567	1,509	**60,358**
Finance leased	-	-	-	-	1,577	-	-	-	**1,577**
On-SoFP PFI contracts and other service concession arrangements	-	295,250	-	-	-	-	-	-	**295,250**
Owned - donated	-	4,211	-	-	1,935	-	47	-	**6,193**
NBV total at 31 March 2017	**24,429**	**304,474**	**3,478**	**-**	**21,872**	**2**	**7,614**	**1,509**	**363,378**

Note 17 Donations of property, plant and equipment

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

Note 18 Revaluations of property, plant and equipment

All land and buildings have been restated to modern equivalent asset value based on a valuation carried out in March 2015, refreshed by a desktop valuation at 31st March 2018 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 asset lives as set out at note 1.7.6.

Gross carrying amount of fully depreciated assets still in use is £41.7m

Note 19 Investment Property

The trust does not hold any investment property.

Note 20 Investments in associates and joint ventures

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

Note 21 Other investments / financial assets

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

Note 22 Disclosure of interests in other entities

The Trust does not have any interests in other parties.

Note 23 Inventories

	2018	2017
	£000	£000
Drugs	6,544	6,126
Consumables	7,796	7,740
Total inventories	**14,340**	**13,866**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £103,855k (2016/17: £101,021k). Write-down of inventories recognised as expenses for the year were £243k (2016/17: £0k).

Note 24 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	26,482	18,326
Provision for impaired receivables	(799)	(1,028)
Prepayments (non-PFI)	5,219	2,544
PFI lifecycle prepayments	6,970	4,522
Interest receivable	4	1
PDC dividend receivable	-	5
VAT receivable	3,303	2,981
Other receivables	7,240	6,494
Total current trade and other receivables	**48,419**	**33,845**
Non-current		
PFI lifecycle prepayments	4,509	6,284
Other receivables	1,023	1,129
Total non-current trade and other receivables	**5,532**	**7,413**
Of which receivables from NHS and DHSC group bodies:		
Current	22,769	14,118
Non-current	-	-

Note 24.1 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	**1,028**	**967**
Prior period adjustments	-	-
At 1 April - restated	**1,028**	**967**
Transfers by absorption	-	-
Increase in provision	(30)	34
Amounts utilised	(85)	(43)
Unused amounts reversed	(114)	70
At 31 March	**799**	**1,028**

Note 24.2 Credit quality of financial assets

	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	£000	£000	£000	£000
0 - 30 days	-	-	-	-
30-60 Days	-	-	-	-
60-90 days	-	-	-	-
90- 180 days	-	-	-	-
Over 180 days	799	-	1,028	-
Total	**799**	**-**	**1,028**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	4,792	-	2,107	-
30-60 Days	888	-	592	-
60-90 days	768	-	458	-
90- 180 days	924	-	1,137	-
Over 180 days	1,069	-	839	-
Total	**8,441**	**-**	**5,133**	**-**

Note 25 Other assets

The Trust does not hold any other assets than those already detailed.

Note 26 Non-current assets held for sale and assets in disposal groups

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

Note 26.1 Liabilities in disposal groups

The Trust does not have any liabilities in disposal groups.

Note 27.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2017/18	2016/17
	£000	£000
At 1 April	**5,207**	**2,716**
Net change in year	(4,103)	2,491
At 31 March	**1,104**	**5,207**
Broken down into:		
Cash at commercial banks and in hand	50	59
Cash with the Government Banking Service	1,054	5,148
Total cash and cash equivalents as in SoFP	**1,104**	**5,207**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**1,104**	**5,207**

Note 27.2 Third party assets held by the trust

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

Note 28.1 Trade and other payables

	2018	2017
	£000	£000
Current		
Trade payables	9,432	9,436
Capital payables	4,550	2,626
Accruals	3,964	2,104
Social security costs	3,267	3,147
Other taxes payable	2,877	2,716
PDC dividend payable	32	-
Accrued interest on loans	136	14
Other payables	33,126	31,149
Total current trade and other payables	**57,384**	**51,192**
Non-current		
Other payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	7,529	6,519
Non-current	-	-

Note 28.2 Early retirements in NHS payables above

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

	2018	2018	2017	2017
	£000	Number	£000	Number
years	-		-	
- number of cases involved		-		-
- outstanding pension contributions	**2,344**		2,253	

Note 29 Other financial liabilities

The Trust does not have any other financial liabilities.

Note 30 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	655	477
Total other current liabilities	**655**	**477**
Non-current		
Other non-current liabilities	-	-
Total other non-current liabilities	**-**	**-**

Note 31 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Loans from the Department of Health and Scoial Care	820	820
Obligations under finance leases	246	618
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	6,880	5,819
Total current borrowings	**7,946**	**7,257**
Non-current		
Loans from the Department of Health and Scoial Care	91,185	56,171
Obligations under finance leases	576	821
Obligations under PFI, LIFT or other service concession contracts	221,654	228,534
Total non-current borrowings	**313,415**	**285,526**

Note 32 Finance leases

Note 32.1 Portsmouth Hospitals NHS Trust as a lessor

Future lease receipts due under finance lease agreements where Portsmouth Hospitals NHS Trust is the lessor:

	31 March 2018 £000	31 March 2017 £000
Gross lease receivables	**-**	**-**
of which those receivable:		
- not later than one year;	-	-
- later than one year and not later than five years;	-	-
- later than five years.	-	-
Unearned interest income	-	-
Allowance for uncollectable lease payments	-	-
Net lease receivables	**-**	**-**
of which those receivable:		
- not later than one year;	-	-
- later than one year and not later than five years;	-	-
- later than five years.	-	-
The unguaranteed residual value accruing to the lessor	-	-
Contingent rents recognised as income in the period	-	-

Note 32.2 Portsmouth Hospitals NHS Trust as a lessee

Obligations under finance leases where Portsmouth Hospitals NHS Trust is the lessee.

	31 March 2018 £000	31 March 2017 £000
Gross lease liabilities	**822**	**1,439**
of which liabilities are due:		
- not later than one year;	246	618
- later than one year and not later than five years;	576	821
- later than five years.	-	-
Finance charges allocated to future periods	-	-
Net lease liabilities	**822**	**1,439**
of which payable:		
- not later than one year;	246	618
- later than one year and not later than five years;	576	821
- later than five years.	-	-
Total of future minimum sublease payments to be received at the reporting date	**-**	**-**
Contingent rent recognised as an expense in the period	-	-

Note 33.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs *	Legal claims **	Total
	£000	£000	£000
At 1 April 2017	**2,081**	**110**	**2,191**
Transfers by absorption	-	-	**-**
Change in the discount rate	20	-	**20**
Arising during the year	-	167	**167**
Utilised during the year	(77)	(13)	**(90)**
Reclassified to liabilities held in disposal groups	-	-	**-**
Reversed unused	(5)	(63)	**(68)**
Unwinding of discount	(86)	-	**(86)**
At 31 March 2018	**1,933**	**201**	**2,134**
Expected timing of cash flows:			
- not later than one year;	110	201	**311**
- later than one year and not later than five years;	440	-	**440**
- later than five years.	1,383	-	**1,383**
Total	**1,933**	**201**	**2,134**

* 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.

Note 33.2 Clinical negligence liabilities

At 31 March 2018, £410,842k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Portsmouth Hospitals NHS Trust (31 March 2017: £389,023k).

Note 34 Contingent assets and liabilities

	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities		
Legal Claims	(63)	(47)
Gross value of contingent liabilities	**(63)**	**(47)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(63)**	**(47)**
Net value of contingent assets	-	-

Note 35 Contractual capital commitments

The Trust has no contractual capital commitments.

Note 36 Other financial commitments

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

Note 37 On-SoFP PFI, LIFT or other service concession arrangements

Note 37.1 Imputed finance lease obligations

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

	31 March 2018 £000	31 March 2017 £000
Gross PFI, LIFT or other service concession liabilities	**388,359**	**406,428**
Of which liabilities are due		
- not later than one year;	18,826	18,069
- later than one year and not later than five years;	73,748	72,986
- later than five years.	295,785	315,373
Finance charges allocated to future periods	(159,825)	(172,075)
Net PFI, LIFT or other service concession arrangement obligation	**228,534**	**234,353**
- not later than one year;	6,880	5,819
- later than one year and not later than five years;	29,528	27,337
- later than five years.	192,126	201,197

Note 37.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

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

	31 March 2018 £000	31 March 2017 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	1,319,022	1,380,350
Of which liabilities are due:		
- not later than one year;	57,979	58,120
- later than one year and not later than five years;	231,916	232,480
- later than five years.	1,029,127	1,089,750

Note 37.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the trust's payments in 2017/18:

	2017/18 £000	2016/17 £000
Unitary payment payable to service concession operator	54,591	50,556
Consisting of:		
- Interest charge	12,251	12,480
- Repayment of finance lease liability	5,819	4,383
- Service element and other charges to operating expenditure	27,091	25,480
- Capital lifecycle maintenance	3,303	3,973
- Revenue lifecycle maintenance	583	363
- Contingent rent	4,872	3,877
- Addition to lifecycle prepayment	672	-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	-	-
Total amount paid to service concession operator	**54,591**	**50,556**

Note 38 Off-SoFP PFI, LIFT and other service concession arrangements

The Trust does not have any off SFP PFI, LIFT or other service concession arrangements.

Note 39 Financial instruments

Note 39.1 Financial risk management

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

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

The Trust was reliant on accessing Interim Deficit Financing cash in 2017/18 from the Department of Health and anticipates relying on those loans in 2018/19. Access to the financing facility is not guaranteed and should these not be available the Trust will be required to manage it's liquidity position through working capital measures (such as further restrictions of payment runs).

All loans received are from the Department of Health and as such the Trust is not exposed to significant interest rate risk.

Whilst the Trust does conduct some foreign currency transactions, these are not of sufficient value or volume to present a risk from currency exchange rate variations.

Note 39.2 Carrying values of financial assets

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

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2017					
Trade and other receivables excluding non financial assets	22,508	-	-	-	**22,508**
Cash and cash equivalents at bank and in hand	5,207	-	-	-	**5,207**
Total at 31 March 2017	**27,715**	**-**	**-**	**-**	**27,715**

Note 39.3 Carrying value of financial liabilities

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018			
Borrowings excluding finance lease and PFI liabilities	92,005	-	**92,005**
Obligations under finance leases	822	-	**822**
Obligations under PFI, LIFT and other service concession contracts	228,534	-	**228,534**
Trade and other payables excluding non financial liabilities	51,242	-	**51,242**
Total at 31 March 2018	**372,603**	**-**	**372,603**

Note 39.3 Carrying value of financial liabilities (continued)

	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total book value £000
Liabilities as per SoFP as at 31 March 2017			
Borrowings excluding finance lease and PFI liabilities	56,991	-	**56,991**
Obligations under finance leases	1,439	-	**1,439**
Obligations under PFI, LIFT and other service concession contracts	234,353	-	**234,353**
Trade and other payables excluding non financial liabilities	45,327	-	**45,327**
Total at 31 March 2017	**338,110**	**-**	**338,110**

Note 39.4 Maturity of financial liabilities

	31 March 2018 £000	31 March 2017 £000
In one year or less	59,188	52,583
In more than one year but not more than two years	18,993	7,945
In more than two years but not more than five years	101,175	76,384
In more than five years	193,247	201,198
Total	**372,603**	**338,110**

Note 40 Losses and special payments

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	14	6	7	0
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	257	79	491	74
Stores losses and damage to property	3	283	3	109
Total losses	**274**	**368**	**501**	**183**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	1	18
Extra-contractual payments	-	-	-	-
Ex-gratia payments	120	60	86	102
Special severence payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**120**	**60**	**87**	**119**
Total losses and special payments	**394**	**428**	**588**	**303**
Compensation payments received		-		-

Note 41 Gifts

The Trust has not made any gifts.

Note 42 Related parties

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

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

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

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£	£	£	£
NHS Coastal West Sussex CCG	0	7,930	621	0
NHS England (Wessex Local Office)	0	12,558	646	0
NHS England (Wessex Commissioning Hub)	0	104,165	0	5,583
NHS Fareham and Gosport CCG	200	109,759	756	1,073
NHS Portsmouth CCG	40	121,581	1,057	2,680
NHS Resolution (formerly NHS Litigation Authority)	22,451	0	0	0
NHS South Eastern Hampshire CCG	209	100,713	539	1,477
NHS West Hampshire CCG	0	9,934	0	133
University Hospitals Southampton NHS Foundation Trust	1,378	8,921	949	2,344
Health Education England	23	17,153	0	22

Note 43 Transfers by absorption

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

Note 44 Prior period adjustments

There have been no priori period adjustments.

Note 45 Events after the reporting date

There no events after the reporting date to report.

Note 46 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	99,396	277,813	101,316	251,585
Total non-NHS trade invoices paid within target	63,750	218,090	95,490	231,674
Percentage of non-NHS trade invoices paid within target	64.14%	78.50%	94.25%	92.09%
NHS Payables				
Total NHS trade invoices paid in the year	2,484	12,775	2,546	13,983
Total NHS trade invoices paid within target	2,025	9,717	2,130	11,801
Percentage of NHS trade invoices paid within target	81.52%	76.06%	83.66%	84.40%

The Better Payment Practice code requires the NHS body to aim to pay 95% of valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later. The Trust did not meet this target, primarily due to payment run restrictions as part of the in year management of working capital.

Note 47 External financing

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

	2017/18 £000	2016/17 £000
Cash flow financing	**33,202**	12,420
Finance leases taken out in year	**0**	825
Other capital receipts	**0**	-158
External financing requirement	**33,202**	13,087
External financing limit (EFL)	**34,045**	19,122
Under / (over) spend against EFL	**843**	6,035

Note 48 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	12,054	10,222
Less: Disposals	(170)	(21)
Less: Donated and granted capital additions	(248)	(158)
Charge against Capital Resource Limit	11,636	10,043
Capital Resource Limit	12,921	14,245
Under / (over) spend against CRL	1,285	4,202

Note 49 Breakeven duty financial performance

	2017/18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(31,773)
Remove impairments scoring to Departmental Expenditure Limit	-
Add back income for impact of 2016/17 post-accounts STF reallocation	-
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	1,072
Breakeven duty financial performance surplus / (deficit)	(30,701)

Note 50 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
		£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		(14,877)	159	148	4,293	830	(2,912)	(23,477)	(17,645)	(30,701)
Breakeven duty cumulative position	9,479	(5,398)	(5,239)	(5,091)	(798)	32	(2,880)	(26,357)	(44,002)	(74,703)
Operating income		432,167	446,161	440,231	451,906	469,094	484,463	504,572	530,382	543,069
Cumulative breakeven position as a percentage of operating income		-1.25%	-1.17%	-1.16%	-0.18%	0.01%	-0.59%	-5.22%	-8.30%	-13.76%

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

Salary and Pension entitlements of senior managers 2017/18

Name	Title	Start date/leaving date (where not in post for full year)	2017/18						2016/17					
			Salary (bands of £5,000) £000	Expenses Payments (Taxable) (total to nearest £100)	Performance Pay and Bonuses (bands of £5,000)	Long Term Performance Pay and Bonuses (bands of £5,000)	All Pension Related Benefits (bands of £2,500)	TOTAL (bands of £5,000)	Salary (bands of £5,000) £000	Expenses Payments (Taxable) (total to nearest £100)	Performance Pay and Bonuses (bands of £5,000)	Long Term Performance Pay and Bonuses (bands of £5,000)	All Pension Related Benefits (bands of £2,500)	TOTAL (bands of £5,000)
Executive Directors in post at 31st March 2018														
Mark Cubbon	Chief Executive	From 31/07/17	115-120	-	-	-	-	115-120	-	-	-	-	-	-
John Knighton	Medical Director	From 11/06/17	130-135 *	-			160-162.5	295-300	-	-	-	-	-	-
Adcock Chris	Director of Finance		160-165	-	-	-	40-42.5	205-210	160-165	-	-	-	17.5-20	180-185
Tim Powell	Director of Workforce & Organisational Development (Interim Chief Executive from 27/05/16 to 31/07/17)	Change in year - see Title	160-165	-	-	-	17.5-20	180-185	145-150	-	-	-	70-72.5	220-225
Paul Bytheway	Chief Operating Officer	From 01/11/17	60-65	-	-	-	40-42.5	100-105	-	-	-	-	-	-
Theresa Murphy	Chief Nurse	From 01/01/18	30-35	-	-	-	15-17.5	50-55	-	-	-	-	-	-
Penny Emerit	Director of Strategy and Performance	From 08/01/18	30-35	-	-	-	5-7.5	35-40	-	-	-	-	-	-
Lois Howell	Director of Integrated Governance	From 02/01/18	25-30	-	-	-	0-2.5	25-30	-	-	-	-	-	-
Emma McKinney	Director of Communications	From 04/12/17	25-30	-	-	-	-	25-30	-	-	-	-	-	-
Executive Directors who left during the year														
Simon Holmes	Medical Director	Until 11/06/17	40-45 **	-	-	-	0-2.5	40-45	185-190 *	-	-	-	90-92.5	275-280
Rob Haigh	Director of Unscheduled Care from 18/07/16 to 22/10/17)		115-120 ***	700	-	-	32.5-35	150-155	145-150 **	800	-	-	10-12.5	160-162.5
Nicola Ryley	Interim Director of Nursing from 22/05/17 to 18/08/17		30-35	-	-	-	-	30-35	-	-	-	-	-	-
Rebecca Kopecek	Interim Director of Workforce and Organisational Development from 27/05/16 to 31/07/17		30-35	-	-	-	12.5-15	45-50	80-85	-	-	-	132.5-135	215-220
Sheila Roberts	Interim Chief Operating Officer from 06/02/17 to 30/09/17		85-90	-	-	-	-	85-90	60-65	-	-	-	-	60-65
Cathy Stone	Director of Nursing until 31/03/17		-	-	-	-	-	-	120-125	-	-	-	2.5-5	125-130
Ursula Ward	Chief Executive until 26/05/16; Preceding Chief Executive until 20/12/2016	Until 20/12/2016	-	-	-	-	-	-	130-135	3,600	-	-	0-2.5	130-135
Simon Jupp	Director of Strategy until 02/01/17; Executive Director on secondment to Solent NHS Trust from 03/01/17		-	-	-	-	-	-	130-135	-	-	-	7.5-10	140-145
Ed Donald	Chief Operating Officer until 02/01/17; Executive Director from 03/01/17		-	-	-	-	-	-	145-150	-	-	-	-	145-150
Non- Executive Directors in post at 31st March 2018														
Melloney Poole	Chair (Non-Executive Director from 01/05/18 until 01/11/17)	From 01/05/17	15-20	-	-	-	-	15-20	-	-	-	-	-	-
Christine Slaymaker	Non-Executive Director	From 15/05/17	05-10	900	-	-	-	5-10	-	-	-	-	-	-
David Parfitt	Non-Executive Director	From 15/05/17	05-10	700	-	-	-	5-10	-	-	-	-	-	-
Gary Hay	Non-Executive Director	From 01/01/18	0-5	-	-	-	-	0-5	-	-	-	-	-	-
Jon Watson	Non-Executive Director	From 07/12/17	0-5	-	-	-	-	0-5	-	-	-	-	-	-
Non- Executive Directors who left during the year														
Greg Brown	Non- Executive Director	From 07/12/17 until 15/03/18	0-5	-	-	-	-	0-5						
Sir Ian Carruthers	Chair	Until 16/06/17	5-10	1,200	-	-	-	5-10	20-25	3,000	-	-	-	25-30
Nellthorp Mark	Non- Executive Director (Interim Chair 19/06/17 to 31/10/17)	Until 30/11/17	10-15	-	-	-	-	10-15	05-10	-	-	-	-	5-10
Conway Elizabeth	Non- Executive Director	Until 28/04/17	0-5	-	-	-	-	0-5	05-10	300	-	-	-	5-10
Erskine Steve	Non- Executive Director Until 31/03/17		-	-	-	-	-	-	05-10	1,800	-	-	-	5-10
Michael Attenborough-Cox	Non- Executive Director	Until 31/10/17	0-5	200	-	-	-	0-5	05-10	1,300	-	-	-	5-10
John Smith	Non- Executive Director until 24/03/17		-	-	-	-	-	-	05-10	1,400	-	-	-	5-10

* Medical Director salary includes remuneration for work other than management responsibilities of £55k-£60k
** Former Medical Director includes remuneration for work other than management responsibilities of £5k-£10k (2016/17 £35k-40k)
*** Director of Unscheduled Care includes remuneration for work other than management responsibilities of £30k-£35k (2016/17 £30k-35k)

Signed: Chief Executive: _____

Date: 29th May 2018

Salary and Pension entitlements of senior managers

B) Pension Benefits

Name	Title	Real increase in pension at retirement age (bands of £2,500) £000	Real increase in pension lump sum at retirement age (bands of £2,500) £000	Total accrued pension at 31/03/2018 (bands of £5,000) £000	Lump sum at pension age related to accrued pension 31/03/2018 (bands of £5,000) £000	Cash equivalent transfer value 31/03/2018 £000	Cash equivalent transfer value 31/03/2017 £000	Real increase in cash equivalent transfer value **** (bands of £5,000) £000	Employers Contribution to Stakeholder Pension* To nearest £100
Mark Cubbon **	Chief Executive								
John Knighton	Medical Director	7.5-10	17.5-20	60-65	175-180	1,170	961	205-210	0
Adcock Chris	Director of Finance	2.5-5	0-2.5	40-45	100-105	666	737	(70)-(75)	0
Tim Powell	Director of Workforce & Organisational Development (Interim Chief Executive from 27/05/16 to 31/07/17)	0-2.5	0.00	15-20	0 ***	224	191	30-35	0
Paul Bytheway	Chief Operating Officer	0-2.5	0-2.5	30-35	70-75	439	351	35-40	0
Theresa Murphy	Chief Nurse	0-2.5	2.5-5	40-45	130-135	836	724	25-30	0
Penny Emerit	Director of Strategy and Performance	0-2.5	0-2.5	20-25	40-45	233	209	0-5	0
Lois Howell	Director of Integrated Governance	0-2.5	0-2.5	5-10	20-25	131	119	10-15	0.0
Emma McKinney **	Director of Communications								

* The Trust has not made contributions to stakeholder pensions
** the NHS Pensions Agency were unable to supply the required information for these officers within the time available
*** No lump sum is shown for employees who only have membership in the 2008 Section of the NHS Pension Scheme.
**** For those officers who joined part way through the year, only the increase relating to the time worked at Portsmouth Hospitals NHS Trust is shown

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

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

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

Signed: Chief Executive: 

Date: 29th May 2018