Portsmouth Hospitals University NHS Trust Annual Report 2020/2021

Annual report and accounts 2020/2021

Contents

WELCOME **4**

1. PERFORMANCE REPORT 6
   - *1.1 Statement from Chief Executive Officer on organisational performance* *6*
   - *1.2 About the Trust* *7*
   - *1.3 Working alongside military personnel* *8*
   - *1.4 Research and innovation* *9*
   - *1.5 Charity support* *10*
   - *1.6 Private Patients* *11*
   - *1.7 Care Quality Commission* *11*
   - *1.8 Organisational structure* *11*
   - *1.9 Strategic direction* *12*
   - *1.10 Key issues and risks* *13*
   - *1.11 Adoption of going concern* *14*
   - *1.12 Performance summary* *15*
   - *1.13 Performance analysis* *15*
   - *1.14 Emergency preparedness, resilience and response* *16*
   - *1.15 Financial performance* *18*
2. ACCOUNTABILITY REPORT 20
   - *2.1 Corporate Governance Report and Directors' Accountability Report* *20*
   - *2.2 Portsmouth Hospitals University NHS Trust Board of Directors* *20*
   - *2.3 Executive Director pay* *27*
   - *2.4 Board Effectiveness* *27*
   - *2.5 Audit Committee* *28*
   - *2.6 Counter-Fraud* *28*
   - *2.7 Cost allocation / setting of charges for information* *28*
   - *2.8 Information Governance* *28*
   - *2.9 Directors' confirmation concerning audit information* *29*
3. ANNUAL GOVERNANCE STATEMENT 30
   - *3.1 Scope of responsibility* *30*
   - *3.2 The purpose of the system of internal control* *30*
   - *3.3 Capacity to handle risk* *30*
   - *3.4 The Risk and Control Framework* *31*
   - *3.5 Risk management in practice* *32*
   - *3.6 Risk management responsibility* *32*
   - *3.7 Risk registers* *33*
   - *3.8 Risk appetite* *33*
   - *3.9 Significant risks* *33*
   - *3.10 Risks to compliance with condition 4 of the Trust's NHS provider licence* *35*
   - *3.11 Quality governance arrangements* *36*
   - *3.12 Equality, diversity and human rights* *37*
   - *3.13 Developing workforce safeguards* *38*
   - *3.14 Trust Board* *39*
   - *3.15 Care Quality Commission* *43*
   - *3.16 Quality Account* *44*
   - *3.17 NHS Pension Scheme governance* *44*
   - *3.18 Carbon reduction* *45*
   - *3.19 Review of economy, efficiency and effectiveness of the use of resources* *45*
   - *3.20 Corporate governance* *46*
   - *3.21 Financial governance* *46*
   - *3.22 Information governance* *46*
   - *3.23 Information governance incidents* *47*
   - *3.24 Review of effectiveness of risk management and internal control* *50*
   - *3.25 Significant internal control issues* *51*
   - *3.26 Conclusion* *51*

4. REMUNERATION AND STAFF REPORT 52
4.1 Investing in staff and workforce *52*
4.2 Remuneration Committee *52*
4.3 Remuneration policy *52*
4.4 Remuneration tables (audited) *52*
4.5 Pension liabilities *52*
4.6 Resourcing *53*
4.7 Volunteers *53*
4.8 Health, safety and wellbeing *54*
4.9 Raising staff concerns *55*
4.10 Fair pay policy (audited) *56*
4.11 Staff engagement and consultation *57*
4.12 The NHS National Staff Survey 2020 .... *58*
4.13 Improving Staff Engagement *59*
4.14 Quarterly Staff Friends and Family Survey *59*
4.15 Workforce Race Equality Standard (WRES) *60*
4.16 Workforce Disability Equality Standard (WDES) *60*
4.17 Gender Pay Gap report *61*
4.18 Off-payroll engagements *61*
4.19 Exit packages (audited) *62*
4.20 Expenditure on consultancy *62*
5. FINANCIAL STATEMENTS 63

WELCOME

Given the remarkable response of our colleagues and partners during the COVID-19 pandemic, we would like to open this report with a message of gratitude. It will come as no surprise that the pandemic affected everyone working at Portsmouth Hospitals University NHS Trust (PHU) during 2020-21, both personally and professionally, yet the incredible support and dedication shown by our teams has meant we were still able to continue providing safe compassionate care to our patients and also each other.

The two 'waves' of the virus, experienced across the country, brought with them extraordinary challenges for our staff across PHU, who rose to them time and again. We have seen teams and individuals achieve incredible results, rapidly transforming our inpatient services to care for significant numbers of people acutely unwell with COVID-19. At the peak of the second wave, 60 per cent of our inpatient beds at Queen Alexandra Hospital were being used to care for people with COVID-19, and we increased our baseline intensive care capacity to 320 per cent of its standard baseline.

We cannot thank or praise enough every single colleague who played their part in this response. Their flexibility and willingness to redeploy to areas, roles and tasks that were not familiar to them and – crucially – their readiness to support each other and work together as one team, in spite of their own personal worries and concerns, was simply second to none.

Of course, the ramifications of COVID-19 are wide-ranging. Colleagues across PHU have worked tirelessly to transform services to ensure our patients can continue to access the care and treatment they need. Establishing effective digital outpatient clinics, where appropriate for patient care, has meant we can continue to see those who need us while keeping patients and colleagues as safe as possible.
Working with our partners in primary care to offer 'Advice and Guidance', a system which allows them to seek advice from a clinician prior to referring a patient, has led to improved waiting times for those who were referred, while others have received timely and appropriate care from their GP.

Similarly, we have responded innovatively in the ways we work with our partners. We piloted and implemented a comprehensive triage approach through the 'NHS 111 First' model, which ensures patients access the urgent care service that best meets their needs by directing them to the most appropriate care setting. Queen Alexandra Hospital then became the first in the country to implement a new 111 streaming tool, delivered through collaboration with NHS Digital and South Central Ambulance Service NHS Foundation Trust (SCAS).

In this challenging context, we have made strong progress strategically throughout 2020-21, both as an organisation in our own right and, importantly, in partnership with organisations and communities. Building on our strong relationship with Portsmouth University, the Trust was awarded university status in July 2020, and we were delighted to welcome Professor Graham Galbraith, vice-chancellor of the University of Portsmouth and Professor Anoop Chauhan, executive director of research at PHU, to the Trust Board. Both Graham and Anoop are notable for their passion and commitment for world class research which, together with the education and training opportunities the partnership offers, brings tangible benefits for our patients and the NHS.

We further developed our strong roots and lasting collaboration with the military, being awarded gold status by the Defence Employer Recognition Scheme, which recognises our commitment to providing the very best care for those who serve, and have served, in the armed forces and their families.
We have also moved forward with significant improvements to our estate, receiving formal confirmation from the Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care, of the approval of our Strategic Outline Case for investing £58 million in our new emergency department, which will transform the care we provide in modern, fit for purpose and future-proofed accommodation.

In addition, March 2021 saw the start of the first construction on the Queen Alexandra site for a number of years, with enabling works beginning for a brand new ward building, which will see additional beds secured for patients requiring rehabilitation from conditions such as head injuries or strokes. The development is a vital component of our wider plans, in collaboration with partners across Portsmouth and South East Hampshire, to make sure that patients who need urgent care are able to access it more quickly and is also key to increasing resilience to support our existing partnership with the Isle of Wight NHS Trust.

We had strong financial performance which saw the organisation achieve a modest surplus and represented the second consecutive year where we have reported a balanced financial position. The financial framework in 2020-21 supported the additional costs incurred as a result of the COVID-19 response.

As we look forward to 2021-22 and beyond, our focus remains on the communities we serve, our patients and our colleagues. Continuing to balance the recovery and restoration of services that were necessarily paused during the peaks of the pandemic, with making sure that we continue to support the health and wellbeing of our colleagues will remain one of our top priorities.

We are incredibly proud of all our teams, who have repeatedly demonstrated such incredible commitment this year. We know that by continuing to work in collaboration with our partners across Hampshire and Isle of Wight, we will continue to provide the highest standards of NHS care for our patients, their carers and the communities we serve.

Melloney Poole OBE
Chairman

Penny Emerit
Chief Executive (Interim)

1. PERFORMANCE REPORT

The purpose and activities of the organisation

1.1 Statement from Chief Executive Officer on organisational performance

Like other health and social care organisations across the country, much of our operational activity throughout 2020/21 was focused on treating significant numbers of people in our communities with COVID-19.

While it is difficult to overstate the impact that this has had on colleagues, and the population we serve, our teams have regularly gone above and beyond in our commitment to maintain as many of our services as possible during the pandemic.

Our performance for the year sits within that context, and I am pleased to report that we have largely maintained our performance in delivering access standards in cancer services, achieving seven of the eight standards throughout the year and all eight standards across four months. We have consistently achieved standards for ‘two week wait’, ‘symptomatic breast cancer’, ’31 days first definitive treatment’ and ’31 days subsequent treatment’.

Our ability to support the NHS response to COVID-19 was achieved by using additional areas to provide more than three times the number of intensive care beds than under business as usual. These were situated within the operating theatre complex and therefore, unavoidably, often restricted the level of elective surgery we were able to provide. Critical care, operating theatre and anaesthetics teams combined to ensure the provision of care throughout, with patients being prioritised according to their clinical need.

Ongoing pressures related to urgent care remained a feature of the health and social care system across Portsmouth and South East Hampshire. We continue to work with our partners to reduce the length of time ambulances wait before patients are seen in our emergency department and we were an ‘early mover’ in the NHS 111 First programme and implemented a new 111 streaming tool in partnership NHS Digital and South Central Ambulance Service NHS Foundation Trust (SCAS) during the course of the year. These form part of our ongoing work, in collaboration with our partners across the system, to ensure patients receive the most appropriate care for their needs.

We were delighted that the Care Quality Commission (CQC) removed their requirement for us to report in relation to our Section 29A Warning Notice, which resulted from their inspection in 2019 and related to how we triaged and cared for patients who self-presented at our emergency department and the absence of significant improvements to reduce ambulance waiting times. The CQC noted that ‘the trust has made significant and sustainable improvements against the issues raised in the warning notice. In addition, the trust has demonstrated that it has built upon initial improvements and is using data to help drive further developments and sustainability.’

Our stroke services performance continued to improve during 2020/21 and we received a SSNAP (Sentinel Stroke National Audit Programme) level A rating (having been previously rated Level B in 2019/20 and Level C in 2018/19). This is the result of incredible hard work from the team in making improvements to our patient pathway, including in diagnostics and by increasing speech and language therapy support for patients.

Despite routine diagnostic activity pausing due to the pandemic at the start of the year, by the end of March 2021 our diagnostics waiting times and activity performance had improved to 94.2% against the 99% target, with PHU currently rated as the second best performing

organisation in the region. The introduction of social distancing, enhanced cleaning and infection prevention measures during both waves one and two of the pandemic have been well managed, enabling us to maintain activity levels. All cancer diagnostics continued without interruption and in April 2020 a replacement CT scanner was installed and supported through national diagnostic imaging funds.

As part of the COVID-19 National Incident Response, financial expenditure between April and September 2020 was based on income being topped up to breakeven to reflect the additional unknown costs of responding to the pandemic. We originally submitted a £9.1m deficit plan for the six month period from October 2020 to March 2021. However, through a detailed review of risks and opportunities, and following the receipt of funding to cover the cost of untaken annual leave, the organisation has been able to achieve a modest surplus, representing the second consecutive year where we have reported a broadly balanced financial position.

The national Friends and Family Test (FFT) was restarted in 2021 having been paused as a result of the pandemic, and between January and March 2021, 89 per cent of our inpatients scored us positively with 5 per cent giving us a neutral score. Furthermore, 94 per cent of our outpatients scored us positively, many of whom had taken up the opportunity to have a virtual appointment during the course of 2020/21.

As we move into 2021/22, alongside our partners across Hampshire and Isle of Wight, we are focused on recovering our performance and restoring our services as effectively, efficiently and swiftly as possible. Tackling the backlog in elective and diagnostic activity, with a focus on addressing health inequalities, remains a priority.

As Chief Executive Officer, I am incredibly grateful for all the hard work and continued commitment from all my colleagues at PHU. Learning from our experiences of 2020/21 will be invaluable in supporting our staff, shaping our future ways of working and delivering sustainable improvement.

1.2 About the Trust

Queen Alexandra Hospital started life more than a century ago as a military hospital. Today it is one of the most modern hospitals in the region, with 1,200 beds housed in light, bright and infection resistant en-suite wards. The current hospital was opened by Princess Alexandra in 1980 and subsequently 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 entered into a long-term agreement to provide facilities management services to the hospital. Portsmouth Hospitals University 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 management, portering, cleaning, security, catering and car parking.

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

The Trust is a major provider of under-graduate and post-graduate education, working with three universities - Southampton, Bournemouth, and particularly with the School of Health and other faculties at the University of Portsmouth. In July 2020, the Trust was able to reflect this close

relationship and changed its Establishment Order and name to "Portsmouth Hospitals University NHS Trust" (PHU). The Trust has a significant reputation for research and innovation and is actively involved with the national agenda in these fields. Some of the Trust's patients are regularly the first in the world to have the opportunity to join trials for new treatments, and even more are the first in the UK to do so.

The Trust provides comprehensive secondary care and specialist services to a local population of 675,000 people across Portsmouth and south east Hampshire. In addition, it offers certain tertiary services to a wider catchment area in excess of two million people. The local population is characterised by its diversity. The rural and urban areas of wealth are contrasted with pockets of deprivation and a variation in life expectancy. Stroke, heart attacks, Chronic Obstructive Pulmonary Disease (COPD), diabetes and liver disease have a high prevalence within the local communities, and the Trust works strategically with public health and local commissioners to provide high quality services to combat and treat these conditions.

During 2020/21

- The Emergency Department saw 93,803 patients
- The Trust dealt with over 57,000 emergency admissions (excluding maternity)
- Over 434,000 outpatient consultations and more than 37,000 day-case admissions were completed
- 4,868 babies were delivered at Trust hospital sites or at home with the support of the Trust's midwifery team - an increase of 140 on the previous year
- Services were delivered by over 8,000 employees and around 700 volunteers. More than 200 military personnel also worked alongside NHS colleagues at Queen Alexandra Hospital.

Most of the Trust's services are provided at Queen Alexandra Hospital (QA) in Cosham, but a range of outpatient and diagnostic facilities closer to patients' homes in local communities are available. Local treatment centres throughout Portsmouth and South East Hampshire are also provided. These include:

- St Mary's Hospital in Portsmouth, which provides midwifery, dermatology and enablement services
- Gosport War Memorial Hospital, where a range of services including the Blake Maternity Unit, Minor Injuries Unit (Urgent Treatment Centre) and diagnostics are provided
- Petersfield Community Hospital, where the Grange Maternity Unit is based.

1.3 Working alongside military personnel

Under Commanding Officer Alister Witt, and subsequently Cdr Karen McCullough, the military medical personnel provide a capable and flexible workforce which works to support the priorities of the Trust. Their number includes consultant doctors, specialist and generalist nurses, and allied healthcare professionals. In providing this service, the Ministry of Defence (MoD) clinicians maintain and develop the clinical skills that will be used to provide medical support to the Royal Navy, Army and Royal Air Force wherever they may be deployed world-wide.

During the last year, military personnel have maintained key leadership roles within the Trust, including Commander Barrie Dekker as Divisional Director for the Surgery and Outpatients Division. This further ensures the flow of best practice between the NHS and MoD. The success of the partnership lies in the quality of the personnel involved and the quality of the placements available to them, and the Trust will continue to build this relationship for the foreseeable future.

The Armed Forces Covenant Lead Nurse (AFCLN) role has gone from strength to strength. Providing support for patients who are serving and retired military personnel and their families, as well as providing training to PHU staff and local primary care colleagues, this postholder also builds partnerships with relevant stakeholder groups. The role has been recognised nationally and the Trust is sharing its experience across the NHS to develop the same positive impact elsewhere.

Working with military personnel, the AFCLN has helped deliver on a number of initiatives over the past year. In line with a long-standing tradition in military history, the 'Challenge Coin' is given in recognition of individuals who have gone 'above and beyond' when performing their duties in relation to the military community. Receiving the coin as a reward for excellent performance builds pride and morale. The coin also provides a natural link between the military and the emergency services, which also have a history of using challenge coins to honour service or special accomplishments in the line of duty.

Receiving the coin is a great honour and team members work hard to get them. The PHU Veteran coin is given to recognise an individual accomplishment on the part of Trust, Engie (estates and facilities teams) and volunteer staff who have:

- Demonstrated care for the military community outside of their normal duties
- Demonstrated being a strong ambassador for the Armed Forces Covenant
- Proactively encouraged understanding of the military culture
- Gone 'above and beyond' in caring for the military community

March 2021 marked the launch of the first virtual chat room for the veteran community, to provide help and support for members of the HM Armed Forces past and present, as well as family members of the military community. The Trust's AFCLN has agreed to be an Employee Recognition Scheme (ERS) mentor for other organisations working towards Silver/Gold status in the Scheme. In recognition of the incredible work done, the Trust has been shortlisted for an English Veteran Award, the winners of which will be announced in September 2021.

1.4 Research and innovation

The Trust is committed to ensuring that every patient who enters the hospital has the opportunity to participate in a clinical trial. Working with patients, universities, industry and other organisations, the Trust continually endeavours to take the best new innovations from cutting-edge science and technology, using them to create real-life tests and treatments that benefit patients more quickly.

Knowing that patients cared for in a research active environment have better outcomes, the Trust aims to grow its research portfolio year on year to be able to offer patients the very best treatments, medicines and services available.

Following the onset of COVID-19, patient enrolment into most research studies was paused nationally and attention was turned to supporting Urgent Public Health (UPH) studies. Nationally,

a collective effort into fast tracking patient recruitment into UPH studies has provided vital new evidence and resulted in changing practice to improve outcomes for COVID-19 patients.

The Trust has recruited patients into a complex portfolio of UPH studies, several of which are multi-arm and interventional. At the end of 2020/21, 8,282 participants had enrolled into clinical research studies and trials, of which 4,457 participants were enrolled into national UPH studies.

The Trust is a leading site nationally for recruitment into the Recovery trial, aiming to identify treatments that may be beneficial for people hospitalised with suspected or confirmed COVID-19. In addition, it has been a leading site for recruitment into the REMPA-CAP trial (Randomised, Embedded, Multi-factorial, Adaptive Platform Trial for Community-Acquired Pneumonia), recruiting COVID-19 patients in critical care. The Trust is also collaborating with the University of Portsmouth, sequencing the virus from infected individuals to identify trends in viral mutations and prevalence.

The Trust, in collaboration with the Wessex Clinical Research Network (CRN) and other partners, was awarded pump priming funding in February 2021 from the Department of Health and Social Care to set up a research vaccine hub in the heart of the city. The hub will be open for business at the end of the financial year.

Locally, the COVID-19 pandemic saw a shift in the research workforce, which was mobilised to work across the Trust supporting key delivery functions (including intensive care, swabbing, the COVID-19 dashboard, HR, patient liaison and medical care through the Specialist Registrar on-call rota) while also leading on the delivery of a complex portfolio of UPH studies.

1.5 Charity support

Over the last year, Portsmouth Hospitals Charity has played a major role in supporting patients and staff through the COVID-19 pandemic. Thanks to incredible support from NHS Charities Together, the local community and the ‘Thank You’ appeal, the Charity was able to provide everything from ‘boost boxes’ filled with treats for staff, to critical incident stress management training. To support patients, the Charity helped provide hygiene supplies for family liaison teams to distribute across hospital wards. The successful ‘Secret Santa’ appeal ensured every patient staying at the Trust on Christmas Day received a gift from the Charity.

Although the response to COVID-19 dominated the work of the Charity over this past year, there were other incredible projects funded. Previous support from charitable funds has enabled the Trust to become a robotically assisted surgery leader, gaining national and international recognition. Research has shown that there is a measurable improvement in quality when surgery is performed using a robot. In 2020, Portsmouth Hospitals Charity supported the full purchase of the Da Vinci robot for the Trust, which has been a great achievement in helping to provide ongoing enhanced care to patients. The demand for robotic surgery is great, with significant scope for more patients to benefit.

Finally, it has long been the ambition of the Charity to provide a garden for staff and patients to enjoy on the QA site. Initially, the vision for the garden was to provide space for organ transplant patients to relax outdoors, but the space will have much wider benefits. The work has now been completed on this beautiful outdoor area and, thanks to a staff competition, it has been officially named as the ‘Garden of Life’.

Portsmouth Hospitals Charity is very grateful for the ongoing support of patients, their loved ones, staff, volunteers and the local community. Staff and departments at the Trust also receive generous support from QA Hospital's League of Friends, for which all are very grateful.

1.6 Private Patients

The Trust's Harbour Suite provides services for patients with private medical insurance and works with the major healthcare insurance companies. Patients without insurance, who choose to pay for their own treatment and care, are also welcome.

In a usual year, income generated from the Harbour Suite contributes to the Trust's general finances to help support improvements in services which benefit NHS patients. However due to the pandemic the unit has not been open for private healthcare.

1.7 Care Quality Commission

The Trust is fully registered with the Care Quality Commission (CQC) to allow it to carry out a wide range of regulated activity. The principal location registration is for QA, and there are other registrations in place for the other key sites at which the Trust provides services.

As outlined in more detail at section 3.15, the Trust was subject to a comprehensive CQC inspection in October 2019 and a specific well-led inspection in November 2019, following which the Trust was rated as follows:

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement	Good	Good	Good	Good	Good

The Trust continues to work on improving quality throughout all its services, but particularly in the CQC's 'safe' domain and across the urgent and emergency care pathway, both of which are remain rated as 'requires improvement'. Like most CQC registered bodies, during the pandemic the Trust has not undergone the comprehensive inspection which would normally have taken place and allowed for a review and revision of its ratings.

The Trust worked with the CQC during 2020/21 to provide evidence of its compliance with a Notice served on the Trust after the 2019 inspection. This was under section 29A concerning practice in the Emergency Department (ED) and focussed principally on:

- Reducing delays to the handover to the Trust of patients brought to the ED by ambulance
- Improving the oversight of self-presenting patients in the ED waiting areas

The Trust is very pleased to report that the Commission confirmed, in a letter dated 1st April 2021, that the requirements have been delivered in full.

The CQC did conduct a brief focused inspection on medicine safety in July 2020. The inspection had a broadly positive outcome, and there was no impact on any of the Trust's ratings.

1.8 Organisational structure

The clinical services in the Trust are provided by four divisions; Clinical Delivery, Medicine and Urgent Care, Networked Services, and Surgery and Outpatients.

Each Division is led by a team consisting of a consultant, a nurse or allied health professional and a manager. Each leadership team is accountable for the quality, performance and financial

sustainability of its division, as well as being responsible for working together across the other divisions to ensure patients receive a seamless pathway of care. The divisions also lead the implementation of the Trust's strategy across all clinical areas and seek to forge strong relationships with partners outside the organisation.

1.9 Strategic direction

Despite the COVID-19 pandemic, the Trust has continued to deliver its five-year strategy launched in July 2018 entitled 'Working Together'. The Trust's vision is 'Working together to drive excellence in care for our patients and communities' and has five strategic aims, each of which is supported by a number of objectives as outlined below:

- Fulfil our role for the communities we serve
    - Fulfil our role as a provider of timely, accessible care to the Portsmouth and South East Hampshire communities
    - Work with partners, leading in the provision of the right specialist services in the region
    - Strengthen our relationship with Defence Medical Services
- Support safe, high quality patient-focused care
    - Get the basics right- deliver high quality care across all clinical services
    - Build an environment and culture where patients, families and carers can take the lead in meaningful care
    - Utilise research, development and academic opportunities to support our core purpose
- Take responsibility for the delivery of care now and in the future
    - Be financially sustainable, identifying opportunities for non-clinical income where appropriate
    - Empower staff to be responsible for service sustainability
- Invest in the capability of our people to deliver on our vision
    - Embed a culture that supports the achievement of our vision
    - Adopt workforce models that reflect new models of care and service needs
    - Support the development and capability of our people and value our staff
- Build the foundations on which our team can best deliver care
    - Optimise our estate portfolio and equipment
    - Enhance IT and information systems
    - Embed improvement in how we work

Delivery of the Trust's strategic aims is underpinned by refreshed Trust values:

- Working together for patients
- Working together with compassion
- Working together as one team
- Working together, always improving

These priorities inform the Trust's business objectives. The Board Assurance Framework records identified risks to the delivery of any of the priorities, and set out details of how these risks will be managed. The Trust is also developing a strategic partnership with the Isle of Wight NHS Trust, although progress on this has been limited by COVID-19. This will be developed further in 2021/22.

1.10 Key issues and risks

The following table lists the most significant risks contained within the Board Risk Register (operational risks); it is notable that these link to the COVID-19 Pandemic.

Board Risk Register		
Opened	**Title**	**Additional actions planned**
06/08/2019	Risk of service interruption due to Coronavirus outbreak causing reduced staffing level as a result of impact on staff wellbeing	• Further mental health and psychological support is currently being put in place for Teams.
04/05/2020	Risk of patient harm arising from delays to care due to COVID-19 pandemic	• Further mitigation by starting to re-introduce usual activity over the next few weeks and months. • Recovery plan for reintroduction of all services agreed and being implemented. Although delivery against the approved recovery plan is broadly on track, the further course of the pandemic is not yet known and it would be premature to reduce the rating of this risk at this time.
14/12/2020	Mismanagement of patient care and experience in urgent care pathway due to high occupancy and poor flow within and beyond the Trust.	• Continued implementation of winter plan and COVID-19 actions. • Implement ambulance handover improvement plan. • Monitor ambulance holds weekly at TLT and report to NHSi and CCG. • Increased community care spaces to be agreed.

The Board Assurance Framework also includes the following high-scoring strategic risks:

Board Assurance Framework	
Risk	**Risk overview**
Risk to Trust's ability to deliver all strategic objectives due to diversion of resources of all types required to manage the COVID-19 pandemic and its recovery	The profile and rating of this risk varied during the year in line with the challenges presented by management of the pandemic. In later months, the risk was revised to include challenges to delivery of mid-to-long term strategic objectives as a result of the need to devote operational and leadership resources to the recovery programme.
Demand for mental health services in the Trust exceeds mental health resource available	Demand for mental health services as increased locally, regionally and nationally as a result of the pandemic. Coupled with more usual demand which could not be met by existing services during the pandemic for a variety of reasons (including staff sickness absence, social distancing requirements etc), this means that the Trust is seeing an increase in crisis presentations at its Emergency Department (ED). Although there is mental health support on the QA site, demand for specialist placements outstrips provision, and patients who need mental health services often remain in non-specialist beds at the Trust for longer than is desirable. The Trust is working with partners and commissioners across the local health and social care system to seek to resolve this position.

Board Assurance Framework	
Risk	**Risk overview**
Governance systems across the Trust are ineffective in the delivery and monitoring of improvements and high standards of care, treatment and performance	The additional challenges to delivery of effective oversight of quality and safety presented by increased operational pressures associated with the pandemic mean that the Trust could not always be sure that its clinical governance systems were adequate / appropriate. Review of systems, processes and structures is underway, but until assurance is available (expected in early 2021/22), the risk rating has remained high .

1.11 Adoption of going concern

The Trust prepares its accounts on a going concern basis, in accordance with the definition as set out in section 4 of the DHSC Group Accounting Manual (GAM). The GAM 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 2021/22 priorities and operational planning guidance issued in March 2021 by NHS England & Improvement confirmed the financial framework arrangements for 2021/22 will continue to support a system-based approach to funding and planning.

This year the Trust has achieved an adjusted £218k financial performance surplus (£2.984m before technical adjustments). Income from Commissioners was largely based on the simplified fixed block income basis introduced in response to the COVID-19 pandemic. Additional costs due to the pandemic were also supported on an actual cost basis for the first half of the year and on a block basis for the second half of the year.

The Trust received Public Dividend Capital of £125.2m to allow repayment of the DHSC loans that had accumulated from previous years deficits and can now move forward with no debt burden to service. Whilst the Trust now carries no loans with DHSC, the historic cumulative deficit as at 31st March 2021 remains at £108.6m and as a result the External Auditor is obliged to issue a referral to the Secretary of State for Health under Section 30(1)(b) of the Local Audit & Accountability Act 2014 reporting that the Trust has breached its statutory duty to breakeven over a rolling period.

For 2021/22 the current financing arrangements will remain in place for the first half of the year, with additional funding to support Elective Recovery post COVID-19. These arrangements include the block payment basis, a continuation of the system top-up and COVID-19 fixed allocation arrangements. The Trust has produced its plans on these assumptions; these have been approved by the Trust Board and it is anticipated that the Trust will continue to provide healthcare services in the public sector.

Financing arrangements for the second half of 2021/22 have not yet been confirmed nationally. The Trust has assumed income and expenditure levels from October 2021 to June 2022 similar to the first half of 2021/22.

The Trust has prepared a cash forecast for the going concern period to June 2022 which shows sufficient liquidity for the Trust to continue to operate. The cash forecast provides headroom for any variation in cashflows caused by changes in the nationally agreed funding arrangements in the second half of the year should this be necessary. The minimum forecast month end cash balance during the going concern period is £5.3m with an average of £15m.

In conclusion, these factors, together with the anticipated future provision of services in the public sector, support the Trust's adoption of the going concern basis for the preparation of the accounts.

1.12 Performance summary

Details of the Trust's performance against its constitutional and statutory obligations can be found in reports in the Trust Board papers section of the Trust website.

Performance against the Trust standards for quality of care is reported in the Trust's Quality Account found also on the Trust website at 'Trust publications'. The publication for 2020-2021 will take place on 30th June 2021.

1.13 Performance analysis

The Trust is monitored by NHS Improvement and the CQC against a range of targets and thresholds as published in the Operating Framework by these bodies. The Trust Board is provided with integrated performance reports summarising quality, operational, finance and human resources performance which is reviewed at public board meetings.

A summary of performance against the key indicators and constitutional standards, by month, is set out below.

Table 1: Operational Performance Dashboard

Operational Dashboard	Target	19/20	20/21 (February & March Cancer Data is National Provisional Published Position)											
		M	A	M	J	J	A	S	O	N	D	J	F	M
% Incomplete Pathways < 18 wks	>=92%	74.4%	65.4%	57.1%	49.3%	46.9%	53.2%	61.6%	65.6%	69.3%	67.6%	64.5%	62.4%	62.3%
No of Incomplete pathways	32808	33803	32771	32011	31835	32777	34777	36627	36223	36529	35984	35807	35964	36670
Incomplete Patients waiting >104 wks	0							✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
Incomplete Patients waiting >52 wks	0	✗ 4	✗ 22	✗ 99	✗ 230	✗ 427	✗ 597	✗ 589	✗ 514	✗ 518	✗ 741	✗ 1579	✗ 2686	✗ 3104
Incomplete Patients waiting >40 wks	0	✗ 467	✗ 903	✗ 1324	✗ 1744	✗ 2388	✗ 3254	✗ 3359	✗ 3249	✗ 3726	✗ 4711	✗ 4513	✗ 4429	✗ 4208
Diagnostic waits < 6 wks	>=99%	✗ 87.5%	✗ 36.0%	✗ 50.9%	✗ 59.2%	✗ 72.2%	✗ 77.9%	✗ 80.6%	✗ 80.2%	✗ 83.5%	✗ 86.7%	✗ 81.6%	! 89.8%	! 94.2%
12 hr Trolley waits	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
All 2-week wait referrals	>=93%	✓ 97.3%	✓ 93.4%	✓ 99.2%	✓ 98.9%	✓ 98.3%	✓ 97.0%	✓ 96.3%	✓ 96.4%	✓ 96.3%	✓ 96.0%	✓ 93.4%	✓ 97.2%	✓ 97.3%
Breast symptomatic 2-week wait referrals	>=93%	✓ 99.1%	✓ 94.7%	✓ 97.2%	✓ 99.0%	✓ 97.8%	✓ 99.4%	✓ 96.1%	✓ 98.1%	✓ 97.2%	✓ 96.6%	✓ 97.5%	✓ 98.5%	✓ 98.2%
31-day diagnosis to treatment	>=96%	! 94.7%	✓ 99.6%	✓ 100.0%	✓ 99.6%	✓ 99.6%	✓ 97.1%	✓ 99.7%	✓ 99.7%	✓ 98.7%	✓ 99.7%	✓ 98.2%	✓ 98.8%	✓ 99.1%
31-day subsequent cancers to treatment	>=94%	✓ 98%	✓ 94%	✓ 100%	✓ 100%	✓ 95.3%	✓ 95.2%	✓ 96.4%	✓ 97%	✓ 100%	✓ 98%	✓ 95%	✓ 100%	✓ 100%
31-day subsequent anti-cancer drugs	>=98%	✓ 100%	✓ 100%	✓ 100%	✓ 100%	✓ 100%	✓ 100%	✓ 100%	✓ 99%	✓ 100%	✓ 100%	✓ 100%	✓ 100%	✓ 100%
31-day subsequent radiotherapy	>=94%	✓ 99%	✓ 97.2%	✓ 98.4%	✓ 99.5%	✓ 99.4%	✓ 99.1%	✓ 98.6%	✓ 98%	✓ 97%	✓ 98%	✓ 98%	✓ 100%	✓ 100%
62-day referral to treatment	>=85%	✗ 82.8%	✓ 85.3%	✗ 81.0%	✓ 87.7%	✓ 89.1%	✓ 91.6%	✓ 85.9%	✓ 85.8%	✓ 87.1%	✓ 87.6%	✓ 86.2%	✗ 73.8%	✗ 82.0%
62-day screening to treatment	>=90%	✓ 100%	✓ 94.7%	✓ 100%	✗ 0%	✓ 100%		✗ 83.3%	✗ 66.6%	✗ 87.5%	✓ 100%	✓ 100%	✓ 90.9%	✓ 95.7%
Cancer maximum wait to treatment 104 days	0	✗ 10	✗ 2.0	✗ 1.0	✗ 3.0	✗ 2.0	✗ 1.0	✗ 1.0	✗ 1.5	✗ 1.0	✗ 2.0	✗ 1.5	✗ 2	✗ 7.5
28 days to cancer diagnosis	>=75%	✓ 85.9%	✗ 72.2%	✓ 89.3%	✓ 91.3%	✓ 90.4%	✓ 88.8%	✓ 87.9%	✓ 86.9%	✓ 91.4%	✓ 91.4%	✓ 86.1%	✓ 82.8%	✓ 86.0%
Cancelled urgent operations	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
Urgent Operations cancelled for a 2nd time	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
Cancelled operations: 28-day guarantee	0	✗ 1	✗ 40	✓ 0	✓ 0	✗ 1	✗ 2	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✓ 0	✓ 0
Total bed days blocked	<1000	✗ 1568	✓ 87	✓ 79	✓ 47	✓ 109	✓ 139	✓ 177	✓ 260	✓ 236	✓ 319	✓ 223	✓ 188	✓ 267
Ambulance delays > 30 mins (PHT validated)	0	✗ 152	✓ 2	✓ 0	✓ 3	✗ 23	✗ 144	✗ 166	✗ 165	✗ 423	✗ 450	✗ 339	✗ 59	✗ 102
Ambulance delays > 60 mins (PHT validated)	0	✗ 124	✓ 1	✓ 0	✓ 2	✓ 0	✗ 97	✗ 87	✗ 125	✗ 440	✗ 623	✗ 495	✗ 6	✗ 8
Arrival to DTA <2.5 hrs	>=45%	! 36.5%	✓ 67.1%	✓ 60.5%	✓ 51.5%	! 41.6%	! 40.6%	! 41.0%	! 38.3%	! 37.4%	! 32.0%	! 31.2%	! 39.5%	! 39.8%
Medically Fit for Discharge (average / mth)	<100	✗ 145	✓ 32	✓ 46	✓ 56	✓ 72	✓ 84	✓ 96	✓ 89	✓ 104	✗ 123	✓ 91	✓ 95	✗ 127

*Note: this is the latest information available at time of publication

**Reporting on incomplete patients waiting >104 weeks did not commence until September 2020

***As a result of the temporary suspension of screening programmes early in the pandemic, no previously screened patients found to have cancer were treated in August 2020.

1.14 Emergency preparedness, resilience and response

The Trust is a Category One Responder under the Civil Contingencies Act 2004 and is required to:

- Assess the risk of emergencies occurring and use this assessment to inform contingency planning
- Put in place emergency plans
- Put in place business continuity arrangements
- Put in place arrangements to warn, inform and advise the public in the event of an emergency
- Share information with local responders to enhance coordination
- Cooperate with other local responders to enhance coordination

Other encompassing legislation includes:

- The NHS Act 2006
- Section 46 of the Health and Social Care Act 2012
- NHS England Emergency Preparedness, Resilience and Response Framework November 2015
- NHS Core Standards for Emergency Preparedness, Resilience and response July 2018
- NHS England Business Continuity Management Framework
- National Occupational Standards for Civil Contingencies
- BS ISO 22301 Societal Security – Business Continuity Management Systems

The Trust is required to work and engage closely with other Category One Responders such as health partners, blue light emergency services, and Local Authorities. In addition, the Trust works and engages closely with category two responders such as communications, energy and transport providers and the voluntary sector to enable effective response to a wide range of incidents.

Such work is carried out through the Hampshire and Isle of Wight Local Resilience Forum (HIOWLRF) and the Local Health Resilience Partnership (LHRP). This is attended by the Trust's Accountable Emergency Officer (AEO) and Emergency Preparedness, Resilience and Response (EPRR) Officer.

As well as generic incident response plans, the Trust has plans in place specifically designed to manage different types of incident such as adverse weather, pandemic flu and lockdown. Ensuring the readiness of these plans is essential, and the Trust tests those plans internally and with partners by conducting desk-top exercises alongside other simulations. The Trust held a full live play exercise in November 2019 of its Incident Response Plan; this is required every three years and is currently involved with a National Health Major Incident for the Pandemic which came to the UK in January 2020. The EPRR team have agreed to participate in a Mass Casualty exercise with the Isle of Wight NHS Trust to understand how we would support them with large numbers of casualties for late 2021. All other exercises that were planned for 2020 were cancelled, both internal events and those involving other agencies.

The COVID-19 Pandemic has tested the Trust in its response to managing a long-term Major Incident through good Command & Control processes laid out in the Trust's Incident Response Plan. This has also pushed the boundaries for supporting large numbers of patients who have been infected with COVID-19 and included identification of escalation areas for Critical Care and Acute Admissions. This incident has given Operational, Tactical and Strategic Commanders a chance to put their training into practice. This will prove invaluable in supporting the Trust in future should similar contingencies be required for other situations.

Each year NHS England (NHSE) assesses the Trust for assurance against the EPRR Core Standards, which set out the minimum levels of preparedness the Trust should have in place. In 2020, NHSE changed the EPRR assurance assessment in response to the prevailing national circumstances. This process required the Trust to:

- Show how it had improved from last year's assurance
- Demonstrate that it begun the process of systematically and comprehensively identifying, learning and embedding lessons to improve EPRR practice
- Ensure this learning is embedded in winter preparedness

After presenting evidence of delivery against the above criteria, the Trust was given a rating of 'substantial assurance'. This acknowledged the amount of work carried out following the previous year's assurance process before the pandemic started, as well as the ongoing management of the COVID-19 response.

In acknowledgment of the increased EPRR activity during the pandemic, the Trust has expanded the team to include an EPRR Lead and a Business Continuity Coordinator. These posts will provide additional resource to support the delivery of the EPRR portfolio.

1.15 Financial performance

The Trust's financial statements for the year ended 31st March 2021 are shown in full from page 63 of this report onwards.

The Trust reported a modest surplus of £218k for the year ended 31st March 2021. This is after having provided for the financial impact of annual leave unable to be taken by staff during the incident response, as well as a national reimbursement to reflect unachieved income as a direct result of the pandemic (e.g. private patient activity stood down as the area was used as a COVID-19 respiratory ward, parking receipts and overseas patients).

This is the second consecutive year whereby the Trust has reported a balanced position and thereby it 'lived within its means'. It is recognised that the Trust still has an underlying run-rate deficit of expenditure over income (with 2019/20 financial balance having been underpinned by £17.5m planned national income from the Provider Sustainability and Financial Recovery Fund); nonetheless, the track record for delivery against planning assumptions will continue to serve the Trust well.

Key points to note in relation to 2020/21 financial performance include:

- Cost improvement plan (CIP): The Trust reported a delivered operational savings and efficiencies totaling £6.1m during 2020/21 (£21.6m in 2019/20, £23.9m in 2018/19). This lower level of savings reflected the pandemic and is in line with comparable NHS organisations. However, it is anticipated that operational savings and efficiencies will increase in 2021/22 – particularly rising to 'near normal' levels during the second half of the new financial year. The relative focus on grip and control will therefore intensify, with a restored focus on divisional financial performance.
- Agency staff expenditure: During the previous financial year 2019/20 the Trust was already able to significantly reduce its reliance on temporary agency staff as a direct result of successfully implementing its workforce investment strategy. Total agency staff expenditure had already therefore reduced to £15.4m in 2019/20 compared with £21.1m and £22.1m for 2018/19 and 2017/18 respectively. These actions served the Trust well during the pandemic response, with the Trust with agency expenditure being £7.4m in 2020/21, comprising:
    - Nursing £1.3m (18%)
    - Medical £4.7m (63%)
    - Other Clinical £1.1m (15%)
    - Administration and Clerical £0.3m (4%)

- Capital Resource Limit (CRL): The Trust has continued to manage its annual capital programme of investments within its delegated CRL. Total capital investment in the Trust was £34.2m in 2020/21 (£22.5m in 2019/20, £22.1m 2018/19) summarised by funding source below:
    - Internally generated CRL £14.1m (an increase of £2.6m on previously reported projections owing to additional capital investment confirmed during March 2021)
    - PFI lifecycle expenditure £5.4m
    - Charitable donations £2.8m
    - Externally funded public dividend capital £11.9m (includes £2.6m COVID-19 investment)

- Cash balance: The Trust ended the financial year with a closing cash balance of £37.3m at 31st March 2021 (£3.9m as at 31 March 2020, £4.6m as at 31st March 2019). The cash balance is a result of planned changes in working capital during March which will reduce in the early part of the next financial year.

- Supplier payments: following a review of internal processes, systems and governance during 2020/21, non-NHS supplier payment performance within 30 days of invoice date remained high at 96.7% for the month of March. The full year position, owing to lower performance levels in the first quarter, was 89.7%. The Trust remains committed to eliminating non-NHS payment delays – this metric will feature as a key Delivering Excellence deliverable for the Trust during 2021/22.

Signed:

Penny Emerit, Chief Executive (Interim)
Date: 7th June 2021

2. ACCOUNTABILITY REPORT

2.1 Corporate Governance Report and Directors' Accountability Report

The Trust's Board of Directors is responsible for the leadership, management and governance of the organisation, and in particular for

- Setting the strategic direction;
- Monitoring performance;
- Ensuring high standards of performance are maintained; and
- Promoting links between the Trust and the local community.

The Trust Board comprises a Chairman, five voting Non-Executive Directors and five voting Executive Directors (including, as required by statute, the Chief Executive, the Chief Financial Officer, a medical practitioner and a registered nurse). The voting membership of the Board is supplemented by a number of non-voting Associate Non-Executive Directors and non-voting Executive Directors who bring complementary and additional skills, experience and expertise to the unitary board of directors.

2.2 Portsmouth Hospitals University NHS Trust Board of Directors

Non-Executive Directors

All of the Trust's Non-Executive Directors, including the Chairman, are appointed to the Trust by NHSI for a fixed term, following open invitation to members of the local community. The Trust Board's formal membership is supplemented, where appropriate, by the local appointment of non-voting associate Non-Executive Directors, who bring skills and experience particularly sought by the Trust Board to enhance its range and depth of expertise.

Melloney Poole OBE – Trust Board Chairman

Melloney Poole joined the Trust Board in May 2017 and was appointed as Chairman on 1st November 2017. She is the Chief Executive Officer of the Armed Forces Covenant Fund Trust (an arms-length body distributing funds from the Ministry of Defence and Her Majesty's Treasury to support the armed forces community). She is a corporate, charity and public administrative law solicitor and previously developed the combined legal service department which now supports all the legal and governance matters for the Arts Council England, the Heritage Lottery Fund, the Millennium Commission and the Community Fund.

In addition, she has been a Non- Executive Director in the NHS since 1993, serving on the boards of three NHS Trusts including leading one Trust through the Monitor process, and is the Vice Chairman of the Health Foundation. She has also been a volunteer and fundraiser for various charities and a magistrate on the Preston bench. She was appointed to the Most Excellent Order of the British Empire as an Officer in the 2010 New Year Honours list in recognition of her contribution to legal and governance services.

Roger Burke-Hamilton

Mr Burke-Hamilton is an ex Senior Civil Servant, with over 25 years in public sector and director level roles in the private sector. He has a technology background with considerable expertise in sourcing and managing supply chains for large critical national infrastructure, business to business logistics, and workforce transformation. Mr Burke-Hamilton has a strong commitment to bring technology innovation into practical daily use for social advancement. He is a Fellow at the Royal Society of Arts and Manufacturing (FRSA) and mentors an entrepreneur who is building a philanthropy platform. Mr Burke-Hamilton sits on the Board at University of Portsmouth as an externally appointed Governor as well as serving as an associate director at this Trust.

Mr Burke-Hamilton's skill set includes setting leadership strategies, technical operations and commercial teams. His capabilities cover developing intellectual property in software using different technology stacks and cloud abstractions, cost modelling, asset valuation techniques, eco-system deployment involving complex cross-category and multi-channel delivery.

Professor Graham Galbraith (from 24th June 2020)

Professor Galbraith has been Vice-Chancellor of the University of Portsmouth since September 2013. He has responsibility for the strategic direction of the university, working with the Board of Governors and senior management team.

He is passionate about higher education and its power to transform the life choices of individuals from a wide variety of backgrounds. He is also committed to leading the university to provide the very best student experience underpinned by internationally excellent research and world class business engagement.

Gary Hay

Mr Hay has been a solicitor for more than 25 years, most of which was spent acting for public sector bodies including the NHS, police, fire and local government. He has acted as trusted legal adviser to many NHS trusts across the country, advising on employment law issues at a senior level. He is a recognised public speaker and is particularly known for his work around equality and diversity. During his time in private practice, Mr Hay sat on the boards of two firms for a combined total of 14 years, prior to serving as an associate director at this Trust. At Capsticks solicitors, as well as helping to shape and deliver an ambitious strategy for growth, he was responsible for a number of key initiatives, including expansion into new geographies, developing new markets and establishing an HR consultancy service.

Mr Hay recently set up his own consultancy focused on training and coaching for lawyers. He is also Chairman of the Helen Arkell Dyslexia Charity.

Commodore Inga J Kennedy CBE QHNS QARNNS
Commodore Kennedy was the Head of the Royal Navy Medical Services, based at Navy Command Headquarters on Whale Island, Portsmouth. She is a Registered Nurse, Midwife and Nurse Lecturer, has undertaken post- graduate studies in education and has had the opportunity to attend the Ashridge Leadership and Management Centre, as well as the Royal College of Defence Studies as an associate. She also serves as an associate director at this Trust.

With a keen interest in the governance and assurance of healthcare, Commodore Kennedy was most recently the Inspector General for the Defence Medical Services, a body which fulfills a role similar to that carried out by the CQC across England. With extensive experience in this area, she further developed systems and processes that deliver credible research-based evidence, providing an assurance of the standard of healthcare delivered across defence services.

Commodore Kennedy was appointed to the Military Division of the Most Excellent Order of the British Empire, as a Commander, in the 2017 New Year's Honours.

David Parfitt
Mr Parfitt joined the Trust Board in May 2017. He is a chartered accountant, with broad commercial experience in a number of complex customer orientated businesses undergoing significant change, including the Granada Group, TSB Group and Lloyds Banking Group where he was the Risk, Control and Accounting Director of its retail banking business. In addition, he has direct experience of the NHS, firstly as a Non-Executive Director of NHS Luton and NHS Bedfordshire Primary Care Trusts as well as a Lay Member (audit and governance) of NHS Luton Clinical Commissioning Group.

Mr Parfitt is also a Non-Executive Director of Sussex Community NHS Foundation Trust, Chairman of Chichester Greyfriars Housing Association, and a Board member/Trustee of The Brendoncare Foundation.

Martin Rolfe
Mr Rolfe is Chief Executive Officer of NATS, the UK's leading provider of air traffic management services. Previously, Mr Rolfe was the Managing Director of Operations at NATS responsible for delivering NATS' regulated UK air traffic business. Prior to joining NATS, he worked for the Lockheed Martin Corporation where he was Managing Director.

Mr Rolfe holds a Master's Degree in Aerospace Systems Engineering from the University of Southampton. His career started with the European Space Agency, working in orbital mechanics. Since then, Mr Rolfe has worked in the aviation domain for more than 20 years across a number of companies leading large multinational teams across Europe, the US, and Asia with customers that include central government departments, military organisations and air navigation service providers.

Christine Slaymaker CBE
Ms Slaymaker joined the Trust Board in May 2017. Prior to this she was Chief Executive of Farnborough College of Technology, rated 'Outstanding' for Quality and Financial Health. She is a business graduate and has held non-executive positions for a number of organisations including Farnborough Aerospace Consortium, Treloar School and College, a Royal Engineers' charity and the Enterprise M3 Local Enterprise Partnership.

Ms Slaymaker was appointed to the most Excellent Order of the British Empire, as a Commander, in the Queen's Birthday Honours List in June 2014. She is from the Portsmouth area and still lives locally.

Vivek Srivastava (from 20th October 2020)
Dr Srivastava is a consultant in Acute Medicine at Guy's & St Thomas' Hospital and Fellow of the Royal College of Physicians and Surgeons of Glasgow. He leads the development and implementation of new roles (e.g. advanced nurse practitioners and physician associates) to help his department provide high quality clinical services.

As a Clinical Coordinator at the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) Vivek has contributed to reports on the quality of care of conditions like sepsis, pulmonary embolism, peri-operative diabetes care and mental healthcare in acute hospitals.

In his academic role, Vivek is passionate about education and training for medical students and leads Acute Care teaching at King's College London School of Medicine. He has also published his work on mental health services, mental health education and predicting re-admissions in elderly patients.

Aswinkumar Vasireddy (from 20th October 2020)
Mr Vasireddy is an Orthopaedic Trauma Surgeon based at King's College Hospital in London, specialising in complex fractures. Prior to this, he has extensive experience in the area, having completed fellowships in both the UK and the United States of America. He also works as a Pre-Hospital Care Doctor and operates as a Consultant in this field with his regional Air Ambulance Service. This expertise led to his appointment as an associate director of this Trust.

He is committed to academia, holding two lecturer posts (Pre-hospital Care and Trauma Sciences). As the only full-time Orthopaedic Trauma Surgeon at King's College Hospital, he is highly involved in training junior doctors and also undertakes significant research in his professional duties.

Executive Directors

The Executive Directors are employees of the Trust. NHS and Trust recruitment guidance and policies are followed in the selection and recruitment of executive directors, including open competition and the involvement of an independent external assessor. The Chief Executive is appointed by the Chairman and Non-Executive Directors. The Executive Directors are recruited by a panel led by the Chief Executive.

As with Non-Executive Directors, the Executive Directors on the Board are supplemented by a small number of non-voting Executive Directors who bring additional expertise and experience to the Board. The first part of this section includes those executives with voting rights.

Penny Emerit – Chief Executive Officer (Interim) (from 24th March 2021) Deputy Chief Executive Officer (until 23rd March 2021)
Ms Emerit joined the Trust in January 2018 from NHSI having held senior leadership roles across the wider health system in London and the South. Ms Emerit's role as Delivery and Improvement Director for NHS Improvement involved oversight of the provider organisations across Hampshire and Isle of Wight and Dorset. Before joining NHS Improvement (and formerly NHS Trust Development Authority) Ms Emerit was the Area Director for South London at NHS England, Director of Delivery at the South East London PCT Cluster and held a number of roles at NHS London Strategic Health Authority, latterly supporting the implementation of the Healthcare for London programme. Ms Emerit joined the NHS as a Management Trainee and holds an Economics degree and Post Graduate Diploma in Healthcare Management.

Mark Cubbon – Chief Executive (until 23rd March 2021)
Mr Cubbon first qualified as a nurse before moving into general and senior management roles within the NHS. He has worked at senior Director level at a number of high-profile London Hospital Trusts, including Deputy Chief Executive Officer at Moorfields Eye Hospital. He also held the role of Managing Director at Whipps Cross, and in the newly merged Barts Health NHS Trust he became their Executive Director for Delivery. Before taking up the post of Chief Executive at Portsmouth Hospitals NHS Trust Mr Cubbon held the role of Regional Chief Operating Officer for the Midlands and East at NHSI.

John Knighton – Medical Director
Dr Knighton spent three years gaining general medicine experience before training in intensive care medicine and anaesthesia in the south west and Wessex. He spent a year as a Visiting Instructor at the University of Michigan Hospital before taking a post in intensive care medicine & anaesthesia at Portsmouth Hospitals Trust at the start of 2000. He led the design of the state-of-the-art Critical Care facilities and was one of the clinical team leading on design for the whole hospital.

Dr Knighton was Clinical Director for the Department of Critical Care from 2010 – 2016 (during which time it was rated as "Outstanding" by the CQC), Chief of Service for Critical Care, Hospital Sterilisation, Anaesthetics & Theatres (CHAT), and Associate Medical Director. He has been a CQC Specialist Advisor for Acute Hospital inspections and has a long held passion for improving patient safety and quality of services, championing an open, learning culture of strong multi-disciplinary team working. He began as Medical Director at PHU in July 2017.

Liz Rix – Chief Nurse
(also acting as Chief Operating Officer 1st September to 30th September 2020)
Ms Rix has previously held a number of Director-level nursing positions in large, integrated Trusts, most recently at University Hospitals of North Midlands NHS Trust where she had been Chief Nurse since 2009. Liz is passionate about delivering quality care for patients through clinical leadership at all levels. She has the experience needed to develop strong nursing teams who manage workforce, patient experience and environment effectively, while also living the Trust values: working together for patients, with compassion, as one team and always improving. Ms Rix is one of the few nurses to graduate from the NHS Management Training Scheme after working in the health service for a number of years.

Nigel Kee – Interim Chief Operating Officer (until 31st August 2020)
Mr Kee trained as a nurse in New Zealand, and brings a wealth of experience having held both Chief Nurse and Chief Operating Officer roles in acute trusts in the NHS. He has over 14 years of Board level experience and has previously served as an acting Strategic Health Authority Chief Nurse at two authorities. He also has commissioning experience in addition to his international roles. Mr Kee is committed to improving health outcomes through development and engagement with the workforce, service redesign, effective healthcare planning and excellent governance. In particular he is passionate about excellence in leadership and operational management.

Chris Evans – Chief Operating Officer (from 1st October 2020)
Mr Evans joined the Trust in October 2020 from Warrington and Halton Teaching Hospitals NHS where he served in the same role. Prior to that, he was Managing Director at Salford Health and Social Care and manager for the Women's and Children's Division at the University Hospital for South Manchester. He commenced his NHS career in 2002 undertaking a range of administrative posts in Salford Primary Care Trust.

Subsequently, he developed his managerial career and gained experience working throughout the region at both Central Manchester University Hospitals and The Christie. He has managed a variety of acute, community and social care services.

Mark Orchard – Chief Financial Officer
Mr Orchard joined the Trust in October 2019 from Poole Hospital NHS Foundation Trust, where for five years he held the post of Executive Director of Finance at one of four NHS providers working together with the Dorset Clinical Commissioning Group as a part of a wave one integrated care system.

He is currently national chair of the NHS Providers' Finance and Commercial Directors' Network. Mr Orchard has also held the Wessex system Finance Director post at NHS England, the Commissioning Finance Director role at Bristol, North Somerset and South Gloucestershire and more latterly, at NHS Bournemouth and Poole. Mr Orchard was national president of the Healthcare Financial Management Association (HFMA) during 2016/17 and served the maximum of three terms as Trustee on their national Board between 2009 to 2019.

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

Lois Howell – Director of Governance and Risk
Ms Howell joined the Trust in January 2018. She is a solicitor by background with an MBA in public sector management and many years' experience in governance and regulatory roles. Ms Howell 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. Ms Howell has held director level roles in a number of NHS and local government bodies. Since July 2020 Ms Howell has also served on the Board of the Isle of Wight NHS Trust as Director of Governance and Risk, in furtherance of the partnership between the two trusts.

Nicole Cornelius – Director of Workforce and Organisational Development
Ms Cornelius joined the Trust as Director of Workforce and Organisational Development in October 2018. She is a Fellow of the Chartered Institute of Personnel and Development, has a M.St from Cambridge University and is a member of the Independent Advisory Panel to the Military. She has over 30 years' public sector experience including Director roles in the Police, the Probation Service and Local Government. Ms Cornelius is passionate about creating an environment of support and wellbeing for staff, particularly in relation to keeping staff safe at work and addressing the issue of violence against staff.

Anoop Chauhan – Director of Research (from 27th July 2020)
Professor Chauhan joined the Trust Leadership Team in July 2020. He had previously been Director of Research at the Trust since 2009 and is also a practising physician in respiratory and general medicine. He has developed opportunities for patients throughout the region to participate in high quality research trials, introduced innovations in clinical pathways, developed new models of care, and helped set up a nationally recognised severe asthma centre in Portsmouth. His research has resulted in a positive impact on disease control, quality of life, healthcare usage and health economic benefits in patients with respiratory conditions.

He has also helped multiple small and medium-sized businesses to secure funding, develop high-quality research studies and technology trials in support of the NHS. He has also set up the Portsmouth Technology Trials Unit to allow more health technology companies to work with patients and the NHS.

Graham Terry – Director of Strategy and Performance (from 24th March 2021)
Mr Terry joined the Trust in February 2018 as deputy director of planning and strategy, from Great Ormond Street Hospital for Children NHS Foundation Trust where he served as head of planning and performance. Before his move to London, Mr Terry held a number of senior roles in provider, and more extensively in commissioning organisations within Hampshire and Isle of Wight. Many of these roles have allowed him to work between primary, secondary and tertiary care, in leading commissioning, planning and contracting functions.

His career in the NHS commenced directly from University in 1998. Over this time Graham has developed his managerial career and has a master's degree in Business Administration (MBA), from the Portsmouth University.

Helen Bray – Director of Communications and Engagement (from 20th April until 26th October 2020)
Ms Bray is an established expert in communications and stakeholder management. Having held a key role in engagement for the 2011 census, her experience includes both public and private sector and has included a significant amount of work undertaken in the United States of America. She has also undertaken roles in the energy industry as well as the Knowledge Transfer Network. She has held Board level roles for the University of Chichester, the Humberside Childcare Trust, and graduated from University of Oxford.

2.3 Executive Director pay

The NHS Very Senior Manager Pay Framework has been adopted by the Remuneration Committee as guidance regarding pay for the executive team. Full details can be found in the Remuneration Report on page 122 of this report.

2.4 Board Effectiveness

All Executive Directors and Non-Executive Directors have annual appraisals and performance development plans. The appraisal includes a self-assessment in line with both the fit and proper persons requirement (FPPR) and the NHSI quality governance framework. No issues or concerns have been raised in connection with these appraisals or self-assessments.

As outlined above, the Trust underwent a 'Well-Led' inspection by the CQC in November 2019. During quarter 2 and 3 of 2019/20, the Board also undertook a Well-Led review, which comprised of a self-assessment followed by external scrutiny by Deloitte. The CQC rated the Trust as 'Good' for being well-led, and the report of the externally assessed well-led review was also broadly positive.

The Trust has maintained a range of board development activities during the 2020/21 financial year, although as a result of the pandemic this has not followed the long-term programme developed in 2019/20 following the Well-Led inspection and review. Board development time has been prioritised to focus on the most urgent matters facing the Trust Board, particularly the Trust's management of the pandemic, staff wellbeing in the light of the associated intense operational pressures and recovery planning. The Board has also devoted developmental time on consideration of its plans for a strategic partnership with the Isle of Wight NHS Trust.

During the pandemic, the Trust Board adapted some of its usual governance arrangements to minimise risk, reduce administrative and non-clinical burdens on operational teams, and promote flexibility and responsiveness. The Board and all assurance committees maintained their regular meeting patterns, but reduced business and agendas to essential assurance activity during the periods of peak activity.

The Trust also established an additional, time-limited committee (Board Major Incident Response Committee (BMIRC)) on 1st April 2020 to support the Trust's Executive Directors in their management of the Trust's response to the COVID-19 pandemic and make urgent decisions required to enable the Trust to respond to the COVID-19 pandemic and associated pressures. The BMIRC met formally on six occasions and supported the Board in remaining effective during the pandemic period. The BMIRC has not met since the end of April 2020 and is no longer in operation; it is discussed in more detail on page 42.

2.5 Audit Committee

The Board Committee structure is set out in the Annual Governance Statement on page 29 of this report, but for the purposes of the Corporate Governance Report section of the Annual Report and Accounts, it is confirmed that the Board has established an Audit Committee, comprised of the following Board members:

- David Parfitt (Committee Chairman)
- Gary Hay
- Martin Rolfe
- Christine Slaymaker

A number of Executive Directors also attend and participate in the Audit Committee's meetings, as well as representatives of the Trust's internal and external auditors and its Counter Fraud Service. The Non-Executive Director members of the Committee have regular opportunities to meet with the auditors in the absence of the Executive Directors.

2.6 Counter-Fraud

During 2020/21 the Counter Fraud Service was provided by the Fraud and Security Management Service (F&SMS), which provides a specialist service for a fixed cost, underpinned by a risk sharing agreement with the Trust. The budget was agreed at the start of the financial year and the appropriate level of resource was made available to meet the fluctuating demands of the Trust. The Trust has an accredited, nominated Local Counter Fraud Specialist (LCFS) who reports directly to the Chief Financial Officer and provides a risk assessed plan of work to meet the NHS Counter Fraud Authority Standards.

The plan was agreed at the start of the year and reviewed throughout the year, with a number of additional off plan activities designed to address system weakness arising from trend analysis, planned activity and reactive criminal investigations. The additional work has included a COVID-19 risk assessment, preparation for the new Government Functional Standard and reviews of the following areas; salary overpayments, secondary employment, declarations of interest, medicines management, and participation in the Cabinet Office National Fraud Initiative. There is a programme of fraud awareness work in place, including a Fraud, Bribery and Corruption Policy, development and maintenance of a new website and delivery of e-learning. During the global pandemic the Trust received higher numbers of local and national fraud alerts and prevention notices. These have been subject to an NHS Counter Fraud Authority (NHSCFA) Fraud Prevention Impact Assessment. All investigation work is conducted in accordance with relevant legislation and an action plan is produced to implement the recommendations following each investigation and proactive exercise to address any system weaknesses. The annual Self Review Tool was rated as "green" in all four generic areas.

2.7 Cost allocation / setting of charges for information

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

2.8 Information Governance

The confidentiality and security of information regarding patients, staff and the Trust are maintained through governance and control policies, all of which underwent extensive review in 2018 in readiness for the implementation of the General Data Protection Regulation 2016/679. Personal information is, increasingly, held electronically within secure IT systems. It is inevitable that in a complex NHS organisation a small number of data security incidents occur. The Trust is diligent in its reporting and investigation of such incidents, in line with statutory, regulatory and best practice obligations.

Any incident involving a breach of personal data is graded and the more serious incidents are reported to the Department of Health and the Information Commissioner's Office (ICO) where appropriate.

As reported in the more detailed description of information governance arrangements set out in the Annual Governance Statement (page 29), the Trust experienced five externally reportable serious incidents in 2020/21 and these were reported using the Data Protection and Security Toolkit.

2.9 Directors' confirmation concerning audit information

The Trust's Directors participated in the governance arrangements described in the Annual Governance Statement throughout 2020/21. In accordance with NHSE/I guidance issued as a result of the COVID-19 pandemic, the Trust temporarily revised its governance arrangements from 16th March 2020 onwards. The revised governance arrangements involved reduced reporting to the Trust Board and Committees (essential performance, financial and quality monitoring items only) and the conduct of meetings by virtual means. On 1st April 2020 the Trust also established an additional Board Committee, the Board Major Incident Response Committee (BMIRC), to support the Trust's Executive in management of the pandemic response.

The confirmation below is made in the context of those revised governance arrangements having been in operation from 1st April 2020 until the date of approval of this report and beyond.

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

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

Signed: Penny Emerit, Chief Executive (Interim)
Date: 7 June 2021

3. ANNUAL GOVERNANCE STATEMENT

3.1 Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that Portsmouth Hospitals University 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.

3.2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable, and not absolute, assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- identify and prioritise risks to the achievement of the policies, aims and objectives of the Trust,
- evaluate the likelihood of those risks being realised,
- assess the impact of those risks, should they be realised, and,
- manage the risks efficiently, effectively and economically.

The system of internal control has been in place in the Trust for the year ended 31st March 2021 and up to the date of the approval of the Annual Report and Accounts.

3.3 Capacity to handle risk

The Trust's risk management processes were assessed as part of both the CQC's well-Led inspection and the Well-Led review.

The CQC reported that "The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. They used a systematic approach to improve the quality of the service. Managers we spoke with at all levels understood the risks to the services and could describe action to reduce risks."

The report of the Well-Led Review included the following summary against Key Line of Enquiry 5: 'Are there clear and effective processes for managing risks, issues and performance?': "Risk management arrangements were widely described to have improved significantly over recent years and we observed a number of elements of good practice, including the Board Assurance Framework and the escalation process for risk between the divisions and the Executive."

During 2020/21, the Board Assurance Framework was updated to ensure enhanced oversight of risks to the delivery of the Trust's annual plan priorities for the delivery of the organisational objectives set out in the Trust strategy, Working Together (adopted in July 2018).

The Board Assurance Framework has been presented to the Board of Directors throughout 2020/21 and is used more effectively in day to day operational management of the Trust - for example, it is regularly reviewed and taken into account by the Trust Leadership Team.

The 2020/21 Internal Audit review of risk management arrangements has found that the Trust's risk management processes provide 'substantial assurance'. Throughout 2020/21 all meetings of the Trust Board and its committees have concluded with a consideration of whether any of the

matters discussed during the meeting should be added to the Board Assurance Framework. The Board Assurance Framework has also been used during 2020/21 to plan for 2021/22 - for example the Internal Audit plan has been closely aligned with the risks reported in the Board Assurance Framework.

Work required to improve the management of operational risk continues. The clinical divisions' risks registers have all been reviewed and updated throughout the year, and work on the corporate functions' risk registers has also been undertaken.

The Board Risk Register is comprised of all risks which require corporate support for management and oversight, as well as those risks on divisional risk registers which score 15 or above, on a scale of 1 to 25, where 25 is the highest risk score. The Board risk register is also presented on a quarterly basis to the Trust Board for review, having been scrutinised in advance by the Quality & Performance Committee.

Executive leadership for both operational and strategic risk is in the portfolio of the Director of Governance & Risk.

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

3.4 The Risk and Control Framework

Operational risk management

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

- identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives;
- evaluate the likelihood of those risks being realised, and the impact should they be realised; and
- manage them effectively.

Risks continued to be identified throughout 2020/21 from a variety of sources, including:

- internal and external reviews and inspections
- internal and external audit activities
- counter fraud activities
- risk assessments
- Care Quality Commission enquiries and observations
- complaints, safety learning events and claims
- alerts received from the Central Alert System
- consultation with staff and patients
- mandatory/statutory targets
- service and quality 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 Management team reviews all divisional risk registers, to ensure effective oversight of the quality of risk management activity in the Trust, as well as the prevailing risk environment. The Quality & Performance Committee reviews the draft Board risk register, before proposing the latter to the Trust Board for review and approval. This process ensures that there is Board oversight of the quality of risk management activity.

During the year 2020/21 a number of risks rated 15 and above were identified. Action plans to mitigate these risks through addressing gaps in control and/or assurance were reported and reviewed as part of the on-going scrutiny through the key committees/groups responsible for the oversight of risk management.

During 2020/21, inevitably, the highest scoring risks have reflected the impact of the pandemic on patients, staff and services. These areas have been the subject of detailed internal and external scrutiny, with extensive action plans in place to mitigate the risks to the Trust.

Future major risks for the Trust relate to management of the recovery period and, in particular, meeting the potentially conflicting expectations of a range of stakeholders including service users, commissioners, regulators and the public. Effective management of the wellbeing needs of staff will also be a challenge after such a prolonged period of additional pressure, and this is likely to be reflected in risk registers in the coming year. The Trust Board will continue to monitor closely the actual and potential impact upon the operational and strategic objectives of the Trust of work with system partners.

3.5 Risk management in practice

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

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

Strategic risk management

The Board uses the Board Assurance Framework (BAF) to record and manage risks to the delivery of the Trust strategic objectives, as set out in the Trust Strategy, Working Together. Risks are allocated to designated Executive Directors so that management of risks can be overseen effectively, and progress reported to the Board through quarterly reports.

The highest risk on the BAF throughout the 2020/21 has been that posed to the delivery of all of the Trust's objectives by the diversion of resources necessary to react appropriately to the pandemic. The rating for that risk is likely to reduce as the latest acute phase of the pandemic abates, but may increase again if further waves occur. Risk associated with the recovery programme, as outlined above, may well replace that risk in 2021/22. Other risks on the BAF have moved up and down, indicating that the BAF is regularly reviewed, and reflects accurately both the changing challenges facing the Trust and the actions taken to mitigate the scale of those risks.

3.6 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 to protect the Trust from loss, damage to its reputation or harm to its patients, staff and the public.

To support the Trust's capacity to manage these risks, a clear Board approved Risk Management Strategy is in place.

Whilst I, as Chief Executive, retain overall accountability for the management of risk, I have delegated oversight to the Director of Governance & Risk. However, elements of responsibility also lie with other employees and the structure of the organisation ensures there is adequate capacity to fulfil these responsibilities.

3.7 Risk registers

All identified risks that cannot be addressed immediately are placed on a risk register and held and managed at the appropriate level within the Trust: specialty, care group, division or corporate department. All risk registers are recorded on the Datix web management system and reviewed at least quarterly, to aid monitoring of the implementation of action plans necessary for mitigation. The transfer of risk registers to the Datix web management system has allowed for further transparency and awareness of risks across the organisation.

Any risk that cannot be managed at the appropriate organisational level or has the potential to affect the whole of the care group, is escalated to the relevant care group's governance committee for consideration and potential inclusion on the care group risk register. A similar process applies to care group risks with escalation to the divisional risk register. It is the responsibility of the divisional governance committees to escalate any risk that cannot be managed at divisional level, or which may have a Trust-wide impact, to the Director of Governance & Risk for consideration and possible inclusion on the Board Risk Register.

The Board Risk Register contains all the Trust's identified corporate risks. This includes those which cannot be managed at a divisional level and/or have the potential to impair or affect the operational or financial ability of the Trust to deliver core services, affect the quality of service provided or which may adversely affect the Trust's profile or reputation, including data security risks. Each risk has a responsible lead charged with overseeing the management of the risk.

3.8 Risk appetite

The Trust's risk appetite is expressed in two ways. Firstly, through the score attributed to particular risk impacts, and secondly through the approach to risks which have specific overall risk scores.

The Trust uses a risk matrix, which is common across the NHS, and is a globally recognised standard for risk measurement and management.

All high risks will be recorded on the Board risk register and reported quarterly by the Director of Governance and Risk to the Board to approve action plans and monitor progress.

3.9 Significant risks

As noted in section 1.11; the current top risks within the Trust relate to implications arising from the COVID-19 pandemic, these will continue to be reviewed and will be down-graded once the national and local situation improves.

Board Risk Register		
Opened	**Title**	**Additional actions planned**
06/08/2019	Risk of service interruption due to Coronavirus outbreak causing reduced staffing level as a result of	• Further mental health and psychological support is currently being put in place for Teams.

Board Risk Register		
Opened	**Title**	**Additional actions planned**
	impact on staff wellbeing	
04/05/2020	Risk of patient harm arising from delays to care due to COVID-19 pandemic	• Further mitigation by starting to re-introduce usual activity over the next few weeks and months. • Recovery plan for reintroduction of all services agreed and being implemented. Although delivery against the approved recovery plan is broadly on track, the further course of the pandemic is not yet known and it would be premature to reduce the rating of this risk at this time.
14/12/2020	Mismanagement of patient care and experience in urgent care pathway due to high occupancy and poor flow within and beyond the Trust.	• Continued implementation of winter plan and COVID-19 actions. • Implement ambulance handover improvement plan. • Monitor ambulance holds weekly at TLT and report to NHSi and CCG. • Increased community care spaces to be agreed.

The highest risk currently relates to concerns for patients who require Mental Health support; this is a system-wide concern. The Trust is engaging with all system partners to improve patient outcomes for this highly vulnerable group.

Board Assurance Framework	
Risk	**Risk overview**
Risk to Trust's ability to deliver all strategic objectives due to diversion of resources of all types required to manage the COVID-19 pandemic and its recovery	The profile and rating of this risk varied during the year in line with the challenges presented by management of the pandemic. In later months, the risk was revised to include challenges to delivery of mid-to-long term strategic objectives as a result of the need to devote operational and leadership resources to the recovery programme.
Demand for mental health services in the Trust exceeds mental health resource available	Demand for mental health services as increased locally, regionally and nationally as a result of the pandemic. Coupled with more usual demand which could not be met by existing services during the pandemic for a variety of reasons (including staff sickness absence, social distancing requirements etc), this means that the Trust is seeing an increase in crisis presentations at its Emergency Department (ED). Although there is mental health support on the QA site, demand for specialist placements outstrips provision, and patients who need mental health services often remain in non-specialist beds at the Trust for longer than is desirable. The Trust is working with partners and commissioners across the local health and social care system to seek to resolve this position.

Board Assurance Framework	
Risk	**Risk overview**
Governance systems across the Trust are ineffective in the delivery and monitoring of improvements and high standards of care, treatment and performance	The additional challenges to delivery of effective oversight of quality and safety presented by increased operational pressures associated with the pandemic mean that the Trust could not always be sure that its clinical governance systems were adequate / appropriate. Review of systems, processes and structures is underway, but until assurance is available (expected in early 2021/22), the risk rating has remained high .

3.10 Risks to compliance with condition 4 of the Trust's NHS provider licence

The Board is required to identify and articulate any risks it has identified to its compliance with condition 4 of its NHS Provider Licence, under the following headings. The risks set out below were identified in an external review (conducted by Deloitte, report produced in January 2020) of the Well Led self-assessment conducted by the Trust Board in line with the NHSI Well-Led Review framework.

Risk	Risk rating	Mitigation
Effectiveness of governance structures		
The Trust keeps its governance arrangements under continual review and has identified a need to strengthen quality and operational governance arrangements. In particular, the Trust seeks confirmation that governance activity leads to appropriate action. The Trust also streamlined performance and accountability activity during the pandemic, and there is a need to re-introduce appropriate and proportionate levels of oversight, monitoring and challenge in order to deliver the challenging operational and strategic objectives of the coming year	Medium	• The Trust has commissioned an external review of whether current governance arrangements and resources match the Trust's needs and ambitions • The review will be completed in May 2021, after which associated recommendations will be reviewed and implemented as appropriate • The Trust re-introduced performance & accountability activity in April 2021 • The impact and effectiveness of the reviews will be monitored
The responsibilities of directors and subcommittees		
Reporting lines and accountabilities between the board, its subcommittees and the executive team		

Risk	Risk rating	Mitigation
The Trust has identified that some of the quality governance arrangements which feed into the Board's Quality & Performance Committee are not as effective as they need to be.	Low	• Revised terms of reference and a new work plan are in development for implementation in Q1 of 2021/22
The submission of timely and accurate information to assess risks to compliance with the conditions of the licence		
The degree and rigour of oversight the Board has over the Trust's performance		
There will be further work on the collection, collation, use and analysis of data and information during 2021/22, but no material risks in this regard have been identified	Low	

3.11 Quality governance arrangements

During 2020/21 the Chief Nurse had delegated responsibility for quality and safety, supported by the Medical Director. In addition, the Trust Leadership Team (executive directors and divisional directors) was responsible for the general management of business, including the delivery of relevant quality and performance standards, on behalf of the Trust Board.

Since their establishment in July 2018, the divisional management teams had attended monthly performance and accountability reviews with the executive team. These monitored the delivery of quality, safety and performance standards in line with the Trust's strategy and operating plan. They were suspended on 30th September 2020 to allow focus on managing the second wave of the pandemic, with the temporary governance arrangements put in their place considered by Quality and Performance Committee. The original arrangements will recommence in April 2021.

The Trust Board continues to receive quality and safety metrics as part of the Integrated Performance Report (IPR). This provides the Board with assurance in respect of the Trust's performance against national priorities, set by NHS Improvement (NHSI) and NHS England (NHSE), and local priorities. Quality, safety and performance elements were reviewed in detail,

monthly by the Quality and Performance Committee, with key issues being escalated to the Board as required. The Trust continues to strive to reach sustainable improvement in its performance against its priorities.

The Trust has continued to hold monthly Quality Assurance Committee (QAC) and Quality Delivery Group (QDG) meetings. The QAC provides assurance that the content of the IPR quality section is robust, reflecting appropriate issues and themes. It also ensures that recovery improvement programmes are delivering required outputs or outcomes. The QDG holds divisions to account for quality recovery and improvement through issues identified at the QAC or through other quality intelligence.

The annual clinical audit plan is linked to the Trust's priorities and risks and is monitored by the Clinical Effectiveness Committee, which reports to the Quality and Performance Committee. The Audit Committee also has oversight of the delivery of the plan.

The process for the management of all serious incidents has been strengthened with weekly executive and senior patient safety team review and early investigation planning, with an enhanced focus on learning. All action plans are reviewed by the Serious Incident Review Group to ensure closure and to identify key themes and shared learning for the organisation.

3.12 Equality, diversity and human rights

The Trust is committed to embedding equality, diversity and inclusion (EDI) in everything it does, with the aim of ensuring our workforce at every level is inclusive and representative of the community we serve.

Appreciating diversity is important to the Trust and helps all staff understand that treating people in the same way does not deliver equality for all. The Trust acknowledges and celebrates individual differences whilst recognising that having a diverse workforce drives innovation, enhances creativity and can increase recruitment and retention.

The Board has adopted a number of key priorities which focus on improving the work experience of employees with a protected characteristic. The Workforce and Organisational Development Committee maintains oversight and delivery of key actions for improvement, ensuring the Trust is compliant in meeting the statutory EDI requirements for public sector bodies.

In 2020, the Trust reviewed its EDI Improvement Plan to respond to the areas in most need of improvement, to strengthen it in light of recent national strategies and to ensure it supports delivery of the Trust's overall strategic EDI aim which is 'to ensure our workforce at every level is inclusive and representative of the community we serve'.

The EDI Improvement Plan has been developed around four key improvement themes:

1. Reduce the number of black and minority ethnic staff and disabled staff reporting a lower likelihood of being appointed from shortlisting through improved and inclusive recruitment processes
2. Take positive steps to ensuring all staff are free from discrimination, violence, abuse and harassment in the workplace
3. Provide inclusive career opportunities for development, leading to a more representative workforce at every level
4. Continue to invest in developing compassionate and inclusive leadership

Underneath this plan sit detailed actions as part of everyday business.

By engaging with diverse groups and staff networks, the Trust aims to develop and improve its understanding of the needs of all staff members, with a view to bettering their work experience at Portsmouth.

The Trust employs a diverse workforce; proportionately greater than the population and communities it serves. The table below provides a high-level summary of the Trust's workforce by protected characteristic and staff group:

Staff Group	Age	Disability			Ethnic Origin		
	Largest Age Group and %	Yes (%)	No (%)	Not Stated (%)	White (%)	BAME (%)	Not Stated (%)
Additional Clinical Services	31-35, 12.8%	2.5%	17.8%	4.1%	20.4%	3.7%	0.3%
Administrative and Clerical	56-60, 14.5%	1.9%	11.9%	3.8%	16.7%	0.8%	0.2%
Estates and Ancillary	61-65, 26.1%	0.0%	0.2%	0.0%	0.2%	0.0%	0.0%
Medical and Dental	26-30, 20.4%	0.9%	10.4%	3.2%	8.7%	4.8%	1.0%
Nursing and Midwifery Registered	26-30, 19.1%	2.6%	23.5%	6.0%	21.1%	10.6%	0.5%
Scientific, Therapeutic & Technical	31-35, 19.5%	0.7%	7.9%	2.4%	9.6%	1.3%	0.2%
Students	21-25, 100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Trust	**31-35, 15.5%**	**8.7%**	**71.9%**	**19.4%**	**76.7%**	**21.1%**	**2.2%**

Staff Group	Sexual Orientation			Marital Status			Maternity
	LGB (%)	Heterosexual (%)	Not Stated (%)	Married/Civil Partnership	Single (%)	Not Stated (%)	Maternity Leave (%)
Additional Clinical Services	0.9%	18.8%	4.7%	11.7%	12.0%	0.7%	17.0%
Administrative and Clerical	0.4%	13.7%	3.5%	8.7%	8.6%	0.4%	9.9%
Estates and Ancillary	0.0%	0.2%	0.0%	0.1%	0.2%	0.0%	0.0%
Medical and Dental	0.3%	10.5%	3.8%	8.2%	4.7%	1.6%	12.6%
Nursing and Midwifery Registered	0.7%	23.1%	8.3%	17.6%	13.6%	0.9%	49.8%
Scientific, Therapeutic & Technical	0.2%	8.3%	2.5%	5.8%	4.9%	0.3%	10.8%
Students	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Trust	**2.6%**	**74.6%**	**22.8%**	**52.0%**	**44.0%**	**4.0%**	**100.0%**

Staff Group	Top 5 Religions/Beliefs					Gender	
	Christianity	Not Stated	Atheism (%)	Other (%)	Islam (%)	Female (%)	Male (%)
Additional Clinical Services	11.1%	7.0%	3.8%	2.3%	0.3%	20.8%	3.6%
Administrative and Clerical	8.0%	4.9%	3.0%	2.0%	0.2%	13.8%	3.8%
Estates and Ancillary	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%	0.3%
Medical and Dental	5.0%	4.4%	2.0%	0.6%	1.6%	6.9%	7.6%
Nursing and Midwifery Registered	18.5%	8.6%	3.0%	2.2%	0.2%	28.5%	3.6%
Scientific, Therapeutic & Technical	5.0%	3.2%	2.1%	0.6%	0.2%	8.5%	2.5%
Students	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Trust	**47.8%**	**28.1%**	**14.0%**	**7.7%**	**2.5%**	**78.6%**	**21.4%**

Data run as at 31/03/2021

Very early in the COVID-19 pandemic, it became evident that members of ethnic minority communities were disproportionately affected by COVID-19. A full risk assessment process was put in place to identify where increased risk existed and recommend measures to reduce risk, including redeployment of staff to lower risk areas and working from home.

Over this period, the Black Lives Matters campaign gained prominence and a series of engagement sessions were held by the Chief Executive and Race Equality Network to understand the views of staff in addressing these complex issues, raising the profile and signaling to staff that these issues are important to the organisation. The Race Equality Network has continued to actively support staff throughout this period.

The national trends of lower uptake of the COVID-19 vaccine by ethnic minority communities was observed at the Trust. As a result, a dedicated engagement session was held for staff from ethnic minorities to dispel myths and answer questions in an attempt to improve uptake with a further session planned.

3.13 Developing workforce safeguards

The Trust achieves its compliance with the "developing workforce safeguards" recommendations by a number of measures. Nursing establishments are reviewed regularly and safer staffing reports, based on the National Quality Board model, are regularly received by Board. The Workforce and Organisational Development Committee, chaired by a non-executive director, has been in operation throughout the year and regularly considers all aspects of staffing for all groups

of staff. It has a specific focus on role development, hard to recruit roles, culture and leadership.

The Committee and the Trust Board approved the annual workforce plan which includes a significant investment to recruit of Band 5 nurses to ensure vacancies are minimised in this group where recruitment can often prove challenging. Following successful overseas recruitment for nurses in 2020/21, the Trust is fully staffed for ward-based band 5 nurses despite the pandemic. The plan for 2021/22 is to apply a similar scheme for overseas medical staff and allied health professionals. The Trust has an active Bank Partner; this has achieved a high level of bank fill. Agency staff are employed, as necessary, to ensure critical gaps are filled and services maintained for all staff groups.

3.14 Trust Board

Board committee structure

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

The Trust Board approves an annual schedule of business to which it will add additional items as required. Exception reports to the Trust Board ensure that it considers key issues and makes effective use of its time. The Trust Board met, on a formal basis, a total of six times during the year and Board papers are published on the Trust website.

The Trust's Standing Orders, Standing Financial Instructions and Reservation and Delegation of Powers were reviewed and revised as part of the Well-led Review considered by Trust Board in February 2020. These have remained in place throughout 2020/21 and have been operated alongside the recommendations implemented as a result of the Well-led Review conducted in February 2020. These included the variation of the Standing Orders to facilitate decision making outside of Board meetings and the reduction of these meetings in number to six per year.

Board performance

As at 31st March 2021, the Trust Board comprised the Chairman, five independent Non-Executive Directors (plus four independent Associate Non-Executive Directors) and nine Executive Directors. Four of the Executive Directors are non-voting (Director of Strategy & Performance, Director of Governance & Risk, Director of Research and Director of Workforce & Organisational Development).

The Trust Board was the central element of the 2020 Well-led Review, conducted by an external reviewer. This noted the strength of leadership provided by the Trust Board's members. The Board itself was noted as providing a positive and supportive environment for challenge and debate. This bolstered the vision and strategy being implemented across the Trust. The Trust has also been rated as 'Good' in the Well-led domain by the Care Quality Commission following a Well-Led inspection in November 2019. Items of outstanding practice noted in the inspection report include improvements made to culture across the organisation.

The operation of the Trust Board and its constituent Committees has been amended significantly following the Well-led Review mentioned above. In particular, the frequency of Trust Board meetings has been reduced from ten to six per year to reflect a greater emphasis on strategic rather than operational matters. The Board has benefitted as its membership becomes increasingly experienced and established, with their operation as a corporate whole supporting the Trust's accountability framework in an appropriate manner. As a central element of this, the

Integrated Performance Report has continued to evolve and has incorporated the findings of the newly-established Quality Assurance Committee as well as Heat Map meetings. The former of these has ensured appropriate oversight of operational concerns; meanwhile, the latter have continued to bring a range of expert voices from across the Trust provide insight and evidence on emerging quality, safety and performance issues.

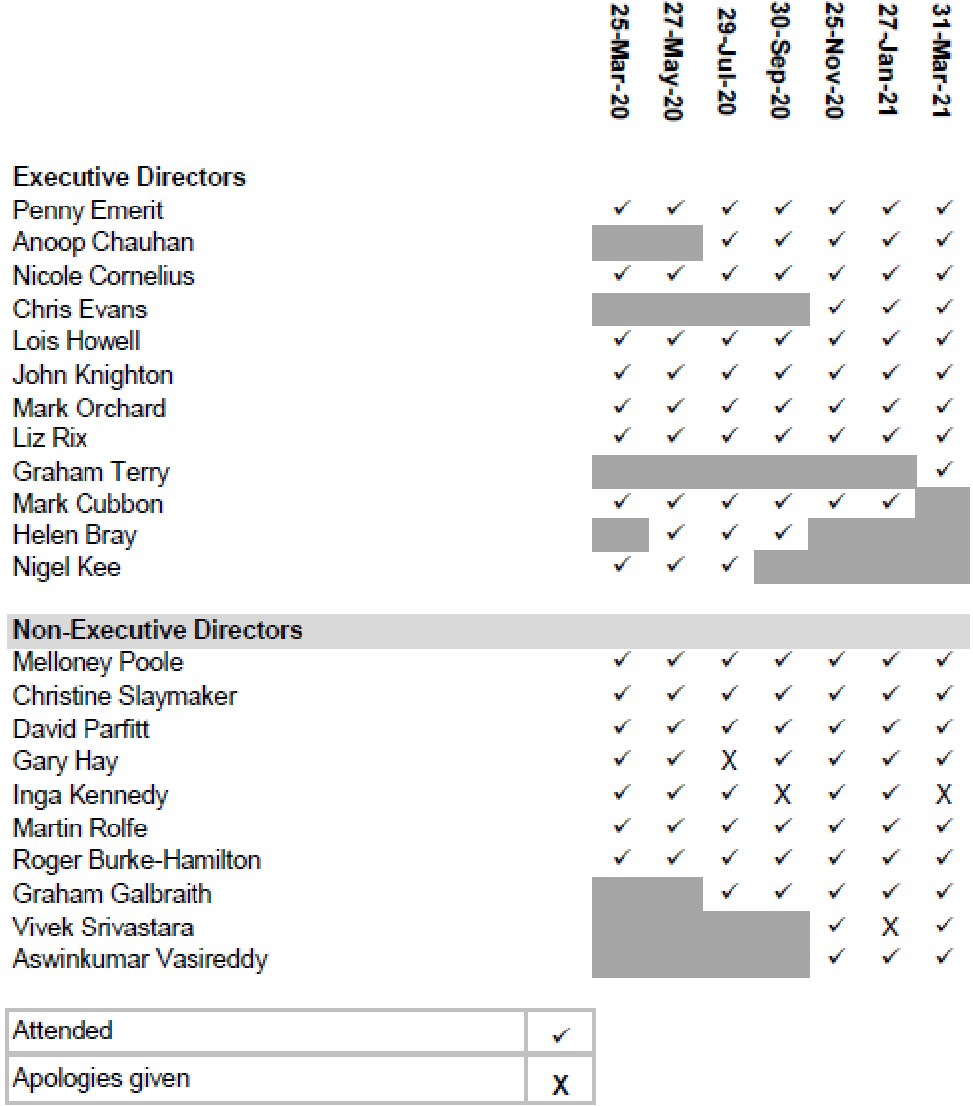
As a result, the Quality and Performance Committee has been able to receive and consider input which has moved from information towards genuine analysis; this has been assisted by the appointment to the Committee of two additional Non-Executive Directors with considerable clinical knowledge. As a result, the information currently presented to Trust Board is based on metrics which are appropriate, triangulated with external sources and provide rigorous analysis that provides insight beyond surface level data. Further support has been provided through the revised presentational format used to consider patient safety and patient experience; in 2021/22, it is intended that the reporting of clinical effectiveness will undergo similar review.

The Board has also been supported in its work on financial planning and oversight by the Finance and Infrastructure Committee. Whilst the conditions under which the Trust has operated have been atypical, with the two halves of the year operating under different financial regimes, the Committee has maintained its focus on sustainability and securing value for money. A series of established tests (e.g. management oversight and scrutiny, quality and safety, benefits realisation) are used to assess business cases, and these have improved the quality of proposals. The reporting of a version of the contracts register which is tailored to the Committee's interests and remit has augmented this. Meanwhile, the formulation of the Operational Plan 2021/22 has continued despite the uncertainties regarding arrangements for the year. The improvements in this arising from the previous co-ordination meetings involving all committee chairs has been embedded and is now an established part of the process.

As a result, 2020/21 built on the positive developments of previous years and saw Trust Board and its committees continue to evolve and support the Trust's ambitions for improvement. Whilst the pandemic has had an inevitable impact on the priorities for the year (as well as operationally, discussed in more depth below), there has been a move towards a more streamlined and strategic work programme. The amended reporting process, with a substantially higher number of items reported through committees after receiving prior scrutiny, has also allowed more efficient use of time in Board meetings. This has supported a higher level focus in discussions which will support the wider health and social care system's aims. Increased attendance at recent meetings (and the very healthy number of stakeholders and members of the public at the Annual General Meeting) are also indicative of an increased prominence for the work of Trust Board.

Processes to ensure that the Trust Board undertakes its duties appropriately are in place. As outlined in other parts of this report, the Chairman of the Trust Board conducts annual appraisals of the Non-Executive Directors and the Chief Executive. The Chief Executive reviews the performance of the Executive Directors. As part of this latter process, the expressed views of Non- Executive Directors are taken into account.

A record of attendance at meetings of the Trust Board is set out below:



TRUST BOARD ATTENDANCE RECORD

	25-Mar-20	27-May-20	29-Jul-20	30-Sep-20	25-Nov-20	27-Jan-21	31-Mar-21
Executive Directors							
Penny Emerit	✓	✓	✓	✓	✓	✓	✓
Anoop Chauhan			✓	✓	✓	✓	✓
Nicole Cornelius	✓	✓	✓	✓	✓	✓	✓
Chris Evans					✓	✓	✓
Lois Howell	✓	✓	✓	✓	✓	✓	✓
John Knighton	✓	✓	✓	✓	✓	✓	✓
Mark Orchard	✓	✓	✓	✓	✓	✓	✓
Liz Rix	✓	✓	✓	✓	✓	✓	✓
Graham Terry							✓
Mark Cubbon	✓	✓	✓	✓	✓	✓	
Helen Bray		✓	✓	✓			
Nigel Kee	✓	✓	✓				
Non-Executive Directors							
Melloney Poole	✓	✓	✓	✓	✓	✓	✓
Christine Slaymaker	✓	✓	✓	✓	✓	✓	✓
David Parfitt	✓	✓	✓	✓	✓	✓	✓
Gary Hay	✓	✓	X	✓	✓	✓	✓
Inga Kennedy	✓	✓	✓	X	✓	✓	X
Martin Rolfe	✓	✓	✓	✓	✓	✓	✓
Roger Burke-Hamilton	✓	✓	✓	✓	✓	✓	✓
Graham Galbraith			✓	✓	✓	✓	✓
Vivek Srivastara					✓	X	✓
Aswinkumar Vasireddy					✓	✓	✓

Attended	✓
Apologies given	X

All members of the Trust Board fully accept the principles contained in the September 2014 Corporate Governance Code relating to accountability, transparency, probity and focus on sustainable success, and the Nolan principles. Each Director of the Trust has passed the 'fit & proper person' test. A register setting out details of company directorships and other significant interests held by members of the Trust board which may conflict with their Board responsibilities is available on the Trust's web-site at https://www.porthosp.nhs.uk/about-us/key-documents.htm

Board committees

The following committees have reported to the Trust Board throughout 2020/21 (all with Non-Executive Directors as Chairs):

- Audit Committee (mandatory):
  The Audit Committee is the senior Board committee responsible for oversight and scrutiny of the Trust's systems of internal control and risk management. It ensures that there are effective internal audit arrangements in place that meet mandatory NHS Internal Audit Standards and provides independent assurance to the Board. In addition, the Committee

reviews the work and findings of External Audit and maintains oversight of the Trust's Counter Fraud arrangements. Membership was in line with the Terms of Reference. The Audit Committee met six times during 2020/21. It was chaired by a Non-Executive Director, who submits a regular report to the Trust Board.

- Quality and Performance Committee:
  This committee, chaired by a Non-Executive Director, reviews the delivery of key national, local and internal performance targets. It also oversees clinical quality and effectiveness to drive continuous improvement. As part of this, the Committee scrutinises specific issues it has identified, or others have referred to it to seek assurance on their management and resolution.

- Finance and Infrastructure Committee:
  The committee reviews financial reporting and management, identifying and monitoring progress against risks related to these areas. It also provides assurance to the Board on all significant performance aspects relating to finance and infrastructure as well as reviewing the financial aspects of investment proposals. The committee is a chaired by a Non-Executive Director.

- Workforce and Organisational Development (OD) Committee:
  This committee, chaired by a Non-Executive Director, reviews all aspects of workforce and organisational development, including monitoring the implementation of the Trust's Workforce and Organisational Development Strategy and compliance with relevant national standards, regulations and local requirements pertaining to staffing. This is with particular focus upon safe staffing of the hospital to provide safe, high quality, patient-centred care and the delivery of the Trust's strategic priorities and ambitions in an affordable manner. Meetings for this committee have been reduced to quarterly (rather than monthly) as part of the implementation of the Well-led Review.

  The Board has overall responsibility for the effectiveness of the governance framework and requires that each of its committees has terms of reference, approved by the Board, which describe its duties, responsibilities and accountabilities, and the process for assessing and monitoring effectiveness. The committees are charged with providing assurance on the matters in their remits, as discussed above.

In addition, the Remuneration Committee has overseen the following areas under delegated authority from the Trust Board (chaired by the Trust Board Chairman):

- The broad remuneration policy and performance management framework
- The setting of individual remuneration arrangements for the Trust's Executive Directors.

<u>Operation during the COVID-19 pandemic</u>

In response to national guidance on safe management of the COVID-19 pandemic, significant restrictions have been in effect for meetings throughout 2020/21. Most notably, all planned Board and Committee meetings have been held virtually; however, with the exception of Remuneration Committee, the scheduled calendar of events was maintained.

Additionally, such meetings have had an appropriate focus on providing direction and seeking assurance in respect of the Trust's handling of the challenges presented by the pandemic. However, wherever possible business as usual has been maintained, with Trust Board undertaking its planned work for the year. Where appropriate, items relating to the pandemic (e.g. recovery planning for elective services, infection prevention and control) have been added to agendas whilst discussions have considered the context of COVID-19 as appropriate. Despite the conditions outlined above, the Finance & Infrastructure Committee and Trust Board undertook their planned consideration of business cases.

As indicated earlier in the report, the Trust also created an additional committee, the Board Major Incident Response Committee (BMIRC). After its establishment on 1st April 2020 it held its inaugural meeting on 2nd April and met on seven occasions during the first wave of the pandemic (concluding on 23rd April). With a focus on making any urgent decisions required between Trust Board meetings, it considered areas such as personal protective equipment, workforce modelling and the Capacity Plan for managing critical care. It also allowed certain Board members to be sighted on the developing situation on site during the period as well as offering support to Executive Directors. However, whilst it remains possible to reconstitute this body should it be required this was not the case during the second wave in the winter of 2020/21.

3.15 Care Quality Commission

All NHS healthcare providers are required by law (Health and Social Care Act 2008 (Regulated Activity) Regulations 2009 and the Care Quality Commission (Registration) Regulations 2009) to register with the Care Quality Commission (CQC) and to deliver compliance with 28 regulations, 16 of which relate to the quality and safety of care received by patients. The CQC periodically inspects healthcare providers to assess compliance with these regulations and, if necessary, places conditions on a Trust's registration when non-compliance is identified.

As noted in section 1.7, the Trust was subject to a full CQC inspection in October and November 2019, following which the Trust rating improved from 'Requires Improvement' to 'Good'. In September 2019, the Trust was also inspected under the 'Use of Resources' framework, resulting in a 'Good' rating.

Ratings	
Overall trust quality rating	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good
Are resources used productively?	Good
Combined quality and resource rating	Good

The Trust worked with the CQC during 2020/21 to provide evidence of its compliance with a Notice served on the Trust after the 2019 inspection under section 29A concerning practice in the Emergency Department (ED), focussed principally on:

- Reducing delays to the handover to the Trust of patients brought to the ED by ambulance
- Improving the oversight of self-presenting patients in the ED waiting areas

The Trust is very pleased to confirm that the Commission confirmed in a letter dated 1st April 2021 that the requirements have been delivered in full.

The CQC did conduct a brief focused inspection on medicine safety in July 2020. The inspection had a broadly positive outcome, and there was no impact on any of the Trust's ratings.

There is regular liaison with the Care Quality Commission regarding delivery of improvements. This has included the introduction in February 2021 of specific quality assurance metrics pertaining to the Emergency Department as part of the weekly reporting on Non-Elective Flow and Transformation to the Trust Leadership Team.

The Trust continues to work on a range of projects to ensure that the improvements delivered during 2020/21 are sustained. The revised approach to quality governance, developed in partnership with the CCGs, continued during 2020/21. This helped to promote an open and transparent governance structure and to balance compliance activities with the pursuit of aspirational and ambitious improvement.

The Trust is not fully compliant with the registration requirements of the Care Quality Commission, due to the rating of 'requires improvement' for the Safe domain.

3.16 Quality Account

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

Due to the COVID-19 pandemic, The National Health Service (Quality Accounts) Regulations 2010 which set out the Quality Account requirements were amended by the 'National Health Service (Quality Accounts) (Amendment) (Coronavirus) Regulations 2020'. This amendment led to the removal of the deadline for publication of the 30th June 2020 and removed the need for external assurance. In light of the pressures caused by COVID—19 NHSE/I recommended a revised deadline of 15th December 2020. The Trust met this deadline; publishing the 2019/2020 Quality Accounts on 15th December 2020.

The Trust Quality Account set out the priorities for 2020/21 and reflected on its achievements in 2019/20. To provide assurance on the accuracy and data quality of the Quality Account, data submissions must be accompanied by a data validation form signed by both the data owner and their line manager. The majority of quality metrics are reported monthly to the Board and the Quality and Performance Committee. The Quality Account for 2020/21 will be published on 30th June 2021 and include the priorities for 2021/22.

3.17 NHS Pension Scheme governance

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions, and payments into the scheme are in accordance with the Scheme rules, and that members' Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations. The Trust provides the NHS Pensions Agency with an annual assurance statement.

3.18 Carbon reduction

The NHS publishes regular updates on carbon reduction and achieving zero carbon for the health and care sector and will require both delivery of the NHS Long Term Plan targets and wider action to reduce carbon emissions across the healthcare supply chain. The Trust is committed to establishing an update of the Trust Carbon footprint and will undertake this work over the coming year.

The Long Term Plan outlines the first steps required to achieve significant carbon reductions. This includes ensuring a Green estate by investing in projects such our LED lighting and electrical vehicle charging points. Further carbon efficiencies and continuous carbon improvement strategies including further reductions in waste, water and carbon energy usage are required.

Adherence to best practice efficiency standards and adoption of new innovations are also essential. Key to these will be delivering improvements, including reductions in single use plastics, throughout the NHS supply chain. (NHS Sustainable Development Unit. www.sduhealth.org.uk/nhs)

In support of the NHS Long Term Plan, the Climate Change Act 2008 and the climate change emergency, key carbon reduction work streams are also under way. The Trust is currently recruiting to the post of Energy and Sustainability Lead. This post will help to develop the Trust's Carbon Reduction Delivery Plans and sustainability strategies.

Joint working with the Trust's PFI provider, The Hospital Company, and Engie to agree energy saving initiatives and management of energy use and carbon emissions at Queen Alexandra Hospital has commenced.

The LED lighting project is now underway and the Trust is working to replace all current lighting (approximately 24,000 units) to low energy LED light fittings, with a projected annual saving of over five million kilowatt hours of electricity. The Green Travel Plan continues to be developed and the Trust is proud to partner Portsmouth City Council in the rollout of the trial of electric scooters. A revised Travel and Transport Strategy will set out the Trust's plan to tackle the effects of local traffic congestion and car parking pressures at Queen Alexandra Hospital. The Trust has recently been granted planning consent for a new public multi story car park which will include electrical vehicle charging points.

The Trust continues to engage with partners in the local healthcare system to collaborate on energy and regional carbon initiatives. As part of this it is participating in the Portsmouth Climate Action Board and Strategy Sub-group in support of the local climate and carbon reduction initiatives.

3.19 Review of economy, efficiency and effectiveness of the use of resources

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

The Trust also underwent its first Use of Resources inspection in September 2019, conducted by NHS Improvement. The report acknowledged improvements in governance and delivering against this year's financial plan, and a low cost per weighted activity unit, which places the Trust in the lowest cost quartile nationally. The overall rating for the use of resources is "Good".

Areas highlighted as outstanding practice include the bed management system (Bedview) and the

Outpatient transformation programme.

Areas identified for improvement include:

- a need to continue to reduce agency spend below the ceiling specified by NHS England and NHS Improvement
- acceleration of Cost improvement Plan (CIP) opportunities to improve underlying deficit
- pursue further reduction of costs in prescribing, waste management, medical staffing, job planning, microbiology
- embed SLR to drive productivity and efficiency
- improve operational performance (although it is of note that the Trust is not commissioned to achieve RTT constitutional standards).

3.20 Corporate governance

Through its governance arrangements, the reviews undertaken by the Trust's Internal Auditors, and the preparation of the Board Governance Memorandum, assurance is provided that the Trust complies with the HM Treasury/Cabinet Office Corporate Governance Code and there are no significant departures from the Code.

The Audit Committee gives specific consideration to matters of probity, propriety and regularity of public finances and value for money. These discussions are based on the work of the external auditors, the Trust's local counter fraud specialist and internal auditors.

3.21 Financial governance

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

The duties and responsibilities of the Finance and Infrastructure Committee include the review of the Trust's financial position and to scrutinise and approve, under delegated limits, the investment appraisal of business cases and wider business development opportunities.

3.22 Information governance

The Director of Governance and Risk is the nominated Senior Information Risk Officer (SIRO). This post holder is responsible (alongside the Medical Director as Caldicott Guardian and the Trust's Data Protection Officer) for ensuring there is a control system in place to maintain the security and confidentiality of personal information.

The Trust has a Data Protection and Data Quality Committee, chaired by the Director of Governance and Risk with representatives from across the Trust, including the Head of Information Governance / Data Protection Officer and all clinical divisions and corporate departments. The Group takes responsibility for overseeing compliance with information governance requirements, including the review of all relevant serious incidents and risks, and gathering evidence and assurance across the ten standards within the Data Security and Protection Toolkit (DSPT).

At the time of writing this report, the submission of evidence for the 2020/21 DSPT has been postponed by NHS Digital until 30th June 2021. It is likely that the Trust will be unable to submit

DSPT as 'standards met' due to the Trust's ability to supply assurance for the following standards:

Standard 6.2.11 – You have implemented on your email Domain-based Message Authentication Reporting and Conformance (DMARC), Domain Keys Identified Mail (DKIM) and Sender Policy Framework (SPF) to make email spoofing difficult
Standard 6.2.12 – You have implemented spam and malware filtering, and enforce DMARC on inbound email.
Standard 8.3.2 – How often in days is automatic patching typically being pushed out to remote endpoints?
Standard 8.3.3 – There is a documented approach to applying security updates (patches) agreed by the Serious Information Risk Owner.
Standard 8.4.2 – All infrastructure is running operating systems and software packages that are patched regularly and as a minimum in vendor support

Action plans for all the above standards have been compiled and will be sent to NHS Digital along with the Trust's DSPT submission.

Risks to information security are managed through the Trust's incident reporting mechanisms and Risk Registers. The top three information governance risks reported on the 2020/21 DSPT, are:

8	Disclosure of confidential information resulting in patient harm and / or regulatory action
2127	Malicious unauthorised access to patient information resulting in patient harm and / or regulatory action
2128	Noncompliance of the core assertions for the DSPT resulting in contractual and reputational risk

Actions are in place to address each of these risks. Delivery of the actions is monitored by the Data Protection and Data Quality Committee, which reports to the Quality and Performance Committee.

3.23 Information governance incidents

As reported in the Annual Governance Statement (from page 29) the Trust experienced five reportable serious incidents in 2020/21 which were reported using the Data Security and Protection Toolkit and are summarised below.

Externally Reportable Incidents				
ICO Reference	**Date Reported**	**What Happened**	**Reported to**	**Outcome**
20511	15th July 2020	Information regarding a deceased child shared with parent of another deceased child	ICO	Co-operating with ICO investigation, awaiting final report from Civil Investigation Team
22045	12th Nov 2020	Patient's details inappropriately shared with	Not required to report	None

Externally Reportable Incidents				
ICO Reference	Date Reported	What Happened	Reported to	Outcome
		other patients via email		
22063	13th Nov 2020	Potential issue of incorrect pathology test results following merge of datasets	DHSC / NHSE / ICO	Closed – no further action
22491	17th Dec 2020	Confidentiality breach after patient's information discussed with a relative without prior consent	ICO	Closed – no further action
23238	4th March 2021	A patient's notes were left at her bedside table and potentially accessible to her visitors.	ICO	Reported – awaiting ICO information request

Data quality and governance

The Trust has a Data Quality Policy to guide and instruct employees involved in the collection, use and management of data, on how to achieve and maintain high levels of data quality to support high quality patient care. The Data Quality Policy emphasises that data quality is the responsibility of the whole Trust, with all employees holding responsibility for the quality of the information they collect and provide. Overall, responsibility for data quality sits with the Trust Board, with delegated responsibility to the Data Protection and Data Quality Committee (DPDQ) and executive leadership through the Director of Governance & Risk. Compliance with the Data Quality Policy and standards is monitored by the DPDQ committee. The DPDQ Committee also has responsibility for setting the Trust's strategy for maintaining and improving data quality. It is responsible for providing assurance on data quality to the Board and identifying risks posed by poor data quality.

Divisional Management Teams hold devolved responsibility for the quality of data recorded within their Division. The PAS Data Quality Team is responsible for improving the quality of the demographic data and the Analytics Department is responsible for running final data quality checks. Information Asset Owners are accountable for the quality of data held in the information assets that they 'own', Information Asset Administrators are responsible for ensuring that data quality procedures, standards and checks are implemented for their assets and team/ward managers and administrative managers hold responsibility for ensuring their staff comply with data quality procedures.

In applying the Trust's Data Quality Policy, there has been an emphasis on 'getting data right first time'. The Trust, therefore, has a formal and on-going programme of training on data quality including induction training, PAS training, system-specific training, remedial and refresher training. In addition, there is an established approach to data quality monitoring activities within the Trust. These involve:

- Routine data quality checks – routinely published information and reports involving information either missing or likely to be incorrect or put in the system late. These comprise of routine reporting to Divisions, Care Groups, Executives and the Outpatient Booking Centre on data quality issues as appropriate. Examples include outpatient appointments with missing information, issues with coding details, issues with patient details, issues with activity validation including 52 week referral to treatment (RTT) breaches, 18 week RTT breaches and six week breaches on diagnostic waiting times.

- Ad hoc data quality checks – as and when deemed required, detailed quality checks are performed on data to determine its accuracy. These are not regular checks, but only carried out when data seems irregular or unexpected. Examples of some ad hoc checks and fixes include audiology fit appointments have been entered onto PAS as telephone appointments, invalid GP Practice codes, incorrect manual entry of referral dates and 12 hour trolley waits in the Emergency Department.
- Spot checks on data quality – throughout the year, there are spot checks performed on the quality of the data recorded on the hospital's systems. These are randomised spot checks undertaken to check the accuracy of the data and any improvements or reductions in this quality. For example, the Data Quality team with IT, every week, selects a randomised number of active patients on our system to run against the digital central point for NHS online services. Many patient details are compared against the information the GP has recorded for this patient. Validations and quality checks are also performed on the full RTT Patient Tracking List.

Benchmarking review of the Trust against other providers within Hampshire and the Isle of Wight health system, as well as national averages, shows the Trust was consistently above its peers for some data quality indicators including:

- The percentage of valid NHS numbers in data held

	PHU	Region	National
Inpatient	99.9%	99.6%	99.5%
Outpatient	100%	99.9%	99.7%
A&E	99.6%	98.7%	97.9%

- When looking into Inpatient activity in data quality reports, the Trust is above the national average for 11 out of 13 KPIs.
- The Trust was part of a national waiting list validation exercise which undertook targeted validation during January 2021. This provided 160 hours of validation, reviewing 4,106 pathways and closing 784 RTT clocks.

The overall quality of the Trust's data is high, and this is apparent when benchmarked against other Trusts. However, opportunities for data quality improvement identified as part of the Trust's benchmarking review include:

- Quality of GP details on Trust systems; this is due to the age of the system. The IT department and the analytics team are working together to improve the accuracy of the data at source.
- Ethnicity recording across the different systems.
- Outpatient recording of outcome and associated referrals details

The Trust is also in the process of re-establishing a Data Quality Steering Group to ensure ongoing data improvement in the overall data quality and provide a forum for further discussion and development of the current data quality exercises.

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare a Quality Account for each financial year. The publication of this document is usually aligned to the publication of the Annual report and accounts, but has been delayed nationally this year in response to the COVID-19 pandemic. The Quality Account for 2019/20 was published in December 2020 and the Quality Account 2020/21 is to be published on 30th June 2021.

3.24 Review of effectiveness of risk management and internal control

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

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

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

Independent sources:

- Internal Audit, which carries out a continuous review of the system of internal control and reports the results of audits and any associated recommendations for improvement to the Audit Committee and to the relevant senior managers
- External Audit work
- The work of the Local Counter Fraud Specialist (LCFS), which is regularly reported to the Audit Committee
- Announced and unannounced visits by the Care Quality Commission

Internal sources:

- Quarterly review of the Board Assurance Framework and Board Risk Register
- Preparation and publication of the 2019/20 Quality Accounts, and quarterly reporting against delivery of the Quality Account objectives to the Quality and Performance Committee
- Quarterly quality reports to the Quality & Performance Committee, which provide more detail about patient safety, patient experience and clinical effectiveness
- Quarterly Health and Safety reports to the Health and Safety Committee and Quality and Performance Committee
- Monthly reports of serious incidents to the Trust Board
- Monthly quality exception reports to the Quality & Performance Committee and Trust Board
- Monthly reports from key directors, including Chief Finance Officer, Chief Nurse and the Chief Operating Officer
- The review of all Internal Audit reports by the Audit Committee and Trust Leadership Team. This process provides assurance that any risks identified by Internal Audit are discussed for potential inclusion on the Board Risk Register and/or Board Assurance Framework.

An Internal Audit programme, designed to ensure that adequate and effective controls over the Risk Management and Assurance Framework process are in place, is carried out each year. This provides me with an objective opinion of the effectiveness of our risk management and internal controls and any agreed actions will be implemented.

The Head of Internal Audit Opinion is that the Trust has reasonable and effective risk management, control and governance processes in place. The COVID-19 pandemic has not impacted on the Head of Internal Audit's overall assessment.

3.25 Significant internal control issues

The Trust's internal auditors have not identified any Priority 1 recommendations (fundamental control issues on which action should be taken immediately).

3.26 Conclusion

The Trust has identified the internal control issues identified at paragraph 3.25 above and has addressed them in a timely way to ensure that the statement of internal control for 2020/21 is unqualified.

Accountable Officer:	Penny Emerit
Organisation:	Portsmouth Hospitals University NHS Trust
Signature:	
Date:	**7th June 2021**

4. REMUNERATION AND STAFF REPORT

4.1 Investing in staff and workforce

The Trust believes that a highly skilled, motivated and engaged workforce is essential to ensuring the delivery of quality integrated care for the population it serves. The Trust has a track record of promoting workforce diversity and engagement, shared values and behaviours and continuous development and learning among its workforce. The Trust employs around 7,500 staff and is the largest employer in Portsmouth.

4.2 Remuneration Committee

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

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

- Agree the remuneration and terms of service for each executive director, including performance related pay;
- Agree overall remuneration in terms of service for senior managers not on National contracts;
- Agree any termination arrangements required for executive directors;
- Monitor the performance of executive directors; and
- Agree special/exceptional payments covering any individual member of staff or staff group.

The Committee membership is comprised of all Non-Executive members of the Board and is chaired by the Board Chairman. The Chief Executive and other executive directors may be invited to attend meetings of the Committee but must withdraw for any issue that personally relates to them.

4.3 Remuneration policy

Remuneration for staff is set through nationally agreed terms and conditions as detailed in Agenda for Change and the national contracts for Consultants and Junior Doctors. The Trust is compliant in its application of these policies. Remuneration for Executive Directors is overseen by the Remuneration Committee.

4.4 Remuneration tables (audited)

Salary and pension entitlements of senior managers are shown in Appendix 1 to this report on pages 122 – 123.

4.5 Pension liabilities

The majority of the Trust's employees are entitled to membership of the NHS Pension Scheme. The scheme is an unfunded defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales.

The scheme is accounted for as if it were a defined contribution scheme; further details can be found in the Trust's accounting policy at note 9 in the Trust's Annual Accounts.

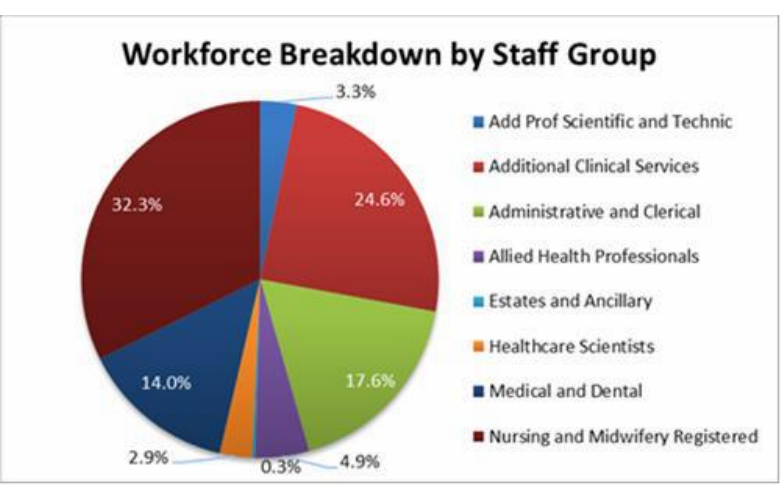
The alternative pension scheme is NEST, a government scheme for auto enrolment run as a trust. NEST is run by its Trustee, NEST Corporation.

4.6 Resourcing

Recruiting and maintaining an effective workforce is a major priority and the Trust's strong partnerships with Bank Partners, which provides the Trust's temporary workforce, Engie and the Ministry of Defence helps the Trust to achieve the goal of maintaining safe services for all patients.

The table below details the Trust's total workforce capacity which is made up of the following staff groups;

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



In addition to the substantive workforce, temporary staffing accounts for 7.5% of the total workforce establishment.

4.7 Volunteers

The Trust is privileged to have over 600 volunteers who support many areas of the organisation. As a result of COVID-19, volunteering was paused in many areas and some volunteers were unable to offer their services. A few experienced individuals have retired; however, many new recruits have joined us either on a temporary or permanent basis.

Volunteers contribute across a wide range of roles. They support staff in delivering high-quality care that goes above and beyond core services, improving the satisfaction and wellbeing for patients and staff. Volunteers have been responsive to the requirements of the Trust especially with the implementation of the Patient Belonging Drop Off Service which came about due to the restrictions on visiting. This was a completely new service and over the last year volunteers have delivered over 30,000 bags and messages to loved ones. Other examples include:

- Supporting the Family Liaison Team by keeping patients in touch with loved ones
- Helping patients undertake lateral flow tests prior to outpatient appointments
- Assisting with administration and patient wellbeing in the Emergency Department
- Helping new International nurses find their way around the hospital and Portsmouth
- Packing and delivering boost boxes to our staff with fundraising team and delivering boxes of toiletries to each ward from donations from the community

The post COVID-19 environment offers the opportunity for volunteers to contribute to changes. Volunteers who have taken a break over the last year have started to return and the following roles will be prioritised to enhance patient experience or enable our staff to deliver high quality care:

- End of Life Volunteers
- Dementia Volunteers
- Dining Companions
- Patient Experience and Feedback Volunteers
- Patient Representatives

Volunteers are an integral part of the Trust and are celebrated in several ways. Volunteers are recognised at the Trust Annual Pride of Portsmouth Awards and by special recognition awards from the Trust Chairman, Melloney Poole OBE. The Trust Chair presents a ‘Kindness of your Heart’ award to volunteer teams or individuals to thank them and show her appreciation for all that they do. The award recognises the dedication and commitment that they have made in their volunteering role in making an immeasurable contribution to the quality of care received by patients. The Trust is privileged to have an exceptional cohort of volunteers who provide valuable support to patients, families, carers and staff.

4.8 Health, safety and wellbeing

The Trust is committed to protecting the on-going health and wellbeing of all staff and, whilst this has been challenging throughout the COVID-19 pandemic, additional focus and resource has been diverted to ensure staff health and wellbeing is a top priority. Implementation of an Employee Assistance Programme, strengthened Occupational Health Support and Health and Wellbeing information has been provided for all staff to ensure they are aware of how to access the appropriate support and receive the appropriate clinical advice.

Risk assessments have taken place for all staff within groups at a high-risk of adverse outcomes from COVID-19, specifically for staff with ethnic minority groups, underlying health conditions, age and Body Mass Index (BMI) and where appropriate staff have been redeployed to lower risk areas, have worked from home or remained at home whilst shielding.

Many staff working through the pandemic have worked in difficult and unpleasant circumstances resulting in a physically and emotionally exhausted workforce.

Wellbeing conversations have been implemented for all staff which has been based on national recommendations, with managers receiving guidance on how to have wellbeing conversations with their teams. To further supplement this, REACT Mental Health Training for Managers has been implemented for front line leaders to enable them to recognise when staff may be experiencing mental health issues and provide them with the tool to have a psychologically informed conversation with their staff, and identify if they are at risk of harm.

Working with our partner NHS organisations, mental health and wellbeing support has been provided to staff through debriefing type sessions to enable staff to process the difficulties of providing healthcare in a pandemic situation, and this will continue as we progress through the recovery phase of the pandemic.

Managing staff sickness

There are associated Human Resources (HR) policies and procedures which support staff and managers within the Trust. The average staff sickness level for the year increased, as a result of COVID-19, to 4.5%. We implemented an innovative Staff Support function to enable employees to ring a central number to report sickness and provide them with advice and occupational health support in a timely manner if necessary. There is a range of measures in place to ensure that absence is managed appropriately and that employees who are unable to fulfil their contractual duties due to ill health or disability are managed fairly and sensitively.

4.9 Raising staff concerns

To ensure that the Trust's vision and values are at the forefront of everything it does, openness, transparency and dealing with any issues that may arise in a confidential, timely, consistent, fair and appropriate manner is fundamental. It is a right of employees in the Trust, if they have any concerns about wrong-doing at work, to be able to raise these concerns through the Trust's Raising Concerns (Whistle Blowing) Policy. Any disclosure or 'whistle-blow' is handled in a confidential manner, taken seriously and investigated appropriately.

The Trust's Freedom to Speak Up (FTSU) Guardian continues to help staff raise concerns in a confidential, supporting and anonymised manner, signposting appropriately. The Guardian is available to be contacted by all staff for advice and support in raising and managing concerns about their working life, including concerns surrounding patient safety and quality and bullying and harassment. This is a key role in promoting an open and honest culture of listening, learning and not blaming, so that concerns raised are welcomed, acted upon in a fair manner and addressed. The Guardian has access to anyone in the Trust, including the Chief Executive, and can, if necessary, seek further support from outside of the Trust.

The Guardian is supported by a number of FTSU Advocates across the organisation who champion the FTSU agenda and provide a direct link between individuals, departments and the FTSU Guardian. The Trust has ensured that the team of Advocates is representative of a broad sector of the workforce.

Staff can raise concerns to the Guardian through a number of routes and over the past year the further development of an online reporting portal using DATIX has proven to be beneficial. The online portal allows staff to raise concerns that will go directly to the Guardian and can be raised anonymously if required.

FTSU Advocates are in place in all Divisions / Care Groups and corporate functions to support the Guardian role. During 2020/21 the Trust's FTSU service has seen marked improvement in the number of concerns being managed effectively at a local level with support and guidance but without the need for escalation. This was referenced within the CQC's most recent Well Led report where it was noted that the culture across the organisation had improved. Staff felt respected, supported and valued. An open culture where patients, their families and staff could raise concerns without fear was also noted. FTSU continues to receive positive feedback on the use of the service, with staff feeling that they are supported and that their concerns are heard and valued. On average 80% of all concerns raised with the Guardian are resolved at a local level without the need to escalate further.

4.10 Fair pay policy (audited)

On pages 122 - 123 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 2020/21 was £220 – £225k, which was the Chief Executive and his salary was comparable with 2019/20. The salary was 8.2 times (2019/20, 7.77 times) the median remuneration of the workforce which was £27,417 (2019/20, £27,260) all of these relate to Band 5 staff members. In 2020/21, no employees received remuneration in excess of the highest-paid director (2019/20, 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.

			2020/21	**2019/20**
	Permanent	**Other**	**Total**	**Total**
	£000	**£000**	**£000**	**£000**
Salaries and wages	282,382	1,801	**284,183**	252,208
Social security costs	28,553	-	**28,553**	25,290
Apprenticeship levy	1,436	-	**1,436**	1,282
Employer's contributions to NHS pensions	49,136	-	**49,136**	44,589
Temporary staff (external bank)		36,091	**36,091**	26,520
Temporary staff (agency)		8,332	**8,332**	16,221
Total gross staff costs	**361,507**	**46,224**	**407,731**	366,110
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**361,507**	**46,224**	**407,731**	366,110
Of which				
Permanent staff costs capitalised as part of assets	1,283	-	**1,283**	1,831
Agency staff costs capitalised as part of assets	992	-	992	773
Average number of employees (WTE basis)				
	Permanent Number	**Other Number**	**2019/20 Total number**	**2019/20 Total number**
Medical and dental	1,046	43	1,089	1,092
Administration and estates	1,277	24	1,301	1,322

			2020/21	2019/20
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Healthcare assistants and other support staff	0	149	149	170
Nursing, midwifery and health visiting staff	3,851	320	4,171	4,045
Scientific, therapeutic and technical staff	708	11	719	707
Healthcare science staff	181	1	182	185
Total average numbers	7,063	548	7,611	7,521
Of which:				
Number of employees (WTE) engaged on capital projects	**26**	16	**42**	21

4.11 Staff engagement and consultation

Effective two-way communication between the Trust, its staff, patients and the wider community is crucial. There are in place a variety of methods to achieve this, which include a regular 'all staff message' from the Chief Executive, a monthly Team Brief, staff bulletin, staff surveys and various other initiatives.

The Trust's three-year Culture Change Programme was launched in March 2018. The programme has a three-stage approach; Discover, Design, Deliver. It was developed by NHS Improvement working in partnership with The Kings Fund and the Centre for Creative Leadership. Its focus is on helping organisations to develop a culture, through staff led change, that enables and sustains safe, high-quality, compassionate care.

Culture Change Agents, who are members of staff from all areas of the Trust and at all grades, were recruited via a selection process and worked together to undertake a cultural audit to identify the gaps between what the culture is now and what it needs to be in the future to deliver successfully the organisational priorities. During 2019, Phase 2 Change Agents considered all 26 recommendations that emerged from Phase 1. Following this they identified which best supported delivery of the organisational strategic priorities and key work streams. Phase 3 began in November 2019 with a newly recruited team of Change Agents who have engaged and worked with staff across the organisation to further shape, test and deliver the proposals agreed in Phase 2.

The Culture Change work was paused during the COVID-19 pandemic, with the monthly workshops restarting in July 2020 with a review and reset. The immediate priorities were re-focused on:

- Agreeing and implementing a Leadership Behaviours model
- Developing a standard Local Induction Pack
- Reviewing and launching an employee long service recognition scheme

The Culture Change Agents made admirable efforts to complete these priorities. The programme as a whole and the individual elements within it were commended and fully endorsed by the Trust Leadership Team.

Details of the national support tool kit can be found at
https://improvement.nhs.uk/resources/culture-leadership/

In support of the Trust's vision to have a compassionate and inclusive leadership culture and in response to the pandemic, leadership development has been focused on health and wellbeing of leaders and their teams and enabling managers to hold effective conversations with staff about their physical and mental health as previously described. Non-essential training resumed for a few months between wave 1 and wave 2 of the pandemic with full commencement planned in April 2021.

Increased provision has been put in place for coaching and mentoring of leaders and they have been able to access support through Leadership Support Circles, which provides leaders and managers with a safe reflective space to share their experiences and challenges of leading at this time.

During 2020/21 the staff appraisal compliance rate reduced as a result of the pandemic, with compliance at 72.2% in February 2021 against a target of 85%. This is expected to increase over the coming months with a renewed focus. Guidance has been provided to ensure appraisal conversations address the recovery of staff and wellbeing, look to the future and cover career aspirations. Many staff will be considering their future careers, having been exposed to both difficult circumstances and new and interesting opportunities to develop and take on new roles; continuation of talent management discussions is important.

Compliance with the Trust's essential skills training and currently stands at 89.2%, remaining above the target of 85%.

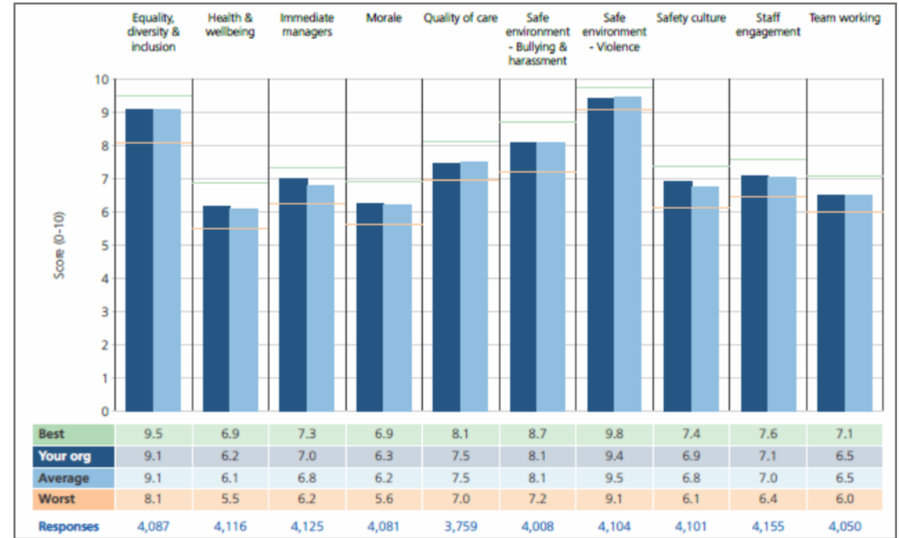
4.12 The NHS National Staff Survey 2020

The NHS Staff Survey is the largest survey of staff opinion in the UK and one of the largest staff surveys in the world. Each year NHS staff are encouraged to share their views on the range of their experience at work, including on development opportunities, health and wellbeing, staff engagement and involvement, and feeling able to raise concerns. Results from this survey are used to improve care for patients and working conditions for staff. The results of the 2020 NSS conducted in the Trust between October and November 2020 can be found below.

The survey ran during October and November 2020 with 4194 members of staff taking part; this is a 54% response rate, 2% higher than in 2019 and above average when compared with the benchmark group of acute and acute and community Trusts.

The survey results showed staff in the service under extreme pressure but still positive about working in the NHS. The overall indicators were broadly stable with an improvement in the health and wellbeing and safety culture measures. The staff engagement score held stable, however the team working score was adversely affected by the disruptive impact of COVID-19.

The survey results are divided into ten themes and can be found at the table below. Of the ten themes, four demonstrate a statistically significant improvement since 2019, four have remained unchanged and two themes have declined.



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.9	7.3	6.9	8.1	8.7	9.8	7.4	7.6	7.1
Your org	9.1	6.2	7.0	6.3	7.5	8.1	9.4	6.9	7.1	6.5
Average	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7.0	6.5
Worst	8.1	5.5	6.2	5.6	7.0	7.2	9.1	6.1	6.4	6.0
Responses	4,087	4,116	4,125	4,081	3,759	4,008	4,104	4,101	4,155	4,050

During 2020, throughout the COVID-19 pandemic the Trust focused on the accessible and timely mental and physical wellbeing of staff which has been borne out in the survey results. Providing wellbeing support for staff is important to the Trust and a continued Trust-wide focus on staff wellbeing remains a priority.

4.13 Improving Staff Engagement

The overall staff engagement theme is made up of responses to nine questions within three sections; motivation, ability to contribute to achievements and recommendation of the Trust as a place to work and receive care and treatment. The score shows stability in the 2020 results and remains above the national acute trust average.

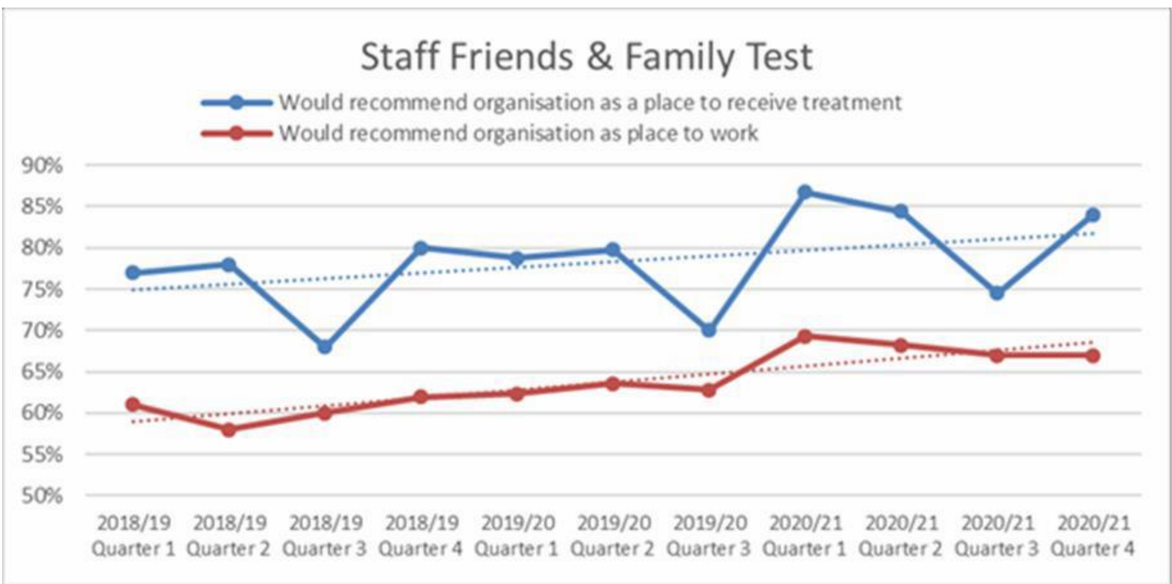
The full findings report of the 2020 NSS have been presented to the Trust Leadership Team and was presented to the Workforce and Organisational Development Committee and the Trust Board in May 2021. An improvement plan was agreed with the Committee to address those areas most requiring improvement, which aligns to other key work streams, such as the three-year culture and leadership programme.

4.14 Quarterly Staff Friends and Family Survey

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

Research has shown a clear relationship between staff engagement and individual and organisational outcome measures, such as staff absenteeism and turnover, patient satisfaction and mortality; and safety measures, including infection rates. The more engaged staff members are, the better the outcomes for patients and the organisation generally. It is, therefore, important that the Trust strengthens the staff voice, as well as the patient voice.

NHS England has 'paused' central data collection since Quarter 4 (2019/20). Although no survey was undertaken locally in Quarter 4 2019/20 due to the national pandemic just being announced, it took place in Quarter's 1, 2 and 4 in 2020/21. Data collection will resume in July 2021 with a new Quarterly Staff Survey. The table below presents the response by the two Staff Friends and Family Test questions since 2018/2019 and demonstrates an upward trajectory.



4.15 Workforce Race Equality Standard (WRES)

The WRES is a requirement for all NHS organisations to publish data and action plans against 9 indicators of workforce race equality.

Research and evidence suggest that black and minority ethnic staff in the NHS have a poorer experience or opportunities than White staff and this has a significant impact on the efficient and effective running of the NHS and impacts the quality of care received by all patients.

WRES aims to ensure employees from black and minority ethnic backgrounds have equal access to career opportunities and receive fair treatment in the workplace and support NHS organisations make the necessary structural and cultural changes needed to advance workforce race equality.

To view the Trust's WRES Annual Report 2020 and improvement priorities, please go to: https://www.porthosp.nhs.uk/about- us/equality/Workforce%20Race%20Equality%20Standard%202020%20-%20Annual%20Report%20v3.pdf

In 2019, the WRES published the Model Employer paper which sets out an ambition to increase black and minority ethnic representation at all levels of workforce by 2028. This ambition has been expedited by the NHS People Plan 2020 to increase senior leader representation by 2025 to equate to either the organisational or community percentage, whichever is highest.

The Trust has set year on year targets to increase ethnic minority representation in bands 7 to VSM and developed actions to achieve this. To view the Trust's Model Employer targets, please go to: https://www.porthosp.nhs.uk/about-us/equality/Model%20Employer%20Targets%20-%20Internet%20Slide.pdf

4.16 Workforce Disability Equality Standard (WDES)

The WDES is a set of 10 measures that enables NHS organisations to compare the work experience of disabled and non-disabled staff. The WDES launched in 2018 last year and 2020 is the second year of reporting. The data gathered is used to develop and publish action plans that aim to improve the work experience of disabled staff. Every year comparisons are made to enable

the Trust to demonstrate progress against the indicators of disability equality.

The WDES is important because it is known and acknowledged that an included and valued workforce helps to deliver high quality patient care and improved patient safety. It also allows the Trust to understand better the experiences of our disabled employees and supports positive change for all by creating a more inclusive environment.

To view the Trust's WDES Annual Report 2020 and improvement priorities, please go to: https://www.porthosp.nhs.uk/about-us/equality/Workforce%20Disability%20Equality%20Standard%202020%20-%20Annual%20Report.pdf

4.17 Gender Pay Gap report

Due to COVID-19, the Government Equalities Office (GEO) and the Equality and Human Rights Commission (EHRC) have suspended enforcement of this year's (2020) gender pay gap reporting deadline.

4.18 Off-payroll engagements

Off-payroll engagements over six months and over £245 per day as at 31st March 2021

Number of existing arrangements as at 31st March 2021	2
Of which the number that have existed:	
For less than one year at the time of reporting	

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 1st April 2019 and 31st March 2020	1
Of which:	
Number assessed as being covered by IR35	0
Number assessed as not being covered by IR35	1
Number engaged directly (through PSC contracted to department) and are on the departmental payroll	0
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

4.19 Exit packages (audited)

Reporting of compensation schemes - exit packages

Exit Packages 2020/21	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special element)			
<£10,000	-	25	**25**
£10,001 - £25,000	-	3	**3**
£25,001-£50,000	-	1	**1**
Total number of exit packages by type	**-**	29	29
Total cost (£)	£0	**£140,000**	**£140,000**

Exit Packages 2019/20	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special element)			
<£10,000	-	27	27
£10,000 - £25,000	-	3	**3**
Total number of exit packages by type	**-**	**30**	**30**
Total cost (£)	£0	**£130,000**	**£130,000**

Exit packages: other (non-compulsory) departure payments	2020/21		2019/20	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Contractual payments in lieu of notice	29	140	30	130
Total	29	140	30	130
Non-contractual payments requiring HMT approval made to individuals where the payment value was	0	0	0	0

4.20 Expenditure on consultancy

The Trust spent a total of £1.9m on external consultancy in the year (£1.8 million in 2019/20).

5. FINANCIAL STATEMENTS

ANNUAL ACCOUNTS 2020/21

The accounts of Portsmouth Hospitals University NHS Trust for the year ended 31st March 2021 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 7th June 2021 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 Ernst & Young LLP, based at Grosvenor House, Grosvenor Square, Southampton, SO15 2BE.

The audit fee for the 2020/21 annual accounts for statutory work carried out by external audit was £106,464 exclusive of non-recoverable VAT. Of this sum, £79,848 has been charged to 2020/21 and the balance, £26,616 will be charged in 2021/22.

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, other items of comprehensive income and cash flows for the year.

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

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: Penny Emerit, Chief Executive (Interim)

Date: 7th June 2021

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, other items of comprehensive income 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; and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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

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

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy.

By order of the Board

Penny Emerit, Chief Executive (Interim)

7th June 2021

Mark Orchard, Chief Financial Officer

7th June 2021

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

Opinion

We have audited the financial statements of Portsmouth Hospitals University NHS Trust for the year ended 31 March 2021 under the Local Audit and Accountability Act 2014. The financial statements comprise the Trust Statement of Comprehensive Income, the Trust Statement of Financial Position, the Trust Statement of Changes in Equity, the Trust Statement of Cash Flows and the related notes 1 to 37. 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 2020/21 HM Treasury's Financial Reporting Manual (the 2020/21 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2020/21 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 University NHS Trust as at 31 March 2021 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 (as amended by the Health and Social Care Act 2012) 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.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Directors use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of 12 months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Directors with respect to going concern are described in the relevant sections of this report. However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Trust's ability to continue as a going concern.

Other information

The other information comprises the information included in the Annual Report and Accounts 2020/21 other than the financial statements and our auditor's report thereon. The directors are responsible for the other information contained within the annual report.

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.

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 course of 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 themselves. 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 National Health Service Act 2006

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

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the NHS Improvement's guidance; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014; or
- we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have nothing to report in these respects.

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

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

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

For 2020/21 the statutory accounts indicate the Trust has a cumulative deficit at 31 March 2021 of £108.6 million over the five-year period to 31 March 2021. On 8 June 2021 we made a referral to the Secretary of State under Sections 30(1)(b) to confirm that the Trust is in breach of its break-even duty.

Responsibilities of the Directors and Accountable Officer

As explained more fully in the Statement of Directors' Responsibilities in respect of the Accounts, set out on page 64, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and for such internal control as the directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Directors are 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 they either intend to cease operations, or has 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 ensuring that the financial statements are prepared in a format directed by the Secretary of State and 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.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect irregularities, including fraud. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below. However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the entity and management.

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant are the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), as well as relevant employment laws of the United Kingdom. In addition, the Trust has to comply with laws and regulations in the areas of anti-bribery and corruption, data protection and health & safety.
- We understood how Portsmouth Hospitals University NHS Trust is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of management, the head of internal audit and those charged with governance and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance. We corroborated this through our review of the Trust’s board minutes, through enquiry of employees to verify Trust policies, and through the inspection of HR policies and other information. Based on this understanding we designed our audit procedures to identify non-compliance with such laws and regulations. Our procedures had a focus on compliance with the accounting framework through obtaining sufficient audit evidence in line with the level of risk identified and with relevant legislation.
- We assessed the susceptibility of the Trust’s financial statements to material misstatement, including how fraud might occur by understanding the potential incentives and pressures for management to manipulate the financial statements, and performed procedures to understand the areas in which this would most likely arise. Based on our risk assessment procedures, we identified manipulation of reported financial performance (through improper recognition of revenue), and management override of controls to be our fraud risks.
- To address our fraud risk around the manipulation of reported financial performance through improper recognition of revenue, we reviewed the Trust’s manual year end receivable and payable accruals, challenging assumptions and corroborating the income and expenditure to appropriate evidence. We tested year-end cut-off arrangements by selecting samples of income and expenditure from either side of the 31 March 2021 balance sheet date and reviewing to supporting evidence to ensure these were recorded in the appropriate financial year. We also undertook cut-off testing of expenditure as at month 6 of the financial year to establish whether the Trust had

incorrectly included expenditure relating to later months that would trigger reimbursement and top-up funding for that period of the financial year that it would otherwise not be entitled to.

- To address our fraud risk of management override of controls, we tested specific journal entries identified by applying risk criteria to the population of manual journals. For each journal selected, we tested specific transactions back to source documentation to confirm that the journals were appropriate. We also evaluated key estimates for any evidence of management bias.

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 reporting criteria issued by the Comptroller and Auditor General in April 2021, as to whether the Trust had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria 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 2021.

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 University NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the Board of Directors of Portsmouth Hospitals University 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.

Kevin Suter.
Ernst + Young LLP

Kevin Suter (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Southampton
15 June 2021

Statement of Comprehensive Income

	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	3	607,334	551,913
Other operating income	4	106,707	87,049
Operating expenses	6, 8	(689,759)	(617,710)
Operating surplus/(deficit) from continuing operations		**24,282**	**21,252**
Finance income	11	8	184
Finance expenses	12	(17,851)	(21,462)
PDC dividends payable		(3,469)	(50)
Net finance costs		**(21,312)**	**(21,328)**
Other gains / (losses)	13	14	94
Surplus / (deficit) for the year		**2,984**	**18**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(5,236)	16
Revaluations	17	1,898	(14,644)
Total comprehensive income / (expense) for the period		**(354)**	**(14,610)**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		2,984	18
Remove net impairments not scoring to the Departmental expenditure limit		407	16
Remove I&E impact of capital grants and donations		(2,223)	491
Remove net impact of inventories received from DHSC group bodies for COVID response		(950)	
Adjusted financial performance surplus / (deficit)		**218**	**525**

Statement of Financial Position

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	14	6,031	3,651
Property, plant and equipment	15	379,927	369,787
Receivables	20	2,586	2,666
Total non-current assets		**388,544**	**376,104**
Current assets			
Inventories	19	17,200	15,092
Receivables	20	25,960	58,998
Cash and cash equivalents	21	37,358	3,902
Total current assets		**80,518**	**77,992**
Current liabilities			
Trade and other payables	22	(79,134)	(77,426)
Borrowings	24	(7,620)	(132,028)
Provisions	26	(266)	(255)
Other liabilities	23	(1,904)	(1,061)
Total current liabilities		**(88,924)**	**(210,770)**
Total assets less current liabilities		**380,138**	**243,326**
Non-current liabilities			
Borrowings	24	(201,841)	(209,461)
Provisions	26	(4,214)	(3,805)
Total non-current liabilities		**(206,055)**	**(213,266)**
Total assets employed		**174,083**	**30,060**
Financed by			
Public dividend capital		211,753	67,376
Revaluation reserve		122,590	126,383
Income and expenditure reserve		(160,260)	(163,699)
Total taxpayers' equity		**174,083**	**30,060**

The notes on pages 74 to 121 form part of these accounts.

Signed:

Name: Penny Emerit

Position: Chief Executive (Interim)

Date: 7th June 2021

Statement of Changes in Equity for the year ended 31 March 2021

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**67,376**	**126,383**	**(163,699)**	**30,060**
Surplus/(deficit) for the year	-	-	2,984	**2,984**
Other transfers between reserves	-	-	-	**-**
Impairments	-	(5,236)	-	**(5,236)**
Revaluations	-	1,898	-	**1,898**
Transfer to retained earnings on disposal of assets	-	(482)	482	**-**
Public dividend capital received	144,377	-	-	**144,377**
Other reserve movements	-	27	(27)	**-**
Taxpayers' and others' equity at 31 March 2021	**211,753**	**122,590**	**(160,260)**	**174,083**

Statement of Changes in Equity for the year ended 31 March 2020

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**62,020**	**141,886**	**(164,592)**	**39,314**
Surplus/(deficit) for the year	-	-	18	**18**
Impairments	-	16	-	**16**
Revaluations	-	(14,644)	-	**(14,644)**
Transfer to retained earnings on disposal of assets	-	(875)	875	**-**
Public dividend capital received	5,356	-	-	**5,356**
Taxpayers' and others' equity at 31 March 2020	**67,376**	**126,383**	**(163,699)**	**30,060**

Information on reserves

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

Financial assets reserve
This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevocable election at recognition.

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

Statement of Cash Flows

	Note	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Operating surplus / (deficit)		24,282	21,252
Non-cash income and expense:			
Depreciation and amortisation	6.1	17,865	17,931
Net impairments	7	407	16
Income recognised in respect of capital donations	4	(2,841)	(129)
(Increase) / decrease in receivables and other assets		32,392	(16,347)
(Increase) / decrease in inventories		(2,108)	(214)
Increase / (decrease) in payables and other liabilities		3,552	19,107
Increase / (decrease) in provisions		407	1,934
Net cash flows from / (used in) operating activities		**73,956**	**43,550**
Cash flows from investing activities			
Interest received		8	191
Purchase of intangible assets		(3,888)	(1,980)
Purchase of PPE and investment property		(28,164)	(17,951)
Sales of PPE and investment property		158	126
Net cash flows from / (used in) investing activities		**(31,886)**	**(19,614)**
Cash flows from financing activities			
Public dividend capital received		144,377	5,356
Movement on loans from DHSC		(125,165)	(820)
Capital element of finance lease rental payments		(354)	(435)
Capital element of PFI, LIFT and other service concession payments		(6,140)	(7,050)
Interest on loans		(369)	(3,315)
Other interest		(1)	(1)
Interest paid on PFI, LIFT and other service concession obligations		(17,837)	(18,076)
PDC dividend (paid) / refunded		(3,125)	(277)
Net cash flows from / (used in) financing activities		**(8,614)**	**(24,618)**
Increase / (decrease) in cash and cash equivalents		**33,456**	**(682)**
Cash and cash equivalents at 1 April - brought forward		**3,902**	**4,584**
Cash and cash equivalents at 31 March	21	**37,358**	**3,902**

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 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Note 1.2 Going concern

The Trust prepares its accounts on a going concern basis, in accordance with the definition as set out in section 4 of the DHSC Group Accounting Manual (GAM). The GAM 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 2021/22 priorities and operational planning guidance issued in March 2021 by NHS England & Improvement confirmed the financial framework arrangements for 2021/22 will continue to support a system-based approach to funding and planning.

This year the Trust has achieved an adjusted £218k financial performance surplus (£2.984m surplus before technical adjustments). Income from Commissioners was largely based on the simplified fixed block income basis introduced in response to the COVID-19 pandemic. Additional costs due to the pandemic were also supported on an actual cost basis for the first half of the year and on a block basis for the second half of the year.

The Trust received Public Dividend Capital of £125.2m to allow repayment of the DHSC loans that had accumulated from previous years deficits and can now move forward with no debt burden to service. Whilst the Trust now carries no loans with DHSC, the historic cumulative deficit as at 31st March 2021 remains at £108.6m and as a result the External Auditor is obliged to issue a referral to the Secretary of State for Health under Section 30(1)(b) of the Local Audit & Accountability Act 2014 reporting that the Trust has breached its statutory duty to breakeven over a rolling period.

For 2021/22 the current financing arrangements will remain in place for the first half of the year, with additional funding to support Elective Recovery post COVID-19. These arrangements include the block payment basis including a continuation of the system top-up and COVID-19 fixed allocation arrangements. The Trust has produced its plans on these assumptions; these have been approved by the Trust Board and it is anticipated that the Trust will continue to provide healthcare services in the public sector.

Financing arrangements for the second half of 2021/22 have not yet been confirmed nationally. The Trust has assumed income and expenditure levels from October 2021 to June 2022 similar to the first half of 2021/22.

The Trust has prepared a cash forecast for the going concern period to June 2022 which shows sufficient liquidity for the Trust to continue to operate. The cash forecast provides headroom for any variation in cashflows caused by changes in the nationally agreed funding arrangements in the second half of the year should this be necessary. The minimum forecast month end cash balance during the going concern period is £5.3m with an average of £15m.

In conclusion, these factors, together with the anticipated future provision of services in the public sector, support the Trust's adoption of the going concern basis for the preparation of the accounts.

Note 1.3 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020/21

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at a Sustainability and Transformation Partnership level. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Comparative period (2019/20)

In the comparative period (2019/20), the trust's contracts with NHS commissioners included those where the trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4 Other forms of income

Grants and donations
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. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, 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 two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The 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 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are ‘machinery of government changes’ and treated as continuing operations.

Note 1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

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

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.

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.

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

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

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

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

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

Depreciation

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

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

Revaluation gains and losses

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

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.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

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 and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

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.

In 2020/21 this includes assets donated to the trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

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 HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

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

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively.

Useful lives of property, plant and equipment

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

	Min life	**Max life**
	Years	**Years**
Land	-	-
Buildings, excluding dwellings	10	75
Dwellings	25	26
Plant & machinery	5	15
Transport equipment	7	7
Information technology	5	10
Furniture & fittings	15	15

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

Note 1.9 Intangible assets

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 where it meets the requirements set out in IAS 38.

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.

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 where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

Amortisation

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

Useful lives of intangible assets

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

	Min life Years	**Max life Years**
Software licences	2	5

Note 1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.11 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 1.12 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income as a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

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

Note 1.13 Leases

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

The Trust as a 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 implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

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

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position 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.

The Trust as a lessor

Finance leases

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

Operating leases

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

Note 1.14 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 HM Treasury's discount rates effective for 31 March 2021:

		Nominal rate
Short-term	Up to 5 years	-0.02%
Medium-term	After 5 years up to 10 years	0.18%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2020:

	Inflation rate
Year 1	1.2%
Year 2	1.6%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.95% in real terms.

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 25.2 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 1.15 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 26 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 26, 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 1.16 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.

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, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

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 calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.17 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 1.18 Foreign exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.19 Third party assets

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

Note 1.20 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.

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 1.21 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.

Note 1.22 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

Note 1.24 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust’s incremental borrowing rate. The trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	£000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	8,213
Additional lease obligations recognised for existing operating leases	(8,213)
Net impact on net assets on 1 April 2022	**-**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(1,253)
Additional finance costs on lease liabilities	(75)
Lease rentals no longer charged to operating expenditure	1,269
Estimated impact on surplus / deficit in 2022/23	**(59)**
Estimated increase in capital additions for new leases commencing in 2022/23	**-**

From 1 April 2022, the principles of IFRS 16 will also be applied to the Trust’s PFI liabilities where future payments are linked to a price index representing the rate of inflation. The PFI imputed lease liability will be remeasured when a change in the index causes a change in future imputed lease payments and that change has taken effect in the cash flow. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred. This is expected to increase the PFI liability on the statement of financial position upon transition to IFRS 16. The effect of this has not yet been quantified.

Other standards, amendments and interpretations

IFRS 14 Regulatory Deferral Accounts -Not EU-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.

IFRS 16 Leases - Standard is effective at 1 April 2022 per the FReM.

IFRS 17 Insurance Contracts - Application required for accounting periods beginning on or after 1 January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted.

Note 1.25 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). This includes the valuation of peripheral buildings on the QA site at depreciated replacement cost on a modern equivalent basis. As part of the valuation the Valuer conducts a site inspection at least every five years and assesses the impact of any construction or improvement work that has been conducted on the buildings.

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

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

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

Note 1.26 Sources of estimation uncertainty

There are no significant sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

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 (£699.5m, 98%) is derived from 'non-trading' healthcare. Of the total income, 2% (£14.5m) 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	
	2020-21	2019-20	**2020-21**	2019-20	**2020-21**	2019-20
	£000's	£000's	**£000's**	£000's	**£000's**	£000's
Income						
External	**699,538**	628,519	**14,503**	10,443	**714,041**	638,962
Internal	**0**	0	**47,186**	50,510	**47,186**	50,510
Total Income	**699,538**	628,519	**61,689**	60,953	**761,227**	689,472
Expenditure						
Segment costs	**650,662**	579,505	**59,458**	59,109	**710,120**	638,614
Common costs	**47,186**	50,510	**937**	330	**48,123**	50,840
Total Expenditure	**697,848**	630,015	**60,395**	59,439	**758,243**	689,454
Retained surplus/(deficit) for the year	1,690	(1,496)	1,294	1,514	2,984	18

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3

Note 3.1 Income from patient care activities (by nature)	**2020/21**	**2019/20**
	£000	**£000**
Acute services		
Block contract / system envelope income*	519,321	368,128
High cost drugs income from commissioners (excluding pass-through costs)	57,473	54,851
Other NHS clinical income	7,295	108,093
Other services		
Private patient income	274	2,784
Additional pension contribution central funding**	15,384	13,618
Other clinical income	7,587	4,439
Total income from activities	**607,334**	**551,913**

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

	2020/21	**2019/20**
Income from patient care activities received from:	**£000**	**£000**
NHS England	149,030	153,878
Clinical commissioning groups	450,443	392,891
Other NHS providers	5,982	297
Non-NHS: private patients	274	2,784
Non-NHS: overseas patients (chargeable to patient)	322	724
Injury cost recovery scheme	816	665
Non NHS: other	467	674
Total income from activities	**607,334**	**551,913**

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

	2020/21	2019/20
	£000	£000
Income recognised this year	322	724
Cash payments received in-year	115	371
Amounts added to provision for impairment of receivables	310	129
Amounts written off in-year	40	176

Note 4 Other operating income

	2020/21			2019/20		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	4,361	-	**4,361**	4,998	-	**4,998**
Education and training	21,860	-	**21,860**	19,950	-	**19,950**
Non-patient care services to other bodies	5,311		**5,311**	12,138		**12,138**
Provider sustainability fund (2019/20 only)			**-**	10,779		**10,779**
Financial recovery fund (2019/20 only)			**-**	6,757		**6,757**
Marginal rate emergency tariff funding (2019/20 only)			**-**	4,516		**4,516**
Reimbursement and top up funding	36,394		**36,394**			**-**
Receipt of capital grants and donations *		2,841	**2,841**		129	**129**
Charitable and other contributions to expenditure **		13,083	**13,083**		1,087	**1,087**
Rental revenue from operating leases		1,568	**1,568**		1,562	**1,562**
Other income ***	21,289	-	**21,289**	25,133	-	**25,133**
Total other operating income	**89,215**	**17,492**	**106,707**	**84,271**	**2,778**	**87,049**

* includes £1.8m of equipment purchased by the Department of Health and Social Care (DHSC)

** reflects the cost of Personal Protective Equipment purchased by DHSC

*** other contract income includes £14.5m Pharmacy Sales and £1.5m Income Generation

Note 5 Additional information on contract revenue (IFRS 15) recognised in the period

	2020/21	2019/20
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	-	828

Note 6.1 Operating expenses

	2020/21	2019/20
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	2,586	3,594
Purchase of healthcare from non-NHS and non-DHSC bodies	11,641	13,908
Staff and executive directors costs	400,837	359,161
Remuneration of non-executive directors	121	85
Supplies and services - clinical (excluding drugs costs)	63,134	54,573
Supplies and services - general	1,968	2,058
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	84,941	76,655
Inventories written down	282	-
Consultancy costs	1,895	1,797
Establishment	6,021	6,423
Premises	18,630	17,230
Transport (including patient travel)	1,656	1,011
Depreciation on property, plant and equipment	16,357	16,909
Amortisation on intangible assets	1,508	1,022
Net impairments	407	16
Movement in credit loss allowance: contract receivables / contract assets	3	186
Movement in credit loss allowance: all other receivables and investments	325	182
Change in provisions discount rate(s)	243	33
Audit fees payable to the external auditor		
audit services- statutory audit	141	93
other auditor remuneration (external auditor only)	-	9
Internal audit costs	67	71
Clinical negligence risk pooling scheme contribution	21,488	16,289
Legal fees	2,041	738
Insurance	338	280
Research and development	4,619	4,345
Education and training	1,282	1,203
Rentals under operating leases	2,597	1,550
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	41,049	35,997
Hospitality	2	9
Other	3,580	2,283
Total	**689,759**	**617,710**

Note 6.2 Other auditor remuneration

	2020/21	2019/20
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above *	-	9
Total	**-**	**9**

* This relates to the preparation of the Trust's quality account.

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2 million (2019/20: £2 million).

Note 7 Impairment of assets

	2020/21	2019/20
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	407	16
Total net impairments charged to operating surplus / deficit	**407**	**16**
Impairments charged to the revaluation reserve	5,236	(16)
Total net impairments	**5,643**	**-**

Note 8 Employee benefits

	2020/21	2019/20
	Total	Total
	£000	£000
Salaries and wages	284,183	252,208
Social security costs	28,553	25,290
Apprenticeship levy	1,436	1,282
Employer's contributions to NHS pensions	49,136	44,589
Temporary staff (including agency)	44,423	42,741
Total gross staff costs	**407,731**	**366,110**
Recoveries in respect of seconded staff	-	-
Total staff costs	**407,731**	**366,110**
Of which		
Costs capitalised as part of assets	2,275	2,604

Note 8.1 Retirements due to ill-health

During 2020/21 there were 2 early retirements from the trust agreed on the grounds of ill-health (3 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £49k (£266k in 2019/20).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

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 2021, is based on valuation data as at 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

Note 10 Operating leases

Note 10.1 The Trust as a lessor

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

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

	2020/21	2019/20
	£000	£000
Operating lease revenue		
Minimum lease receipts	1,568	1,562
Total	**1,568**	**1,562**

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	1,568	1,562
- later than one year and not later than five years;	999	1,049
- later than five years.	156	371
Total	**2,723**	**2,982**

Note 10.2 The Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where the 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 £90,000.

- Matrix Park - used for Pharmacy and Procurement, the lease period is for 10 years (expires 2029) and has an annual value of £224,000.

- Mitchell Way lease - used for the health records storage and office buildings, the lease period is for 17 years (expires 2027) and has an annual value of £195,000.

- Fort Southwick office buildings and car parks - used for off site car parking and administration, the lease period is for 10 years (expires 2029) and has an annual value of £572,000.

	2020/21	2019/20
	£000	£000
Operating lease expense		
Minimum lease payments	2,597	1,550
Total	**2,597**	**1,550**

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease payments due:		
- not later than one year;	2,844	1,588
- later than one year and not later than five years;	7,840	4,937
- later than five years.	3,767	4,163
Total	**14,451**	**10,688**
Future minimum sublease payments to be received	-	-

Note 11 Finance income

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

	2020/21	2019/20
	£000	£000
Interest on bank accounts *	8	184
Total finance income	**8**	**184**

* Interest on the Government Banking Service accounts was suspended in 2020/21 due to the revised cash regime put in place in response to the COVID-19 pandemic

Note 12.1 Finance expenditure

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

	2020/21	2019/20
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	-	3,307
Interest on late payment of commercial debt	2	1
Main finance costs on PFI and LIFT schemes obligations	11,218	11,587
Contingent finance costs on PFI and LIFT scheme obligations	6,618	6,489
Total interest expense	**17,838**	**21,384**
Unwinding of discount on provisions	13	78
Total finance costs	**17,851**	**21,462**

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

	2020/21	2019/20
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	2	1

Note 13 Other gains / (losses)

	2020/21	2019/20
	£000	£000
Gains on disposal of assets	158	126
Losses on disposal of assets	(144)	(32)
Total gains / (losses) on disposal of assets	**14**	**94**
Other gains / (losses)	-	-
Total other gains / (losses)	**14**	**94**

Note 14.1 Intangible assets - 2020/21

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2020 - brought forward	**9,674**	**9,674**
Additions	3,888	**3,888**
Disposals / derecognition	(1,428)	**(1,428)**
Valuation / gross cost at 31 March 2021	**12,134**	**12,134**
Amortisation at 1 April 2020 - brought forward	**6,023**	**6,023**
Provided during the year	1,508	**1,508**
Disposals / derecognition	(1,428)	**(1,428)**
Amortisation at 31 March 2021	**6,103**	**6,103**
Net book value at 31 March 2021	**6,031**	**6,031**
Net book value at 1 April 2020	**3,651**	**3,651**

Note 14.2 Intangible assets - 2019/20

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2019 - as previously stated	**10,159**	**10,159**
Additions	1,980	**1,980**
Disposals / derecognition	(2,465)	**(2,465)**
Valuation / gross cost at 31 March 2020	**9,674**	**9,674**
Amortisation at 1 April 2019 - as previously stated	**7,466**	**7,466**
Provided during the year	1,022	**1,022**
Disposals / derecognition	(2,465)	**(2,465)**
Amortisation at 31 March 2020	**6,023**	**6,023**
Net book value at 31 March 2020	**3,651**	**3,651**
Net book value at 1 April 2019	**2,693**	**2,693**

Note 15.1 Property, plant and equipment - 2020/21

	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 2020 - brought forward	**26,613**	**312,458**	**3,484**	**2,933**	**79,469**	**40**	**20,301**	**2,959**	**448,257**
Additions	-	5,876	197	6,589	11,402	-	6,317	5	**30,386**
Impairments	-	(5,378)	(265)	-	-	-	-	-	**(5,643)**
Revaluations	123	1,281	-	-	1,441	1	-	58	**2,904**
Reclassifications	-	-	-	(2,132)	2,132	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(7,811)	-	(2,929)	-	**(10,740)**
Valuation/gross cost at 31 March 2021	**26,736**	**314,237**	**3,416**	**7,390**	**86,633**	**41**	**23,689**	**3,022**	**465,164**
Accumulated depreciation at 1 April 2020 - brought forward	**-**	**9,099**	**139**	**-**	**54,860**	**40**	**12,282**	**2,050**	**78,470**
Provided during the year	-	8,315	154	-	4,755	-	2,932	201	**16,357**
Revaluations	-	-	-	-	965	1	-	40	**1,006**
Disposals / derecognition	-	-	-	-	(7,667)	-	(2,929)	-	**(10,596)**
Accumulated depreciation at 31 March 2021	**-**	**17,414**	**293**	**-**	**52,913**	**41**	**12,285**	**2,291**	**85,237**
Net book value at 31 March 2021	**26,736**	**296,823**	**3,123**	**7,390**	**33,720**	**-**	**11,404**	**731**	**379,927**
Net book value at 1 April 2020	**26,613**	**303,359**	**3,345**	**2,933**	**24,609**	**-**	**8,019**	**909**	**369,787**

Note 15.2 Property, plant and equipment - 2019/20

	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 2019 - as previously stated	**26,597**	**317,257**	**3,262**	**469**	**83,342**	**61**	**29,882**	**3,389**	**464,259**
Valuation / gross cost at 1 April 2019 - restated	**26,597**	**317,257**	**3,262**	**469**	**83,342**	**61**	**29,882**	**3,389**	**464,259**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	10,392	132	2,526	3,748	-	3,904	7	**20,709**
Reversals of impairments	-	16	-	-	-	-	-	-	**16**
Revaluations	16	(15,269)	90	-	1,528	1	-	68	**(13,566)**
Reclassifications	-	62	-	(62)	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(9,149)	(22)	(13,485)	(505)	**(23,161)**
Valuation/gross cost at 31 March 2020	**26,613**	**312,458**	**3,484**	**2,933**	**79,469**	**40**	**20,301**	**2,959**	**448,257**
Accumulated depreciation at 1 April 2019 - as previously stated	**-**	**556**	**-**	**-**	**57,793**	**61**	**22,899**	**2,287**	**83,596**
Accumulated depreciation at 1 April 2019 - restated	**-**	**556**	**-**	**-**	**57,793**	**61**	**22,899**	**2,287**	**83,596**
Provided during the year	-	8,527	139	-	5,153	-	2,868	222	**16,909**
Impairments	-	16	-	-	-	-	-	-	**16**
Revaluations	-	-	-	-	1,031	1	-	46	**1,078**
Disposals / derecognition	-	-	-	-	(9,117)	(22)	(13,485)	(505)	**(23,129)**
Accumulated depreciation at 31 March 2020	**-**	**9,099**	**139**	**-**	**54,860**	**40**	**12,282**	**2,050**	**78,470**
Net book value at 31 March 2020	**26,613**	**303,359**	**3,345**	**2,933**	**24,609**	**-**	**8,019**	**909**	**369,787**
Net book value at 1 April 2019	**26,597**	**316,701**	**3,262**	**469**	**25,549**	**-**	**6,983**	**1,102**	**380,663**

Note 15.3 Property, plant and equipment financing - 2020/21

	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 2021									
Owned - purchased	26,736	5,344	3,123	7,390	28,828	-	11,388	731	**83,540**
Finance leased	-	-	-	-	1,265	-	-	-	**1,265**
On-SoFP PFI contracts and other service concession arrangements	-	287,282	-	-	-	-	-	-	**287,282**
Owned - donated/granted	-	4,197	-	-	3,627	-	16	-	**7,840**
NBV total at 31 March 2021	**26,736**	**296,823**	**3,123**	**7,390**	**33,720**	**-**	**11,404**	**731**	**379,927**

Note 15.4 Property, plant and equipment financing - 2019/20

	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 2020									
Owned - purchased	26,613	5,729	3,345	2,933	21,705	-	8,010	909	**69,244**
Finance leased	-	-	-	-	1,625	-	-	-	**1,625**
On-SoFP PFI contracts and other service concession arrangements	-	293,440	-	-	-	-	-	-	**293,440**
Owned - donated/granted	-	4,190	-	-	1,279	-	9	-	**5,478**
NBV total at 31 March 2020	**26,613**	**303,359**	**3,345**	**2,933**	**24,609**	**-**	**8,019**	**909**	**369,787**

Note 16 Donations of property, plant and equipment

£0.9m of the donated assets were received from the Portsmouth Hospitals Charity (registered charity number 1047986).

£1.9m of the donated assets were from the Department of Health and Social Care as part of the response to the coronavirus pandemic.

Note 17 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 2019, refreshed by a desktop valuation at 31st March 2021 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 £45.3m

Note 18 Disclosure of interests in other entities

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.

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 19 Inventories

	31 March 2021	31 March 2020
	£000	£000
Drugs	8,999	7,590
Consumables	8,201	7,502
Total inventories	**17,200**	**15,092**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £133,010k (2019/20: £108,510k). Write-down of inventories recognised as expenses for the year were £282k (2019/20: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £12,336k of items purchased by DHSC.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 20.1 Receivables

	31 March 2021	31 March 2020
	£000	£000
Current		
Contract receivables	10,518	37,917
Allowance for impaired contract receivables / assets	(210)	(207)
Allowance for other impaired receivables	(1,295)	(1,005)
Prepayments (non-PFI)	5,050	4,611
PFI lifecycle prepayments	4,894	5,000
PDC dividend receivable	176	520
VAT receivable	3,815	3,893
Other receivables	3,012	8,269
Total current receivables	**25,960**	**58,998**
Non-current		
Contract receivables	843	864
PFI lifecycle prepayments	54	330
Other receivables	1,689	1,472
Total non-current receivables	**2,586**	**2,666**
Of which receivable from NHS and DHSC group bodies:		
Current	8,088	35,294
Non-current	1,689	1,472

Note 20.2 Allowances for credit losses

	2020/21		2019/20	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**207**	**1,005**	**21**	**838**
Prior period adjustments			-	-
Allowances as at 1 April - restated	**207**	**1,005**	**21**	**838**
Transfers by absorption	-	-	-	-
New allowances arising	3	428	207	397
Reversals of allowances	-	(103)	(21)	(215)
Utilisation of allowances (write offs)	-	(35)	-	(15)
Allowances as at 31 Mar 2021	**210**	**1,295**	**207**	**1,005**

Note 20.3 Exposure to credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has relatively low inherent exposure to credit risk.

Note 21 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.

	2020/21	2019/20
	£000	£000
At 1 April	**3,902**	**4,584**
Net change in year	33,456	(682)
At 31 March	**37,358**	**3,902**
Broken down into:		
Cash at commercial banks and in hand	9	31
Cash with the Government Banking Service	37,349	3,871
Total cash and cash equivalents as in SoFP	**37,358**	**3,902**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**37,358**	**3,902**

Note 21.1 Third party assets held by the Trust

The Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

Note 22.1 Trade and other payables

	31 March 2021 £000	31 March 2020 £000
Current		
Trade payables	14,417	9,773
Capital payables	5,160	6,161
Accruals	12,920	3,271
Social security costs	4,181	3,826
Other taxes payable	3,912	3,322
Other payables	38,544	51,073
Total current trade and other payables	**79,134**	**77,426**
Non-current		
Other payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	5,851	6,565
Non-current	-	-

Note 22.2 Early retirements in NHS payables above

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

	31 March 2021 £000	31 March 2021 Number	31 March 2020 £000	31 March 2020 Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-

Note 23 Other liabilities

	31 March 2021 £000	31 March 2020 £000
Current		
Deferred income: contract liabilities	1,904	1,061
Total other current liabilities	**1,904**	**1,061**
Non-current		
Other deferred income	-	-
Total other non-current liabilities	**-**	**-**

Note 24.1 Borrowings

	31 March 2021 £000	31 March 2020 £000
Current		
Loans from DHSC *	-	125,534
Obligations under finance leases	353	354
Obligations under PFI, LIFT or other service concession contracts	7,267	6,140
Total current borrowings	**7,620**	**132,028**
Non-current		
Obligations under finance leases	644	997
Obligations under PFI, LIFT or other service concession contracts	201,197	208,464
Total non-current borrowings	**201,841**	**209,461**

* On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 were extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment.

Note 24.2 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2020	**125,534**	**1,351**	**214,604**	**341,489**
Cash movements:				
Financing cash flows - payments and receipts of principal	(125,165)	(354)	(6,140)	**(131,659)**
Financing cash flows - payments of interest	(369)	-	(11,218)	**(11,587)**
Non-cash movements:				
Application of effective interest rate	-	-	11,218	**11,218**
Carrying value at 31 March 2021	**-**	**997**	**208,464**	**209,461**

Note 24.3 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2019	**126,362**	**1,786**	**221,654**	**349,802**
Prior period adjustment	-	-	-	**-**
Carrying value at 1 April 2018 - restated	**126,362**	**1,786**	**221,654**	**349,802**
Cash movements:				
Financing cash flows - payments and receipts of principal	(820)	(435)	(7,050)	**(8,305)**
Financing cash flows - payments of interest	(3,315)	-	(11,587)	**(14,902)**
Non-cash movements:				
Application of effective interest rate	3,307	-	11,587	**14,894**
Carrying value at 31 March 2020	**125,534**	**1,351**	**214,604**	**341,489**

Note 25 Finance leases

Note 25.1 The Trust as a lessor

The Trust does not hold any finance leases as a lessor.

Note 25.2The Trust as a lessee

Obligations under finance leases where the trust is the lessee.

	31 March 2021	31 March 2020
	£000	£000
Gross lease liabilities	**997**	**1,351**
of which liabilities are due:		
- not later than one year;	354	354
- later than one year and not later than five years;	643	907
- later than five years.	-	90
Net lease liabilities	**997**	**1,351**
of which payable:		
- not later than one year;	353	354
- later than one year and not later than five years;	644	907
- later than five years.	-	90

Note 26.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims *	Other **	Total
	£000	£000	£000	£000	£000
At 1 April 2020	**332**	**2,100**	**156**	**1,472**	**4,060**
Transfers by absorption	-	-	-	-	**-**
Change in the discount rate	(7)	266	-	(16)	**243**
Arising during the year	-	-	68	217	**285**
Utilised during the year	(9)	(71)	(19)	-	**(99)**
Reclassified to liabilities held in disposal groups	-	-	-	-	**-**
Reversed unused	(3)	-	(19)	-	**(22)**
Unwinding of discount	19	(22)	-	16	**13**
At 31 March 2021	**332**	**2,273**	**186**	**1,689**	**4,480**
Expected timing of cash flows:					
- not later than one year;	9	71	186	**-**	**266**
- later than one year and not later than five years;	36	284	-	**-**	**320**
- later than five years.	287	1,918	-	**1,689**	**3,894**
Total	**332**	**2,273**	**186**	**1,689**	**4,480**

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

** Relates to Clinicians Pension Tax Reimbursement.

Note 26.2 Clinical negligence liabilities

At 31 March 2021, £440,007k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Portsmouth Hospitals University NHS Trust (31 March 2020: £414,452k).

Note 27 Contingent assets and liabilities

	31 March 2021	31 March 2020
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims *	(26)	(37)
Employment tribunal and other employee related litigation **	(132)	(75)
Gross value of contingent liabilities	**(158)**	**(112)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(158)**	**(112)**
Net value of contingent assets	**-**	**-**

* The contingent liabilities for NHS Resolution legal claims are based on an assessment of probability of the claim succeeding made by NHS Resolution.

** Employment tribunal and other employee related litigation claims are based on a 50% chance of the claim succeeding.

Note 28 On-SoFP PFI, LIFT or other service concession arrangements

Note 28.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2021	31 March 2020
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**333,537**	**350,895**
Of which liabilities are due		
- not later than one year;	18,164	17,358
- later than one year and not later than five years;	72,893	73,933
- later than five years.	242,480	259,604
Finance charges allocated to future periods	(125,073)	(136,291)
Net PFI, LIFT or other service concession arrangement obligation	**208,464**	**214,604**
- not later than one year;	7,267	6,140
- later than one year and not later than five years;	33,575	32,896
- later than five years.	167,622	175,568

Note 28.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

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

	31 March 2021	31 March 2020
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**1,315,390**	**1,327,419**
Of which payments are due:		
- not later than one year;	66,602	63,972
- later than one year and not later than five years;	266,408	255,888
- later than five years.	982,380	1,007,559

Note 28.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2020/21	2019/20
	£000	£000
Unitary payment payable to service concession operator	**70,074**	**64,830**
Consisting of:		
- Interest charge	11,218	11,587
- Repayment of balance sheet obligation	6,140	7,050
- Service element and other charges to operating expenditure	40,177	35,605
- Capital lifecycle maintenance	5,049	3,707
- Revenue lifecycle maintenance	872	392
- Contingent rent	6,618	6,489
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	3,455	-
Total amount paid to service concession operator	**73,529**	**64,830**

Note 29 Financial instruments

Note 29.1 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.

All loans received are from the Department of Health and Social Care 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 29.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	12,727	-	-	**12,727**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents	37,358	-	-	**37,358**
Total at 31 March 2021	**50,085**	**-**	**-**	**50,085**

Carrying values of financial assets as at 31 March 2020	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	47,310	-	-	**47,310**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents	3,902	-	-	**3,902**
Total at 31 March 2020	**51,212**	**-**	**-**	**51,212**

Note 29.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	-	-	**-**
Obligations under finance leases	997	-	**997**
Obligations under PFI, LIFT and other service concession contracts	208,464	-	**208,464**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	70,925	-	**70,925**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2021	**280,386**	**-**	**280,386**

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	125,534	-	**125,534**
Obligations under finance leases	1,351	-	**1,351**
Obligations under PFI, LIFT and other service concession contracts	214,604	-	**214,604**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	70,278	-	**70,278**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2020	**411,767**	**-**	**411,767**

Note 29.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2021	31 March 2020 restated*
	£000	£000
In one year or less	89,443	213,524
In more than one year but not more than five years	73,536	74,840
In more than five years	242,480	259,694
Total	**405,459**	**548,058**

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

Note 29.5 Fair values of financial assets and liabilities

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

Note 30 Losses and special payments

	2020/21		2019/20	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	28	7	39	16
Bad debts and claims abandoned	170	51	491	200
Stores losses and damage to property	1	121	1	51
Total losses	**199**	**179**	**531**	**267**
Special payments				
Ex-gratia payments	100	97	94	143
Total special payments	**100**	**97**	**94**	**143**
Total losses and special payments	**299**	**276**	**625**	**410**
Compensation payments received		-		-

Note 31 Related parties

Portsmouth Hospitals University 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 and Social Care Ministers, Portsmouth Hospitals University 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 and Social Care 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 2021.

	Receipts from Related Party £'000	Payments to Related Party £'000	Amounts due from Related Party £'000	Amounts owed to Related Party £'000
Health Education England	21,935	15	198	0
NHS England	182,500	6	906	3,155
NHS Fareham and Gosport CCG	124,893	0	40	0
NHS Portsmouth CCG	137,223	0	54	7
NHS Resolution	0	21,788	0	0
NHS South Eastern Hampshire CCG	148,122	0	960	0
NHS West Hampshire CCG	12,235	0	3	0
NHS West Sussex CCG	7,968	0	1	0
Isle of Wight NHS Trust	7,595	171	864	54
University Hospital Southampton NHS Foundation Trust	10,090	1,943	901	522

The Trust has also received revenue and capital payments from a number of charitable funds, including Portsmouth Hospitals Charity and the League of Friends. The Trust is the corporate trustee of the Portsmouth Hospitals Charity. The total value of grants made to the Trust by the Charity was £1.8m.

Note 32 Events after the reporting date

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

Note 33 Better Payment Practice code

Non-NHS Payables	2020/21 Number	2020/21 £000	2019/20 Number	2019/20 £000
Total non-NHS trade invoices paid in the year	112,195	325,006	103,879	285,622
Total non-NHS trade invoices paid within target	100,618	308,822	43,058	191,705
Percentage of non-NHS trade invoices paid within target	89.7%	95.0%	41.5%	67.1%
NHS Payables				
Total NHS trade invoices paid in the year	2,439	15,835	2,809	15,244
Total NHS trade invoices paid within target	1,861	13,622	2,285	11,660
Percentage of NHS trade invoices paid within target	76.3%	86.0%	81.3%	76.5%

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

During 2020/21 the Trust reviewed internal processes, systems and governancein order that it may improve timely payment to it's business critical suppliers at a time of economic hardship during the COVID-19 pandemic. This is measured in non-NHS Payables performance by number increasing from 41.5% in 2019/20 to 89.7% in 2020/21.

Note 34 External financing limit

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

	2020/21 £000	2019/20 £000
Cash flow financing	(20,738)	(2,267)
Other capital receipts	-	-
External financing requirement	**(20,738)**	**(2,267)**
External financing limit (EFL)	16,231	574
Under / (over) spend against EFL	**36,969**	**2,841**

Note 35 Capital Resource Limit

	2020/21 £000	2019/20 £000
Gross capital expenditure	34,274	22,689
Less: Disposals	(144)	(32)
Less: Donated and granted capital additions	(2,841)	(129)
Plus: Loss on disposal from capital grants in kind	-	-
Charge against Capital Resource Limit	**31,289**	**22,528**
Capital Resource Limit	31,360	22,529
Under / (over) spend against CRL	**71**	**1**

Note 36 Breakeven duty financial performance

	2020/21 £000
Adjusted financial performance surplus / (deficit) (control total basis)	218
IFRIC 12 breakeven adjustment	37
Breakeven duty financial performance surplus / (deficit)	**255**

Note 37 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		(14,877)	159	148	4,293	830	(2,912)
Breakeven duty cumulative position	9,479	(5,398)	(5,239)	(5,091)	(798)	32	(2,880)
Operating income		432,167	446,161	440,231	451,906	469,094	484,463
Cumulative breakeven position as a percentage of operating income		(1.2%)	(1.2%)	(1.2%)	(0.2%)	0.0%	(0.6%)

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(23,477)	(17,645)	(30,701)	(35,826)	1,708	255
Breakeven duty cumulative position	(26,357)	(44,002)	(74,703)	(110,529)	(108,821)	(108,566)
Operating income	504,572	530,382	543,069	558,702	638,962	714,041
Cumulative breakeven position as a percentage of operating income	(5.2%)	(8.3%)	(13.8%)	(19.8%)	(17.0%)	(15.2%)

* 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 35 and does not count in the performance against the control total for the year.

Salary and Pension entitlements of senior managers 2020/21

Name	Title	Start date/leaving date (where not in post for full year)	2020/21 Salary (bands of £5,000) £000	2020/21 Expenses Payments (Taxable) (total to nearest £100)	2020/21 Performance Pay and Bonuses (bands of £5,000)	2020/21 Long Term Performance Pay and Bonuses (bands of £5,000)	2020/21 All Pension Related Benefits*** (bands of £2,500)	2020/21 TOTAL (bands of £5,000)	2019/20 Salary (bands of £5,000) £000	2019/20 Expenses Payments (Taxable) (total to nearest £100)	2019/20 Performance Pay and Bonuses (bands of £5,000)	2019/20 Long Term Performance Pay and Bonuses (bands of £5,000)	2019/20 All Pension Related Benefits (bands of £2,500)	2019/20 TOTAL (bands of £5,000)
Executive Directors in post at 31st March 2021														
Penny Emerit	Director of Strategy and Performance until 23/03/2021, Chief Executive from 24/03/2021	See Title for Dates	155-160	-	-	-	0-2.5	155-160	155-160	-	-	-	70.0-72.5	225-230
John Knighton	Medical Director		165-170 *	-	-	-	35-37.5	205-210	165-170 *	-	-	-	45.0-47.5	200-205
Mark Orchard	Chief Financial Officer	From 01/10/2019	145-150	-	-	-	27.5-30	175-180	70-75	-	-	-	27.5-30.0	100-105
Chris Evans	Chief Operating Officer	From 01/10/2020	75-80	-	-	-	40-42.5	115-120	-	-	-	-	-	-
Lois Howell	Director of Governance & Risk		130-135	-	-	-	55-57.5	185-190	105-110	-	-	-	25-27.5	135-140
Liz Rix	Chief Nurse	From 10/06/2019	145-150	-	-	-	0	145-150	80-85	-	-	-	0.0	80-85
Nicole Cornelius	Director of Workforce & Organisational Development		135-140	-	-	-	175-177.5	315-320	130-135	-	-	-	32.5-35.0	160-165
Graham Terry	Director of Strategy and Performance	From 24/03/2021	0-5	-	-	-	0 **	0-5	-	-	-	-	-	-
Anoop Chauhan	Executive Director of Research	From 27/07/2020	90-95	-	-	-	75-77.5	170-175	-	-	-	-	-	-
Executive Directors who left during the year ending 31st March 2021														
Mark Cubbon	Chief Executive	Until 23/03/2021	220-225	-	-	-	72.5-75	290-295	205-210	-	-	-	82.5-85.0	285-290
Nigel Kee	Interim Chief Operating Officer	Until 30/09/2020	95-100	-	-	-	30-32.5	125-130	100-105	-	-	-	152.5-155.0	250-255
Helen Bray	Director of Communications and Engagement	From 20/04/2020 to 26/10/2020	105-110	-	-	-	5-7.5	110-115	-	-	-	-	-	-
Executive Directors who left during the year ending 31st March 2020														
Adcock Chris	Chief Financial Officer	Until 30/06/2019	-	-	-	-	-	-	40-45	-	-	-	10-12.5	50-55
Paul Bytheway	Chief Operating Officer	Until 30/06/2019	-	-	-	-	-	-	40-45	-	-	-	15-17.5	60-65
Emma McKinney	Director of Communications	Until 02/08/2019	-	-	-	-	-	-	25-30	-	-	-	7.5-10.0	35-40
Non- Executive Directors in post at 31st March 2021														
Melloney Poole	Chair		35-40	-	-	-	-	35-40	35-40	-	-	-	-	35-40
Christine Slaymaker	Non-Executive Director		10-15	-	-	-	-	10-15	5-10	600	-	-	-	5-10
David Parfitt	Non-Executive Director		10-15	-	-	-	-	10-15	5-10	1,200	-	-	-	5-10
Gary Hay	Non-Executive Director		10-15	-	-	-	-	10-15	5-10	-	-	-	-	5-10
Roger Burke-Hamilton	Non-Executive Director		10-15	-	-	-	-	10-15	5-10	-	-	-	-	5-10
Martin Rolfe	Non-Executive Director		10-15	-	-	-	-	10-15	5-10	-	-	-	-	5-10
Inga Kennedy	Non-Executive Director		-	-	-	-	-	-	-	-	-	-	-	-
Graham Galbraith	Non-Executive Director	From 24/06/2020	5-10	-	-	-	-	5-10	-	-	-	-	-	-
Aswinkumar Vasireddy	Associate Non-Executive Director	From 28/10/2020	0-5	-	-	-	-	0-5	-	-	-	-	-	-
Vivek Srivastava	Associate Non-Executive Director	From 28/10/2020	0-5	-	-	-	-	0-5	-	-	-	-	-	-
Non- Executive Directors who left during the year ending 31st March 2021														
N/A			-	-	-	-	-	-	-	-	-	-	-	-
Non- Executive Directors who left during the year ending 31st March 2020														
N/A			-	-	-	-	-	-	-	-	-	-	-	-

* Medical Director salary and pension entitlements includes remuneration for work other than management responsibilities of £40k-£45k (£40k-£45k in 2019/20)
** Pension information not available due to timing of taking up post
*** The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

Signed: Chief Executive (Interim):

Date: 7th June 2021

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 31/03/2021 (bands of £5,000) £000**	**Lump sum at pension age related to accrued pension 31/03/2021 (bands of £5,000) £000**	**Cash equivalent transfer value 31/03/2021 £000**	**Cash equivalent transfer value 31/03/2020 £000**	**Real increase in cash equivalent transfer value (bands of £5,000) £000**	**Employers Contribution to Stakeholder Pension* To nearest £100**
Penny Emerit	Director of Strategy and Performance until 23/03/2021, Chief Executive from 24/03/2021	0-2.5	0-2.5.0	30-35	50-55	392	368	15-20	0
John Knighton	Medical Director	2.5-5.0	(2.5)-0	75-80	190-195	1,675	1,562	75-80	0
Mark Orchard	Chief Financial Officer	0-2.5	(5)-(2.5)	40-45	80-85	691	634	40-45	0
Chris Evans	Chief Operating Officer	0-2.5	2.5-5.0	33-35	60-65	455	377	30-35	0
Lois Howell	Director of Governance & Risk	2.5-5.0	2.5-5.0	15-20	25-30	276	214	55-60	0
Liz Rix	Chief Nurse	0	0	0	0	0	0	0	0
Nicole Cornelius	Director of Workforce & Organisational Development	0	0	0-5	0**	186	48	135-140	0
Anoop Chauhan	Executive Director of Research	2.5-5.0	7.5-10	75-80	205-210	1,738	1,530	115-120	0

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

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

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

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

Signed: Chief Executive (Interim):

Date: 7th June 2021