

Barking, Havering and Redbridge
University Hospitals



NHS Trust



Annual Report and Accounts

2010/11

Welcome from the Chief Executive and Chairman

Welcome to our Annual Report for 2010/11.

We hope that this report will give you a real flavour of the enormous amount of work taking place at our hospitals to deliver the best possible care to our population.

We have seen many developments in the past year, and had great success in certain areas. But there have also been challenges, and services that have needed particular attention.

We have continued to work hard to reduce our deficit and to deliver our Cost Improvement Programme. New ways of working led to savings of £23 million over the year, although this was still some way off our target of more than £35 million.

Major cost savings still need to be made this financial year, with our dedicated staff ensuring that patient care and services continue to improve.

We are working closely with our partners and the Department of Health to ensure that we reach our target for breaking even, and can therefore work towards achieving Foundation Trust status.

The Trust was registered with eight conditions by the Care Quality Commission during the year. These conditions have been helpful in focusing our efforts in making key improvements. Despite several of these conditions now being lifted by the CQC and evidence of improvements in all areas, there is no complacency at the Trust about the need to improve quality, and to continue to deliver quality care in every clinical area.

This is particularly the case in our Maternity department, where attracting and retaining trained staff is a continuing challenge. The CQC issued a warning notice requiring improvements in Maternity in March 2011, and we are working with staff and local women to ensure that their concerns are addressed so that we can rebuild confidence in the quality of our services. Demand across the board means that we are still struggling to reach the standards we would like in certain areas, such as waiting times in our Accident and Emergency departments.

But it is important that the challenges we are facing in some areas do not overshadow the genuinely outstanding care which we achieve in others. To cut our use of agency staff – and therefore to improve continuity of care for our patients – we have focussed on recruiting permanent front-line staff this year.

Major recruitment drives have seen highly qualified nurses and midwives join our hospitals, along with experienced therapists and consultants.

We are confident that we have high calibre staff on our wards who will continue to work towards our aims of ensuring that patients have the best possible experience of our services.

We have both joined the Trust this year – replacing Sir David Varney as Chairman and John Goulston as Chief Executive – and have been struck by the hard work and dedication of our staff and volunteers.

We are determined that, with their support and that of our partners and stakeholders, we can continue to move forward, tackle challenges head-on, and be proud of the service we provide to our patients.



A handwritten signature in black ink that reads "Edwin Doyle". The signature is written in a cursive style.

Edwin Doyle
Chairman



A handwritten signature in black ink that reads "Averil Dongworth". The signature is written in a cursive style.

Averil Dongworth
Chief Executive

Key Statistics

Serving 750,000 people from a variety of backgrounds and across a wide area, this Trust is one of the largest in the country.

We deliver services from two large district general hospitals – Queen’s in Romford and King George in Goodmayes.

Our staff work hard to ensure that patient care is at the heart of everything we do – despite the extremely high numbers of people we treat every day of the year.

Between April 2010 and March 2011, the Trust recorded the following activity:

Outpatients

King George handled **51,672** new outpatient appointments, with another **114,658** follow-up appointments – a total of **166,330** booked appointments.

Queen’s saw **110,158** new and **283,160** follow-up outpatient appointments – a total of **393,318**.

The Trust as a whole dealt with **684,605** booked outpatient appointments across all the sites where it operates clinics.

A&E attendances

King George saw **76,671** A&E attendances last year, whilst Queen’s had **103,903** people through the doors.

That is a total of **180,574** attendances at our Accident and Emergency departments.

Births

Midwives at King George delivered **2,042** babies, with another **7,681** being born at Queen’s.

Including home births, the total number of babies born was **9,931**.

Inpatients

King George had **45,069** inpatient admissions during the year, with **84,235** patients staying at Queen’s.

Inpatient admissions across the Trust totalled **129,530**.

Hitting the targets

Like all Trusts, we work to meet national targets which are set down by the Government. These cover a wide range of services, and include the maximum amount of time people should wait to be treated.

We have worked extremely hard this year to improve waiting times, although this is still an issue in some areas.

The table below sets out our performance over the year.

Existing and National Priorities	2010/11 Target	Performance		
		2008/09	2009/10	2010/11
18 week referral to treatment waiting times Admitted Non-admitted	No longer a target	93.52% 96.94% (Q4 reporting period)	91.44% 95.73% (April–Feb)	No longer a target
A&E waiting times 4-Hour max. wait in A&E from arrival to admission, transfer or discharge	Q1=98% Q2-4=95%	96.02%	97.31%	95.30%
Access to genito-urinary medicine (GUM) clinics	98%	99.16%	99.93%	99.06%
Cancer urgent referral to first outpatient appointment waiting times 2-Week GP referral to first outpatient appointment	93%	99.00%	99.75%	96.65%
Cancelled operations Cancelled operations not re-admitted within 28 days	5%	2.87%	2.33%	2.65% (Apr–Feb)
Cancer diagnosis to treatment waiting times 31 Day diagnosis to treatment – all cancers	96%	95.40%	96.89%	99.90%
Cancer urgent referral to treatment waiting times 62 Day urgent referral to treatment – all cancers	85%	82.10%	81.62%	83.69%

Existing and National Priorities (Continued)	2010/11 Target	Performance		
		2008/09	2009/10	2010/11
Clostridium difficile infections	See individual targets in each column.	Cases identified 126 Max. No. of cases ² 219	Cases identified 82 Max. No. of cases ² 145	Cases identified 110 Max. No. of cases ² 128
The Department of Health given number for that period for both GPs, residential homes, community hospitals and the Trust was no more the 597. Only 218 cases were identified. Department of Health guidance changed splitting acute trust numbers from community numbers identifying hospital acquired and community acquired infection.				
Delayed transfers of care Percentage of inpatients with delayed transfer of care	3.5%	2.63%	3.78%	4.28%
Engagement in clinical audits Local National	Targets	319 32	347 44	384 49
Ethnic coding data quality Ethnicity recorded for all inpatients	95%	94.90%	96.34% (April-Feb)	97.74%
Inpatients waiting longer than the 25 week standard	No longer a target	75	1	No longer a target
MRSA bacteraemias ³ The 'cases identified' figures are those numbers of patients who acquired MRSA and the 'maximum numbers' shown are those allowed under the Department of Health targets.	See individual targets in each column.	Cases identified 37 Max. No. of cases 40	Cases identified 28 Max. No. of cases 39	Cases identified 15 Max. No. of cases 11
Outpatients waiting longer than the 13 week standard	No longer a target	6	0	No longer a target
Participation in heart disease audits	N/A	Yes	Yes	Yes



Celebrating our people

Staff Honored



This year saw the Trust's fourth Outstanding Achievement Awards. The awards were devised to recognise and celebrate outstanding individual or team achievement and performance.

Top staff from departments and services across the Trust were honored at the annual awards ceremony.

Taking the prize for Outstanding Patient Care was Janet Copp – Clinical Nurse Specialist in Haematology and Oncology.

The packed ceremony held at Queen's Hospital heard how she works tirelessly to ensure that patients are put at their ease, making herself available day and night to talk to them on the phone and allay any concerns they may have.

In the Working Smarter, Not Harder category, matrons Cathy Dunne and Pauline Osborn took top honors for developing the Virtual Ward.

The scheme helps patients either avoid admission to hospital, or to enjoy a reduced length of stay, by developing services in their own home.

Leading the Trust through the swine flu pandemic won Sheila O'Mahony the Unsung Hero award.

Sheila, the Trust's Head of Infection Control, became Flu Director during the outbreak, developing and implementing a pandemic flu plan which saw both hospitals through the potential crisis.

Taking the Unsung Hero Award for the Trust's partner organisations was the security team at Queen's Hospital – employed by Sodexo.

The trained experts on the front line regularly have to deal with confrontation and difficult situations, but have built up a strong reputation for being approachable and helpful at all times.

Porter George Chennells was named as the Employee of the Year – chosen from the Trust's 12 Employees of the Month.

Countless Accident and Emergency department staff put him forward for the honour.

Volunteers Thanked



A couple who give up their free time to visit hospital patients became the recipients of a special appreciation award.

Vivien and Alan Fitch began visiting patients at King George Hospital back in 2000. They now also visit patients at Queen's Hospital.

The pair were nominated for the award by Trust Volunteer Co-Ordinator, Jean Thompson, who said: "Vivien and Alan visit the wards each week to talk to patients and keep them company.

"This is particularly beneficial when a patient has no relatives living nearby. The patients and their relatives are always so grateful to them for the time they give up - and that has a positive effect on their recovery."

Vivien and Alan were presented a Volunteer Appreciation Award by the Trust.

National Recognition for Junior Doctor



A trainee cardiologist at Queen's Hospital was shortlisted for the title of Junior Doctor of the Year.

Rameen Shakur made it to the last three in the prestigious British Medical Journal Awards. Around 650 people were considered for the award from across 25 countries.

Rameen, 28, has been working at Queen's as a Specialist Registrar since October, and thinks that the judges put his name on the shortlist because of his interest in research and teaching.

He is undertaking research on heart failure mechanisms, and has set up a pan-London research teaching group.

The BMJ say that their annual awards "recognise individuals, organisations or initiatives that have demonstrated outstanding and measurable contributions to healthcare".

As well as working as a cardiology registrar – the first cardiologist ever to be shortlisted for Junior Doctor of the Year – Rameen is also a clinical teacher in medicine at Oxford University, an honorary research fellow at the National Heart and Lung Institute and has published a number of books and papers as well as presenting at conferences around the world.

He trained at Cambridge, Oxford and Edinburgh medical schools and was also a Fellow at Harvard and Mayo medical schools in the USA.

"I have a real passion for teaching and research," said Rameen. "Encouraging students and doctors to take part in research and clinical audit can lead to huge improvements in patient care."

New developments

Acute Elderly Unit



The Trust opened its Acute Elderly Unit this year, with impressive results. The 90-bed unit stretches across three wards at Queen's Hospital, with a 30-bed dedicated acute rehabilitation ward at King George.

Patients over the age of 80 – or those over 70 with complex elderly needs – are now cared for in the unit by specialist staff.

All patients are seen by an elderly care specialist on arrival, and there are double the usual number of therapists on hand to help with rehabilitation. The success of the unit has been astonishing.

Within weeks of the unit opening in June the number of falls was cut by half, the number of pressure ulcers reduced by 30%, and the recording of patients' vital signs went up by 35%.

Elderly patients are recovering so well in the Acute Unit that, in just nine weeks, the average length of stay fell by two days.

All of the wards have a dedicated nutrition assistant who makes sure that people are getting the food and drink that they need.

And nurses make sure that they visit every patient regularly and do regular reviews of their condition.

The Trust is working to improve care of the elderly across the board, and is in-line with national strategies for the care of older people and treating dementia. Groups have been set up to review pain assessment and management, to improve the promotion of continence and to improve patient experience.

Dignity champions have also been put in place to ensure that patients are treated with respect, and a Productive Ward scheme has been introduced which has seen nurses' direct patient care time increased by 12%.

Matron Jackie Wray said: "By cohorting elderly patients within these areas, they have greatly enhanced services. It is a specific focus for social services and the discharge team so that patients can be moved home, or into a care home, as soon as they are ready.

"There is also be mental health liaison nurses based on the unit so that they can work closely with people suffering from dementia."

Stroke Care



The new Hyper Acute Stroke Unit at Queen's became the first in London to be fully operation last summer.

Patients now have access to specialist techniques and care 24 hours a day – leading to much better outcomes.

The Unit has been extremely successful and a National Sentinel Stroke Audit showed that it is delivering top quality care.

The Queen's HASU was rated in the top quarter across the whole country, and was given the highest possible rating for the quality of the care it provides.

Two years ago it was among the worst performing in England. A year later the service had improved enough to move it into the middle category, and in 2010 it was one of the best.

Consultant stroke physician Khaled Darawil said: "These results are very impressive. Our rating has improved year-on-year and we are now giving our patients some of the best care in the whole country."

The new unit is one of eight across London which provides patients with 24/7 access to specialist stroke staff, the latest CT scanning equipment and clot busting drugs (thrombolysis).

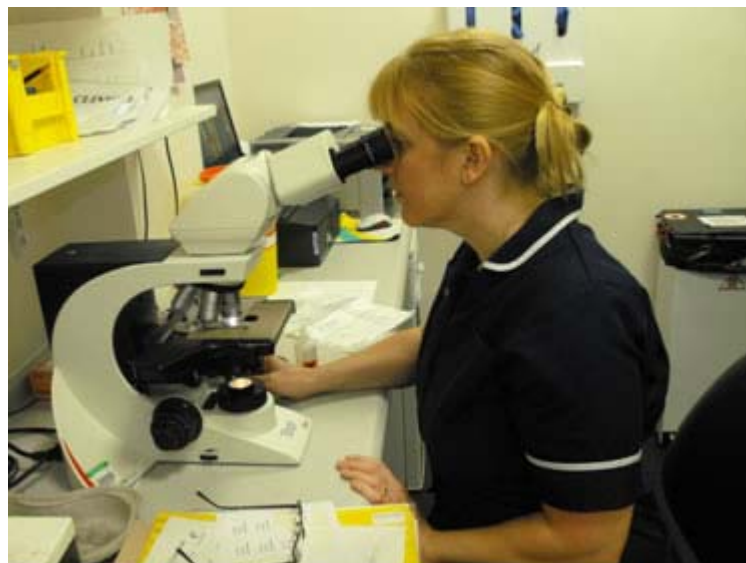
Each year around 11,000 people suffer a stroke in London, making it the second biggest killer in the capital and the most common cause of disability. The introduction of the eight HASUs is expected to save around 400 lives a year.

As well as expert emergency care, the Trust also has a dedicated rehabilitation service for stroke patients to get them back on their feet and reduce long-term disabilities.

The Trust has also become the first NHS organisation ever to be given a Life After Stroke Award.

The Stroke Association named the Trust as having the Most Improved Stroke Service in the country.

Sexual Health



A new, state-of-the-art sexual health centre has opened its doors to the public.

The Sydenham Centre has moved into a new building on the Barking Hospital site.

The new facilities – built to the Trust’s specifications - are spread across two floors, including extra consultation rooms, laboratory space, a pharmacy, phlebotomy areas, counselling rooms and offices.

The extra space and more congenial environment will be appreciated by the hundreds of patients who use the Centre every week.

It has allowed the Trust to provide extra HIV clinics. Previously three clinics were run a week – now there are four. There are also special rooms specifically for talking to patients about their medication, and the importance of taking it regularly.

Community support teams, who work with HIV patients, are based at the centre, and an on-line forum has also been set up for clinic patients.

The forum gives people with HIV the chance to talk to other people in the same situation to they can share experiences and support each other.

The Sydenham Centre is an integrated sexual health and family planning service, so as well as diagnosing and treating STIs, the trained advisors also deal with contraceptive services.

The local population has high levels of teenage pregnancy and repeat abortions, and the Trust is working hard to tackle the problem.

As well as the community support team, health advisors, nurses and a sexual health Consultant are all based at the centre.

A walk-in service is now available every weekday except Wednesdays, so people don’t have to make an appointment for sexual health or family planning issues. And with both services on site, someone arriving for STI screening can also receive advice on contraceptives at the same time.

“This is such a busy centre,” said General Manager Maureen Ross, “but we now have so much space here that we can grow with the population and the needs of the service.”

Trauma Team Success



The trauma team at Queen's Hospital has been praised for playing a vital part in a Trauma Network.

The Accident and Emergency department at Queen's forms part of the North East London and Essex Trauma Network – launched in April 2010.

Trauma centres across the region had been working towards the launch for two years – aiming to give patients the best possible emergency care.

Now, if someone suffers a traumatic injury, they will be taken directly to the very best A&E department for their needs.

The region's Multi Trauma Centre is at the Royal London Hospital. But Queen's houses a Specialist Trauma Unit for head, facial and spinal injuries.

If a patient has major injuries to their head, neck or spine they will be brought directly to the Romford hospital. Previously they would have been taken to their nearest A&E before being transferred to Queen's for specialist treatment. Arriving directly at a neurosurgical centre means that the time from injury to potentially life-saving surgery is minimised. Patients also have access to the expertise of the neuro-intensive care team who ensure that patients with acute brain or spinal injuries receive the highest standard of management.

The first performance assessment of the Trauma Network has taken place, and shows that it is proving extremely successful and improving care and outcomes for patients.

Acting Director of Trauma Derek Hicks said: "The Network is working extremely well. We are getting the right patients brought to us first time.

"With specialist knowledge of head, facial and spinal injuries, patients have better outcomes if they come to us directly. The focus of the team on head

and spinal injuries means that they are attentive to the small things that can make a big difference in the long term.”

The radiographers working with the trauma team at Queen’s ensure that patients arriving at the hospital are given a CT scan in an average of just 35 minutes. The national target is 60 minutes.

Improving patient experience

The Trust continues to work hard to improve the experience of patients while they are in our hospitals.

There is far more to hospital care than ensuring that people receive the best clinical treatment.

It is also important that they feel listened too, and are treated with privacy and dignity as a valued individual.

Our Visible Leadership scheme – with senior nursing staff back on the wards one day a week – is still proving very successful in highlighting areas of improvement. Senior staff – including our Director of Nursing – join a ward to look at key indicators of patient care, including hand hygiene and nutrition assessment.

In the past year the scheme has seen impressive results, with improvements across the board.

The Productive Ward programme has made a big difference to meal times this year.

A dedicated Healthcare Support Worker now prepares patients for their meals, new colour-coded boards help the hostess to understand a patient’s dietary requirements, and there is more help available for those who have difficulty feeding themselves.

Where possible, people are also given the chance to sit at a dining table and eat with other patients.

The changes have made mealtimes much quicker, meaning that staff have more time to spend on direct patient care.

We continue to treat patients in single sex areas to ensure their dignity, and work closely with the patient representatives on our Improving Patient Experience Group to ensure they are fully involved in the development of Trust services.

The national survey of NHS patients helps us to identify where people feel we are doing well, and which areas they feel we could improve.

This year we have introduced our own patient survey, so people can use hand-held computers or static kiosks at both hospitals to give us feedback on our services there and then.

We can access results regularly, so can act on patients' opinions to implement changes quickly and effectively.

Patient Experience	2008/9	2009/10	2010/11	Target
Number of formal complaints received	940	566	660	539
Number of Patient Advice and Liaison Service enquiries	8,209	9,988	7,218	No target
Percentage of patients who always feel they were treated with dignity and respect (Annual Inpatient Survey)	70%	72%	74%	No target
Percentage of patients who were always given enough privacy when discussing their condition or treatment	63%	64%	67%	No target



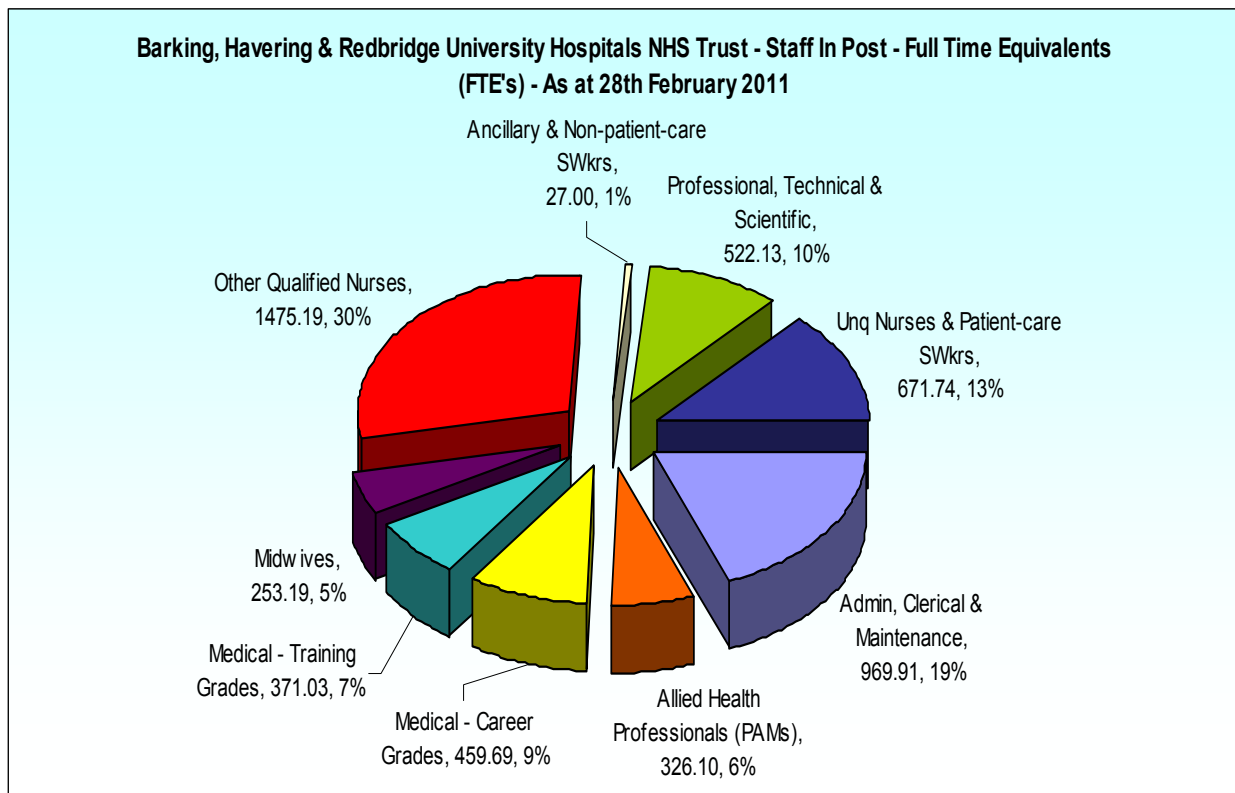
Our Staff

The Trust employs more than 5,000 Full Times Equivalent (FTE) staff, who are our most important resource. Around 70 per cent of them work in direct clinical care, with a further 11 per cent in clinical support roles.

Without our skilled and dedicated workforce we could not continue to make a difference to the people who need to use our services.

From March 1st 2010 to February 28th 2011 our actual number of FTE staff in post increased by more than 141. The change was due to successful recruitment campaigns which have significantly increased the number of front-line staff working directly with patients on our wards.

This means we can reduce our use of agency staff and locums, improving continuity of care for patients.



Sickness absence

Trust-wide sickness absence for 2010/11 was 4.53% - a reduction of 1% on the previous year.

In light of our improvements, and in line with national, regional and local requirements to improve workforce productivity and efficiency, we have reviewed and revised our sickness absence target to 3.60% for the coming year.

Staff survey

The latest NHS staff survey results were published by the Care Quality Commission in March 2011. The results help us to review and improve the experiences of our staff so they in turn can provide better care to patients.

Almost 306,000 NHS staff across the country were asked about their experiences. Almost 400 members of staff at this Trust completed the survey. The findings showed that we had performed well on appraisal – ensuring that staff have an annual review with their manager. The organisation has put real effort into this area over the past 18 months, and it was pleasing to see that it had paid dividends. Few staff, compared to similar organisations, experienced physical violence from patients, service users, their relatives or other members of the public in the previous 12 months.

However, there were a number of important areas where we performed poorly. We are using the findings to inform and implement changes to improve the work experience of all our staff. The work started immediately with each division preparing an action plan. The Trust's Executive Team will be working to engage with staff, understand their perspectives and support them in the delivery of high quality care.

Sustainability

The year was marked by several new advances in our commitment to sustainable development; among them, a reduction in CO₂ emissions, continued progress on waste management, the introduction of the revived sustainable travel agenda and increased dialogue with local stakeholders. This commitment has two main objectives - to continue improving our performance and to act as a driving force within the healthcare sector.

The Trust has developed a new strategy to address concerns related to the sustainable development. This document discusses the drivers behind the agenda, leads within the Trust and the governance structure in reporting sustainability issues. The key focus has been implementing the strategy and pursuing opportunities that lead to a low carbon world.

The new strategy has given the Trust a better framework for our activities, with an emphasis on identifying ways in which we can reduce carbon emissions. This is a role the Trust is uniquely placed within the community to fulfil through our supplier relationships and the skills and expertise of our staff.

There are significant opportunities in helping deliver a low carbon society. Improving our performance in this area will enable us to better treat our patients, while delivering environmental and social benefits to society.

Our programme focuses on delivering energy for a low carbon world, through decarbonising power generation, reducing the Trust's carbon footprint and helping key stakeholders cut their carbon emissions, including patients and visitors. To achieve this, we need to build trust among all our stakeholders and this is the role of our four supporting focus areas - energy management, waste management, sustainable travel and sustainable procurement. These are in turn underpinned by responsible business practices and behaviours. We track progress against all of these through key performance indicators and via stakeholder dialogue and feedback.



The Trust Board Members

Chairman: Edwin Doyle



Edwin replaced Sir David Varney as Chairman, and was appointed to the role on August 31st 2010.

Living in Wanstead, Edwin was previously the Chair of NHS Redbridge and has also been a Non Executive Director for Chingford, Wanstead and Woodford PCT.

He is a former civil engineer and was Director of Technical Services for the London Borough of Newham. Edwin has also recently been an adviser/consultant in corporate management, urban regeneration and public services.

Chief Executive: Averil Dongworth



Averil was appointed as Chief Executive in February 2011, replacing John Goulston.

She was previously the Chief Executive of Barnet and Chase Farm Hospitals based in North London. She led the Trust from February 2004 having joined from Barnet Primary Care Trust, where she was also Chief Executive. Prior to

that Averil was Chief Executive at City and Hackney Community Services NHS Trust.

Medical Director: Stephen Burgess



Stephen was appointed as Acting Medical Director in December 2011, taking over the role from Ian Abbs.

Stephen joined the Trust as a consultant in Obstetrics and Gynaecology in 1989 at King George Hospital. He has a special interest in colposcopy. He chaired the Senior Medical Staff Committee at King George Hospital from 1993 to 1998, when he was appointed as the Trust's Medical Director. He was instrumental in the merger of Redbridge Health Care and Havering Hospitals Trust into the current BHR Hospitals Trust. He stood down from the post in March 2006, returning to full time clinical practice.

In September 2008 he took up the role of Divisional Director of Surgery.

Director of Human Resources: Ruth McAll



Ruth McAll joined the Trust in December 2008. She has 15 years experience as an HR Director with a variety of NHS Trusts, including mental health, community and Foundation Trusts.

Ruth works to develop a structure and function for HR that helps staff and managers deliver good practices in people management.

Ruth was a member of the national pensions review, lead in HR networks and NHS conference.

Director of Delivery: Neill Moloney



Neill Moloney joined BHR in May 2008 from Barts and the London NHS Trust where he was Head of Information and Performance. Prior to this he was a General Manager for four years at Mid Essex Hospitals NHS Trust in Chelmsford and Birmingham Heartlands and Solihull NHS Trust, managing a range of clinical and non clinical services.

As a Commissioning Manager for Birmingham Health Authority, Neill led on development of the winter and emergency plans and was responsible for commissioning specialised services.

With a background in business planning, information provision and operational management, Neill's priorities are to ensure plans and enabling strategies are in place to support the delivery of the Trust's clinical services.

Director of Nursing: Deborah Wheeler



Deborah joined the Trust as Director of Nursing in January 2010 from the Whittington NHS Trust where she held the post of Director of Nursing and Clinical Development. Deborah trained as a nurse at St Bartholomew's Hospital, and spent her clinical career in orthopaedic nursing. She subsequently held a variety of management posts at the Royal National Orthopaedic Hospital, Stanmore.

Deborah has lived in the Barkingside area for the last 25 years. Her children were born in Barking Hospital and King George Hospital.

Director of Finance: David Wragg



David joined the Trust in April 2009 after nine years as Finance Director at the Queen Elizabeth Hospital NHS Trust in Woolwich, SE London, where he also looked after estates and facilities management.

David had a leading role in the project to merge the Queen Elizabeth Hospital NHS Trust with Bromley Hospitals NHS Trust and Queen Mary's Hospital NHS Trust to form South London Healthcare NHS Trust.

He has also contributed financial leadership to the Picture of Health project, which has made important and far reaching recommendations for the reorganisation of acute hospital services in outer SE London.

Before joining Queen Elizabeth, David spent 15 years working in management consultancy and external audit for NHS organisations.

Director of Strategy and Planning: Robert Royce



Robert joined the Trust in January 2010.

Previously, Robert was Director of Operations, Planning, Estates and Facilities in a large acute trust in Wales. He has also been Interim Director of Operations, Division of Emergency Care and Specialist Medicine at South London Healthcare NHS Trust.

Robert is working towards achieving our agenda of improving the quality of our services and our patients' experience, meeting our financial targets and implementing our clinical strategy.

Non-executive directors

Barbara Liggins has a business background of 33 years in banking and senior management. Since 1996 she has worked at board level, initially as a Member of the Essex Police Authority and since 2004 as a BHR Non-Executive Director. She is the Chair of Trustees at Essex Police Museum and retired as a magistrate serving on the South West Essex Bench at the end of 2008.

Barbara has 20 years NHS experience in various roles including being a member of the Barking and Havering Family Practitioners Committee, a conciliator for North and South Essex Health Authorities as well as being a convener for Southend General Hospital.

Keith Mahoney was appointed from December 2008 and has 30 years' experience with major retail organisations. In his role as Head of Logistics (Food) for Marks and Spencer, he managed a budget of £200 million. Keith is also a volunteer for many charities.

Professor Raymond Playford is the Deputy Warden and Professor of Medicine at Queen Mary's School of Medicine and Dentistry, and has had a long and illustrious career within the NHS and world-renowned teaching hospitals and universities.

William Langley was appointed as a Non-Executive Director and Chair of the Audit Committee in July 2010.

He is a qualified accountant with more than 30 years experience working for major organisations in electronics, the food industry, publishing and travel. He has held directorships of businesses operating in Japan, South East Asia, South Africa and the UK.

He now works on consultancy projects, and carries out work as a charity trustee and as a member of voluntary sector committees and lives in Havering.

George Wood recently retired from Ford after 33 years, and joined the Trust in August 2010.

He held various senior positions with the organisation including Managing Director of Ford Credit Brazil and later Vice President of the Region. More recently he was Director of the UK Customer Service Centre.

Cllr Michael White joined the Conservative Party in 1982 and has been involved in politics ever since. He has been a Member of Havering Council since 1994 and in 1998 he became Deputy Leader of the Conservative Group

on Havering Council and Deputy Leader of the Council in 2002. His responsibilities were e-government and communications but he later took on responsibility for the Council's drive to improve its Comprehensive Performance Assessment (CPA) score.

In May 2004 he became Leader of the Council and was re-elected leader in 2010. Michael is also a member of the London Thames Gateway Development Corporation Board, he is Vice-Chair of Thames Gateway London Partnership; and from 2008 to 2010 was Deputy Leader of London Councils.

He joined the Trust in November 2010.

Farewell

During the year 2010/11 the Trust said goodbye to Chief Executive John Goulston, Chairman Sir David Varney, Medical Director Ian Abbs and Non Executive Directors Mark Hicks, Renata Drinkwater and Stuart Cruickshank. We would like to thank them for their for their invaluable contribution to the Trust.

Operating and Financial Review 2010/11

The requirement for NHS bodies to prepare an Operating and Financial Review as part of the annual report was introduced in 2005/6. The OFR seeks to provide information on the developments, trends, performance and business position of the Trust in terms both of the year in question and future development.

The Trust agreed a Plan with NHS London for 2010/11 for an income and expenditure deficit of £19.4m, excluding the technical impact of asset impairments and International Financial Reporting Standards (IFRS). This position compared with an outturn deficit of £22.3m in 2009/10. The key movements within the Plan compared with the previous year's position included an adverse movement in income of £13m, related to the risk share agreement with the local PCTs, a Cost Improvement Programme (CIP) savings target of £35.9m and inflationary cost pressures (including pay awards) of £14.3m and other net adverse I&E changes of £5.1m in aggregate.

The Trust finished the year with a deficit of £33.0m, excluding the technical impact of fixed asset impairment reversals (£8.7m favourable) and IFRS (£1.1m), which was £13.6m above the control total. The primary reason for this was a shortfall of £12.9m against the Trust's Cost Improvement Programme target (£23.0m achieved against the target of £35.9m). The Trust also saw a significant over-performance against its PCT contracts (£11.8m), although the benefit of this was largely offset by cost pressures, primarily as a result of the higher levels of patient activity compared with contract, including high cost agency staffing. High levels of temporary staffing remains a key issue for the Trust (£41m in 2010/11, 14.7% of total pay, compared with 15.3% in 2009/10), although action has been taken to reduce both price and usage.

Although the Trust saw an increase in cash balances of £0.7m in the year, this was primarily due to an injection of £30m of Public Dividend Capital from the Department of Health (received in Q4), to finance the adverse cash impact of the I&E deficit. The difficulties in managing the cash consequences of the I&E deficit during the year were manifested in a poor performance against the Better Payment Practice Code, with only 57% non-NHS invoices (by value) paid within the target 30 day period, compared with 81% the previous year.

The Trust achieved its financial performance targets in meeting its External Financing Limit (EFL) and Capital Resource Limit (CRL).

The 2010/11 deficit increased the Trust's cumulative deficit, as measured against the breakeven duty, to £150m, incurred over the six year period to 31 March 2011.

As reported in the 2009/10 OFR, the Audit Commission published a s19 Report (under the Audit Commission Act) to the Secretary of State, due to the failure of the Trust to meet its statutory breakeven target. In January 2011, the Audit Commission followed this up with a section 8 public interest report. The purpose of this report was to bring the Trust's financial standing to the attention of the public and to seek the Trust's response to:

- its failure to meet its statutory financial duties
- the seriousness of its current financial position; and
- the action that it now needs to take to improve its financial position and meet its statutory financial duties on a sustainable basis.

The Report also highlighted some of the key underlying factors for the deficit, including:

- a high level of fixed costs as a result of the Queen's Hospital PFI scheme
- Significantly lower non-PbR income compared with other Trusts
- High levels of agency staff costs

In response, the Trust is reviewing its longer term financial strategy, within the overall context of the Health4NEL strategy for the future configuration of health services within NE London, including the decision on the services to be provided at King George Hospital.

The Trust is currently planning for a deficit of £35.0m in 2011/12 (excluding the impact of impairments and IFRS), an increase of £2m from the 2010/11 position. Although the Trust is planning for a further CIP of £28.4m (7%, compared with a national tariff assumption of 4%), this is more than offset by inflationary generic cost pressures of £17m (4.3%, compared with tariff assumption of 2.5%) and the loss of non-recurrent benefits from 2009/10 (e.g. Challenged Trust Board funding of £3.2m) and full-year effect cost pressures from 2009/10, e.g. investment in additional midwifery and ward nursing staff. At the time of writing (May 2011) the Trust had yet to agree its Plan with NHS London, primarily due to a difference in income assumptions with local PCTs and the final Plan deficit is likely to be in the region of £40m.

Financial Governance

The Trust's financial situation is monitored by the Trust Board and in detail by its Finance Committee, which is chaired by Non Executive Director George Wood. The Trust Audit Committee, which is chaired by William Langley, monitors the Trusts governance arrangements.

The Trust's current external auditors are the Audit Commission. The cost of their work performed amounted to £306k for the year.

Pension liabilities have been accounted for in accordance with note 1.7 of the Accounts.

Remuneration

The remuneration package and conditions of service for Executive Directors is agreed by the Trust Remuneration Committee, a Committee of the Board of Directors consisting of all of the Non-Executive Directors, including the Chairman of the Trust.

The remuneration for certain Executive Directors does include performance related bonuses and none of the Executives receives personal pension contributions other than their entitlement under the NHS pension scheme.

Each year, the Remuneration Committee considers the contribution of each Director against the functions of the post as defined in the current job description and as foreseen for the future. This is carried out in parallel with a review of the individual's career development and potential opportunities for progression. The Remuneration Committee considers the matter of succession planning, although all Executive Directors hold permanent contracts.

The notice period for Executive Directors is six months and there are no arrangements for termination payments or compensation for early termination of contract.

Non-Executive Directors, including the Chairman, are appointed by The Appointments Committee for specified terms subject to re-appointment thereafter at intervals of no more than four years and to the relevant laws relating to the removal of a Director. The Constitution currently requires Non-Executive Directors to retire after eight years' service.

The Remuneration Committee met six times during 2010/11

Remuneration Committee Members

Mrs Barbara Liggins, Chair of the Remuneration Committee/Non Executive Director

Mr Edwin Doyle, Interim Chairman

Professor Ray Playford, Non Executive Director

Mr Keith Mahoney, Non Executive Director

Mr George Wood, Non Executive Director

Mr William Langley, Non Executive Director

Mr Michael White, Non Executive Director

In Attendance:

Mrs Ruth McAll, Executive Director of HR and OD

Mrs Averil Dongworth, Chief Executive

In determining Directors' pay and conditions, the Remuneration Committee took into account comparative information available from NHS Partners survey and the IDS Boardroom Pay Report.

The level of remuneration for non-executive Board Members is based on an average expected workload of three to four days a month for Non-Executive Directors and two to three days a week for the Chairman.

The contracts of Directors who served during the year are summarised in the table below.

	Starting date	Until
<u>Chairman</u>		
E. Doyle (Interim)	August 2010	
Sir David Varney	January 2010	June 2010
B. Liggins (Shown in Non Executive Directors)	June 2010	August 2010
<u>Non-Executive Directors</u>		
M. Hicks	Jan 2004	May 2010
S. Cruickshank	June 2008	June 2010
B. Liggins	January 2010	
K. Mahoney	December 2008	
R. Playford	February 2009	
G. Wood	August 2010	
W. Langley	July 2010	
M. White	November 2010	
<u>Chief Executive</u>		
J. Goulston (Seconded to SHA)	March 2008	
A. Dongworth (Seconded from Barnet & Chase Farm NHS Trust)	February 2011	
<u>Medical Director</u>		
S. Burgess (Acting)	January 2011	
I. Abbs (Seconded from Guys & St Thomas)	April 2010	December 2010
Y. Drabu (Seconded to DOH)	March 2006	
<u>Director of Human Resources</u>		
R. McAll	December 2008	
<u>Director of Finance</u>		
D. Wragg	April 2009	
<u>Director of Nursing & Clinical Governance</u>		
D. Wheeler	January 2010	
<u>Director of Delivery</u>		
N. Moloney	May 2008	
<u>Director of Strategy & Planning</u>		
R. Royce	January 2010	

Directors' Salary Table

	From	Until	2010/11			2009/10		
			Salary	Bonus Payments	Benefits in Kind	Salary	Bonus Payments	Benefits in Kind
All Figures in £'000s			(bands of £5,000)	(bands of £5,000)	(to nearest £100)	(bands of £5,000)	(bands of £5,000)	(to nearest £100)
Chairman								
E. Doyle (Interim)	August 2010		20 - 25	-	-	-	-	-
Sir David Varney	January 2010	June 2010	0 - 5	-	-	0 - 5	-	-
B. Liggins (Shown in Non Executive Directors)	May 2008	December 2009	-	-	-	-	-	-
B. Liggins (Shown in Non Executive Directors)	June 2010	August 2010	-	-	-	-	-	-
Non-Executive Directors								
R. Drinkwater		March 2010	-	-	-	5 - 10	-	-
M. Hicks		May 2010	0 - 5	-	-	5 - 10	-	-
S. Cruickshank		June 2010	0 - 5	-	-	5 - 10	-	-
B. Liggins	January 2010		5 - 10	-	-	15 - 20	-	-
K. Mahoney			5 - 10	-	-	5 - 10	-	-
R. Playford			5 - 10	-	-	5 - 10	-	-
G. Wood	August 2010		0 - 5	-	-	-	-	-
W. Langley	July 2010		0 - 5	-	-	-	-	-
M. White	November 2010		0 - 5	-	-	-	-	-
Chief Executive								
J. Goulston (Seconded to SHA)			180 - 185	-	-	180 - 185	-	-
A. Dongworth (Seconded from Barnet & Chase Farm NHS Trust)	February 2011		35 - 40	-	-	-	-	-
Medical Director								
S. Burgess (Acting)	January 2011		40 - 45	-	-	-	-	-
I. Abbs (Seconded from Guys & St Thomas)	April 2010	December 2010	135 - 140	-	-	-	-	-
Y. Drabu (Seconded to DOH)			170 - 175	-	-	170 - 175	-	-
Director of Human Resources								
R. McAll			110 - 115	-	-	95 - 100	-	-
Director of Finance								
D. Wragg			150 - 155	-	-	150 - 155	-	-
Director of Nursing & Clinical Governance								
D. Wheeler	January 2010		100 - 105	-	-	20 - 25	-	-
E. Wright - Interim	November 2009	December 2009	-	-	-	15 - 20	-	-
D. Weir Hughes		October 2009	-	-	-	65 - 70	-	-
Director of Delivery								
N. Moloney			115 - 120	-	-	115 - 120	-	-
Director of Strategy & Planning								
R. Royce	January 2010		140 - 145	-	-	30-35	-	-

* Benefits-in-kind means the taxable value of benefits provided. The values are calculated in accordance with Inland Revenue rules and relate to leased cars less the contribution made by the employee.

Directors' Pensions Table

Pension Benefits Name and title	Real increase in pension at age 60 (bands of £2,500) £k	Real increase in pension lump sum at aged 60 (bands of £2,500) £k	Total accrued pension at age 60 at 31 March 2011 (bands of £5,000) £k	Lump sum at age 60 related to accrued pension at 31 March 2011 (bands of £5,000) £k	Cash Equivalent Transfer Value at 31 March 2011 £	Cash Equivalent Transfer Value at 31 March 2010 £	Real increase in Cash Equivalent Transfer Value £	Employer's contribution to stakeholder pension £
J Goulston Chief Executive	5-7.5	15-17.5	35-40	115-120	728,532.30	683,804.65	17,428.12	0
S Burgess Medical Director	(0-2.5)	(0-2.5)	60-65	190-195	1,338,606.68	1,390,505.45	-64,556.40	0
D Wheeler Director of Nursing & Clinical Governance	5-7.5	15-17.5	35-40	110-115	588,812.05	554,899.95	12,474.00	0
R Royce Director of Strategy & Planning	10-12.5	32.5-35	40-45	120-125	733,785.95	571,666.67	101,878.66	0
N Moloney Director of Delivery	0-2.5	2.5-5	25-30	80-85	319,264.31	360,822.34	-36,401.31	0
R McAll Director of HR	5-7.5	15-17.5	35-40	115-120	714,381.36	666,539.38	19,958.64	0
D Wragg Director of Finance	0-2.5	2.5-5	25-30	85-90	440,815.64	467,917.01	-28,469.67	0

As Non Executive Directors do not receive pensionable remuneration, there are no entries in respect of pensions for them.

The Government Actuary Department (GAD) factors for the calculation of Cash Equivalent Transfer Factors (CETVs) assume that benefits are indexed in line with CPI which is expected to be lower than RPI which was used previously and hence will tend to produce lower transfer values.

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. Where individuals have left the Trust during the year the cash equivalent transfer values provided by the NHS Business Services Authority (NHS Pensions) at 31 March 2011 are reported and not at the date of leaving.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures include the value of any pension benefits in another scheme or arrangement that the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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 pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

The Trust has not made any contributions to Stakeholder Pensions for senior managers during the year.

Foreword to the accounts

These accounts for the year ended 31 March 2011 have been prepared by the Barking, Havering and Redbridge University Hospitals NHS Trust under section 98(2) of the National Health Service Act 1977 (as amended by section 24(2), schedule 2 of the National Health Service and Community Care Act 1990) in the form which the Secretary of State has, with the approval of the Treasury, directed.

Averil Dongworth
Chief Executive

Date: June 7th 2011

Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Trust

The Chief Executive of the NHS has designated that the Chief Executive should be the Accountable officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Department of health. These include

- 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
- The expenditure and income of the trust has been applied to the purpose intended by parliament and conform to the authorities which govern them
- Effective and sound financial management systems are in place
- Annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year

To the best of my knowledge and belief, I have properly discharge the responsibilities set out in my letter of appointment as an accountable officer

Averil Dongworth
Chief Executive
Date: June 7th 2011

Statement of Directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that

these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

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

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

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

By order of the Board

Averil Dongworth
Chief Executive



David Wragg
Director of Finance

Date: June 7th 2011



STATEMENT ON INTERNAL CONTROL 2010/11

1. Scope of Responsibility

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

As designated Accountable Officer for the Trust I have overall accountability for risk management in the Trust. The Medical Director and Director of Nursing lead on clinical risk management issues, whilst the Finance Director is responsible for financial risk at Board level. The operational responsibility for risk management at corporate level is assigned to the Clinical Governance Director in the Trust's Clinical Governance Directorate.

The Audit Committee oversees performance of the risk management systems in place in the Trust, via the Finance Director and the Clinical Governance Director. The Clinical Governance Committee until December 2010 and the Quality and Strategy Committee thereafter, oversee the regular and routine monitoring of detailed clinical performance. The Committees provide exception reports of high-level clinical risks to the Trust Board. Key risks are also highlighted to and reviewed by the Audit Committee and the Trust Board on a regular basis through the Assurance Framework and Risk Register. Operationally risks are considered through the Divisional Boards and the Productivity, Efficiency and Quality Programme Board.

The Trust has engaged with and participates in the work of its Health and Social Care Partners across North East London using established networks and communication systems. The Trust meets regularly with the Provider Agency working on behalf of NHS London. Close working exists with ONEL, NHS Barking & Dagenham, NHS Havering, NHS Redbridge and NHS South West Essex in order to take forward the delivery of healthcare, this takes place through regular commissioning, operational and strategy meetings.

2. The Purpose of the System of Internal Control

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

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

The system of internal control has been in place in Barking, Havering and Redbridge University Hospital NHS Trust for the year ended 31 March 2011 and up to the date of approval of the annual report and accounts.

3. Capacity to Handle Risk

The overall strategy of the Trust is to maintain systematic and effective arrangements for managing risks throughout the organisation, whether clinical or non-clinical, financial or organisational, so as to ensure they are reduced to a minimum practicable level.

These arrangements are described in the Trust's corporate governance manual approved by the Trust Board that includes the Standing Orders, Standing Financial Instructions and Scheme of Delegation.

A Risk Management Strategy and Policy was implemented in 2004, against which the Trust reviews progress annually, and updates the strategy accordingly. Amendments and additions to the Strategy are approved by the Trust Board.

I, as Accountable Officer, hold overall responsibility for all areas of risk management and until January 2011 the previous Accountable Officer held specific responsibility for Health and Safety within the Trust. I am supported by:-

- The Medical Director, who holds executive responsibility for medical leadership and Clinical Governance and Clinical Risk Management.
- The Director of Nursing, who holds executive responsibility for nursing practice, the patient experience and safeguarding vulnerable persons and is the Trust nominated lead for Infection Control. .
- The Director of Finance, who holds executive responsibility for financial risk management and from January 2011 responsibility for Health and Safety within the Trust.
- The Director of Human Resources, who is the executive responsible for employment and implementation of employment legislation, training and education.
- The Director of Planning and Delivery is the executive responsible for performance against targets and Information Governance
- The Director of Strategy holds executive responsibility for business planning and IT strategy.
- The Clinical Governance Director holds operational responsibility for Health & Safety and day-to-day responsibility for co-ordinating and facilitating the implementation of risk management and clinical governance procedures; providing risk management advice whilst maintaining the Trust's register of risks and the assurance framework.

I rely on Divisional Directors, Clinical Directors, Divisional Nurses and Managers, Matrons and ward/service managers to be alert to risk assessment, management and reporting within their own areas, and in turn they ensure their staff are alert to

identifying and reporting risks related to Health and Safety, patient care or the hospital environment. The Department of Health, professional bodies and various regulatory bodies, such as the Health and Safety Executive all offer guidance on good practice; this is reinforced by workplace-based assessments and training given at a local level.

There is a continuing programme of Risk Management Training embedded into the Trust's Corporate Induction Programme for all staff, with risk management training forming an integral part of the risk management policy. There is also a series of Senior Leaders Events which are attended by Trust Board members, senior clinicians and managers which reviewed the outcomes of the Mid Staffs enquiry and the subsequent Francis report; and Hospital Standardised Mortality Ratio and risk assessed the Trust position against these findings and outcomes.

The Trust participates in all required external quality accreditation programmes and participates in British Standards Institute accreditation having 11 accredited areas. The Trust engages in the Patient Safety First Campaign, the Global Trigger Tool and the Chief Nursing Officer's High Impact Nursing Challenges, and has an internal Patient Safety checklist that is used across the Trust. Participation in the Department of Health Safety Express Programme using the 'Safety Thermometer' to collect information to form a complete picture for patients that may be at risk is in place.

The introduction of the Quality Care 24/7 project aims to mitigate the risk of patients potentially being disadvantaged by being admitted "out of working hours". Changes in rotas for junior doctors across specialties ensure there is an increase in senior doctors available and there are multi-skilled dedicated teams to attend acutely unwell patients and in-patients as separate teams.

Wards and Departments receive monthly feedback on incidents and complaints for review and learning. These are sent to a range of key staff including ward sisters and matrons for review and action to reduce risk.

The Trust's Local Counter Fraud Service delivered 28 fraud awareness training sessions across the Trust, covering 985 staff, including as part of the Trust's Induction Programme and with specific training for various departments.

As part of the NHS Counter Fraud and Security Management Services Annual Fraud Awareness Month in June 2010, the Local Counter Fraud Specialist, together with two Counter Fraud Specialists from the NHS Counter Fraud and Security Management Service met with key Trust officers to promote counter fraud activity, and publicity material was also shared with departments. Eight Trust policies have been fraud proofed.

The Trust was assessed by the Counter Fraud and Security Management Service to be performing well during 2009/10.

During 2010/11, the Trust continued its investment in a series of Governance workshops for staff to raise awareness of the Trust Governance Manual (approved by the Trust Board in November 2008) and to enforce principles of sound governance.

There are clear objectives set each year and potential risks to achieving these objectives are outlined in the assurance framework and an action plan developed to mitigate the risk.

4. The Risk and Control Framework

The risk and control framework existing within the Trust has continued to develop over the year using key performance indicators to enable a more accurate level of risk prediction and assessment. These systems are central to informing the decision making process in the provision of a safe and secure environment for patients, staff and visitors. The corporate risk framework is comprised of the following elements:

The Risk Management Strategy and Policy is in line with and accredited by the NHS Litigation Authority's Risk Management Standards level 1 accreditation. It recognises the impact that local, corporate and extreme risks may have on the finances, reputation or both of the organisation and provides guidance on measuring, mitigating and managing the residual risks. This was reviewed, updated and received Trust Board approval in January 2011.

The Board Assurance Framework (BAF) is a cohesive document populated by the identified risks to the Trust potentially not meeting its objectives, the extreme risks identified through the risk register and any risks to the Trust's reputation through poor publicity or external accreditation shortfalls. Identified gaps in control following risk assessment are mitigated via action plans which are monitored through the most appropriate committee structure.

The Board Assurance Framework is presented to the Audit Committee at each meeting and the Committee receives a presentation of Divisional extreme and high risks along with mitigating action plans via a rolling programme of presentation.

The Risk Register is maintained as the focal point of risk evaluation and is maintained as a "live" document. Each Division receives an electronic copy of their risk register on a monthly basis. The new risks identified through changes in service, serious incidents, incident and complaint investigation, safety alerts and changes in control measures or resources are added to the risk register as they arise, supported by a risk assessment to ensure accurate and reflective grading and for extreme risks an action plan. There is also an annual programme of risk assessment, which includes health and safety risk assessment carried out at a local and corporate level to identify new risks. The Health and Safety risk register is used to populate the corporate register.

The extreme components of the risk register are transferred to the BAF and their associated action plans are monitored either through the Productivity, Efficiency and Quality Programme Board, the Audit or Clinical Governance Committee and ultimately the Trust Board for final decisions by exception.

The Audit Committee as a sub-committee of the Trust Board holds delegated responsibility for the monitoring and inquisition of the risk register and the BAF. The Committee continues an established programme of risk review. The process examines the risks, the mitigating actions and future action plans for appropriateness and strength seeking to identify any further weakness or threat to patient safety, finance or reputation. In this way the Audit Committee can provide assurance to the Trust Board of the robustness of the control systems in place.

Financial Control

Following a review of all financial control systems within the Trust and the implementation of the Governance Manual a range of implemented actions ensured that sound budgetary control and clear financial reporting systems are in place and embedded in working practice. The Internal Audit opinion following review is that there is substantial assurance of sound systems.

Counter Fraud systems of control are in place to reduce and investigate incidents of fraud through Parkhill Counter Fraud Services. A rolling programme of staff training is in place to assist staff in identifying potential fraudulent situations and identify weaknesses in current systems. The systems of control have led to high impact outcomes protecting Trust assets, and a strengthening of employment procedures to detect bogus documentation which may be used by potential employees to secure employment fraudulently.

Data Security at the Trust utilises the N3 network and NHS standards to manage and control data security and maintain confidentiality. The NHS standard for encryption is the cipher AES256. The Trust do encrypt all PC's and laptops, enforcing policies which prevent the copying of data to unsecure and non encrypted portable devices, in order to give greater security to patient data and other NHS specific data.

The Trust's primary responsibility is that the delivery of patient care should remain the highest priority and unaffected where possible by encryption. A balance of risk to patient care against risk to personal data security is used in determining whether the use of unencrypted devices should continue as an interim measure. Where it is felt that continued reliance upon unencrypted data is necessary for the benefit of patients, a risk assessment must be undertaken and the outcome of the assessment must be reported to the Information Governance Board.

All electronic external routes to and from the Trust are managed through firewalls. In addition to this appliances manage the incoming email and also protect users from viruses and malware. Servers which store data are maintained within a locked and secure environment, which has additional protection against environmental factors, such as water and fire.

Liberating the NHS – Equity & Excellence

Trajectory to FT status (as set out in *Equity and excellence: Liberating the NHS*) is a standing item on the Trust Board.

Engagement with Public Stakeholder's in Managing Risk is through interaction with a range of different bodies and groups as detailed below:

The Trust provides reports and Executives and Senior Managers attend relevant meetings of the three local authority Health Scrutiny Committees. These committees seek reassurance on the Trust's performance across a range of topics such as complaints, individual services, Quality Accounts and CQC compliance with Registration standards.

The *Patient Experience Committee* (PEC) is chaired by the Executive Director of Nursing and was established to include representatives from patient forums as well as Trust staff. The Committee's remit is to identify improvements required from National patient surveys, the establishment of robust internal survey of patient's

experiences and the provision of patient information that is of a consistent high standard.

The *Improving Patient Experience Group* (IPEG) set up in 2008 provides the Trust with feedback on a range of patient related topics as well as participating in surveys, sitting on the Clinical Governance / Quality and Strategy Committee and providing information on issues that impact on how patients perceive and experience care and treatment given by the Trust. The group is confident in challenging Trust practices where necessary in a forum that is open and honest.

Local Involvement Networks (LINKs) have been given powers to enter health and social care premises to observe and assess the nature and quality of services and obtain the views of the people using those services. In carrying out these 'Enter and View' visits the LINKs may be able to validate the evidence that they have already collected from local service users, patients, their carers and families, which can subsequently inform recommendations and are fed back to the Trust for action planning.

In addition to written patient satisfaction surveys, Real Time Surveys have been introduced into the Trust. The chosen system provided by Elephant Kiosks Limited is simple for patients and staff to operate, with functionality to produce detailed reports for use at ward level and for assurance to the Trust Board.

A range of surveys have been designed with core questions to enable wide range of feedback and the benchmarking of performance across divisions and departments. The surveys currently available are aimed at capturing feedback from patients using the following services:

- Accident and Emergency
- Inpatient
- Outpatient
- Children's Services
- Maternity

Hand held devices and kiosks where patients answer questions about their care and can highlight concerns or offer praise. Real time surveys will be used to monitor and improve patient experience and reduce risk on an ongoing basis.

The Trust has a range of Committees in which external stakeholders, patients and commissioners participate.

Additional Internal Controls have been put in place to strengthen risk management process e.g. *The Performance Dashboard* is embedded in the organisation key performance indicators that form the performance dashboards for clinical and non-clinical reporting has strengthened the data analysis process. Data is reviewed monthly via the committee structure to the Trust Board. Any changes outside agreed parameters trigger an exception commentary and the application of root cause analysis is required. A consistent and strong system of monitoring complaints, incidents and safety alerts is in place. The triaging of incidents and complaints continues and all 'red' issues are circulated to the executive and divisional teams for shared awareness and action. The increased utilisation through staff training of Dr Foster data and enhanced review of mortality data allows for early identification of potential problems which can be analysed and clinical improvements made as needed. These processes help support a 'no surprises' culture and the early identification of trajectory change.

The *Clinical Audit and NICE* database maintains progress against these key elements for clinical safety.

The “*Visible Leadership*” programme lead by the Director of Nursing has been in process for a full year and continuous improvements in the weekly audit cycle have been demonstrated.

The Trust continues to participate in the *ISO quality framework*, there are currently 11 areas accredited through the British Standards Institute (BSI). A similar format is used to prepare for external Quality Assurance reviews.

A full induction and statutory and mandatory training programmes are in place for all staff.

Compliance with Equality, Diversity and Human Rights, control measures are in place to ensure that the organisation is compliant with all its obligations under equality, diversity and human rights legislation. The Trust has worked closely with its local health partners to fully implement the approved Single Equality Scheme. All Trust policies have been equality impact assessed and these also apply to any changes in service requirements.

Compliance with the NHS Pension Scheme regulations is in place. 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 in to the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Compliance with the Climate Change Act 2008 – the Trust has undertaken a climate change risk assessment and developed an Adaptation Plan, to supports its emergency preparedness and civil contingency requirements, as based on the UK Climate Projections 2009 (UKCP09), to ensure that this organisation’s obligations under the Climate Change Act are met.

Care Quality Commission Registration and Conditions - In accordance with requirement, the Trust registered with Care Quality Commission (CQC) on 27th January 2010. Registration was granted from 1st April 2010 but with 8 conditions and time frames as described below. The achievement of the release of the 8 conditions were supported by action plans and monitored through the Trust Committee structures.

Topic	Deadline	Extended to	Outcome
Resuscitation	31.12.10		Awaited
Appraisal	31.12.10		Awaited
Discharge planning	30.06.10		Lifted
Pressure damage	30.06.10	31.12.10	Awaited
Staffing			
Nurse	31.07.10	30.09.10	Lifted
Mat & Mid.	31.07.10	30.11.10	Enforcement*
Child Protection	31.07.10		Lifted
Nurse Mandatory	31.07.10		Lifted
Treatment rooms	30.04.10		Lifted

*Warning Notices

Following a series of unannounced visits, the Trust received a copy of the CQC report into their unannounced visit to Queen's Hospital Maternity Department. Enclosed with the report were Warning Letters relating to three Outcomes:

Outcome 4 / Regulation 9 – Care and Welfare of Service Users
Outcome 13 / Regulation 22 – Staffing
Outcome 11 / Regulation 16 – Safety, Availability & Suitability of Equipment

In addition, there were continuing concerns about a further three Outcomes:

Outcome 1 / Regulation 17 – Respecting and Involving People who use Services
Outcome 14 / Regulation 23 – Supporting Staff
Outcome 21 / Regulation 20 - Records

There were short deadlines for compliance set, with which the Trust complied. A full on-going action plan was developed which is monitored internally and externally via NHS London and the Trust Commissioners. The final report was published on 20th April 2011.

It is therefore the case that the Trust is not fully compliant with the CQC essential standards of quality and safety.

5. Review of effectiveness and significant control issues

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of Internal Audit's work. The overall opinion of the Head of Internal Audit for 2010/11 is that **significant assurance** can be given on the effectiveness of internal control for financial year 2010/11.

Executive managers within the organisation, who have responsibility for the development and maintenance of the system of internal control, provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by a range of external agencies and internal assessments and accreditation which include the Care Quality Commission, the Audit Commission, Parkhill Internal Audit Services, Dr Foster, Clinical Audit and internal quality and accreditation systems.

Significant control issues identified through the Trust's internal review include:

Finance: The Trust posted a deficit of £33.0M in 2010/11, excluding the technical impact of fixed asset impairment reversals (£5.7M benefit) and IFRS (£1.1M). The Trust had a deficit control total of £19.4M agreed with NHS London, therefore there was an adverse variance of £13.6M against Plan. This was primarily related to a shortfall of £12.9M against the Trust's Cost Improvement Programme target (£23.0M achieved against a target of £35.9M). The 2010/11 deficit increased the Trust's

cumulative deficit, as measured against the breakeven duty, to £150m, incurred over the six year period to 31 March 2011.

As reported in the 2009/10 SIC, the Audit Commission published a s19 Report (under the Audit Commission Act) to the Secretary of State, in 2010, due to the failure of the Trust to meet its statutory breakeven target. In January 2011, the Audit Commission followed this up with a section 8 public interest report. The purpose of this report was to bring the Trust's financial standing to the attention of the public and to seek the Trust's response to:

- its failure to meet its statutory financial duties
- the seriousness of its current financial position; and
- the action that it now needs to take to improve its financial position and meet its statutory financial duties on a sustainable basis.

The Report highlighted some of the key underlying factors for the deficit, including:

- a high level of fixed costs as a result of the Queen's Hospital PFI scheme
- Significantly lower non-PbR income compared with other Trusts
- High levels of agency staff costs

In response, the Trust is reviewing its longer term financial strategy, within the overall context of the Health4NEL strategy for future configuration of health services within NE London, including the decision on the services to be provided at King George's Hospital. The Trust is currently planning for a deficit of £35.0m in 2011/12 (excluding the impact of impairments and IFRS), a marginal increase from the 2010/11 position.

Targets: The Trust did not achieve the following targets:

- **Type 1 emergency care target of 95% for 2010/11.** The Trust had 0 patients who were detained in the A & E Department in excess of 12 hours during 2010/11.
- The **MRSA Bacteraemia** target of 11 was exceeded by 2 further cases bringing the total to 13. Full root cause analysis is completed on every case.
- **RTT – Incomplete Pathways.** All performance targets related to 18 weeks and Referral to Treatment waiting times have been met in March with the exception of the median wait target for incomplete pathways. This includes the reintroduction of the 90% and 95% admitted and non-admitted RTT targets. Following intensive validation the RTT incomplete median has reduced from a performance of 14 weeks in November 2010 to 10 weeks in March 2011. Discussions continue with Commissioners on securing additional activity in order to clear the backlog and achieve this performance standard over the coming months. It is anticipated that median waiting times will not form part of the DoH Performance framework for 2011-12.
- **62 Days Urgent Referral To Treatment Of All Cancers.** March's performance achieved the majority of the Cancer targets with the exception of the 62-day target for screening and consultant upgrade; the 62-day performance has been achieved in month at 90.43%, but failed the 2010-11 target with a performance of 83.69%. The under-achieving tumour sites are Lung, Haematology, Upper GI and H&N. Updated action plans have been requested to ensure that the performance from April 2011 achieves the individual Cancer targets.

A number of actions have been taken to change the way the patients are monitored on their pathways to ensure that any issues are identified and escalated much sooner in the process. A new reporting database has been implemented that allows us to track real-time the number of breaches that have occurred ensuring that we are able to pro-actively manage the in-month treatments to give a greater opportunity to meet the standards. The action plans will also be monitored at the weekly meetings held by the GM for Oncology and the Divisional Manager for Clinical Support Services.

- **Delayed Transfers Of Care (DTOC).** Although the overall performance for the past year has failed to meet the DoH target of 3.5% there has been significant and sustained improvement since December 2010 when each month the target has been achieved. As a result of close scrutiny of each case and improved joint working daily DTOC numbers have decreased to an average of 38 listed patients. Actions which have led to this improved performance include a regular meeting with Essex to develop a policy around referrals to Brentwood Community Hospital as well as into the community to increase the speed of the transfer process for Essex patients. Weekly meetings are held with Redbridge Social Services and all Boroughs participate in the fortnightly Complex Discharge Team meeting.

The Complex Discharge Partnership Board meetings involving PCTs, Social Services and Community Health Services continue to drive forward the actions for change. Their most recent focus being:

- Community support – implementation of “Jonah” as lead system and rapid reduction in Length of Stay (LoS) for patients over 20 days;
- Continuing care framework;
- Leadership of Therapies and implementation of single intermediate care re-ablement pathway;
- Admission avoidance out of hospital;
- Planning for the Easter, Royal Wedding and early May bank holidays.

The discharge team is now at full staffing establishment with new staff members carrying out training and induction into the organisation. Team meetings and team building continues to ensure new systems and processes are adhered to. A review of the role and function of this team is to take place in the near future.

The Care Quality Commission took enforcement action against BHRUT in March 2011. Following a responsive review of the Trust’s maternity services in January 2010 the CQC issued 3 warning notices which related to the care and welfare of people who use services, staffing and equipment within the Maternity Department at Queen’s Hospital. The CQC also had 3 moderate concerns i.e. respecting and involving people, supporting workers and records.

The Trust provided information to enable the equipment warning notice to be downgraded to a minor concern prior to the publication of their final report, and has provided the CQC with evidence to enable them to review the actions taken by the Trust to rectify the failings identified. The CQC deadlines were met and a decision is awaited from the CQC.

The Trust developed and urgently implemented a range of actions that were monitored at the most senior level to ensure the CQC concerns were appropriately addressed. The actions taken at a high level include:

- Increase to staffing levels in key areas ie. labour ward Queen's, postnatal ward and antenatal ward. This has been achieved in the interim by the utilisation of temporary staff.
- Increased recruitment of midwives. In total there have been 50 new recruits secured in the past 3 months, some of whom have commenced with the remainder due to start by the end of June. Further recruitment is continuing.
- A new triage system for labouring women has been implemented, incorporating a telephone system and the obstetric assessment process has been changed to incorporate more senior clinician presence. Work continues on this to ensure the system is maintained 24/7.
- Training programmes have been reviewed and new ones developed to incorporate new starters from differing backgrounds as well as updating and development for existing staff.
- Working closer with local women to ensure changes are acceptable and meet women's needs.
- Developing a programme of workshops to address communication
- Working closer with staff on the shop floor to ensure changes are developed in partnership and owned by them.
- The full action plan has been in place for the conditions against registration and currently for the warning notices and close monitoring through the Trust Committee structure for both the conditions and the enforcement continues.

The Board Assurance Framework and Quality Dashboard have identified the above significant control issues within the year and corrective plans have been implemented.

This concludes the Statement of Internal Control for Barking, Havering and Redbridge University Hospitals Trust.

Signed:

Date: June 7th 2011



Averil Dongworth
Chief Executive

