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London Borough of Hammersmith & Fulham

Housing, Health And Adult Social Care Select Committee

Agenda

Wednesday 8 January 2014
7.00 pm
St. Mary's Hospital, Praed Street, London W2 INY

MEMBERSHIP

Administration:	Opposition	Co-optees
Councillor Lucy Ivimy (Chairman) Councillor Joe Carlebach Councillor Oliver Craig Councillor Peter Graham Councillor Peter Tobias Councillor Andrew Brown	Councillor Stephen Cowan Councillor Rory Vaughan Councillor Daryl Brown	Patrick McVeigh, HAFAD Bryan Naylor, Age UK

CONTACT OFFICER: Sue Perrin
Committee Co-ordinator
Governance and Scrutiny
☎: 020 8753 2094
E-mail: sue.perrin@lbhf.gov.uk

Reports on the open agenda are available on the Council's website:
http://www.lbhf.gov.uk/Directory/Council_and_Democracy

Members of the public are welcome to attend.

Date Issued: 20 December 2013

London Borough of Hammersmith & Fulham

Housing, Health And Adult Social Care Select Committee
Agenda

8 January 2014

Item		Pages
1.	**WELCOME AND INTRODUCTIONS**	1
2.	**MINUTES**	2 - 11

To approve as an accurate record, and the Chairman to sign the minutes of the meeting of the Housing, Health & Adult Social Care Select Committee held on 13 November 2013.

3. APOLOGIES FOR ABSENCE

4. DECLARATIONS OF INTEREST

If a Councillor has a disclosable pecuniary interest in a particular item, whether or not it is entered in the Authority's register of interests, or any other significant interest which they consider should be declared in the public interest, they should declare the existence and, unless it is a sensitive interest as defined in the Member Code of Conduct, the nature of the interest at the commencement of the consideration of that item or as soon as it becomes apparent.

At meetings where members of the public are allowed to be in attendance and speak, any Councillor with a disclosable pecuniary interest or other significant interest may also make representations, give evidence or answer questions about the matter. The Councillor must then withdraw immediately from the meeting before the matter is discussed and any vote taken.

Where Members of the public are not allowed to be in attendance and speak, then the Councillor with a disclosable pecuniary interest should withdraw from the meeting whilst the matter is under consideration. Councillors who have declared other significant interests should also withdraw from the meeting if they consider their continued participation in the matter would not be reasonable in the circumstances and may give rise to a perception of a conflict of interest.

Councillors are not obliged to withdraw from the meeting where a dispensation to that effect has been obtained from the Audit, Pensions and Standards Committee.

5. IMPERIAL COLLEGE HEALTHCARE NHS TRUST: CONSULTATION ON ITS FOUNDATION TRUST APPLICATION — 12 - 42

This report informs members about the Trust's consultation on its proposals and plans for becoming a foundation trust.

6. IMPERIAL COLLEGE HEALTHCARE NHS TRUST: BUSINESS PLAN UPDATE

This report will follow.

7. IMPERIAL COLLEGE HEALTHCARE NHS TRUST: CANCER SERVICES UPDATE

This report will follow.

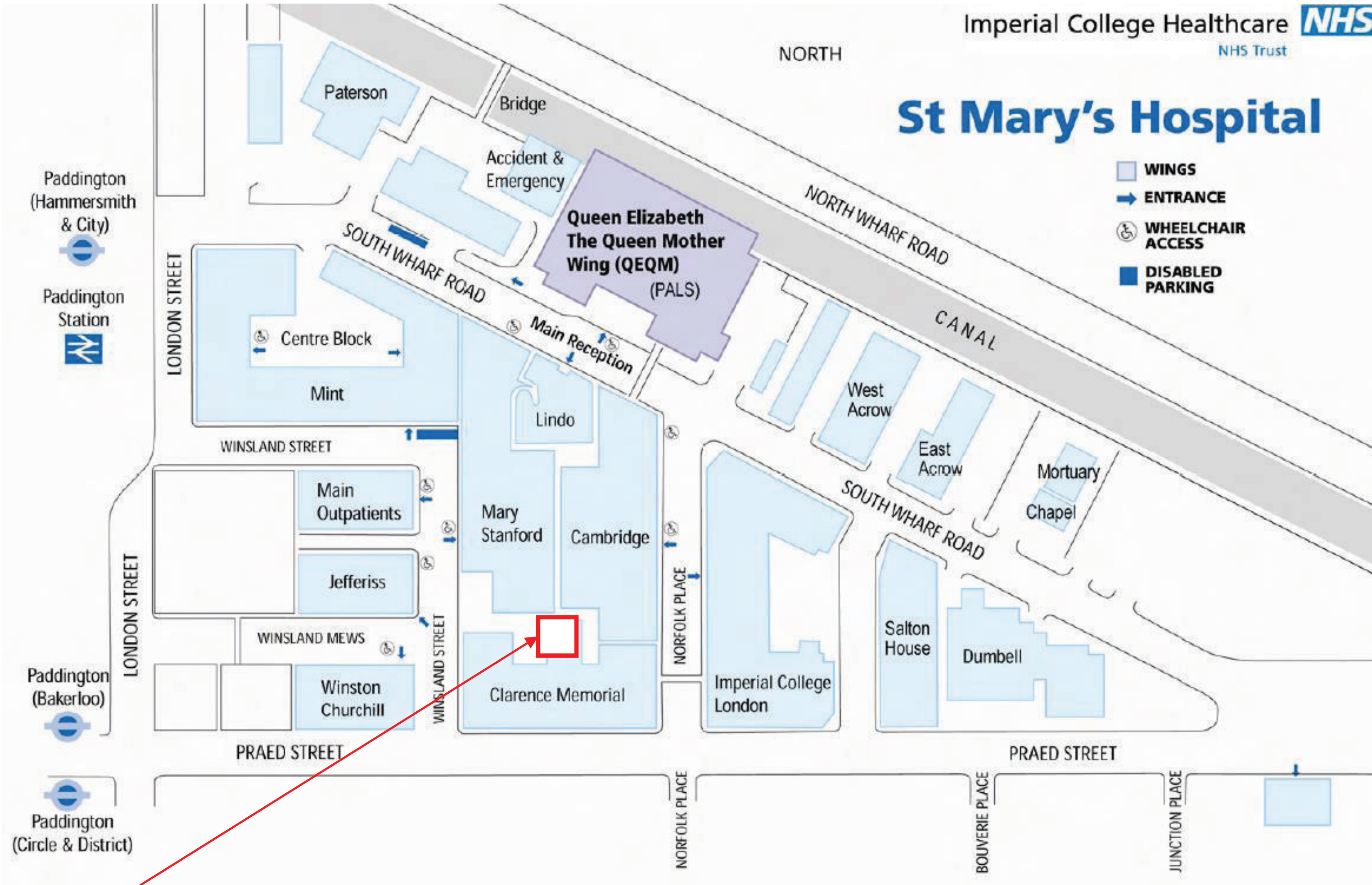
8. DATES OF NEXT MEETINGS

The Committee is asked to note that the dates of the meetings scheduled for this municipal year are as follows:

21 January 2014

19 February 2014

2 April 2014



Board Room, Clarence Wing (Entrance from Praed Street)

London Borough of Hammersmith & Fulham

Housing, Health And Adult Social Care Select Committee

Minutes

Wednesday 13 November 2013

PRESENT

Committee members: Councillors Lucy Ivimy (Chairman), Joe Carlebach, Stephen Cowan, Oliver Craig, Peter Graham, Rory Vaughan, Andrew Brown and Daryl Brown

Co-opted members: Patrick McVeigh (HAFAD) and Bryan Naylor (Age UK)

Care Quality Commission: Gale Stirling, Head of Regional Compliance
H&F Clinical Commissioning Group: Daniel Elkeles, Chief Officer and Dr Tim Spicer, Chair
Imperial College Healthcare NHS Trust: Professor Nick Cheshire, Chief Executive, Dr Chris Harrison, Medical Director Bill Shields, Chief Executive

Officers: Stella Baillie (Tri-borough Director, Provided Services, Mental Health Partnerships and Safeguarding for Adult Social Care), Liz Bruce (Tri-borough Executive Director of Adult Social Care), Craig Bowdery (Scrutiny Manager), Mike England (Director Housing Options, Skills and Economic Development), David Evans (Service Development Project Manager) and Sue Perrin (Committee Co-ordinator)

23. MINUTES AND ACTIONS

RESOLVED THAT:

The minutes of the meeting held on 10 September 2013 be approved and signed as an accurate record of the proceedings.

24. APOLOGIES FOR ABSENCE

Apologies were received from Councillor Peter Tobias.

25. DECLARATIONS OF INTEREST

Minutes are subject to confirmation at the next meeting as a correct record of the proceedings and any amendments arising will be recorded in the minutes of that subsequent meeting.

Councillor Joe Carlebach declared a personal interest in respect of 'Shaping a Healthier Future Proposals' in that he is a trustee of Arthritis Research UK.

26. CARE QUALITY COMMISSION

Gale Stirling, Head of Regional Compliance, London provided a presentation on the role of the Care Quality Commission (CQC) and its revised direction.

All care homes, home care agencies and hospitals were inspected at least once a year. Inspections, which were mostly unannounced, focused on quality and safety as experienced by service users.

The presentation set out the key changes including the appointment of Chief Inspectors of Hospitals, Social Care and Primary Care and Community Care. Inspections were continuing as normal, alongside these developments.

There would be a new approach to inspecting social care services, with homes rated as: outstanding, good, requires improvement and inadequate. Larger and improved inspections teams would consider whether a service was: safe, effective, caring, responsive to people's needs and well-led.

The CQC worked closely with a number of agencies, including overview and scrutiny committees (OSCs). It was hoped that there would be regular contact between OSCs and the CQC and that they would be able to work together and share information. The CQC made available Information for councillors and scrutiny committees on its website and a two monthly bulletin was available by e-mail alert.

Councillor Lucy Ivimy stated that the committee did not have the capacity to monitor standards across the borough, and would welcome notification from the CQC of any services which were a cause of concern.

Ms Stirling responded to Councillor Stephen Cowan's queries in respect of performance management, training and skills set of inspectors and providers being able to mislead the CQC. All inspectors received two months induction training and ongoing training. In addition to performance appraisal, there was a quality monitoring system whereby line managers reviewed inspectors' judgements and evidence and feedback from providers. Initially inspectors were not allowed to undertake an inspection on their own, and only very small units were inspected by a single inspector.

Whilst most providers considered themselves ready for a CQC inspection, this was often lost because of the unannounced nature of visits. Inspectors were trained to ask probing questions, and were supported whilst on inspections. There were regular team meetings, which were followed by reflections sessions, to which they could bring issues for team discussion/learning.

Ms Stirling responded to Councillor Peter Graham that there was a variable standard of services in the borough. There had been an increase in the level

of adult social case non-compliance during the last eighteen months, resulting in a number of services being inspected several times. However, there were some excellent services, and over all the borough compared reasonably with other boroughs. There had not been significant changes in the inspection to bring about this increase, which could possibly be attributed to more experienced inspectors.

All services were inspected annually, with the exception of some dentists, who were on a two year programme. Inspection of GPs was a new responsibility and currently 20% of GPs had been inspected.

Ms Stirling responded to Councillor Rory Vaughan that a borough based report was available and a copy would be provided.

Action: Gale Stirling

In response to a query from Councillor Joe Carlebach, Ms Stirling stated that the CQC worked with Monitor by sharing information and advising of any concerns. In respect of care provided by different organisations, the patient pathway was reviewed, with patient experience as the primary focus.

Councillor Andrew Brown queried the CQC's work with patients and how it could ensure that there was not another 'Mid-Stafforshire'. Ms Stirling responded that the CQC worked with Healthwatch (and previously LINks), local focus groups and organisations with direct access to patients, for example Age UK and also talked directly to patients and their families. The feedback was integrated into the inspection regime.

In respect of Mid-Staffordshire, the CQC had reviewed its whistle-blowing policies and talked to patients' groups. Sharing of information was now a key focus of inspections.

Councillor Oliver Craig queried CQC reporting to the public. Ms Stirling responded that information was available on the website and through newsletters and e-mail alerts. Ms Stirling was not aware of whether hits on the website were monitored, and would provide a written answer.

Action: Gale Stirling

Mr Naylor referred to older people dignity champions, who provided information in respect of their visits to hospitals and care homes to the CQC, and the lack of direct feedback. Ms Stirling responded that this information was very helpful and feedback was likely to be given through Healthwatch. In addition information was taken from 'experts by experience' who made themselves known to the team and the range of people who worked with them. Mr Naylor suggested that the CQC took a more proactive approach.

Action: Gale Stirling

Councillor Ivimy thanked Ms Stirling for attending the meeting and for her presentation.

RESOLVED THAT:

The report be noted.

27. SHAPING A HEALTHIER FUTURE PROPOSALS

This item was taken after the Francis Report.

Dr Tim Spicer and Daniel Elkeles outlined: the background to the Shaping a Healthier Future (SaHF) Proposals; the acceptance of the changes to NHS services in North West London by the Secretary of State; and the Urgent and Emergency Care Review report, which had been published earlier that day. A report of the key points from the review was tabled.

The proposals would be implemented over five years. Providers would continue to develop outline business cases and there would be stakeholder workshops and public drop-in sessions to identify the most appropriate range of services at Charing Cross and Ealing hospitals.

The presentation set out where the Programme Board should: continue as planned; respond to urgent priorities; and give further consideration as to how to proceed.

Mr Elkeles stated that the review supported the North West London direction of travel. There would be a system-wide transformation over the next three to five years, with a fundamental shift in the provision of urgent care away from hospitals. Broader emergency care networks would be developed, dissolving traditional boundaries between hospital and community-based services.

Urgent and Emergency care would be provided from:

- Emergency Centres capable of assessing and initiating treatment for all patients;
- Major Emergency Centres, larger units, capable of assessing and initiating treatment for all patients and providing a range of specialist services; and
- Urgent Care Centres with walk-in facilities, including GP out-of-hours care, and services for minor injuries and illnesses.

Charing Cross would be designated an Emergency Centre; St. Mary's and Chelsea and Westminster Major Emergency Centres; and Hammersmith an Urgent Care Centre.

The Shaping a Healthier Future and Imperial College Healthcare NHS Trust representatives then responded to Members' questions.

Approximately 70% of walk-in patients would be treated in the Charing Cross Emergency Centre. It was unlikely that ambulance patients would be taken there. Suspected heart attack patients would currently and in the future be taken to Hammersmith Hospital Heart Centre. Similarly, following a major car

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accident, a patient would currently and in the future be taken to the major trauma centre at St. Mary's Hospital. The hyper-acute stroke unit would be located at St Mary's Hospital, as it had been agreed that it should be sited with the major trauma centre.

Professor Nick Cheshire responded to a query in respect of reduced in-patient beds, that elective surgery was becoming more efficient, with many patients requiring only an overnight stay and then progressing to rehabilitation.

Mr Elkeles responded to a query in respect of Charing Cross as a specialist hospital that there was an ambitious proposal for a substantial site, with a range of services and an Emergency Centre. The distinction between Charing Cross and St. Mary's was the model which, Professor Sir Bruce Keogh, the National Medical Director had proposed for the whole country.

There were three key differences between an Emergency Centre and an Urgent Care Centre: a 24/7 GP presence and emergency treatment for children; an enhanced range of diagnostic services; and beds for assessment and initiating treatment. Members commented on the deficiencies in GP training in respect of children.

Councillor Graham referred to the previous rationalisation of services, whereby the number of stroke units had been reduced from 32 to eight, and queried how many lives had been saved. Professor Cheshire responded that the outcome was not just in terms of survival but also reduced impairment. The number of lives saved was not known, but might be in the region of 400 across London.

Councillor Carlebach queried the resource for GP extended hours. Dr Spicer responded that proposals had been put forward, as seven day access to GP surgeries was essential to the reforms. A number of practices had already opted to open at weekends to cope with winter pressures. Collective access to services would be facilitated by GP networks. It was agreed that an update should be added to the work programme.

Mr Elkeles stated that three practices in Westminster were open all day on Saturdays and Sundays, and it was intended to extend across the tri-borough, by the end of winter. These practices had been advertised in local newspapers and on telephone kiosks, and patients ringing 111 were informed.

Councillor Rory Vaughan queried the definition of 'immediate access to specialist consultant opinion'. and the closure of Hammersmith A&E Department as soon as practical. Mr Elkeles responded that the emergency teams would work together, with support being provided by the Accident & Emergency (A&E) consultants at the major hospitals to Charing Cross and Ealing hospitals, in person or possibly by teleconference. Proposals in respect of Hammersmith Hospital A&E Department would be brought to a future meeting. The department was a medical unit, and not for blue light ambulances. It could not provide safe care to walk-in emergency patients. Mr

Elkeles confirmed that the heart attack and renal units would continue at Hammersmith Hospital.

Councillor Vaughan queried why GPs had not been balloted in respect of the proposals. Dr Spicer responded that the Clinical Commissioning Group (CCG) had followed the appropriate constitutional measures and had sought opinion through events in GP practices. The proposals had been a standing agenda item for the Governing Body for the previous eighteen months.

Professor Cheshire responded to Councillor Andrew Brown that Charing Cross would continue to provide a range of out-patient and diagnostic services, but it might be necessary for in-patient treatment to be provided at another hospital. Professor Cheshire confirmed that it was not possible to provide comprehensive state of the art services at all three hospitals. There needed to be appropriately trained staff, support services and technology. In addition, there was a relationship between volume of patients and outcome. Professor Cheshire provided examples of improved mortality rates and of the reduced length of stay in vascular and cardio-vascular surgery.

Councillor Cowan queried the services and buildings which would remain on the Charing Cross site. Mr Elkeles responded that the land sale would fund new developments at Charing Cross and St. Mary's. The scale of the services and buildings remaining at Charing Cross would be shared with the Joint Health Overview & Scrutiny Committee, at its December meeting.

Professor Cheshire stated that there would be consultants on site at Charing Cross, but not Accident & Emergency consultants. Charing Cross would be part of a bigger hospital system, with St. Mary's providing full emergency services. Patients with suspected heart attack and fractured neck of femur were already being taken to Hammersmith and St. Mary's hospital respectively. It would be necessary to educate patients to understand the limits of the new centres. The 30% of walk-in patients who would not be treated at Charing Cross would, for example have a heart attack, early stage stroke or abdominal pains. Those who called an ambulance would be taken to a Major Emergency Centre.

Councillor Cowan considered that as there had not been a ballot of GPs, their support was only an opinion. Dr Spicer responded that the CCG had acted within its constitution and consulted with its membership.

Mr Patrick McVeigh commented that short stays in hospital would need to be supported by district nurses, and gave free parking for district nurses as an example of how other boroughs were helping to support the process. The strategy needed to set out how out of hospital (OOH) care would work now and in the future and identify the number of people to be employed and any gaps. Mr Elkeles responded that, until other services were in place in the community, the changes could not be made.

Mr Bryan Naylor queried the Imperial College Healthcare NHS Foundation Trust status application being progressed when the Charing Cross options were unavailable. Mr Bill Shields responded that the business case would set

out the direction of travel, and would take into account the SaHF proposals and Professor Keogh's review.

The Chairman then opened the meeting to questions from members of the public.

Professor Cheshire confirmed that the UCC would be able to provide emergency treatment for diabetic and asthmatic patients.

Mr Andrew Slaughter queried the differences between UCCs and Emergency Centres and set out some of their similarities: both would be able to deal with broken bones; admit for rehabilitation and assessment; and provide 24/7 GP children's services. Whilst the UCCs would be GP led, there would be immediate access to A&E consultant opinion. Mr Elkeles responded that the Emergency Centres would have some beds. UCCs would have 24/7 GP care and would have a full range of diagnostic services.

Professor Cheshire responded to a query in respect of emergencies being dealt with at Hammersmith Hospital, that it was not suitable for 'unselected' emergency admissions, as this required an enormous range of diagnostic facilities and expertise to monitor 24/7. Mr Elkeles added that there would only be beds for specialist emergency admissions. In respect of the transfer of the UCC from Hammersmith Hospital to the White City Centre, a detailed proposal would be brought to a future meeting.

Mr Slaughter queried the impact of the dedicated elective centre at Central Middlesex on elective services at Charing Cross and the percentage of the Charing Cross site remaining in five years time. Mr Elkeles responded that proposals were currently being developed to maintain a range of services on the Charing Cross site.

Dr Spicer responded to Mr Slaughter's queries in respect of the budget cut of £29million that the borough had historically received over per capita funding on the basis of the national formula. The changed formula, if implemented, could bring about a reduction of £29 million funding over a number of years. NHS England required two year budgets to be prepared, although allocations would not be known until late December. Savings of 5% had already been made, and this was expected to continue.

A member of the public commented on the requirement for concrete evidence in respect of additional community and primary care.

In accordance with paragraph 27 of the Overview and Scrutiny Procedure Rules, the Committee extended the meeting by 30 minutes.

Dr Spicer responded to the concerns raised that services would not be closed until OOH services were working efficiently to safely care for patients. The proposals would be implemented over a five year transition period, during which providers would seek to use capacity differently, for example through better use of skill mix, telephone consultations, virtual wards and joint working with social care.

Councillor Carlebach stated that he had not been provided with a response to his questions at a previous meeting in respect of flu vaccinations for vulnerable people. Dr Harrison responded that he held this information and would provide a written answer.

Action Dr Chris Harrison

In conclusion, it was confirmed that there would be an Emergency Centre at Charing Cross Hospital.

28. FRANCIS REPORT

Craig Bowdery presented the report, which reviewed the recommendations of the Francis Report regarding local authority scrutiny and their impact on health scrutiny in Hammersmith & Fulham.

The Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC, had been set up to examine the commissioning, supervisory and regulatory organisations in relation to their role monitoring the Mid Staffordshire Trust between January 2005 and March 2009, during which time, failings at the hospital are thought to have caused between 400 and 1,200 deaths.

In total, the Francis Report made 290 recommendations. Members considered the six recommendations which related directly to local authority health scrutiny committees.

Recommendation 47
Engagement with the CQC had been covered in a previous item.

Recommendation 119:
A presentation on the role of Healthwatch and a CCG annual health performance report would be added to the work programme.

Councillor Vaughan commented on the large remit of the committee and whether there were sufficient meetings, although the Joint Health Overview & Scrutiny Committee facilitated further scrutiny of the Shaping a Healthier Future proposals.

Members commented on the difficulty in pursuing complaints, with only fairly general answers being provided because of the requirements of the Data Protection Act.

RESOLVED THAT:

The report be noted.

29. HEALTH & WELLBEING STRATEGY

David Evans introduced the draft Health & Wellbeing Strategy between the Council and H&F CCG, produced by the Health & Wellbeing Board (HWB).

Councillor Andrew Brown commented that the strategy seemed to be describing the status quo, rather than the new joint working between local government and the NHS. Priority 1 of the vision was an overarching priority. Mr Evans responded that the primary aim of the HWB was to promote integration and partnership working between the NHS, social care, public health and other local services, rather than replicate work already being done by the Council. The HWB considered that it could have the greatest impact in developing integrated care, by identifying blockages to help organisations work more effectively to promote the agenda.

Councillor Ivimy considered that information sharing and security implications was a key blockage. Councillor Marcus Ginn responded that there were also legal, technical and cultural issues. New IT systems would enable the local authority and GP practices to share information securely. Lack of good information sharing was a key blockage preventing a seamless integrated network of care.

Councillor Cowan suggested that the strategy was similar to other documents and that there should be consultation with residents on how the vision could be aligned with service delivery. The strategy appeared to be an aspiration, did not have drivers to deliver and did not set out how the priorities would be achieved.

Councillor Ginn responded in respect of the drivers to deliver on these aspirations, which had been based on the key issues identified by the HWB. There were financial drivers in that SaHF would only be delivered if a large proportion of the acute budget was transferred to the community budget. The pressures on the CCG budget would be resolved by reducing waste from care pathways, joint commissioning with local authorities and improved outcomes. In addition, there were local authority budget pressure.

The strategy was a compromise between diverse organisations represented on the Board and therefore less specific in some aspects. The strategy would evolve and drill down to deliverables over the next few years.

Councillor Cowan did not consider that there had been a strong history of working together to build integrated health and social care (priority six), and suggested that it should be replaced with a priority to demonstrate openness and challenge of the status quo in order to improve outcomes.

Councillor Vaughan commented that the strategy did not focus on what was happening in practice, but did include some previous priorities such as the public health budget.

The guillotine fell at this point.

30. SAFEGUARDING ADULTS IN HAMMERSMITH & FULHAM

This item was deferred.

31. WELFARE REFORM: UPDATE

This item was deferred.

32. WORK PROGRAMME AND FORWARD PLAN 2013-2014

The work programme was received.

33. DATES OF NEXT MEETINGS

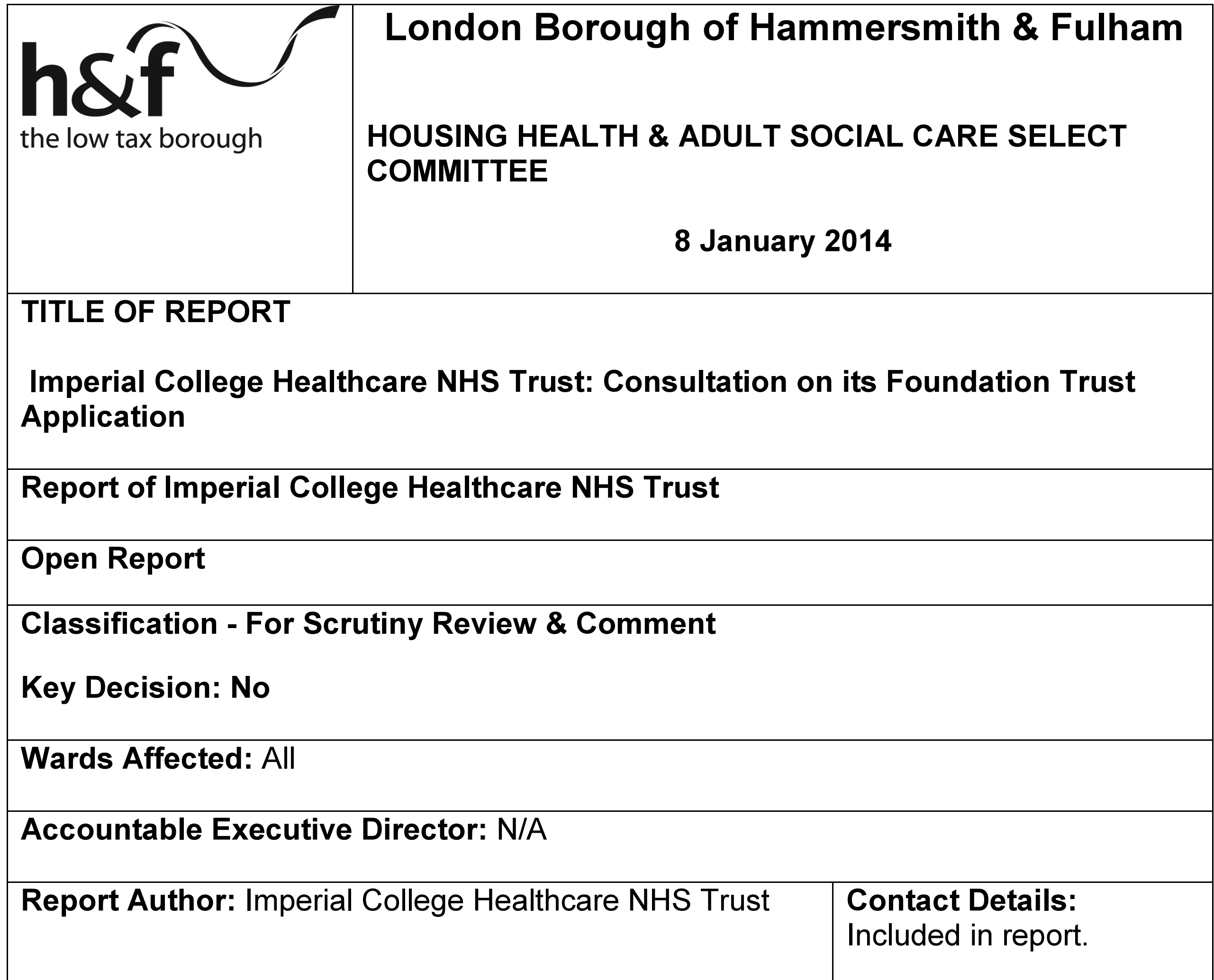
21 January 2014

Meeting started: 7.00 pm
Meeting ended: 10.30 pm

Chairman ....

Contact officer: Sue Perrin
Committee Co-ordinator
Governance and Scrutiny
☎: 020 8753 2094
E-mail: sue.perrin@lbhf.gov.uk

Minutes are subject to confirmation at the next meeting as a correct record of the proceedings and any amendments arising will be recorded in the minutes of that subsequent meeting.



	London Borough of Hammersmith & Fulham **HOUSING HEALTH & ADULT SOCIAL CARE SELECT COMMITTEE** **8 January 2014**
TITLE OF REPORT **Imperial College Healthcare NHS Trust: Consultation on its Foundation Trust Application**	
Report of Imperial College Healthcare NHS Trust	
Open Report	
Classification - For Scrutiny Review & Comment **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: N/A	
Report Author: Imperial College Healthcare NHS Trust	**Contact Details:** Included in report.

1. EXECUTIVE SUMMARY

1.1 This report informs the Committee about the Trust's consultation on its proposals and plans for becoming a foundation trust and seeks its views and comments.

2. RECOMMENDATIONS

2.1. Members are asked to consider the consultation document and comment.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	N/A		

Imperial College Healthcare NHS Trust consultation on its foundation trust application

1. Purpose of this paper

1.1 To inform the respective Health Overview and Scrutiny Committees for the London Borough of Hammersmith & Fulham, Royal Borough of Kensington & Chelsea, and Westminster City Council about the Trust's consultation on its proposals and plans for becoming a foundation trust and seek its views and comments.

2. Reasons for wanting to become a foundation trust

2.1 The Trust sees becoming a foundation trust as an important step for the organisation - not an end in its own right. It is a symbol of a well-organised, well-run, well-led organisation which delivers healthcare to the highest standards of safety and quality.

2.2 Achieving foundation trust status is therefore seen as a means towards:

- bringing our Trust closer to our patients and local communities
- further strengthening engagement with our people
- providing greater freedom to innovate and develop our services

3. The foundation trust consultation

3.1 The Trust's consultation document 'Working in Partnership' (attached as appendix 1) sets out its plans to be NHS foundation trust. It explains the reasons for the application and what becoming a foundation trust will mean for the organisation and the people who work for the Trust, its patients and the public, and partner organisations.

3.2 A key part of the Trust's foundation trust application is the consultation with its patients, people, the public and partner organisations. The Trust would therefore like to hear what the Overview and Scrutiny Committees think of the proposals.

3.3 The consultation period is expected to run for a period of 12 weeks from 11 November 2013 until 10 February 2014. As part of this consultation, the Trust will be meeting with elected representatives, overview and scrutiny committees, staff, partner organisations and holding public meetings.

4. Areas for views and responses

4.1 In particular, the Trust would welcome the Overview and Scrutiny Committees' views and comments on its proposals covering:

- vision for its future as an organisation
- minimum age for membership
- public, patient and staff constituencies
- public membership for the whole of Greater London
- no subdivision of the patient membership
- staff to automatically become members unless they choose to opt out
- subdivision of staff membership
- membership levels
- size and composition of the council of governors
- minimum age of governors
- arrangements for council of governor elections
- plan for the board of directors

5. Trust information

5.1 Imperial College Healthcare NHS Trust was created in October 2007 by merging St Mary's NHS Trust and Hammersmith Hospitals NHS Trust and partnering with the faculty of medicine at Imperial College London.

5.2 The Trust treats patients at every stage of life – from conception through to care of the elderly – with over 55 specialist services for both adults and children. There are five hospitals in the Trust.

5.2.1 Charing Cross Hospital: a general hospital that provides a range of adult clinical services. The hospital currently hosts one of eight hyper-acute stroke units in London. It is also a key site for teaching medical students from Imperial College London.

5.2.2 Hammersmith Hospital: a general hospital and is well known for its research achievements, hosting a large community of Imperial College London postgraduate medical students and researchers. The hospital hosts the heart attack centre for north west London.

5.2.3 Queen Charlotte's & Chelsea Hospital: provides maternity and women's and children's services. The hospital has extensive high-risk services and cares for many women with complicated pregnancies. The hospital also has a midwife-led birth centre for women with routine pregnancies who would like a natural childbirth experience.

5.2.4 St Mary's Hospital: a general acute hospital that diagnoses and treats a range of adult and paediatric conditions. The hospital also provides maternity services and hosts one of four major trauma centres for London.

5.2.5 Western Eye Hospital: dedicated to ophthalmology offering the only 24-hour emergency eye care service in west London.

6. Trust performance

6.1 A focus on quality has brought benefits to patients, with indicators demonstrating that the Trust is maintaining and improving its performance, in a range of areas resulting in swifter, safer treatment for patients.

6.2 The sum of these efforts is reflected in the Trust's mortality rates, which are amongst the lowest in the country.

6.3 Financially, having eliminated the underlying deficit in 2011-12, the Trust's plan for 2012-13 was to deliver a surplus to provide a stable platform for an application to become a foundation trust. On an annual turnover of £971 million, the surplus of £9 million was an £8.5 million overachievement on plan. This demonstrated the continued improvement the Trust has made and needs to sustain into 2013-14.

6.4 While the Trust has made good progress it faces current and future challenges and recognises areas for further improvement. Throughout 2013-14, there continues to be a focus on meeting all the national cancer standards, preventing infections wherever possible and improving patient experience.

7. Proposals for becoming a foundation trust

7.1 Monitor, the regulator of health services in England, requires the Trust to develop new governance arrangements that will increase community and partnership working through a membership structure and council of governors. The basic governance structure of all NHS foundation trusts includes:

- membership
- council of governors

- board of directors

7.2 Membership

7.2.1 Membership of a foundation trust is an excellent way of becoming more involved in the way that healthcare works. It is proposed that the minimum age for membership should be 16 and would be drawn from three constituencies:
- Public members
- Patient members
- Staff members

7.2.2 Public
- The proposal is for a single public constituency for Greater London covering the 32 London Boroughs and the City of London

7.2.3 Patient
- Anyone who has been a patient of the Trust, including private patients, within the last five years is eligible to become a member
- Some foundation trusts have sub-divided the patient constituency - for example to include 'carers'. The Trust is not proposing any sub-divisions

7.2.4 Staff
- Staff membership is open to any current employee of Imperial College Healthcare NHS Trust with a permanent, temporary or fixed-term contract for at least 12 months
- In order to ensure that input from the staff constituency is representative, it is proposed to sub-divide the staff constituency into two sections: clinical and non-clinical

7.2.5 Members would be asked to indicate which level of membership they would like to have when they join. The proposed membership levels are:
- Informed Member – receive information
- Involved Member – attend meetings and events
- Active Member – participate in surveys/projects/elections

7.3 Council of governors

7.3.1 The council of governors is the body through which the membership maintains dialogue with the Trust board. It has a number of important roles and responsibilities. Any foundation trust member would be eligible to become a governor so long as they are not disqualified by statutory or other grounds as set out in the Trust constitution.

7.3.2 Public, patient and staff governors would be voted in by their constituencies via elections whereas partner governors will be appointed by the partner organisations.

7.3.3 Monitor requires all governors to be aged 16 years or over and the Trust proposes 16 as a minimum age.

7.3.4 Foundation trust legislation stipulates minimum requirements for the composition of the council of governors, i.e. it must include staff representatives as well as representatives from the public, the local authority, education and partner organisations. It is also mandatory that public and patient governors together comprise over 50 per cent of the council of governors.

7.3.5 Elections would be held for all public, patient and staff representatives on the council of governors. The Trust is proposing the following:
- governors would normally be elected for a three-year term
- governors would be entitled to stand for election again once their term was completed up to a maximum of nine years
- elections would be carried out by a recognised independent third party
- elections would be conducted using the 'first past the post' system
- should vacancies arise, these would be filled either by appointing the runner-up in the previous election (should that be within six months of the election) or by having a by-election for that vacancy

7.3.6 The proposed composition of the council of governors provides for two governor positions from local authorities. Nominated partners would choose their own process for deciding governor appointments.

To ensure our council of governors is representative, we propose a total of 31 governors, which would be allocated as follows:

Constituency	Section/Partner	Number of seats
Public	Greater London	8
Patients	Patients within the last five years	8
Staff	Clinical	4
	Non-clinical	1
Nominated partners	Clinical commissioning groups	1
	NHS England	1
	Local authorities	2
	University: Imperial College London	1
	AHSC partners	3
	Independent medical charity	1
	Voluntary organisation	1
Total size of council of governors		**31**

7.4 Board of directors

7.4.1 As a foundation trust the Trust will continue to have a board of directors made up of non-executive directors (NEDs) and executive directors. They will be legally accountable for the running of the organisation setting the Trust's strategic aims and objectives. The Trust board will be responsible for the management, leadership and day-to-day performance of the organisation.

7.4.2 All NHS and NHS foundation trusts are required to have a board of directors in which a majority are NEDs. The chairman of the Trust is automatically appointed to the council of governors.

8. Trust vision for the future

8.1 The Trust's vision and values reflect its position as the major provider of acute healthcare services to the residents of north west London, with a leading reputation in specialist services, academic research and medical education. In delivering this vision, the Trust is committed to always putting patients first, making high quality, safe and compassionate care its top priority.

8.2 The proposed Trust vision is:
"To improve the health and wellbeing of all the communities we serve and, working with our partners, accelerate the implementation into clinical practice of innovations in research, teaching and clinical service in order to transform the experience of our patients."

8.3 Four strategic objectives have been developed to support the achievement of this vision:
"1. To develop and provide the highest quality, patient-focused and efficiently delivered services to all our patients.
2. To develop recognised programmes where the specialist services the Trust provides defining services) are amongst the best, nationally and internationally and leverage this expertise for the benefit of our patients and commissioners.

3. With our partners, ensure high-quality learning environment and training experience for health sciences trainees in all disciplines and develop a satisfied workforce that is representative of the communities the Trust serves.
4. With our partners in the academic health science centre and leveraging the wider catchment population afforded by the Academic Health Science Network, innovate in healthcare delivery by generating new knowledge through research, translating this through the AHSC for the benefit of our patients and the wider population."

8.4 To help deliver the best quality healthcare into the future, the Trust has been working in partnership with its commissioners and other healthcare partners across north west London to develop plans to consolidate core teams, skills and facilities onto specific hospital sites.

8.5 The Trust's emerging clinical strategy has been developed following the principles set out in Lord Darzi's 2007 strategy for the capital, Healthcare for London and more recently, the *Shaping a healthier future* programme for north west London. Both are firmly based on three principles which the Trust strongly supports:

- Localising routine medical services where possible means better access to care closer to home and improved patient experience
- Centralising specialist services where necessary drives up quality through better clinical outcomes and safer services for patients
- Integrating patient pathways between primary and secondary care, with involvement from social care, to give patients a joined-up service

8.6 The Trust's strategic aims are consistent with the *Shaping a healthier future* proposals to ensure patients benefit from the:

- most modern medical techniques/models of care
- highest standards of clinical expertise
- best possible facilities.

8.7 The Trust sees each of its three main hospitals developing their own distinctive and interconnecting character:

- Hammersmith Hospital: continuing on its path as a specialist hospital with a strong focus on research
- St Mary's Hospital: being the acute/emergency hospital for central London
- Charing Cross Hospital: developing as a flagship local specialist health and social care hospital with planned/elective surgical innovation and care services

8.8 All three hospital sites would continue providing local services as well as their particular unique function.

9. Next steps

9.1 An important part of the Trust's application for foundation trust status is to consult with our patients, people, the public and partner organisations. The consultation period runs until 10 February 2014.

9.2 The findings of this consultation will be submitted to the Trust's board of directors who will review and consider all the feedback and use it to shape the final application for foundation trust status. A summary of the results of the consultation and the Trust response will be made publicly available.

9.3 The timetable following the consultation period features the following next steps:

- Spring 2014: NHS Trust Development Authority assesses the foundation trust application for submission to Monitor
- Summer 2014: Monitor undertakes official assessment
- December 2014: The Trust is awarded foundation trust authorisation.

APPENDIX 1

Working in Partnership

Imperial College Healthcare NHS
NHS Trust

Working in Partnership

A consultation on our NHS foundation trust application

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23 Alternative formats

Insert: response/membership application form

Introduction

This consultation document sets out our plans to become an NHS foundation trust. It explains the reasons for our application and what becoming a foundation trust will mean for our organisation and the people who work for us, our patients and the public, and our partner organisations.

Thank you for taking the time to consider our proposals to become a foundation trust. In particular, we would welcome your views on whether you agree with:

- our vision for our future as an organisation
- the minimum age for membership
- our proposal to have public, patient and staff constituencies
- our proposal to offer public membership to the whole of Greater London
- our proposal not to subdivide the patient membership
- our proposal for staff to automatically become members unless they choose to opt out
- our proposal to subdivide staff membership
- our proposed membership levels
- our proposed size and composition of the council of governors
- the minimum age of governors
- the proposed arrangements for council of governor elections
- the proposed plan for the board of directors.

Your views are important to us and we intend to set our priorities and shape arrangements to ensure your views and expectations are considered before we submit our final application to become a foundation trust. Throughout this document there are questions we would like you to respond to.

Please complete the enclosed response form or complete it online by visiting www.imperial.nhs.uk/foundation-trust by 10 February 2014.

020 3312 7674

ft@imperial.nhs.uk

www.imperial.nhs.uk/foundation-trust

@ImperialNHS

Introduction from chair and chief executives

Becoming a foundation trust is an important step for our organisation - not an end in its own right. It should be seen as a symbol of an NHS organisation that is organised, run and led well.

We see achieving foundation trust status as a means towards:

- bringing our Trust closer to our patients and local communities
- further strengthening engagement with our people
- providing greater freedom to innovate and develop our services.

Ultimately, becoming a foundation trust will support the Trust's continuing development and improvement as an organisation that operates effectively on a daily basis in the interests of the patients we serve.

Over the past two years, we have reviewed, strengthened and developed our systems and processes to ensure we are listening and responding to our patients, people and partners. We have reinforced our leadership team and our governance arrangements to ensure we are providing the highest quality care and safeguarding our patients.

The Trust has achieved significant progress and is currently performing well on key areas, such as targets for waiting times, controlling and preventing cases of infection, and achieving a financial surplus.

We have also reviewed how we organise our clinical services and have put an improved internal structure in place to better reflect our clinical priorities. This also means our services are more closely aligned with the research and educational activities that we and our partners at Imperial College London are focusing on in our role as an academic health science centre.

All the members of our Trust board and our executive team, right through to the people working in our hospital wards and clinics, are keenly aware of the further challenges we face. We can never be complacent. It is essential that we continue to focus on getting the fundamentals right in everything we do, based on our main priorities of quality, safety and compassion.

Only through working together – 'from ward to board' – will we achieve not just the best clinical quality and outcomes for our patients, but the highest satisfaction for our patients too.

To help us deliver the best quality healthcare into the future, we have been working in partnership with our commissioners and other healthcare partners across north west London to develop plans to consolidate our core teams, skills and facilities onto specific hospital sites. We believe that our clear vision and strategy for the future will enable us to deliver a step-change in the quality of care and treatment we provide.

All these developments support our aim to achieve foundation trust status by the end of 2014. Throughout this process, our approach will always be guided by the Trust's core values, and by our absolute commitment to improving the care and treatment our patients receive.

Putting patients first remains at the centre of everything we do and this will continue should we become a foundation trust.

We look forward to considering your views.

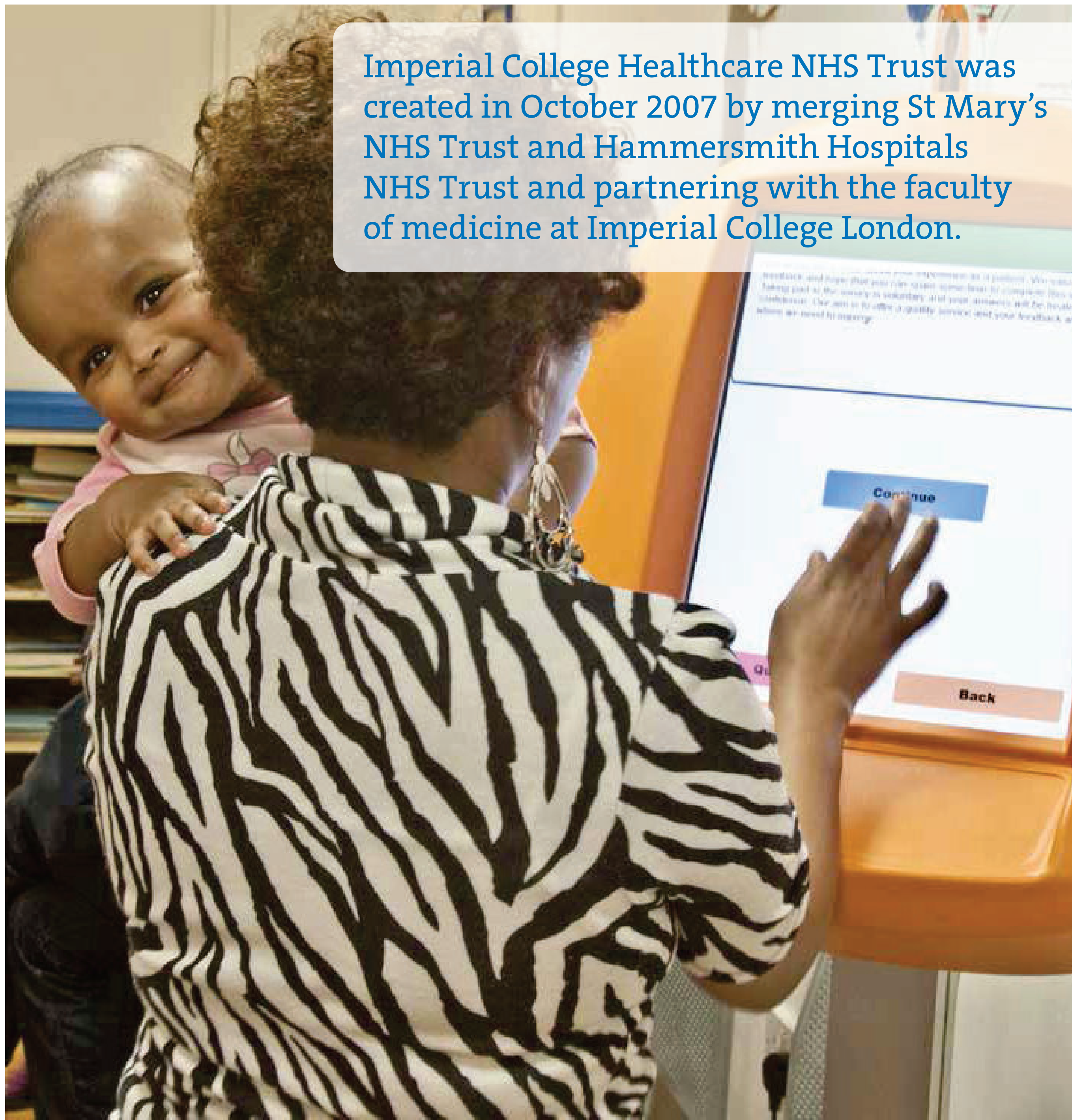
Sir Richard Sykes
Chair

Nick Cheshire
Chief executive

Bill Shields
Chief executive

About us

Imperial College Healthcare NHS Trust was created in October 2007 by merging St Mary's NHS Trust and Hammersmith Hospitals NHS Trust and partnering with the faculty of medicine at Imperial College London.



Now one of the largest NHS trusts in the country, in March 2009 we came together with Imperial College London to establish one of the UK's first academic health science centres (AHSCs).

The Trust has consistently provided high quality care by overall UK standards. We provided specialist care for patients from over 80 commissioners nationwide in 2012-13, as well as providing a comprehensive range of healthcare services to our local population of nearly two million people in north west London.

The Trust is a centre of excellence hosting the National Institute for Health Research's largest Biomedical Research Centre in the UK.

What we do

Our hospitals

There are five hospitals in the Trust:

Charing Cross Hospital

Charing Cross is a general hospital that provides a range of adult clinical services. The hospital currently hosts one of eight hyper-acute stroke units in London. It is also a key site for teaching medical students from Imperial College London.

Hammersmith Hospital

Hammersmith is a general hospital and is well known for its research achievements, hosting a large community of Imperial College London postgraduate medical students and researchers. The hospital hosts the heart attack centre for north west London.

Queen Charlotte's & Chelsea Hospital

Queen Charlotte's & Chelsea provides maternity and women's and children's services. The hospital has extensive high-risk services and cares for many women with complicated pregnancies. The hospital also has a midwife-led birth centre for women with routine pregnancies who would like a natural childbirth experience.

St Mary's Hospital

St Mary's is a general acute hospital that diagnoses and treats a range of adult and paediatric conditions. The hospital also provides maternity services and hosts one of four major trauma centres for London.

Western Eye Hospital

Western Eye is dedicated to ophthalmology. It offers the only 24-hour emergency eye care service in west London.

Our services

The Trust treats patients at every stage of life – from conception through to care of the elderly – with over 55 specialist services for both adults and children. These clinical services are organised into four clinical divisions:

- Investigative sciences and clinical support
- Medicine
- Surgery, cancer and cardiovascular
- Women's and children's

Our major partner

Imperial College London

The Trust came together with Imperial College London in March 2009 to create the UK's first academic health science centre (AHSC). Imperial College London has a campus on each of our main sites and is closely integrated with all our clinical specialities.

Performance highlights 2012-13

Throughout 2012-13 the Trust made important progress as one of the largest acute trusts in the country.

- There were almost 1.3 million patient encounters at our hospitals
- 811,000 outpatients attended our hospitals
- 280,000 patients attended our emergency departments
- 82,500 patients were admitted for emergency care
- We undertook 65,000 day case procedures
- 9,500 babies were born at Queen Charlotte's & Chelsea and St Mary's hospitals
- We treated over 1,800 stroke patients
- 450 primary angioplasty heart attack treatments were performed in Hammersmith Hospital's heart attack centre
- Over 700 head injuries were treated in the major trauma centre at St Mary's Hospital
- More than 46,000 patients were recruited into clinical trials
- More than 600 individual research projects were active
- 13 nominations and awards were received for excellence in medical education
- We employed some 9,500 people
- Our annual turnover was £971 million

We improved the quality of care to our patients

Our focus on quality has brought benefits to patients, with indicators demonstrating that the Trust is maintaining and improving its performance, in a range of areas resulting in swifter, safer treatment for patients.

- 97.2 per cent of patients attending our emergency departments were treated, admitted or discharged within four hours, which is above the national target of 95 per cent.
- We met the six week diagnostic test target each month.
- We improved our referral to treatment performance – achieving the three standards (admitted performance; non-admitted performance; and incompletes) at aggregate Trust level; and in 53 out of 57 of our specialties by March 2013.
- We improved performance against the eight national cancer targets – from achieving three in June 2012, to achieving all eight in March 2013.
- The number of patients who acquired an MRSA blood stream infection in our hospitals, fell from 13 patients in 2011-12 to eight in 2012-13, against a threshold of nine cases.
- The number of cases of *C. difficile* fell from 142 in 2011-12 to 86 in 2012-13, against a threshold of 110 cases.

The sum of these efforts is reflected in our mortality rates, which are amongst the lowest in the country, as evidenced in the fact we are in the top four performing trusts for Summary Hospital-Level Mortality Indicator (SHMI) ratios.

We received the highest rating – Level Three – in the NHS Litigation Authority's (NHSLA) assessment of our acute services in August 2012. The Trust received excellent results passing 48 out of the 50 standards. The standards are specifically developed to reflect issues that arise in the negligence claims reported to the NHSLA.

While the Trust has made good progress it faces current and future challenges and recognises areas for further improvement. Throughout 2013-14, there continues to be a focus on meeting all the national cancer standards, preventing infections wherever possible and improving patient experience.

Across the Trust we are working hard to ensure that patients receive not only high quality clinical care but timely, safe and caring treatment as well.

Getting things right for those that matter

Listening and responding to our patients and the people who work for us, is fundamental in our mission to deliver quality care.

The Trust continues to develop new and existing initiatives to ensure patients and families have a good experience of our care. Simple feedback systems are in place to tell us what we are getting right and where we can improve. We adopt a 'ward to board' approach, providing visible and accessible leadership and a commitment to openness in all that we do.

We are engaging with our people based on the commitment to giving staff at all levels the opportunity to approach and hear from senior managers through a range of initiatives.

Improving our financial performance

Having eliminated the underlying deficit in 2011-12, our financial plan for 2012-13 was to deliver a surplus to give us the stable platform for an application to become a foundation trust. We delivered the financial improvements for the year by scrutinising every function of the Trust to identify efficiency savings and eliminate wastage.

On an annual turnover of £971 million, the surplus of £9 million was an £8.5 million overachievement on our plan. This demonstrated the continued improvement the Trust has made and needs to sustain into 2013-14. We also delivered cost improvements of £54.1 million, which was £2 million more than planned.

Caring for the future

World first for Ovarian Cancer

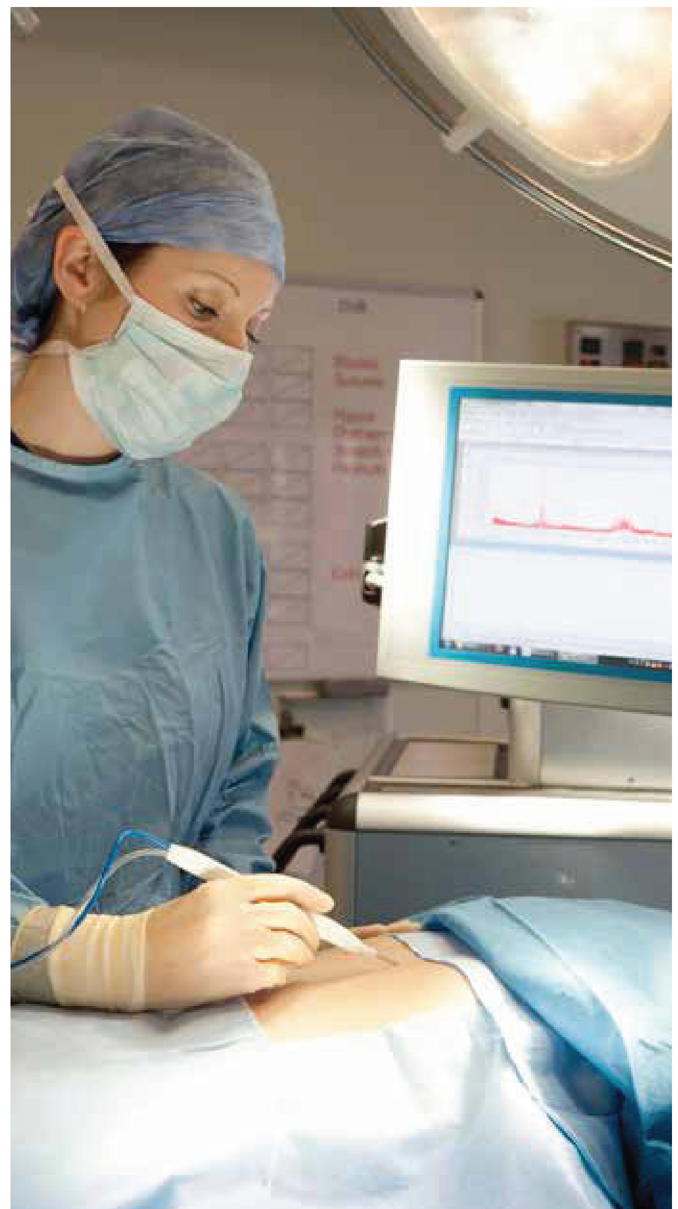
Together with our partners Ovarian Cancer Action, we pioneered the first ever implant of an alfapump® system as part of the treatment for ovarian cancer. The device is implanted under the skin to manage malignant ascites by draining a dangerous build-up of fluid from the abdomen into the bladder to be passed out in urine. This system has the potential to provide a significant level of improvement to the quality of life for women with ovarian cancer and to reduce the number of hospital visits. If clinical trials are successful, the implants could change treatment for many types of cancer.

High-tech vest helps investigate abnormal heartbeats

Our cardiologists were the first in the UK to test a high-tech vest to accurately pinpoint the cause of rapid and abnormal heartbeats. The Trust was one of only three centres worldwide, and the first in the UK to use the system. Each vest contains around 250 electrodes that are used to determine exactly where in the heart abnormal electrical activity is causing problems. Computer images are then generated to produce an 'electrical map' of the patient's heart, which can be used to track the rhythm disturbances to within a few millimetres, so treatment can be planned.

Developing new technology to offer tailored treatments

The Imperial Clinical Phenome Centre brings together a unique collection of state-of-the-art technologies that analyse the chemical make-up of tissue or body fluid samples. This helps doctors to accurately predict how a disease will progress and how well the patient is responding to treatment. The centre has developed an 'intelligent knife' that can tell surgeons immediately whether the tissue they are cutting is cancerous or not.



Our vision for the future

The Trust's emerging vision and strategic objectives

To improve the health and wellbeing of all the communities we serve and, working with our partners, accelerate the implementation into clinical practice of innovations in research, teaching and clinical service in order to transform the experience of our patients

Four strategic objectives have been developed to support the achievement of this vision:

1. To develop and provide the highest quality, patient-focused and efficiently delivered services to all our patients.
2. To develop recognised programmes where the specialist services the Trust provides (defining services) are amongst the best, nationally and internationally and leverage this expertise for the benefit of our patients and commissioners.
3. With our partners, ensure high-quality learning environment and training experience for health sciences trainees in all disciplines and develop a satisfied workforce that is representative of the communities the Trust serves.
4. With our partners in the academic health science centre and leveraging the wider catchment population afforded by the Academic Health Science Network, innovate in healthcare delivery by generating new knowledge through research, translating this through the AHSC for the benefit of our patients and the wider population.

Our clinical strategy has been developed following the principles set out in Lord Darzi's 2007 strategy for the capital, *Healthcare for London* and more recently, the *Shaping a healthier future* programme for north west London. Both are firmly based on three principles which we strongly support:

- Localising routine medical services where possible means better access to care closer to home and improved patient experience.

The Trust's vision and values reflect its position as the major provider of acute healthcare services to the residents of north west London, with a leading reputation in specialist services, academic research and medical education. In delivering this vision, we will always put patients first, making high quality, safe and compassionate care our top priority.

- Centralising specialist services where necessary drives up quality through better clinical outcomes and safer services for patients.
- Integrating patient pathways between primary and secondary care, with involvement from social care, to give patients a joined-up service.

Our plans are consistent with the *Shaping a healthier future* proposals to ensure patients benefit from the:

- most modern medical techniques/models of care
- highest standards of clinical expertise
- best possible facilities.

Our hospitals are home to acute medicine centres including the major trauma centre at St Mary's Hospital, the hyper-acute stroke unit at Charing Cross Hospital and the heart attack centre at Hammersmith Hospital. Working closely with the London Ambulance Service, our acute medical teams are fully prepared with the skills and equipment to provide high-quality lifesaving care around the clock. Paramedics take patients directly to one of these centres rather than the nearest A&E, giving patients access to specialist care and better chances of survival and full recovery.

The development of our clinical strategy for services across our hospital sites has been led and defined by our senior clinicians based on improving both the outcomes and the experience of patients while they are under our care.

We see each of our three main hospitals developing their own distinctive and interconnecting character: with Hammersmith continuing on its path as a specialist hospital with a strong focus on research; St Mary's being the acute/emergency hospital for central London; and Charing Cross developing as a flagship local specialist health and social care hospital with planned/elective surgical innovation and care services.

Operating from three main hospital sites all providing local services as well as their particular unique function:

- Hammersmith Hospital: Specialist
- St. Mary's Hospital: Major Acute
- Charing Cross Hospital: Local and Elective

Plans to improve healthcare as a foundation trust and AHSC

Being an AHSC with Imperial College London brings significant benefits for our patients, staff, students and local population, as we take new discoveries and innovations, and promote their application in our hospitals and across the NHS.

Imperial College London has a campus on each of our main sites and is closely integrated with all our clinical specialties. The Clinical Sciences Centre of the Medical Research Council is also based at Hammersmith Hospital, providing a strong foundation for clinical and scientific research.

Imperial College Health Partners

The Trust is a member of Imperial College Health Partners, which formed in June 2012 as an exciting development to promote the diffusion and adoption of discoveries and innovations into everyday clinical practice across north west London. The partnership is a limited company bringing together healthcare providers, including acute and specialist hospital, mental health, and community care services, working in partnership with Imperial College London.

Imperial West

In March 2013, Imperial College London launched its vision for Imperial West, a new research and translation campus in White City, west London. The centrepiece of plans for the major new campus, which is situated a short walk from Hammersmith Hospital, will be the £150 million Research and Translation Hub. The hub will provide state-of-the-art space for academics and business partners that can be adapted to keep pace with the changing demands of scientific discovery and innovation.

Application for AHSC designation 2014-2019

Imperial College AHSC has begun its application to the Department of Health to be redesignated an AHSC from April 2014 for a further five years. The role expected of AHSCs is to:

- increase strategic alignment of NHS providers and their university partners, specifically in world-class research, health education and patient care
- improve health and healthcare delivery, including the increased translation of discoveries from basic science into benefits for patients.

Through this, AHSCs will be able to realise their potential as drivers of economic growth through research partnerships with commercial life science organisations.

Question 1: Do you agree with our vision and strategy for the future?

Our values

Across the Trust, our people are focused on getting the fundamentals right in everything we do – that means we operate on the principles of quality, safety and compassion and our shared values.

Provide the highest quality care

We will:

- involve patients in their treatment decisions and outcomes
- demonstrate a respect for privacy, dignity, choice and independence
- reassure patients and take time to talk to them as individuals
- ensure we achieve the highest standards of patient safety
- be caring, compassionate and kind to others
- show empathy and be sensitive to an individual's needs
- offer support, advice and encouragement to others.

Respect our patients and colleagues

We will:

- engage, listen to and value the contribution of others
- be polite, courteous and non-judgemental in our communication
- encourage involvement and ownership
- appreciate, recognise and reward the contribution of individuals and teams
- be respectfully open and honest in giving and receiving feedback
- appreciate the qualities of individuals and work together towards a common purpose
- be responsible and accountable for our own and collective actions.

Encourage innovation in all that we do

We will:

- encourage and support creativity to generate ideas for ongoing success
- explore and push the boundaries of research, technology and clinical practice to give us a competitive edge
- develop confidence and maximise potential through learning, nurturing and development
- endeavour to continuously improve and implement positive change
- create a stimulating teaching environment through sharing knowledge and experience with others.

Work together for the achievement of outstanding results

We will:

- embrace teamworking to get the best results
- demonstrate integrity and transparency in our decision-making
- recognise and be responsive to change to protect and grow our activities
- use our energy and initiative in seeking opportunities to invest in our future success
- ensure wise and responsible use of resources
- strive to continuously improve on performance.

Take pride in our success

We will:

- be motivated and ambitious to achieve success
- demonstrate a commitment to excellence
- share and celebrate achievements and success, building pride in our reputation
- embrace challenge and work together to overcome problems
- be approachable, visible and inspirational as a role model for others.

What is a foundation trust?

A foundation trust is a type of NHS organisation that offers significant opportunities for patients and members of the public to get involved in how it is run. Foundation trusts also have more financial freedom than other NHS trusts and are regulated differently.

Foundation trusts are part of the NHS and subject to NHS standards, performance ratings and systems of inspection – they are free at the point of use.

However, foundation trusts are different from existing NHS trusts in several important ways. Foundation trusts:

- are independent legal entities - public benefit corporations
- devolve decision-making from central government to local organisations and communities
- have different governance arrangements to NHS trusts as they are accountable to local people, who can become members and governors
- are not directed by government so have greater freedom to decide, with their members and governors, their own strategy and the way services are run
- can be more responsive to their local communities; anyone who lives in the areas they serve, works for the foundation trust, or has been a patient or service user, can become a member
- are not run for profit, but do have more financial freedom to raise capital funds from both the public and private sectors, they can also retain financial surpluses to invest in the delivery of new NHS services, whereas NHS trusts have to return their surpluses to the Treasury
- are regulated by Monitor, rather than the Department of Health.

Regulation

Monitor is the regulator of health services in England, and being independent of central government, is directly accountable to parliament.

In relation to foundation trusts, there are three main strands to their work:

- determining whether NHS trusts are ready to become foundation trusts
- ensuring that foundation trusts comply with the conditions they signed up to, that they are well-led and financially robust
- supporting foundation trust development.

For information visit the Monitor website: www.monitor-nhsft.gov.uk

Our hospitals will continue to offer high-quality NHS care to our patients. We will still be judged against national performance targets, including those set by England's independent healthcare inspector the Care Quality Commission.

For more information visit the Care Quality Commission website: www.cqc.org.uk

Why we want to be a foundation trust

Becoming a foundation trust will demonstrate that our healthcare meets the highest standards of safety and quality and that the Trust is a well-governed organisation.

It will also give us freedom to develop and improve facilities and services that our patients, people and partners tell us they need.

We know from other NHS trusts who have made the transition to foundation trust status, that the greater freedom to plan and develop our services based on what our patients need and to manage our own finances will allow us to build on our successes and make further significant improvements. This will ensure that:

- we see patients quickly and efficiently
- we can provide services that are as safe as possible
- patients have a good experience of our healthcare
- we make best use of research and education to enhance our understanding of healthcare and develop a workforce which is highly skilled
- we develop our facilities and equipment to provide a modern, high-quality environment.

What will becoming a foundation trust mean?

- Achieving foundation trust status is a means to an end – it is a symbol of a well-organised, well-run, well-led organisation.
- We intend to use this process as an opportunity to develop relationships and engage our people to develop the right model of membership and governance.
- Our membership and council of governors will bring the Trust closer to the people we serve and work for us.
- Everyone working for the Trust will automatically be a member with a choice to opt-out.
- As a foundation trust, if we make a financial surplus we can invest this in services and would have more freedom to borrow for capital projects, like new buildings.
- We would still be required to deliver on national targets and standards like the rest of the NHS, but we would have greater flexibility in how we achieve these.

Becoming a foundation trust will help ensure we keep our patients at the heart of running our hospitals, further strengthen our engagement with our people, and give us greater freedom to grow and develop our services.

Benefits for patients and public

Becoming a foundation trust will enable us to improve the quality of our services as well as our facilities for both healthcare and research. Foundation trust status will bring financial freedom enabling us to direct surpluses and to responsibly borrow money to invest in improvements to our hospital environments. This will allow us to provide healthcare in modern, fit-for-purpose facilities.

Benefits for our people

Our employees keep us at the forefront of healthcare provision and research. Foundation trust status will give the people who work for us a stronger voice by providing a new forum where staff can provide feedback and influence decision-making.

Benefits for the Trust

A structured process to engage and consult with our people, patients, public and partners on a regular basis. Increased financial freedoms will enable us to greatly improve our services and facilities for both care and research, at a faster pace in more efficient facilities. Foundation trust status will bring greater flexibility enabling the Trust, working with our partners, to better manage itself based on shared priorities with greater freedom from central control.

Our proposals

How it will work – our proposed governance arrangements

Governance is the way in which the organisation structures itself to ensure there is effective strategic leadership and executive management functions, to use taxpayers' money wisely and meet all aspects of our duty of care to patients, commissioners and the public.

Monitor, the regulator of health services in England, requires us to develop new governance arrangements that will increase community and partnership working through a membership structure and council of governors.

The basic governance structure of all NHS foundation trusts includes:

- membership
- council of governors
- board of directors.

The membership

Membership of a foundation trust is an excellent way of becoming more involved in the way that healthcare works.

Foundation trusts offer patients, members of the public, the people who work for them and other partners, the opportunity to become a member of the Trust. Becoming a member gives people more of a say in how the Trust is run. Members are able to:

- vote in elections for the council of governors, or stand for election as a governor
- give opinions on plans for the future direction and development of the Trust
- attend key meetings and events
- receive regular information about the Trust
- convey their views to governors
- act as ambassadors for the Trust
- access Health Service discounts.

Having an engaged and effective membership will enable the Trust to ensure that we represent our patients, people and the local communities we serve, providing a real opportunity for people to get involved in the work of the Trust and influence the local healthcare landscape.

Membership is free and open to all those over the age of 16 provided that they meet the membership criteria.

Question 2: Do you agree that the minimum age for membership should be 16?

The constituencies

The foundation trust membership will be drawn from three constituencies:

- Public members
- Patient members
- Staff members

Our patients are from diverse backgrounds. To develop an effective membership we must actively seek to make our public and patient memberships representative of those who use our services.

We aim to ensure our public and patient membership is:

- sizeable – our aim is to have 10,000 patient and public members by the end of 2014
- representative – in terms of age, gender, ethnicity, socio-economic status and geographical location.

Public constituency

Foundation trusts can choose between having a single 'public' constituency and a constituency that is divided into distinct geographical areas. Our proposal is for a single public constituency for Greater London covering the 32 London Boroughs and the City of London.

In order to become a public member of our proposed Foundation Trust, you:

- must reside in the region of Greater London
- must apply for membership by filling out and submitting a membership application form
- cannot be a member of Trust staff, who are only eligible to join the staff constituency.

Trust volunteers will also be able to join the public constituency provided that they reside in the Greater London region.

Question 3: Do you agree that the public constituency should encompass the whole of Greater London?

Patient constituency

Foundation trusts can choose if they wish to add a constituency for patients. Anyone who has been a patient of the Trust, including private patients, within the last five years is eligible to become a member.

Some foundation trusts have sub-divided the patient constituency to include 'carers'. It should be noted however, that splitting this constituency would require a minimum of three sub-sections.

Question 4: Do you agree that we should have a public and a patient constituency?

Question 5: Do you agree that the patient constituency should not be sub-divided to include carers?

Staff constituency

Our people are partners in the development and delivery of our services and are central to the success of our organisation. As such, we believe that all staff should automatically become members of the Trust, unless they specifically choose to opt out.

Staff membership is open to any current employee of Imperial College Healthcare NHS Trust with a permanent, temporary or fixed-term contract for at least 12 months. In order to ensure that input from the staff constituency is representative, we propose sub-dividing the staff constituency into two sections: clinical and non-clinical.

Opportunities for involvement

As a member you can choose how often and to what extent you want to be included. Members will

Question 6: Do you agree that staff members should automatically become members of the Trust unless they choose to opt out?

Question 7: Do you agree that only staff directly employed by the Trust should be eligible for staff membership?

Question 8: Do you agree that the staff constituency should be sub-divided as clinical and non-clinical?

be asked to indicate which level of membership they would like to have when they join. As a member you can change your level of membership at anytime.

Informed Member – receive information, newsletters and updates from us about important changes to healthcare.

Involved Member – receive regular information; get involved by attending annual public meetings and a range of activities including health events; and, vote in elections for council of governors.

Active Member – play a more active role; receive information and regularly get involved in activities such as focus groups, surveys, consultations, service development projects; volunteer to support a service; help to collect views from other local people on a range of issues; and, a whole range of other activities. You may also want to consider standing for election as a governor.

The level of engagement chosen does not affect a member's eligibility to vote in the elections for the council of governors.

Question 9: Do you agree with the proposed levels of engagement with our members as described?

Council of governors

The council of governors is the body through which the membership maintains dialogue with the Trust board. It has a number of important roles and responsibilities, including:

- ensuring that the Trust operates in accordance with its licence as a foundation trust
- representing the views of, and provide a link to, the public, staff and partner organisations
- further developing and approving the membership strategy
- appointment of the chairman
- appointment of the non-executive directors
- approving the appointment of the chief executive
- commenting on the forward plans and strategic direction of the Trust including any significant changes in the services provided
- appointing the Trust's auditor
- receives annual report and accounts.

Proposed composition of the council of governors

Foundation trust legislation stipulates minimum requirements for the composition of the council of governors, i.e. it must include staff representatives as well as representatives from the public, the local authority, education and partner organisations. It is also mandatory that public governors comprise over 50 per cent of the council of governors.

To ensure our council of governors is representative, we propose a total of 31 governors, which would be allocated as follows:

Constituency	Section/Partner	Number of seats
Public	Greater London	8
Patients	Patients within the last five years	8
Staff	Clinical	4
	Non-clinical	1
Nominated partners	Clinical commissioning groups	1
	NHS England	1
	Local authorities	2
	University: Imperial College London	1
	AHSC partners	3
	Independent medical charity	1
	Voluntary organisation	1
Total size of council of governors		**31**

Question 10: Do you agree with the proposed size and composition of the council of governors?

Who can become a governor?

Any member is eligible to become a governor so long as they are not disqualified by statutory or other grounds as set out in our constitution.

Public, patient and staff governors are voted in by their constituencies via elections whereas partner governors will be appointed by the partner organisations.

Monitor requires all governors to be aged 16 years or over and we propose 16 as a minimum age.

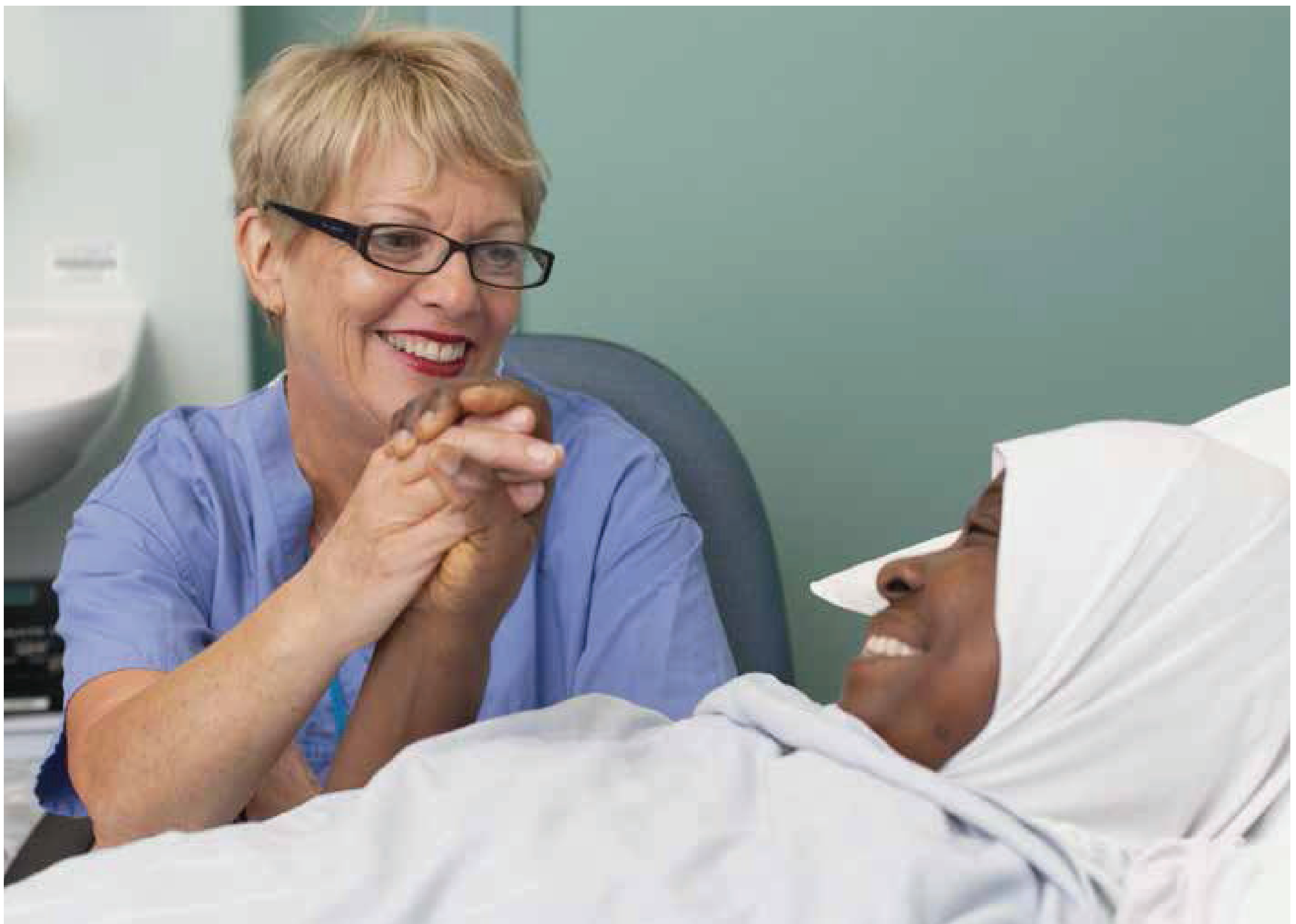
Elections

Elections would be held for all public, patient and staff representatives on the council of governors. We propose the following:

- governors would normally be elected for a three-year term
- governors would be entitled to stand for election again once their term was completed up to a maximum of nine years
- elections would be carried out by a recognised independent third party
- elections would be conducted using the 'first past the post' system
- should vacancies arise, these would be filled either by appointing the runner-up in the previous election (should that be within six months of the election) or by having a by-election for that vacancy.

Question 11: Do you agree with the minimum age of governors being 16?

Question 12: Do you agree with our proposed arrangements for elections?



The board of directors

Background

As a foundation trust we will continue to have a board of directors made up of non-executive directors (NEDs) and executive directors. They will be legally accountable for the running of our organisation. They set our strategic aims and objectives, and are responsible for the management, leadership and day-to-day performance of the organisation.

All NHS and NHS foundation trusts are required to have a board of directors in which a majority are NEDs. The chairman of the Trust is automatically appointed to the council of governors. The board of directors is the overall accountable body for the running of the Trust.

NEDs are appointed from outside the Trust to constructively challenge and contribute to the development of the Trust, support and scrutinise the performance of executive directors, and add value through their skills and experience. NEDs must be members of the foundation trust.

The executive directors are responsible for all aspects of the day-to-day running of the Trust and have specific, delegated areas of responsibility.

The proposed structure of the board of directors

We propose that our board of directors should comprise:

- a non-executive chair
- a chief executive
- non-executive directors
- executive directors.

The board will have a majority of NEDs.

The chair

Our chair is a non-executive director. As well as being the chair of our board of directors they will also be the chair of our council of governors once we become a foundation trust. This dual role ensures a direct link between our directors and governors by ensuring that our governors are involved in and can contribute to our future plans.

Non-executive directors

Our non-executive directors are appointed from outside our organisation. They have significant experience and specialist expertise gained from a wide-range of backgrounds. They use their experience to help improve our organisation by providing challenge to the development and implementation of our plans. They use their specialist expertise to support our executive directors in specific areas of their work, and scrutinise their performance.

Executive directors

Our executive directors are responsible for the day-to-day running of our organisation. They each have personal professional expertise and are responsible for specific areas of the business.

Question 13: Do you agree with our proposed plan for the board of directors?

Let us know what you think

Why comment on our proposals?

A key part of our foundation trust application is consultation with our patients, people, the public and partner organisations. We would like to hear what you think of our proposals and provide you with an early opportunity to apply for membership.

We will carefully review and consider all the feedback we receive and this will be reflected in our application for foundation trust status.

A summary of the results of the consultation and our response will be made publicly available.

When can you comment?

Our consultation will run for a period of 12 weeks from 11 November 2013. As part of this consultation, we will be meeting with elected representatives, overview and scrutiny committees, staff, partner organisations and holding public meetings, where you can give us your views.

Public meetings will be held on:

- **Wednesday 11 December 2013** (18.00-19.30) Small Hall, Kensington Town Hall, Kensington W8 7NX
- **Tuesday 17 December 2013** (18.00-19.30) Oak Suite, W12 Conference Centre, Hammersmith W12 0HS
- **Thursday 16 January 2014** (18.00-19.30) Great Western 2, Hilton Hotel, Paddington W2 1EE

Refreshments will be provided.

How to have your say

You will find enclosed a response form with a membership section. Please tell us what you think by completing and returning in the FREEPOST envelope provided.

You can respond online at www.imperial.nhs.uk/foundation-trust.

You can find out more at our website, by emailing us or phoning us on our dedicated helpline to find out more.

You could attend any of our public meetings to present your views.

We look forward to hearing from you.

020 3312 7674

ft@imperial.nhs.uk

www.imperial.nhs.uk/foundation-trust

@ImperialNHS

The deadline for submitting responses is 10 February 2014.

There is no deadline for joining as a member.

Next steps

The findings of this consultation will be submitted to the Trust board.

Changes to our proposed arrangements will be considered on the basis of the findings.

We will provide feedback to you on the outcomes of the consultation should you wish to receive this (if so please indicate this on the response form provided).

Note: You can ensure that you are continuously involved, informed and consulted by signing up as a member of the Trust using the response form provided.

Longer term

Spring 2014: NHS Trust Development Authority assesses our foundation trust application for submission to Monitor

Summer 2014: Monitor undertakes official assessment

December 2014: Imperial College Healthcare NHS Trust is awarded foundation trust authorisation (if successful)

Alternative formats

This document is also available in other languages, large print, and audio format upon request.

Este documento encontra-se também disponivel noutros idiomas, em tipo de imprensa grande e em formato áudio, a pedido.

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Dipas kërkesës, ky dokument gjithashtu gjendet edhe në gjuhë të tjera, me shkrim të madh dhe në formë dëgjimore.

Public consultation on our foundation trust plans:

From Monday 11 November 2013 to Monday 10 February 2014

Imperial College Healthcare NHS Trust
Communications directorate
Salton House
St Mary's Hospital
Praed Street
London W2 1NY

020 3312 7674

ft@imperial.nhs.uk

www.imperial.nhs.uk/foundation-trust

@ImperialNHS

Contacts

Charing Cross Hospital
Fulham Palace Road
London W6 8RF
020 3311 1234

Hammersmith Hospital
Du Cane Road
London W12 0HS
020 3313 1000

Queen Charlotte's & Chelsea Hospital
Du Cane Road
London W12 0HS
020 3313 1111

St Mary's Hospital
Praed Street
London
W2 1NY
020 3312 6666

Western Eye Hospital
Marylebone Road
London NW1 5QH
020 3312 6666

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www.imperial.nhs.uk

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