Imperial College Healthcare NHS Trust

**Strategic lay forum**
Wednesday 23rd April, 13:30 - 16:00
In-person and via Microsoft Teams (online)

| **Strategic lay forum attendance:** | |
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| Shanaka Dias | Co-chair |
| Ed Lother | Co-chair |
| Phayza Fudlalla | Deputy co-chair |
| Stephanie Nash | Deputy co-chair |
| John Black | Strategic lay forum member |
| Agnes Seecoomar | Strategic lay forum member |
| Bridget Harris | Strategic lay forum member |
| Lila Mann | Strategic lay forum member |
| Stephanie Vas | Strategic lay forum member |
| Graeme Crawford | Strategic lay forum member |
| Mariya Stoeva | Strategic lay forum member |
| **Patient safety partners:** | |
| Caron Bluestone | Patient safety partner |
| **Observers:** | |
| Shailesh Malde | Lay partner |
| Ashley Pearce | Lay partner |
| **Trust and other organisation attendance:** | |
| Michelle Dixon | Director of engagement and experience |
| Linda Burridge | Head of patient and public partnerships |
| Meera Chhaya | Community engagement manager |
| Lea Tiernan | Patient safety engagement and involvement lead |
| Maria Piggins | Partnerships and training manager, Patient Experience Research Centre (PERC), Imperial College London |
| Ian Lush | Chief executive of Imperial Health Charity |
| Kate Pleydell | Arts engagement curator |
| Faye Oliver | Strategic communications |
| Stuart Forward | Strategic communications |
| Matthew Tulley | Director of redevelopment |
| Deirdra Orteu | Redevelopment clinical design director |
| Victor Chamberlain | Head of redevelopment communications |
| Jazz Thind | Chief financial officer |
| Claire Hook | Chief operating officer and deputy chief executive |
| Shona Maxwell | Chief of staff |
| Julian Redhead | Medical director and consultant emergency medicine |
| Andrew Worthington | Deputy chief nurse |
| Ben Holden | Consultant in public health |
| Hannah Franklin | Health equity programme manager |
| **Apologies:** | |
| Peter Jenkinson | Director of corporate governance and trust secretary |

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| Lorraine Brown | Head of the patient advice and liaison service |
| Darius Oliver | Associate director of communications |
| Bob Klaber | Director of strategy, innovation and research, consultant paediatrician |
| Candice Savary | Strategic lay forum member |
| Michelle Knapper | Clinical review and elective patient experience lead |
| Zohra Davies | Lay partner and potential member of the strategic lay forum |

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| **1.** | **Welcome - Shanaka Dias, co-chair, strategic lay forum** | **Action** |
| | Shanaka opened the meeting, and the apologies were noted. | |
| **2.** | **Minutes and action log - Linda Burridge, head of patient and public partnerships** | |
| | **Minutes:**<br>There were no amendments to the minutes which were approved. Linda explained the draft insights from the deep dive session on how we are using data to ensure we are user focused, has been included in the minutes.<br><br>Linda noted most actions have been completed, with the exception of scheduling a session on West London Children Service's transition from children's care to adult care. Michelle added this area of healthcare has now been included as one of the priorities in the quality accounts. The quality accounts will also come to the strategic lay forum for input.<br><br>**Acton log:**<br>Linda explained the action log has been updated and positively the patient voice partner remuneration policy can be closed as this has now been approved. The next step is to develop the communication material to support the policy.<br><br>Linda outlined the forum's plan for future deep dive sessions:<br>• June - how we reduce 'do not attends'<br>• July - integrated care and integrated neighbourhood teams<br>• September - communication and information for patients (customer relationship management); the scope for this session will need to be defined<br>• November - healthcare in a digital age<br><br>Othe prospective deed dives are: the user focused strategy and workforce/culture. Linda said we need to confirm if we cover these topics which we can do later in the year. Shanaka added that if there are any topics the forum is interested in to approach himself, Ed or Linda.<br><br>Linda updated the forum on refresh of the PPI strategy, which we are referring to as the user focused strategy as it will have a wider remit than just involvement. She said we have done initial scoping with the strategic lay forum and colleagues and next steps will be to develop the engagement plan to develop the overall vision, ensure we are aware of all current work in this area across the Trust and to explore how this strategy will align with others. The engagement plan will include a workshop in autumn which the strategic lay forum will be invited to. | Action: Quality priorities and the overall quality report to come to the strategic lay forum for input (Michelle/Shona)<br><br>Action: Invite the strategic lay forum to the user-focused strategy workshop in the autumn (Linda) |

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| | Shanaka added it would be important to highlight the numerous ways the forum has made an impact and added value to the Trust. | |
| **3.** | **Deputy co-chairs update - Phayza Fudlalla, deputy co-chair, strategic lay forum; Stephanie Nash, deputy co-chair, strategic lay forum** | |
| | **Feedback from the Trust leadership forum**<br>The leadership forum was held on Thursday 3rd April 2025. Phayza explained it was a privilege to be invited and hear from senior leaders about the challenges, achievements and progress the Trust is making. The session was a great networking session and an opportunity to listen and learn about how the Trust will approach the challenges to improve efficiency and productivity. Phayza added it was good to have forum representation and emphasised the importance of focusing on the right things and supporting the Trust's strategy to remain patient centred.<br><br>Shanaka also attended and explained that the Trust is facing financial challenges and the forum's role is very important to help the Trust remain patient centred.<br><br>**Feedback and highlights from the Trust standing committee discussion on the strategic lay forum annual report**<br>Ed, Phayza and Stephanie attended the standing committee to present annual report from the strategic lay forum. The report was positively received where Ed explained the role of the forum and how the forum want to help the Trust remain patient centred. Phayza discussed the improvements to patients in local communities, data and organisational culture and leadership. Stephanie spoke about openness and transparency. Phayza shared that the standing committee support and endorse the strategic lay forum and provided reassurance that the Trust is committed to collaboration and responding to patients' and communities' needs.<br><br>Ed explained the chair was very encouraging and requested the forum bring the report to next year's standing committee. A helpful challenge from the chair was to understand how the work is consistently heard as opposed to be being pushed by executive advocates of the forum. Michelle echoed this comment and suggested one option would be to embed the work of the forum within the Trust's governance. Shanaka emphasised the importance of keeping the forum informal and so a balance would need to be found between the two. | |
| **4.** | **St Mary's redevelopment update - Matthew Tulley, director of redevelopment; Deidra Orteu, redevelopment clinical design director; Victor Chamberlain, head of redevelopment communications** | |
| | Shanaka welcomed the presenters. Matt gave an update and recapped the announcement from January 2025 where the redevelopment of all three schemes has been pushed back to 2035. Thanks to initial funding the team can continue with the design and planning of St Mary's hospital, up to planning consent which is a three-year process.<br><br>Matt reminded the forum the redevelopment project is to build an 800-bed hospital with integrated research facilities alongside care facilities as well as expanding services as part of Paddington Life Sciences. The business case is very strong, highlighting improvements in hospital efficiency/maintenance and commercial/economic growth.<br><br>Lila questioned whether the redevelopment of St Mary's hospital would create parking facilities for patients. Matt explained there will be little parking as Paddington has the best transport connections in London. Westminster City Council also discourage driving or parking within this area. Matt reassured the forum that patients and visitors will be able to access the hospital.<br><br>Matt explained the recent launched of the West Tech corridor strategy which links together the development of White City, the South Kensington | |

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| | College campuses and Paddington Life Sciences. There was also agreement to set up a St Mary's redevelopment taskforce with Westminster City Council and several other partners, i.e. local MPs, Imperial Health Charity, Imperial College to review alternative funding sources. This is at the beginning stage as the taskforce are in the process of appointing an independent chair to steer the work. The taskforce is a positive step is creating good engagement with key stakeholders.<br><br>A design team have been appointed to build the Fleming Centre which is currently in RIBA stage two. The plan is to submit the planning application later this year with the aim of receiving planning approval late spring/early summer 2026. There will also be two rounds of consultation, May/June 2025 and autumn 2025.<br><br>Shanaka thanked the presenters and highlighted the forum's concern around how patients access the building as well as the risks associated with a change in government. Shanaka was keen to understand how or where in the process will the team be engaging with community groups and lay partners. Matt explained this will happen throughout the whole design process, especially during the consultation phases.<br><br>Mariya questioned whether the accessibility strategy and equality, diversity and inclusion strategy will be embedded into the major plans. Deidra supported the comment and reassured the forum this would be included in the engagement process. The team are focusing on the experience of users as well as the development of the building. Michelle added it would be helpful for the team to come back at a later stage to discuss the wider engagement plan for the redevelopment of St Mary's hospital.<br><br>John wondered whether crowd funding was an opportunity to generate funding. Matt explained the Trust is a non-foundation hospital which cannot borrow money; but other local authorities and universities can. As the team continue to work with more stakeholders, this could become an opportunity. Ian added, Imperial Health Charity owns some of the land and so one option would be to use this as collateral for funding/loans. The Charity can also support with fundraising where the completion of the Fleming Centre provides an opportunity to generate interest from investors to support the redevelopment of St Mary's Hospital. Ian also added, the Charity can borrow money if the hospital is unable to. A helpful action was to share the external communications and positioning regarding research.<br><br>Once the Fleming Centre is built, Lila was keen to understand whether the brand of Imperial will be re-visited. Michelle explained there are three broad sub-brands, NHS, private care and research and innovation. Work has begun to develop the research and innovation sub-brand which links with Paddington Life Sciences and the Fleming Centre. Michelle added once the plan has been developed it would be beneficial for the forum to review at a later meeting.<br><br>Phayza was keen to understand whether there is any guidance on how to build a new hospital. Matt explained there is lots of guidance, which is being used, e.g. the New Hospital Programme is creating a new set of guidance entitled *Hospital 2.0*. | Action: The wider engagement plan for the redevelopment of St Mary's to be shared with the forum when developed (Victor/Michele)<br><br>Action: Share the external communications and positioning regarding research (Meera/Hannah)<br><br>Action: Imperial brand and offer to be discussed at the forum (Michelle) |

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| | Shailesh highlighted the importance of having mandatory 'must haves' to manage the 'nice to have's.<br><br>Stephanie Vas recommended using involvement of disability specialists in the redevelopment of the hospital. Stephanie also questioned whether any of the proposed changes will have a negative impact on patients. Linda welcomed the comment and mentioned this would be managed via the quality impact assessment which will be explained in more detail in the next agenda item.<br><br>Stephanie Vas was keen to understand whether the Trust completed case studies on how patients including people with disabilities/neurodiverse use the hospital, i.e. from home to hospital. This would provide an accurate understanding of patient journeys and support the redevelopment. Linda mentioned this method of insight has been used in the past in the form of patient stories and similar research within the cancer improvement programme. Michelle added this is a really important area of work. In the short term, the Trust has a project (sitting within outpatient improvement) looking at what we can do within our current systems to capture individual needs (e.g. autism or visual impairment) and have a consistent response. Longer term, the Trust is working up a specification for a 'contact relationship management' system (common in-service industries but not in the NHS) that gives a single view of each contact/patient (their needs/interactions/preferences), allowing the team to evaluate impacts and improvements. The latter needs to be set up as a project and will be looking for lay involvement.<br><br>Ed questioned whether there is any part of the design process which looks at building smaller facilities in different locations as this would create a cheaper budget using a wide set of commercial partners. Also, with technology advances will the redevelopment of St Mary's hospital be relevant in the future? Matt explained certain set of services work together and it is important to think about this alignment when planning the build. In terms of future technology, the complexities of healthcare are great so there will always be a need for healthcare facilities and we will built flexible sites for future use of technology.<br><br>Shanka thanked the presenters and advocated the forums support to have the patient voice part of the process. | |
| **5.** | **Deep dive: how can we ensure we remain patient-centred considering our uniquely challenging financial and operational situation for 2025/26? - Jazz Thind, chief financial officer; Claire Hook, chief operating officer and deputy chief executive; Shona Maxwell, chief of staff; Julian Redhead, medical director and emergency medicine consultant; Andrew Worthington; deputy chief nurse** | |
| | Jazz highlighted key points on what NHS Trusts have been asked to do with regards to their financial and operational performance:<br>• The NHS received an additional £22 billion last year, and this has been absorbed by pay awards and the impact of inflation while the need for planned and urgent emergency care has grown. All integrated care boards (ICBs) are still expected to break even overall.<br>• To meet the gap, NHS Trusts are required to spend one per cent less and do significantly more with the money we have, delivering a four per cent increase in productivity overall. | |

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| | • The Trust will not be paid additional money for planned care activity above an agreed level, and the level will be lower than this year's activity.<br>• NHS Trusts continue to have stretched operational targets.<br><br>Nationally, Trusts have been asked to:<br>• Reduce substantive establishment by one per cent.<br>• Reduce bank staff by 15 per cent and agency staff by a third.<br>• Reduce half of the growth in corporate and other 'non-patient facing' roles since 2018/19. For the Trust, this would mean a reduction of 30.4 million in 2025/26.<br><br>Jazz explained the agreed actions and outcomes the Trust must take within the next financial year are to:<br>• Deliver a breakeven plan. This includes £80.1 million in cost improvements. This will be the main focus as the opportunity to grow our income is very limited.<br>• Reduce our workforce by 451 whole time equivalent posts, with around two thirds coming from a reduction in the use of bank and agency.<br>• The income that we can earn from planned care has (currently) been capped to 115.5 per cent of pre-pandemic elective activity levels compared to 121 per cent of elective activity in 2024/25.<br>• The contract with North West London ICB includes £4.3 million of additional income to reflect last year's over-performance against block services, such as maternity.<br><br>Shanaka opened the floor for discussions. John emphasised the importance of improving productivity and creating change both quickly and efficiently and was keen to understand what strategies were being put in place to achieve this. Jazz explained there are a few things the Trust is focusing on to improve productivity. Within the cost base, the Trust is maximising the use of infrastructure and assets (people as well as estates). Examples include improving outpatients and theatre scheduling and reviewing services to enhance productivity.<br><br>Claire explained the Trust has several ideas in terms of how productivity can be improved. The challenging part is how this can be done quickly. The transformation team have been supporting with change programmes as well as performance and support teams who have shifted their focus on the productivity challenge. Claire added the key thing to be mindful of is that although we need to deliver the changes quickly, we need to involve the correct people at the right time.<br><br>Mariya was keen to understand whether the reduction in workforce includes clinical staff in key areas, i.e. outpatients. If so, what plans are in place to mitigate the risk to patient care. Julian was keen to reassure the forum that the Trust is not planning on making redundancies and that most savings will come from temporary staff as opposed to permanent. Julian stressed the importance of protecting key services and ensuring patient care and safety is at the forefront of all decisions. Mariya thanked Julian for his response and questioned whether in-patient equipment would be impacted by the cost savings. Julian explained there are two types of money, revenue and capital. Equipment will not be impacted as this is funded via capital which the Trust have an allocated amount. | |

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| | Michelle explained when there is a huge financial pressure on the Trust, it is important to not make quick decisions which could have a long-term negative impact. There is the possibility that some decisions maybe wrong however this will be monitored via patient feedback and data. Michelle used the example of the outpatient programme where dashboards are used to monitor experience, not just the financial metrics and there is opportunity to expand this.<br><br>Phayza questioned to what extend the Trust is using patient data to co-ordinate services as well as the NHS 10-year strategy, i.e. moving patients from hospital to community. Julian explained the whole systems integrated care (WSIC) dashboard is the largest linked database of patient information across Europe. The WSIC database provides key information on how patients access healthcare throughout all NHS services. This provides an opportunity to track patient journeys and understand/provide the necessary care. Julian also highlighted the importance of continuity of care to ensure those who require services more frequently have a smooth healthcare journey.<br><br>Agnes explained at times data is not aligned which creates problems for the patient. Julain agreed with this comment but added some improvements have been made, i.e. A&E staff are now able to view general practitioner notes.<br><br>Andy explained the process of quality impact assessments, which evaluate the potential impact of cost improvement programmes on patient care and quality, with the ability to reject proposals that negatively affect quality. The quality impact assessment is measured against CQC domains, i.e. safe, effective, caring, responsive, well led. Scores below six can commence without any further sign off however those who score seven or above are presented at a clinical review meeting chaired by the medical director and/or chief nursing officer. The aim is to use the quality impact assessment process for business plans, change projects, improvement plans, business cases and major consultations to assess the potential impact on the quality of patient care.<br><br>As well as patient quality, Ed questioned whether patient experience should be included in the form as an additional measure. Andy welcomed Ed's comment and explained although patient experience is not an individual measure it is certainly weaved into the five domains the CQC measure against.<br><br>For the assessments that are approved, Shanaka questioned whether there are measures in place to identify whether it is working or whether any changes can be made. Julian explained data/information collected via patient feedback, the forum and friends and family test can provide an overview as to whether the programme is working.<br><br>Shanaka asked whether there were any learnings that can be applied from a similar financial situation the NHS faced 10 years ago to the current climate. Julian empathised the importance of the Trust being in control of its finances; if this does not happen an external body will take control which will negatively impact the Trust. Michelle added the importance of being brave | Action: The strategic lay forum to input into the quality impact assessment review which is currently underway (Meera/Andy) |

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| | in making the big changes as opposed to lots of little changes which may not have the desired outcome.<br><br>John, Graeme and Ashely asked questions about staffing and permanent roles and the impact of this on costs. Julian explained there are two types of staff, bank and agency and to cover sickness the Trust will always need some contingency staff.<br><br>In terms of income generation, Phayza questioned whether other sources have been considered, i.e. research. Julian said a key source of income is the private care at Imperial where all the money is invested back into the Trust.<br><br>Shanaka thanked the speakers for their presentation.<br><br>**Deep dive points**:<br>• The Trust needs to consider making wider and larger scale changes, based on metrics and input from staff, patient and communities, that will deliver the same or better outcomes but in a more sustainable way with longer term cost improvements. This is in contrast to more but smaller less transformational changes or finance reductions that rely on delivering the same healthcare but with a smaller budget.<br>• The forum welcomes the review of the quality impact assessment template, will feed into the review and encourages all cost improvements to include communications and involvement with staff and patients.<br>• The Trust can include patient experience in the quality impact assessment and use project management approaches, such as logging any possible impacts on a risk register.<br>• There is opportunity to use our existing data and insights to monitor any adverse impacts of cost improvements. For example, the Trust could routinely look at safety incidents, risks, staff sickness, datix entries, FFTs and complaints in any site with a significant cost improvement programme to ensure any negative impact is rapidly addressed.<br>• The income generated by private patients is very positive for the Trust. The Trust can do more to publicise this and ensure it's understood as part of the overall finance situation at the Trust. | |
| **6.** | **Health inequities 'neighbourhood approach' - Dr Ben Holden, consultant in public health; Hannah Franklin, health equity programme manager** | |
| | Ben began discussions by defining population health which includes a wide range of activities the Trust does to improve people's health, this includes vaccinations, screenings and improving people's health behaviours (smoking cessation, reducing alcohol intake, diet and exercise). Linked to this are other inequalities such as access, outcomes and experiences which are a key part of improving the quality of care.<br><br>Data indicates groups of people face different barriers to having good health and come to hospital sicker than others, i.e. poorer housing, lack of jobs, live in deprived areas. One Trust focus for health population heath is to overcome the barriers and support people as early as possible by working | |

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| | with other partners such Westminster City Council. Lila added another element is nutrition and how this changes culturally.<br><br>Agnes was keen to understand how the impact is measured. Ben explained the key measures, i.e. waiting times which can be broken down to area and/or ethnicity which helps identify whether there is an unfair disadvantage to certain groups. He will share additional data reports that explains this.<br><br>Hannah added the aim is to reduce the gap in the data between those that experience barriers and those that do not, which can be achieved through a quality improvement approach. Hannah added the 'do not attend' project is a key example. 'Do not attend's were higher in deprived areas and the team actively called those patients prior to their appointment and attendance improved.<br><br>Ben explained the 'core 20' approach to addressing health inequities and presented a map of the areas in North West London which fall into the top 20 per cent deprived households in the country. People living within these areas are more likely to experience inequalities in access and care. Ben and Hannah are proposing to start with areas close to Trust sites and sought the forum's feedback.<br><br>Karen asked what the team see as the biggest challenge, how will this will be mitigated and what is causing the biggest harm to patients. In terms of harm, when we think about poverty and deprivation the assumption is to refer to income, but another measure includes access as when you review the top 20 per cent of deprived areas, e.g. lack of GPs and transport links are key issues. The challenges the team face were broken down into short (language barriers, not registered with a GP), medium (access to housing, better jobs) and long term (how do we make better opportunities for the children of these families) barriers. Ben explained the aim is to focus on a few key neighbourhoods and ask them what their issues are. By focusing on key neighbourhoods, the Trust can get a deeper understanding, better engagement and establish better outcomes in a sustainable way. The forum supported this and added the following comments.<br><br>Karen added from a patient safety perspective, the team are educating and informing patients in a way they understand from the outset. This maybe via language or other methods but the aim is to have safer patients.<br><br>The forum asked several questions which focused on what additional help and support would be provided to those living in deprived areas. Have community groups been approached and is the team collaborating with local authorities to add value? Also, the importance of inclusivity and ensuring patients are not digitally excluded was also highlighted.<br><br>Hannah explained the team do not have pre-conceived ideas as the priority is to work collaboratively to understand what the need is. In terms of community engagement, the team have collaborated with community clinics and will continue to do so as the work begins. Digital exclusion is a stream of work at the Trust which links with the outpatient programme where efforts are under way to ensure access is not hindered to those who are not tech savvy. Ben stressed the importance of building connections which will allow the Trust to be better connected with community health and wellbeing workers across North West London. Phayza added the importance of | Action: Data report to be shared with the forum (Ben / Meera) |

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| | linking in with holistic hubs in the community. Bridget echoed this comment and highlighted the importance of connecting with transport for London, local authorities and family hubs.<br><br>Agnes mentioned at times services work in silo and so one suggestion would be to hold a networking/signposting session with key people from the community. Ben welcomed the comment but explained there is already a lot of great work which is happening in the community and so the aim is to connect with the already fantastic work.<br><br>Stephanie Vas questioned whether the team were working with the local Healthwatch and offered the support of members at action on disability Kensington and Chelsea should any research opportunities arise.<br><br>Stephanie referred to the Connecting Care for Children (CC4C) model and whether this would be rolled out in an adult setting. In terms of new models of care, this is the national direction of travel of connecting care with GPs and the community. The dream would be to have this as the normal way of delivering care but due to the financial barriers this may take some time. Ben is hopeful the NHS 10 Year Plan will outline a strategy to move this forward. | |
| **8.** | **Meeting close** | |