Imperial College Healthcare NHS Trust

**Strategic lay forum**
Wednesday 17th September 2025 09:30 - 12:00
In-person and via Microsoft Teams (online)

| **Strategic lay forum attendance:** | |
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| Shanaka Dias | Co-chair |
| Ed Lowther | Co-chair |
| Phayza Fudlalla | Deputy co-chair |
| Stephanie Nash | Deputy co-chair |
| Agnes Seecoomar | Strategic lay forum member |
| Bridget Harris | Strategic lay forum member |
| Graeme Crawford | Strategic lay forum member |
| Lila Mann | Strategic lay forum member |
| John Black | Strategic lay forum member |
| Stephanie Vas | Strategic lay forum member |
| Candice Savary | Strategic lay forum member |
| Zohra Davies | Strategic lay forum member |
| Shailesh Malde | Strategic lay forum member |
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| **Observers:** | |
| Jeanette Longfield | Observer |
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| **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 |
| Michelle Knapper | Clinical review and elective patient experience lead |
| Lea Tiernan | Patient engagement manager |
| Maria Piggin | Partnerships and training manager, Patient Experience Research Centre (PERC), Imperial College London |
| Peter Jenkinson | Director of corporate governance and trust secretary |
| Gail Scott-Spicer | Chief executive, Imperial Health Charity |
| Linda Watts | Associate director of digital transformation |
| Robbie Cline | Acute provider collaborative chief information officer |
| Paul Harrison | Digital, data and technology communications manager |
| John Wintour-Pittom | Head of operations, telecommunications |
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| **Apologies:** | |
| Bob Klaber | Director of strategy, innovation and research, paediatrician |
| Darius Oliver | Associate director of communications |
| Stuart Forward | Strategic communications |
| Faye Oliver | Strategic communications |
| Lorraine Brown | Head of the patient advice and liaison service |
| Deirdra Orteu | Redevelopment clinical design director |
| Siobhan Jordan | Director of nursing |

| 1. | **Welcome - Shanaka Dias, co-chair, strategic lay forum** | **Action** |
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| | Shanaka opened the meeting and the apologies were noted. | |
| **2.** | **Minutes and action log - Linda Burridge, head of patient and public partnerships** | |
| | **Minutes:**<br>Linda reviewed the previous meeting's minutes, noting an amendment regarding a document Shailesh shared about developing strategic projects, which was forwarded to Bob Klaber and Ben Holden for feedback. No other corrections were raised.<br><br>**Acton log:**<br>• **Forum terms of reference update:** Linda explained the need to update the strategic forum's terms of reference to include the current activities such as reviewing the executive manager board quality (EMBQ) user insights report and regular meetings including the chairs' attendance at the leadership forum.<br>• **Strategic lay forum nhs.net email accounts:** Linda discussed the ongoing challenges and benefits of maintaining dedicated nhs.net email accounts for forum members, emphasising the importance of these accounts for accessing documents and internal communications. Linda asked forum members whether this was still required or if the current method of communication is sufficient. The forum members agreed to continue the activation of nhs.net email accounts. We agreed that Meera remind members to complete their training and activate their accounts.<br>• **Future deep dives and meeting planning:** Linda outlined plans for a deep dive on research scheduled for November 12th, focusing on inclusivity in research and the translation of research benefits into patient care, and encouraged members to consider topics for future deep dives, noting the need for advance planning to secure relevant speakers. | Action: Linda to update the terms of reference for the strategic lay forum to include current activities<br><br>Action: Meera remind forum members to complete training to activate @nhs.net accounts |
| **3.** | **Deputy co-chair's update**<br>• **Insights and experience executive management board (quality) report - Phayza Fudlalla, deputy co-chair**<br>• **Discussion points for next meeting with Prof Tim Orchard (18 Sept) - Stephanie Nash, deputy co-chair** | |
| | **Insights and experience executive management board (quality) report**<br>Phayza summarised the highlights from insights and experience executive management board (quality) report for June/July. There has been a steady but high level of complaints, particularly regarding values and behaviour in urgent and emergency medicine and noted a decline in participation rates for the friends and family test in areas such as inpatient transport and maternity postnatal wards, prompting the need for urgent action to increase engagement.<br><br>The rollout of a new friends and family test patient experience system, which initially caused a decline in participation due to iPad compatibility issues, now resolved, and mentioned delays in launching translated surveys and divisional reporting. | |

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| | She noted a slight improvement in the national cancer patient experience survey results, though the Trust remains low in national rankings, and highlighted the deployment of on demand video and telephone interpreting devices in A&E and urgent treatment centers, with positive initial staff feedback.<br><br>Michelle discussed the development of a comprehensive improvement program for maternity services in response to declining scores and participation, the unique structure of the Maternity and Neonatal Voices' Partnership, and ongoing work to assess and enhance quality standards through staff and patient insights. Michelle also addressed questions about the friends and family test, explaining the use of targeted text messages and in-person iPad surveys to increase participation, and discussed the need to further improve response rates and tailor feedback mechanisms to different patient groups.<br><br>**Discussion points for next meeting with Prof Tim Orchard (18 Sept)**<br>Stephanie outlined the discussion points for the next meeting with Prof Tim Orchard which include:<br>• The last two deep dive sessions: engagement session on the 10-year plan and Violet Melchett health hub (July), and the patient-focus in Trust IT projects (September) as well as the future deep dive session on research.<br>• Children's services and in particular their input into outpatients and patient centred transitioning from children to adult services.<br>• Acute provider collaborative consolidation and governance changes.<br>• User involvement strategy (PPI strategy review). | Action: the forum to plan a deep dive session on maternity |
| **4.** | **Deep dive: the patient-focus in Trust IT projects; Robbie Cline, acute provider collaborative chief information officer; Paul Harrison, digital, data and technology communications manager; John Wintour-Pittom, head of operations telecommunications; Linda Watts, associate director of digital transformation** | |
| | Robbie discussed patient related IT systems and in particular the integrated care board (ICB) strategy to bring IT systems together across hospitals in North West London (acute provider collaborative) and the importance of communication between hospitals and patients.<br><br>A key component of what the team are trying to do is centralise the use of Cerner which is the main patient record electronic system staff use, i.e. if you have an allergy diagnosed in West Middlesex hospital and you attended Imperial where a clinician prescribes you a drug that will contraindicate, the system will alert the clinician. This covers most clinical records but not all specialist services. Robbie explained work on specialist services is building where a unified approach in oncology and endoscopy is being implemented by the end of the year. The intention ultimately is to eradicate the fragmented IT landscape, so patient care is unified.<br><br>The forum members had several questions which focused on:<br>• Why the system is so fragmented - Robbie explained IT systems have been selected by individual services and Trusts without looking at the bigger picture, hence the fragmented nature of patient related IT systems.<br>• The connection between different hospitals - All 12 acute hospitals in North West London are on the same instance of the Cerner | |

electronic patient record system. Other Trusts across London are on different instances of Cerner from other suppliers and GPs are on still other systems. The London Care Record is a portal that gives access to some data from these other systems to GPs and hospital clinicians across London.

- What access do GPs have to patient records - GPs use a different system to hospitals. They have access to the London Care Record, which gives them information from our hospitals including appointments, test results, discharge summaries and clinic letters.
- When do patients see hospital test results on the Care Information Exchange - Many test results are available immediately. For potentially sensitive categories of results such as histopathology and radiology there is a 28-day delay in the publication of the results on the patient portal. This is to allow time for clinicians to communicate the results directly to their patients.

John discussed the improvements being made to call handling/email contact, emphasising IT is the enabler, but to see the change teams must work with the clinical services.

Linda Watts explained how Cerner is updated on a yearly basis to allow for improvements to function in the system. Ed questioned how updates are chosen as there will be both patient and clinician priorities which may clash. Linda explained the team engage with several patients' groups, i.e. digital patient reference group to ensure the right decision is made. There are also 12 clinician-led stakeholder groups representing different aspects of care to make sure that changes support the clinical priorities of the Trust.

Robbie discussed the concept of technical debt which is underinvestment over years in certain aspects of the Trust's IT infrastructure which means teams have to play catch up. This takes place when things are done in a fragmented way. Robbie explained the need for a resilient IT structure to maintain a reliable and secure IT service and drew reference to the digital and data strategy which focuses on seven steps:

- ICT infrastructure - resilient infrastructure provides fast, reliable, secure services to all staff
- Digital record - removal of the paper in clinical records. Information is now digital and recorded in a structured format
- Data sharing - information is shared between organisations and available for authorised users to view
- Patient empowerment - patients can access their records and contribute to content. Patients can take care of their own health and care
- Integrated care - management of complex pathways
- Population health management - exploitation of the data through analytics and AI
- Innovation - digitalisation enables new models of care

Lila questioned whether patients' records are monitored if they do not want to receive information digitally. Robbie explained all patients tick a box as to whether they want to receive information digitally or not but highlighted at times this can lead to errors due to the fragmented nature of systems. The intention is to have this aligned.

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| | Candice focused on integration and the need to have a common language across systems and where in the seven steps this was incorporated. Robbie explained integration is across all seven steps; a key challenge faced with Cerner is that it is great at sending information out but not good at receiving information. This is important if patients want to re-schedule their appointments.<br><br>Shailesh raised a question about data quality across multiple systems. Robbie responded by outlining efforts to address inconsistencies through the federated data platform, which aggregates data for consistent reporting and supports clinical prioritisation, waiting list decisions and appointment coordination.<br><br>Robbie explained a common theme is that information is communicated in multiple ways. At present, two products are available:<br>• DrDr - this platform is used to book outpatient appointments digitally where an account is not needed<br>• Care information exchange (Patient Knows Best) - this platform requires an account<br><br>The rationale behind two systems is to cater for patients' individual needs however the reality is that patients tend to receive information twice and letters being sent 'just in case', which can sometimes conflict with other correspondence.<br><br>Forum members questioned how the multiple forms of information will be minimised as well as how the Trust can stay on top of the changes in communication and the preferred method patients want. Robbie explained the development of a 'consent engine' that notes the preferred communication method patients want so we can use that in future. There was a brief discussion on how to capture more insights and 'stories' to inform this work. Michelle highlighted the need to look at the issues systematically to focus on where the most appropriate engagement would be.<br><br>Stephanie Vas discussed the need to ensure these systems are accessible for all as community members have found the systems confusing. It was noted that the language we use for communications needs to be consistent. Reflecting on the 10 Year NHS plan, Phayza was keen to understand what measures are in place to ensure those who are digitally vulnerable are not left behind.<br><br>Robbie referenced the communication preferences platform which will ensure peoples unique needs are recorded. This will allow flexibility, more choice and ensuring that we meet patients' communication needs. Forum members welcomed this comment and mentioned volunteers or digital champions as an avenue to support patients who are not digitally competent.<br><br>Michelle explained that this is being done in the outpatient programme where direct support is available to those who are not digitally competent. One considered approach is that when Trust staff resources are freed-up when many patients move to online and digital, they can move to assist patients who are digitally vulnerable or need more support. | Action: the forum to consider a future deep dive session on the communication preferences platform |

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| | The group discussed the dynamics of an IT development and where decisions are made, who leads them and who is the 'client'. Shanaka asked which team is responsible for user experience at the Trust. Michelle said this is a current gap in our governance, but one teams are currently discussing who is the 'client' in a positive way.<br><br>To conclude, Shanaka emphasised the importance of the patients' experience to bring data together. IT is the enabler but there are behavioural aspects of using it correctly, which comes from engaging directly with patients/clinician teams.<br><br>He added this was a useful first deep dive on the issue and it would be helpful to explore further issues from a user lens. The following next steps were suggested:<br>• To have future sessions specifically on data, data sharing and the communication preferences work when it's further progressed.<br>• Encourage the Trust to reflect on and address the governance and decision making gap on where and how decisions are made regarding IT and operational changes that affect patient experience. E.g. sending text messages, self-book appointments approaches, developments to the patient service centre.<br>• Ask to Trust to plan in and include staff use and uptake of new IT systems as a dependency for the success of new systems. We noted inconsistent use of the London Care Record on accessing blood test results. Without consistent and appropriate uptake of new systems, poor patient experiences will continue.<br>• To tell the story of the progress made so far and share patient-centred IT developments with colleagues and other audiences. There is an opportunity to acknowledge the innovations already achieved and by sharing information on it, it will support further culture change. | |
| **5.** | **Lay partner evaluation - Meera Chhaya, community engagement manager** | |
| | Meera presented an overview of the lay partner evaluation plan, outlining the framework adopted (OKR model: objectives and key results), method of assessment (quantitative/qualitative) and engagement plan deadline.<br><br>The forum welcomed the plan and highlighted the importance of continual evaluation. Notable feedback and suggestions included:<br>• **Capturing value and impact** - Forum members discussed the importance of gathering both anecdotal and measurable evidence of lay partner contributions, including before and after project assessments, stories of impact, and tracking training participation, with Meera agreeing to incorporate these elements into the evaluation. Linda said that the impact of lay partners can be hard to note as colleagues cite that they subtlety affect staff behaviour to be more patient-focused and less silo-oriented. This is mostly captured through quotes and stories from colleagues. The group agreed this information is important to note and that the impact of lay partners is part of the culture change that can lead large programmes with a strong user experience design element, such as outpatients and cancer improvement.<br>• **Lay partner terminology and awareness -** Forum members questioned the definition of a lay partner and the need for clarity. | Action: Meera to circulate the definition and description of a lay partner |

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| | Meera advised she would circulate a definition and description of a lay partner and mentioned terminology is related to lay partner awareness, one of the measures in the plan.<br>• **Diversity and representation** - The importance of creating a dashboard to compare the diversity of lay partners with the community served, ensuring true representation. Meera confirmed ongoing efforts to collect and report on these metrics.<br>• **Remuneration** - Analysing the return on investment to assess the value provided relative to cost. Meera welcomed the comments and explained plans to evaluate the impact of remuneration as a separate project in February 2026 where the suggestion can be incorporated.<br>• **Recognition and feedback mechanisms -** Suggestions were made to introduce awards or recognition for lay partners and to include patient compliments in evaluation reports, with Meera noting these ideas for future implementation. | Action: Meera to introduce awards or recognition for lay partners as part of the lay partner programme |
| **6.** | **Changes to our organisational structure - Peter Jenkinson, director of corporate governance and Trust secretary** | |
| | Peter provided an update on the evolution of the acute provider collaborative where four acute trusts in Northwest London are moving from a collaborative to a group model to enable more agile executive decision making, with a single accountable officer overseeing all four organisations. He noted the current governance structure is holding back some decisions that need to be made to realise significant strategic developments.<br><br>He said the core principles of the changes were that local leadership of the individual trusts will remain at a CEO level, that quality patient care for patients must be maintained and this approach will not cost more than the current governance arrangements. The new leader will be responsible for shaping the executive structure and ensuring efficiency, while maintaining statutory responsibilities and quality focus at the individual Trust level. The expectation is that after a transition period, there is a single group CEO with a new governance structure by April 2026.<br><br>The process is to appoint the group CEO from among the current chief executives. Ed will represent the forum on the stakeholder panel for the CEO appointment process and further updates will be provided as the transition progresses, including opportunities for involvement in ward accreditation and peer review programmes. Ed requested for any questions to be emailed to Linda to ensure concerns are raised.<br><br>Peter also discussed the potential for the Trust to apply for foundation Trust status. This was outlined in the 10 year plan and he anticipates the governance requirements for this is that the Trust must demonstrate its approach to patient and public engagement. He added the forum has as key role in shaping future engagement and assurance processes around this.<br><br>Forum members questioned how the new structure would benefit patients and whether it would increase costs, to which Peter responded that the aim is to improve service delivery and efficiency without adding costs, and that the boards are committed to ensuring the new structure is cost-neutral or cost-saving. Agnes asked what evidence there is that it is a | Action: Include lay partners in the ward accreditation and peer review programmes<br><br>Action: Forum members to email questions re: appointment of group CEO to Linda - completed<br><br>Action: Peter to attend the forum meeting in November to provide an update on the changes to our organisational structure. |

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| | move that will improve patient and staff experience. She noted redundancy costs, service moves and what that means for staff having to travel between sites. Peter reiterated the principles that quality standards must be maintained and that this structure will not cost more. Michelle gave examples of how patient interpreting support and procurement and cancer improvement would improve patient care if they were under a group governance approach.<br><br>Peter explained that more will be known after the group CEO recruitment process and that he will attend the forum meeting in November to provide an update. | |
| **7.** | **AOB - Linda Burridge, head of patient and public partnerships** | |
| | **Linda outlined two upcoming community lay partner listening events:**<br>• 5 - 6:30pm Thurs 25 Sept (online)<br>Lea Tiernan, patient safety engagement and involvement lead who will provide an update on the patient safety programme.<br>Deirdra Orteu, redevelopment clinical design director who will provide an update on the Fleming centre.<br><br>• 5 - 6:30pm Thurs 11 Dec (in person)<br>Deirdra Orteu, redevelopment clinical design director who will provide an update on the redevelopment. | |
| **8.** | **Meeting close** | |