CHIEF EXECUTIVE'S MONTHLY UPDATE REPORT – SEPTEMBER 2018

Authors: John Adler and Stephen Ward Sponsor: John Adler **Trust Board paper D**

Executive Summary

Context

The Chief Executive's monthly update report to the Trust Board for September 2018 is attached. It includes:-

(a) the Quality and Performance Dashboard for July 2018 attached at appendix 1 (the full month 4 quality and performance report is available on the Trust's public website and is hyperlinked within this report);

(b) key issues relating to our Strategic Objectives and Annual Priorities

Questions

1. Does the Trust Board have any questions or comments about our performance and plans on the matters set out in the report?

Conclusion

1. The Trust Board is asked to consider and comment upon the issues identified in the report.

Input Sought

We would welcome the Board's input regarding content of this month's report to the Board.

For Reference

Edit as appropriate:

1. The following **objectives** were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[Yes]
Consistently meeting national access standards	[Yes]
Integrated care in partnership with others	[Yes]
Enhanced delivery in research, innovation & ed'	[Yes]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[Yes]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	[Yes]

2. This matter relates to the following **governance** initiatives:

a. Organisational Risk Register [Not applicable]

If YES please give details of risk ID, risk title and current / target risk ratings.

Datix Risk ID	Operational Risk Title(s) – add new line for each operational risk	Current Rating	Target Rating	CMG
XXXX	There is a risk …			XX

If NO, why not? Eg. Current Risk Rating is LOW

b. Board Assurance Framework [Not applicable]

If YES please give details of risk No., risk title and current / target risk ratings.

Principal Risk	Principal Risk Title	Current Rating	Target Rating
No.	There is a risk …		

3. Related **Patient and Public Involvement** actions taken, or to be taken: [N/A]

4. Results of any **Equality Impact Assessment**, relating to this matter: [N/A]

5. Scheduled date for the **next paper** on this topic: [October 2018 Trust Board]

6. Executive Summaries should not exceed **2 pages**. [My paper does comply]

7. Papers should not exceed **7 pages.** [My paper does comply]

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **6 SEPTEMBER 2018**

REPORT BY: **CHIEF EXECUTIVE**

SUBJECT: **MONTHLY UPDATE REPORT – SEPTEMBER 2018**

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1 Introduction

1.1 My monthly update report this month focuses on:-

(a) the Board Quality and Performance Dashboard attached at **appendix 1**;

(b) the Board Assurance Framework (BAF) and Organisational Risk Register;

(c) key issues relating to our Annual Priorities, and

(d) a range of other issues which I think it is important to highlight to the Trust Board.

1.2 I would welcome feedback on this report which will be taken into account in preparing further such reports for future meetings of the Trust Board.

2 Quality and Performance Dashboard – July 2018

2.1 The Quality and Performance Dashboard for July 2018 is appended to this report **at appendix 1**.

2.2 The Dashboard aims to ensure that Board members are able to see at a glance how we are performing against a range of key measures.

2.3 The more comprehensive monthly Quality and Performance report continues to be reviewed in depth at a joint meeting of the People, Process and Performance Committee and Quality and Outcomes Committee. The month 4 quality and performance report is published on the Trust's website.

Good News:

2.4 **Cancer 31 day** was achieved in June. **52+ weeks wait –** 0 patients (compared to 16 patients same period last year). **Mortality** – the latest published SHMI (period January 2017 to December 2017) has reduced to 97 and is within the threshold. **Cancer Two Week Wait** – have achieved the 93% threshold for over a year. **Never events** – 0 reported in July. **Delayed transfers of care** - remain within the tolerance. However, there are a range of other delays that do not appear in the count. **C DIFF –** was within threshold for July. **Pressure Ulcers** - 0 **Grade 4** reported during July.

Grade 3 and 2 are well within the trajectory for the month. **CAS alerts** – we remain compliant. **Inpatient and Day Case Patient Satisfaction (FFT)** achieved the Quality Commitment of 97%. **TIA (high risk patients)** – 70.2% reported in July. **Moderate harms and above** – June (reported 1 month in arrears) was within threshold. **Statutory and Mandatory Training** reported from HELM is at 90% (rising trend).

Bad News:

2.5 **UHL ED 4 hour performance** – was 76.3% for July, system performance (including LLR UCCs) was 83.1%. **Referral to Treatment –** our performance was below the NHS Improvement trajectory but the overall waiting list size (which is the key performance measure for 18/19) is only 0.78% off plan. **Diagnostic 6 week wait –** standard not achieved, however, significant improvement in performance from June. **MRSA –** 1 case reported this month. **Cancelled operations** and **patients rebooked within 28 days** – continued to be non-compliant. **Cancer 62 day treatment** was not achieved in June – further detail of recovery actions in is the Q&P report. **Sickness absence** – 3.8% reported in June (reported 1 month in arrears). **Fractured NOF** – was 58.8% in July. **Ambulance Handover 60+ minutes (CAD+)** – performance at 4%.

3 Board Assurance Framework (BAF) and Organisational Risk Register

3.1 The Board Assurance Framework (BAF) and organisational risk register have been kept under review during July 2018 and a detailed BAF and an extract from the risk register are included in the integrated risk and assurance paper featuring elsewhere on the Board agenda.

Board Assurance Framework

3.2 The BAF remains a dynamic document and all principal risks have been updated by their lead Directors (to report performance for July) and have been reviewed by their relevant Executive Boards during August 2018, where they have been scrutinised ahead of the final version to Board today.

3.3 The three highest rated principal risks on the BAF are in relation to staffing levels, emergency care pathway and financial sustainability.

Organisational Risk Register

3.4 The Trust's risk register has been kept under review by the Executive Performance Board and across all CMGs during July and displays 68 risks rated as high (i.e. with a current risk score of 15 and above).

3.5 Thematic analysis of the organisational risk register shows the two common risk causation themes are workforce shortages and imbalance between service demand and capacity. Managing financial pressures, including internal control arrangements, is also recognised on the risk register as an enabler to support the delivery of the Trust's objectives. These findings on the risk register are reflective of our highest rated principal risks identified on the BAF.

4 Carbapenem Resistant Organism (CRO) Outbreak

4.1 We recently identified a group of patients carrying a carbapenem resistant organism (CRO), which is a bacteria that is resistant to a wide range of antibiotics including carbapenems.

4.2 Between 22 July and the 18 August we proactively screened 470 patients across 14 locations (12 medical wards, ITU and a care home) and identified 49 patients who were confirmed as 'colonised' with the bacteria (where the resistant bacteria can be found in the gut but is not causing an infection).

4.3 Because a number of patients were affected by the same organism (CRO) with each case being linked by time or place, we declared an outbreak on the 31st July 2018.

4.4 At the peak of the outbreak, ten wards were either restricted or closed to admissions. The restrictions contributed to some delays in patients waiting for beds but preventing the spread of CRO is vitally important for UHL. We continue to monitor the situation very carefully and continue to take the right precautionary measures to ensure that CRO does not spread further.

4.5 All affected patients have been managed in line with isolation precautions, keeping carrier patients separate from non-carrier patients to reduce the risk of spread. Isolation involved carrier patients being in single rooms or being cohorted in designated bays or wards as the number of patients identified exceeded side room capacity.

4.6 We have ensured that all our staff on the affected wards follow stringent hand hygiene and strict use of personal protective equipment (PPE) including wearing of theatre scrubs by staff when on a restricted ward. Public Health England (PHE) have been working closely with us to provide advice and guidance on the patients with CRO and the Trusts senior Infection Prevention and microbiology teams have provided expert and professional advice to wards on a daily basis.

4.7 In line with national guidance, all wards have been deep cleaned and fogged with hydrogen peroxide once all patients with CRO have been discharged to ensure that the organism has been eradicated from the environment.

4.8 At the present time we have eleven in-patients who are not yet medically fit for discharge (not as a result of CRO) with only one ward remaining that is restricted to admissions.

4.9 I should like to pay tribute to the many staff who have gone "above and beyond" to deal effectively which what has been a very challenging situation. These staff include nursing, facilities, infection prevention, microbiology, medical, estates and management colleagues, all of whom have worked very well together over a prolonged period. I would also particularly like to thank Eleanor Meldrum, our Acting Chief Nurse, who has led our response to the outbreak in her capacity as Acting Director of Infection Prevention and Control.

5 Emergency Care

5.1 Our performance against the four hour standard for July 2018 was 76.3% and 83.1% for Leicester, Leicestershire and Rutland as a whole.

5.2 Performance was below the revised (more challenging) NHS Improvement trajectory for July, having been achieved for the first 3 months of the financial year.

5.3 We continue to develop and adapt our emergency care action plan in the light of experience and I list below a number of the key, additional, actions now in train which are included within the updated plan:-

- in respect of ambulance handover, in conjunction with East Midlands Ambulance Service we have agreed to cohort directly from ambulances when there is any offloading delay over 20 minutes – this frees up the ambulance and crew more quickly;
- the Emergency Department Floor Management Team is now in place during the evenings as well as at weekends and further recruitment is underway, with interviews scheduled for early September 2018;
- improving the flow through Majors by introducing a dedicated stream for ambulatory patients – the rapid cycle test of this change commences on 17th September 2018;
- the creation of medical exemplar wards for the use of NerveCentre and eBeds and utilising this as a resource to drive the full roll-out across the Trust between now and the end of October 2018, with the clear aim of reducing interruptions on the ward in order to release staff capacity to execute simple discharges;
- we have set a trajectory for all of the Clinical Management Groups to reduce the number of 'stranded' and 'super stranded' patients (adults only) and ensure they are doing everything required in order to achieve the standards set;
- piloting a new clinical model for the front door and primary care stream to improve efficiency and effectiveness of streaming and deflection – rapid cycle testing to commence 12th September 2018.

5.4 In parallel, the Trust is working with Health and Social Care partners to finalise the Leicester, Leicestershire and Rutland Winter Plan 2018/19.

5.5 The approach to finalising the Winter Plan 2018/19 involves:-

- a review of system performance for 2017/18,
- identification of the major causes of pressure,
- identifying and applying lessons learned, both local and national,
- agreeing a series of actions to avoid similar issues in future,
- focusing, in particular, on frail patients (as discussed at the Trust Board Thinking Day on 9th August 2018),
- undertaking an assessment of readiness.

5.6 Steady progress is being made to produce the plan by the end of September 2018, for submission to the regulators. There remains some work to engage members of the public through marketing and campaigns to ensure patients are aware of services available to them and to help manage expectations, recognising that patient experience can be poor if the expectation is different to what is available to patients. Individual health and social care organisations have each been asked to review and submit their plans which will be shared and consolidated into one. They will also incorporate demand and capacity plans, business continuity plans, flu and infection control preparedness and adverse weather protocols. These will be checked and practised via simulation exercises, to ensure the system is clear on arrangements, contingencies and to test for any gaps that exist ahead of Winter.

5.7 Key elements of the UHL component of the Winter Plan 2018/19 are as follows:

- additional adult medical capacity at all three sites, including an additional 28 bedded ward at the Leicester Royal Infirmary and 28 bedded modular ward at Glenfield Hospital,
- a planned reduction in elective activity,
- changes to the Children's front door and improvements in the discharge function, including the implementation of 'red to green' for Children's,
- the establishment of a dedicated team to review patients "outlied" on a daily basis.

5.8 The Leicester, Leicestershire and Rutland A&E Delivery Board will monitor progress of the plan and, more importantly, will ensure that any learning as we go through Winter is incorporated into updated versions, for continuous improvement.

5.9 Further details of the Winter Plan 2018/19 will be the subject of report by the Chief Operating Officer to the September 2018 meeting of the People, Process and Performance Committee. That Committee continues to review our emergency care performance and plans for improvement at each of its meetings, and details of the Committee's most recent consideration of the position are set out in the summary of that meeting which features elsewhere on this Board agenda.

6. <u>Consolidation of Level 3 Intensive Care Services</u>

6.1 The Leicester, Leicestershire and Rutland Joint Health Overview and Scrutiny Committee is to meet on 4th September 2018 and consider again the Trust's plans for the consolidation of level 3 intensive care services.

6.2 We have prepared and submitted a paper for consideration by the Joint Committee which:

- explains the background to the proposed service moves,
- explains the clinical necessity to transfer level 3 ICU beds from the Leicester General Hospital site,
- explains why the service move did not happen in accordance with the original timescales, and how the service has been sustained since the issue was first raised in 2014,
- explains why the consolidation is still determined as clinically urgent,

- explains what will happen if the service moves do not take place,
- explains why it is not appropriate to undertake public consultation for the ICU scheme,
- explains the timeline for this project, and the interdependencies between this project and other key developments.

6.3 Together with our Medical Director and Director of Strategy and Communications, I will be attending the Joint Committee and will update the Board orally on the outcome at the Board meeting on 6th September 2018.

7. Next Steps to Better Care in Leicester, Leicestershire and Rutland

7.1 NHS organisations in Leicester, Leicestershire and Rutland (LLR) have published the Better Care Together 'Next steps to better care in Leicester, Leicestershire and Rutland (LLR)'.

7.2 The report has been produced by the three NHS Trusts and three Clinical Commissioning Groups in LLR working alongside a range of partners including local councils who combine to improve services in order to secure better health outcomes for the whole population.

7.3 Further details are set out in the report by the Director of Strategy and Communications on the Sustainability and Transformation Partnership which features elsewhere on today's Board agenda.

8. Developing the Long Term Plan for the NHS

8.1 On 18th June 2018, the Prime Minister set out a funding settlement for the NHS England over the next 5 years. In return, the NHS has been asked to set out a long term plan for the future of the NHS by Autumn 2018, setting out our ambitions for improvement over the next decade, and our plans to meet them over the 5 years of the funding settlement.

8.2 On 9th August 2018, NHS England and NHS Improvement published an 'Engagement Briefing' on the development of the long term plan for the NHS, which sets out some of the agreed working groups that will feed into its development, an outline of the timeline and the process for wider engagement.

8.3 The briefing attached as **appendix 2** to this paper sets out further details of the approach which is being adopted.

9. Quality Improvement Strategy

9.1 The Trust has been, and continues to be, engaged in a great deal of activity aimed at improving the quality of the care that we provide and improving organisational culture and effectiveness. Perhaps the two most high profile examples of our work are the Quality Commitment and the UHL Way. However, when we compare ourselves to other organisations (particularly those that would be described as high performing), our approach cannot be described as comprehensive or fully "joined-up" and the

evidence is that this is likely to inhibit our journey from “requires improvement to outstanding”.

9.2 Over the summer, in conjunction with a range of colleagues, I have been researching best practice in this crucial area and assessing what supporting resources are available; the latter are now considerable, particularly from NHS Improvement. The key here is to establish a clear vision and framework within which the many activities are placed, thus ensuring a coherent and comprehensive approach. Ultimately this will be described in a new Quality Improvement Strategy..

9.3 This work builds on several recent discussions at Trust Board Thinking Days, which have had a range of helpful external inputs, and I intend to engage the wider leadership community through the forthcoming Leadership and Consultant Conferences. I also intend to form a steering group to guide the development of the QI Strategy and ultimately aim to bring the Strategy to the Trust Board for final approval in December. There will be further opportunities for Board input prior to this via the Thinking Days.

10. <u>Armed Forces Corporate Covenant – Gold Award</u>

10.1 On 30th July 2018, the Ministry of Defence announced that UHL was one of 50 organisations to receive the Ministry’s Employer Recognition Scheme (ERS) Gold Award for 2018. The ERS Gold Award recognises employers who actively support the Armed Forces community and encourage others to follow their lead.

10.2 The Trust signed the Armed Forces Covenant in 2015 and has been awarded ‘Gold’ having demonstrated outstanding support for those who serve and have served in the Armed Forces. The award scheme, which attracts entries from every organisation in every part of the country, in both public and private sectors, has seen a rapid increase in participation since its launch in 2014.

10.3 I set out below the comments of the Chairman, Col (Ret’d) Ian Crowe, Non-Executive Director, our Armed Forces Champion and Mr V Smith the Trust Reserves Ambassador which emphasise the importance we attach to this prestigious award and our continuing commitment in this arena:

Mr K Singh, Chairman
“We are extremely proud to receive this prestigious award in recognition of our support for the Armed Forces community. It is important that we are able to meet the needs of this community, both as employers and in the services we provide. This accolade serves to underline our on-going commitment to support those who serve or have served in our Armed Forces”;

Col (Ret’d) I Crowe, Non-Executive Director
“I’m pleased the Trust has been recognised with this national award. Trust staff, particularly our Workforce staff, have worked tirelessly to develop our support for the Armed Forces community and I would like to pay tribute to them. I am proud of everyone at UHL who has worked so hard to reach the high standards required of this award. Long may we continue to develop and foster relations with our local Armed Forces community”;

Mr V Smith, Trust Reserves Ambassador
"This is excellent news and I'm really pleased the Trust has been recognised in this way. As the Trust's Reserves Ambassador, I would like to express my appreciation on behalf of all the Reservists, service leavers and family members with Armed Forces connections, employed by UHL, who are so ably supported by the Trust".

11. Conclusion

11.1 The Trust Board is invited to consider and comment upon this report and the attached appendices.

John Adler
Chief Executive
31th August 2018

Quality & Performance

		YTD Plan	YTD Actual	Jul-18 Plan	Jul-18 Actual	Trend*	Compliant by?
Safe	S1: Reduction for moderate harm and above (1 month in arrears)	142	65	<=12	12	●	
	S2: Serious Incidents	<37	17	3	3	●	
	S10: Never events	0	4	0	0	●	
	S11: Clostridium Difficile	61	25	5	4	●	
	S12 MRSA - Unavoidable or Assigned to 3rd party	0	0	0	0	●	
	S13: MRSA (Avoidable)	0	1	0	1	●	Aug-18
	S14: MRSA (All)	0	1	0	1	●	Aug-18
	S23: Falls per 1,000 bed days for patients > 65 years (1 month in arrears)	<5.6	6.8	<5.6	7.0	●	
	S24: Avoidable Pressure Ulcers Grade 4	0	0	0	0	●	
	S25: Avoidable Pressure Ulcers Grade 3	<27	2	<=3	1	●	
	S26: Avoidable Pressure Ulcers Grade 2	<84	25	<=7	7	●	
Caring	C3: Inpatient and Day Case friends & family - % positive	97%	97%	97%	97%	●	
	C6: A&E friends and family - % positive	97%	96%	97%	95%	●	
	C10: Single Sex Accommodation Breaches (patients affected)	0	26	0	2	●	
Well Led	W13: % of Staff with Annual Appraisal	95%	91.1%	95%	91.1%	●	
	W14: Statutory and Mandatory Training	95%	90%	95%	90%	●	
	W16 BME % - Leadership (8A – Including Medical Consultants) - Qtr 4	28%	28%	28%	28%		
	W17: BME % - Leadership (8A – Excluding Medical Consultants) - Qtr 4	28%	14%	28%	14%		
Effective	E1: 30 day readmissions (1 month in arrears)	<8.5%	9.2%	<8.5%	9.1%	●	
	E2: Mortality Published SHMI (Jan 17 - Dec 17)	99	97	99	97	●	
	E6: # Neck Femurs operated on 0-35hrs	72%	62.2%	72%	58.8%	●	
	E7: Stroke - 90% of Stay on a Stroke Unit (1 month in arrears)	80%	85.2%	80%	83.5%	●	
Responsive	**R1: ED 4hr Waits UHL**	95%	80.7%	95%	76.3%	●	See Note 1
	R2: ED 4 Hour Waits UHL + LLR UCC (Type 3)	95%	86.3%	95%	83.1%	●	See Note 1
	R4: RTT waiting Times - Incompletes (UHL+Alliance)	92%	86.5%	92%	86.5%	●	See Note 1
	R6: 6 week – Diagnostics Test Waiting Times (UHL+Alliance)	<1%	1.7%	<1%	1.7%	●	
	R12: Operations cancelled (UHL + Alliance)	0.8%	1.2%	0.8%	1.5%	●	See Note 1
	R14: Delayed transfers of care	3.5%	1.4%	3.5%	1.2%	●	
	R15: % Ambulance Handover >60 Mins (CAD+)	TBC	2%	TBC	4%	●	
	R16: % Ambulance handover >30mins & <60mins (CAD+)	TBC	6%	TBC	8%	●	
	RC9: Cancer waiting 104+ days	0	11	0	17	●	

		YTD Plan	YTD Actual	Jun-18 Plan	Jun-18 Actual	Trend*	Compliant by?
Responsive Cancer	RC1: 2 week wait - All Suspected Cancer	93%	94.1%	93%	93.1%	●	
	RC3: 31 day target - All Cancers	96%	95.4%	96%	96.4%	●	
	RC7: 62 day target - All Cancers	85%	76.2%	85%	74.5%	●	Dec-18

Enablers

		YTD Plan	YTD Actual	Qtr1 18/19 Plan	Qtr1 18/19 Actual
People	W7: Staff recommend as a place to work (from Pulse Check)		60.3%		60.3%
	C10: Staff recommend as a place for treatment (from Pulse Check)		70.5%		70.5%

		YTD Plan	YTD Actual	Jul-18 Plan	Jul-18 Actual	Trend*
Finance	Surplus/(deficit) £m	(22.8)	(22.7)	(0.4)	(0.4)	●
	Cashflow balance (as a measure of liquidity) £m	1.0	4.6	1.0	4.6	●
	CIP £m	7.3	7.3	3.5	2.4	●
	Capex £m	8.1	5.7	3.8	2.2	●

		YTD Plan	YTD Actual	Jul-18 Plan	Jul-18 Actual	Trend*
Estates & facility mgt.	Average cleanliness audit score - very high risk areas	98%	96.0%	98%	95.0%	●
	Average cleanliness audit score -high risk areas	95%	94.0%	95%	92.0%	●
	Average cleanliness audit score - significant risk areas	85%	**94%**	85%	**94%**	●

* Trend is green or red depending on whether this month's actual is better or worse than the average of the prior 6 months

Please note: Quality Commitment Indicators are highlighted in bold. The above metrics represent the Trust's current priorities and the code preceding many refers to the metrics place in the Trust's Quality & Performance dashboards. Please see these Q&P dashboards for the Trust's full set of key metrics.

Note 1 - **'Compliant by?'** for these metrics a are dependent on the Trust rebalancing demand and capacity.

Developing the long term plan for the NHS

Briefing from the Long Term Plan Engagement Team – england.ltp@nhs.net

Scope

On 18th June the Prime Minister set out a funding settlement for the NHS in England for the next five years. In return, the NHS has been asked to set out a long term plan for the future of the NHS by Autumn, setting out our ambitions for improvement over the next decade, and our plans to meet them over the five years of the funding settlement.

Working groups are now being established, bringing together local and national system leaders, partners and stakeholders, to shape the final plan. Agreed working groups, and some of those who will be involved in leading them, include:

Life course programmes

- **Prevention and Personal Responsibility** - Duncan Selbie, Dr Neil Churchill, Dr Vin Diwaker, Dr Amanda Doyle
- **Healthy Childhood and Maternal Health** - Sarah-Jane Marsh, Professor Russell Viner, Professor Jacqueline Dunkley-Bent, Dr Matthew Jolly
- **Integrated and Personalised Care for People with Long Term Conditions and the Frail Elderly (including Dementia)** – Caroline Abrahams, Julian Hartley, Martin Vernon, Matthew Winn

Clinical priorities

- **Cancer** – Cally Palmer, Lynda Thomas, Paula Head
- **Cardiovascular and respiratory** – Professor Stephen Powis, Professor Mike Morgan, Simon Gillespie, Juliet Bouverie
- **Learning Disability and Autism** – Ray James, Dr Jean O'Hara, Rob Webster
- **Mental Health** – Claire Murdoch, Paul Farmer, Sheena Cumiskey

Enablers

- **Workforce, Training and Leadership** – Dr Ruth May, Professor Ian Cumming, Jim Mackey, Dr Navina Evans
- **Digital and Technology** – Dr Simon Eccles, Sarah Wilkinson, Steve Dunn, Matthew Swindells
- **Primary Care** – Dominic Hardy, Dr Amanda Doyle, Dr Nikita Kanani, Professor Helen Stokes-Lampard
- **Research and Innovation** – Dr Sam Roberts, Professor Tony Young, Roland Sinker, Professor Dame Sue Hill
- **Clinical Review of Standards** – Professor Stephen Powis, Professor Carrie MacEwan, Imelda Redmond
- **System Architecture** – Ben Dyson, Ian Dodge, Matthew Swindells
- **Engagement** – Simon Enright, Sian Jarvis, Imelda Redmond, Rachel Power

Engagement

As articulated by the Prime Minister and Simon Stevens, the development of the long term plan will need to be based on the advice and experience of clinical experts and other stakeholders, including representatives of patients and the public.

Engagement with these groups will therefore be a key feature of our work at all points of the plan's development, and will primarily be based around three components:

Seeking views from key stakeholders	Programme-led engagement on policy	Engagement with staff, patients and the public
• Meetings with leaders from key stakeholder organisations to seek initial views and commitment to ongoing contribution to the process.	• Ongoing engagement by programme teams with relevant stakeholder organisations and system leaders, to co-develop, refine and test emerging policy proposals.	• Focused engagement with frontline staff, patients and the public through NHS and stakeholder networks, to seek wider views and priorities for the plan.

In addition to engagement on the content of the long term plan, we will also be developing our thinking around the role that an 'NHS Assembly', made up of representatives of NHS staff and patients, should play in overseeing the delivery of the plan's ambitions going forward.

Timeline

The Prime Minister has asked the NHS to prepare its long term plan in time for the 2018 Autumn Budget; we anticipate that this will be mid-November.

The indicative timeline for engagement with stakeholders and development of policies is therefore as follows:

August

- Initial engagement with stakeholders to invite views and establish ongoing participation.
- Establishment of working groups and planning for policy development and engagement programmes.

September

- Ongoing engagement with stakeholders by individual programme teams.
- Focussed engagement with patients, staff and the public through established forums and stakeholder networks.
- Development of initial policy proposals informed by engagement.

October/ November

- Continuing engagement with stakeholders by individual programme teams to test and finalise policy proposals.
- Reconciliation and prioritisation of policy proposals against each other and the available funding.

Please contact england.ltp@nhs.net for all enquiries.