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NHS ENGLAND – BOARD PAPER

Title:

Second progress report from the Empowering People and Communities Taskforce

Lead Director:

Professor Jane Cummings, Chief Nursing Officer
Dr Neil Churchill OBE, Director for Experience, Participation and Equalities

Purpose of Paper:

- This is the second progress report on the work of the Empowering People and Communities Taskforce.
- It includes data for the Public Participation Dashboard.

Patient and Public Involvement:

How have you involved patients and the public in this work?

- Patient and public involvement has been integral to all aspects of the Taskforce's work programme.
- Each meeting is preceded by a workshop focusing on one of NHS England's priority programmes, which includes the voices of patients, carers, the voluntary, community and social enterprise sector.
- In addition to the face-to-face engagement, the Taskforce has also been active on twitter, hosting at least two social media conversations around each meeting, and ensuring that all information is available online

The Board invited to:

- Note the work to date of the Taskforce and the planned work programme for the next six months;
- Note the indicators in the public participation dashboard set out for the health and care system and for NHS England; and
- Approve the priorities identified for improvement

Second progress report from the Empowering People and Communities Taskforce

Purpose

1. This paper provides a second update on the work to date of the Empowering People and Communities Taskforce. The Taskforce is due to continue until December 2018 and further updates will be provided, along with recommendations for the future.

2. The Board is invited to:
   - Note the work to date of the Taskforce and the planned work programme for the next six months;
   - Note the indicators in the public participation dashboard set out for the health and care system and for NHS England; and
   - Approve the priorities identified for improvement.

Background

3. The Empowering People and Communities Taskforce was established for one year to strengthen the contribution of people, patients and the voluntary, community and social enterprise (VCSE) sector in delivery of the Next Steps on the Forward View.

4. The Taskforce's approach has already been demonstrated to add insight and value to the priorities and national programmes set out in our Next Steps plan, working collaboratively with different priority areas. It has also supported the adoption of good practice and contributed to good governance in supporting evidencing how we meet our legal duties on public participation.

5. The Taskforce engages patients, clinicians and managers through social media and an issue-based workshop focused on one of NHS England's priorities prior to each meeting. Its previous paper to the Board, in February, included an update on progress with the development of a new 'public participation dashboard' and developing improvement objectives with a focus on the cancer programme. This paper provides a second update from the Taskforce at the mid-point of its activity.

Status Update

6. There are three areas where progress has been made since the previous Board report:

A: Public participation dashboard

7. An innovative public participation dashboard was developed to provide NHS England with oversight and assurance on how patients and communities are being involved. This provides a high-level overview or 'snapshot' of public participation practice on a biannual basis, enabling activity to be tracked over time in both quantitative and qualitative ways. Improvement plans will be developed on issues arising from the

dashboard, including support to emergent Integrated Care Systems and Sustainability and Transformation Partnerships.

8. Since our last update, the dashboard has been further developed. It comprises six indicators, covering public participation in NHS England and CCGs, and uses data from a range of sources which, taken together, should demonstrate at an indicative level, whether public participation is happening at an appropriate scale, whether legal duties are being met and whether 'quality standards' are being achieved.

9. The dashboard is presented at appendix 1, along with a summary of each indicator. Further explanation about data sources and findings is included below.

10. Indicator 1: NHS England consideration of 13Q duty applicability:

    a. NHS England has a legal duty under section 13Q of the National Health Service Act 2006 (as amended) to 'make arrangements' to involve the public in commissioning (also known as 'public participation').

    b. The agreed assurance process includes the completion of 'public involvement assessment forms' by commissioners and others involved in strategic and operational decision-making, to assess whether or not the 13Q duty applies to the activity or proposal under consideration. Information about completed forms, as well as a descriptive narrative, is reported quarterly to each of the NHS England Oversight Groups.

    c. For this indicator, data is presented about numbers of completed 'public involvement assessment forms' across regions and services, as well as judgements about the applicability of the '13Q' duty. Completion of a form indicates that appropriate consideration has been given as to whether the 13Q duty would apply to the project or initiative. The reporting of forms where the duty is not judged to apply ('not applicable') indicates that due process is being followed in assessing activity even where the duty is not triggered.

    d. There may be minor discrepancies with reported figures across regions and services due to the current manual collation of forms. It is anticipated that data quality will improve following the rollout of the online 'public involvement assessment form' from March 2018.

10. Indicator 2: Experiences of NHS England Patient and Public Voice Partners and Chairs:

    a. This indicator summarises the views and experiences of our Patient and Public Voice (PPV) Partners (members of the public who work with NHS England regularly in a public participation role), focusing on their impressions of the extent to which NHS England values public participation and whether their involvement is having an impact on our work.

    b. Data is taken from responses to the annual survey of 'PPV Partners' and of chairs of NHS England committees / task forces with PPV Partner members.

    c. Findings are largely positive, with 78% of PPV Partners agreeing that NHS England values Patient and Public Involvement (PPI) to 'a great' or 'some' extent, and 88% agreeing that the committee they are part of values PPI. 61% of respondents feel that their contribution as a PPV Partner has had an impact on the work area.

11. Indicator 3: NHS England consultations – quality sample:

    a. This indicator is not yet available but will, in future, be available on an annual basis and will provide insight into the quality of NHS England's consultations and consultation reports, and about how well we meet our obligations to effectively feedback to participants and others about the outcomes and impact of consultation.

12. Indicator 4: CCG compliance with 14Z2 statutory guidance requirements:

    a. CCGs have a legal duty under section 14Z2 of the National Health Service Act 2006 (as amended) to 'make arrangements' to involve the public in commissioning (also known as 'public participation').

    b. During 2017 a new indicator was developed and tested for inclusion in the CCG Improvement and Assessment Framework (IAF) core data set, and became 'Indicator 50: compliance with statutory guidance on patient and public participation in commissioning health and care'. The indicator is based on 'Patient and public participation in commissioning health and care: statutory guidance for CCGs and NHS England' revised guidance published in April 2017 on CCGs' statutory '14Z2' duty, and looks at CCG's engagement practices across the five domains of governance, annual reports, commissioning, feedback and evaluation, equality and reducing health inequality.

    c. Data is taken from the results of a comprehensive desktop assessment and review process during July-October 2017 to assess all 207 CCGs' engagement practices using this framework. Scores included here are final, and will be published on MyNHS in July.

    d. Key findings are that:
        i. Around half of all CCGs nationally (51%) were judged to be good or outstanding. Only a small minority (less than 2%) were judged inadequate. However, a small minority (5%) were judged outstanding, and there is room for improvement everywhere;
        ii. Almost all CCGs (93%) have good or outstanding governance of their engagement activities;
        iii. A majority (60%) have good or outstanding annual reporting, but a significant minority (40%) need to improve this;
        iv. A large majority (78%) have good or outstanding day-to-day engagement practices;
        v. Less than half (43%) have feedback arrangements that are rated good or outstanding. Most (56%) need to improve this. Feedback is the weakest domain, with more CCGs needing to improve this than any other aspect of their engagement; and
        vi. A majority (60%) take good or outstanding account of equalities and health inequalities in their engagement, but a significant minority (39%) need to improve this.

13. Indicator 5: Perceptions of local system partners of CCGs:

    a. This indicator should provide an indication as to how well CCGs are engaging with patients / the public and how well they act on what they have heard, as judged by respondents to the annual 360 survey (including local partners and stakeholders such as the local authority, local Healthwatch, NHS Trusts, health overview and scrutiny, and the voluntary and community sector (VCS)).

    b. Data is taken from the 2016/17 CCG 360 Stakeholder Survey National Report (and annex). The survey was conducted by Ipsos MORI on behalf of NHS England using online methods with telephone follow-up, with surveys distributed to stakeholder samples supplied by CCGs.

    c. Responses show that approximately half of stakeholders (excluding the CQC) are satisfied with steps taken by their local CCG to engage with patients / the public, agree that their local CCG acts on the views of the public when making commissioning decisions, and communicates how those views have been acted upon. A significant majority of local Healthwatch organisations and patient groups report a positive working relationship with their CCG. It is clear that some CCGs have areas for improvement, particularly around engaging with ‘seldom heard’ groups.

14. Indicator 6: Sustainability and Transformation Partnerships (STPs) / Integrated Care Systems (ICS’) – emerging practice:

    a. This indicator showcases an example of good practice in public participation being undertaken by STPs / ICS’. Data is identified through field work undertaken by the Public Participation team to identify good practice (presented in qualitative case study format). This example outlines the positive and proactive approach to widening participation taken by West Yorkshire and Harrogate ICS.

15. As the first iteration of the dashboard, some caution should be exercised in making conclusions about findings and potential trends from this singular dashboard. However, there are clearly some positives to be taken, for example around the establishment of relationships, embedding of public participation into ‘business as usual’ and learning from exemplars in the field. The overall impression is one of variability however, and moving forwards the focus will be on how to support improvements ‘across the board’ so that the ambitions of the Five Year Forward View and a new relationship with people and communities can become increasingly the norm. There is a particular need to ensure that ‘seldom heard’ groups and those who experience health inequalities are included.

B: Developing partnerships with the VCSE Sector

16. VCSE organisations are vital partners in supporting NHS England meet its obligations through the Equality Act, address health inequalities and ensure that our programmes meet the needs of the most disadvantaged. Overall our partnership with the sector, including grassroots organisations, is one way to challenge the inverse care law.

17. A recent analysis of the way in which NHS England engages with the VCSE sector, conducted on behalf of the Taskforce, found variability in our approach to the sector. In some areas there are good working relationships with VCSE organisations, and

there have been attempts to develop mechanisms to support wider engagement, such as the VCSE Health and Wellbeing Alliance which is operated in partnership with the Department for Health and Social Care and Public Health England. However, the analysis concluded that engagement is often driven by personal knowledge or contacts and there is not currently a systematic way to ensure an inclusive approach to involvement in strategic planning. Our engagement tends to focus on large condition-specific organisations, overlooking organisations with more of a focus on the life-course or whole-person and often not utilising the range of engagement mechanisms available.

18. In May, a new VCSE action plan was published by the Joint VCSE Review setting out a vision in which VCSE organisations work with the NHS to co-design and co-deliver health and care services with local people. Inequality in access to services, of our public services and their outcomes was the strongest message the Review heard during its consultation.

19. At its best the VCSE sector can play a number of roles in connecting the NHS better with people and communities. It can support the voice of those who are seldom heard, deliver holistic and inclusive services that affect but go beyond clinical need and be partners in the development of strategy and delivery of programmes. As NHS England focuses more strongly on integration, both in localities and in across the life-course, we need a fresh approach to partnership working with the VCSE sector which brings out its strengths.

20. The vision of the Empowering People and Communities Taskforce is for a renewed and inclusive partnership that maximises our collective impact on shared priorities to the tangible benefit of patients, carers and local communities

C: Developing improvement objectives

21. In addition to embedding a focus on empowering people and communities within business-as-usual as outlined above, the Taskforce is also developing clear recommendations about how people, communities and the VCSE sector can better help deliver existing commitments from the Forward View and other strategies for the benefit of all. In our first update in February, we reported on the detailed look the Taskforce had taken at the implementation of the Cancer Strategy. Since then, the cancer team has provided two further updates to the Board on progress through the Health Inequalities papers.

22. More recently the Taskforce has taken a similar look at the Mental Health Programme and co-production. The Five Year Forward View for Mental Health was of great interest to the Taskforce, having been co-produced in partnership with over 20,000 people with mental ill health and involving ‘experts by experience’ in the development of all care pathway documents and service recommendations.

23. The Taskforce were pleased to hear strong examples of co-production both by the national team and local providers and commissioners. The scale of inequalities experienced by some groups are clearly recognised and there are a number of initiatives in place to address this such as peer mentorship, personal development and skills training targeted specifically at Black men in secure care.

24. However, the Taskforce noted that, whilst co-production is being embedded in many areas, there are a number of areas in which improvements could be made. The Taskforce has written to the Mental Health programme to suggest further consideration is given to the following (see Appendix 2 for copy of the letter):

    a. Diversity in Involvement and Co-production – How we can ensure that we can demonstrate tangible involvement and influence over decisions at all levels by a diversity of service users and that this diversity in participation is maintained the higher up people go in our governance structures, and how we can strengthen co-production among commissioners, to better support patient and public voice partners and grassroots organisations in the commissioning process.

    b. Integration of care - The development of Integrated Care Systems provides a valuable opportunity to join services up and improve user experience. This requires strong engagement with the local VCSE sector which provides many such interventions. We therefore need to strengthen VCSE involvement in the work Integrated Care Systems are doing to deliver aspects of the Mental Health Strategy.

    c. Data and measurement - Data collected about the experiences of patients can provide rich insights yet compared with other priority programmes, there are limitations in the information we get from service users about how they access services and their experiences of care.

25. The Mental Health Programme will be responding to the recommendations made by the Taskforce by early July and a verbal update provided at the Board meeting.

Implications

Resources Required

26. The Taskforce will continue to make recommendations over the next six months for different NHS England corporate priority areas which may require some re-prioritisation of attention or resources within existing strategies to ensure that there is a sharper focus on patient experience, involving patients and the public in their work, and building effective partnerships with voluntary sector organisations. However, this will be worked through with each corporate priority area to ensure that it does not preclude delivery of other priorities.

Next steps

27. Over the remaining period to the end of 2018, the Taskforce will focus on the following improvement objectives:

A: Improvement actions to support improvement in public participation

28. We will continue to work with NHS England Oversight Groups to support actions to increase the quality of 13Q assessment forms and associated public participation activity, in support of the legal duty.

29. The Public Participation team will respond to feedback as part of the PPV Partners and chairs survey, including through provision of support, guidance and training to NHS England colleagues and PPV Partners themselves.

30. A dedicated programme of support is already in place to support public participation by CCGs and STPs / ICS', and this will continue to evolve during 2018/19.

31. There will also be work undertaken to develop the fourth indicator around NHS England's consultation processes.

B. Developing closer partnerships with the VCSE sector

32. Taking into account the analysis of our existing partnerships with VCSE organisations and the VCSE action plan, the Taskforce will develop detailed recommendations for NHS England to better embed ways of working with the VCSE sector, including a focus on governance, leadership, capability, and ways of working.

33. There are also opportunities to fully engage the VCSE sector in the new long-term plan for the NHS, in part through the proposed new NHS Assembly which, the Board paper noted, will build upon recommendations from the Empowering People and Communities Taskforce.

C. Supporting better empowerment of people and communities within NHS England priority programmes

34. The Taskforce will continue to work with other NHS England priority programme areas in a similar manner to the focused look at the cancer and mental health programmes to date. This will include a focus on the personalised care programme, on frailty, and on a further two topics to be determined.

35. This will further enable NHS England to demonstrate how it is learning from patient experience, engaging people across the strategic priorities, and working closely with the VCSE sector.

Recommendations

36. The Board is invited to:
    - Note the work to date of the Taskforce and the planned work programme for the remainder of the year;
    - Note the indicators in the public participation dashboard set out for the health and care system and for NHS England; and
    - Approve the priorities identified for improvement.

Author **Emma Easton, Head of Voluntary Partnerships and Neil Churchill, Director of Experience, Participation and Equalities**

APPENDIX 1

Public participation temperature check

NHS England consideration of 13Q duty applicability (services)

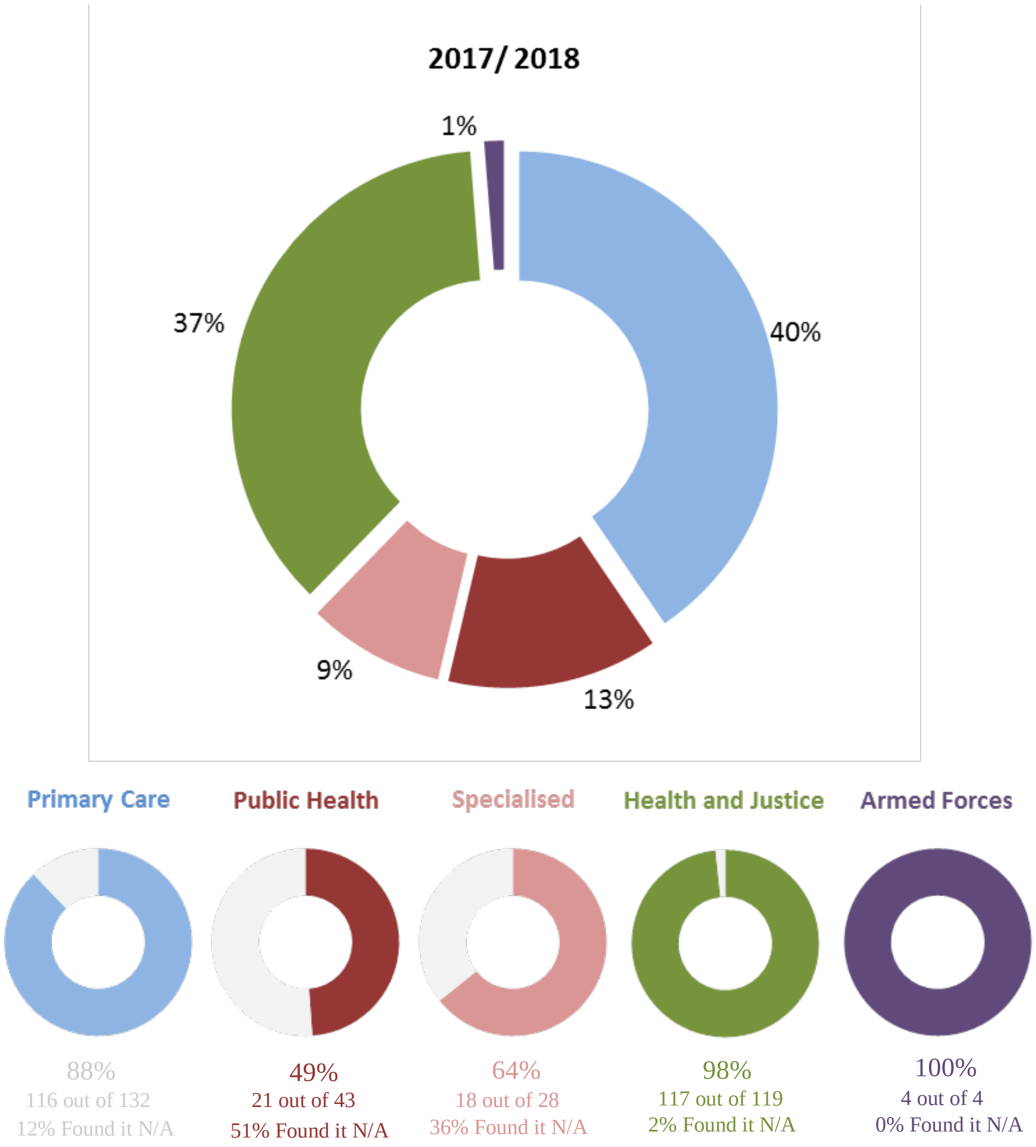


Figure One (above) shows completed ‘public involvement assessment forms’ by service, and decisions made about the ‘applicability’ of the 13Q duty.

NHS England consideration of 13Q duty applicability (regions)

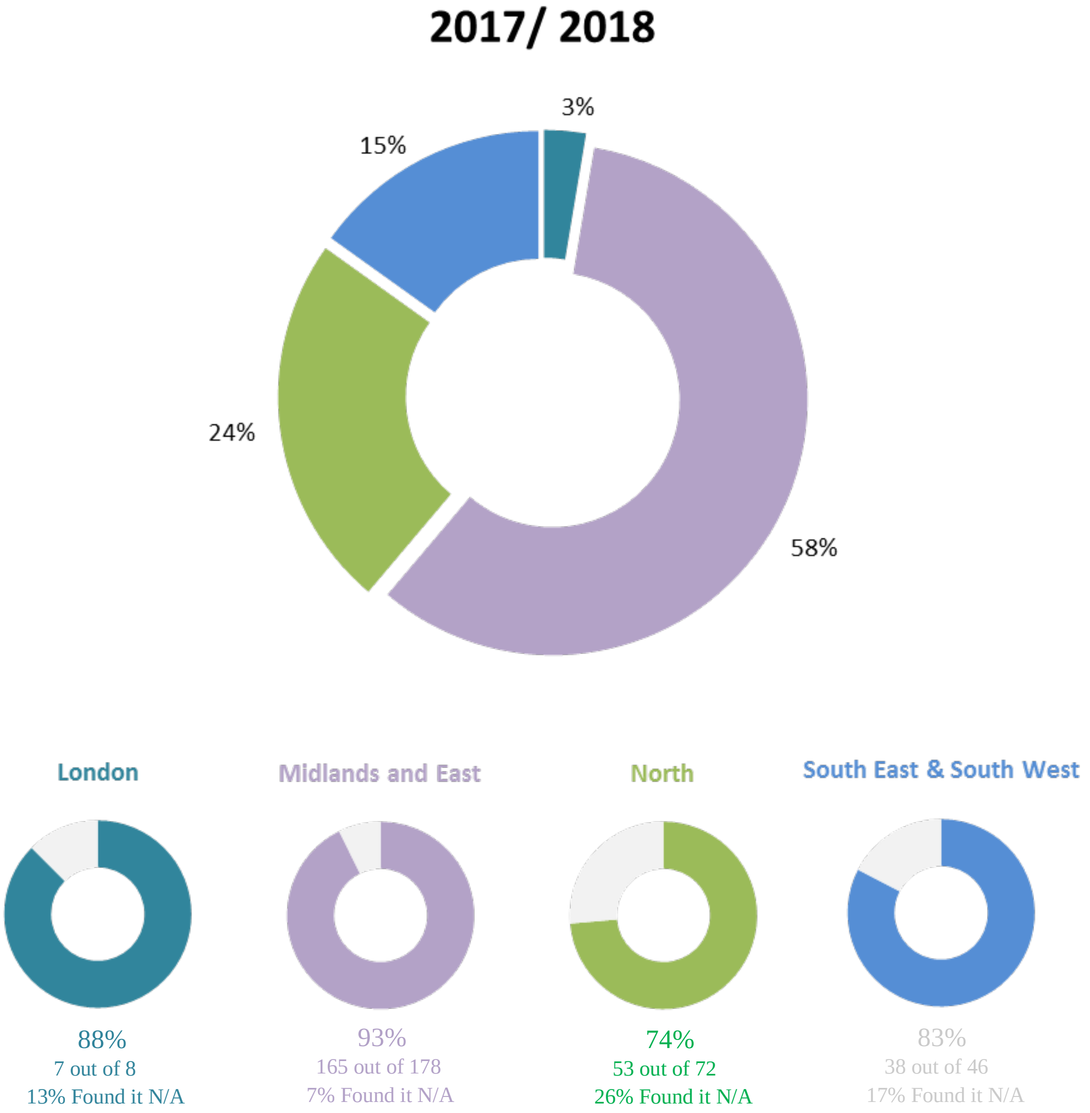


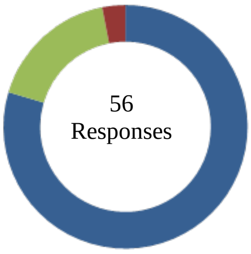
Figure two (above) shows completed ‘public involvement assessment forms’ by region, and decisions made about the ‘applicability’ of the 13Q duty.

PPV Partners’ and chairs’ experiences of NHS England

2017-2018

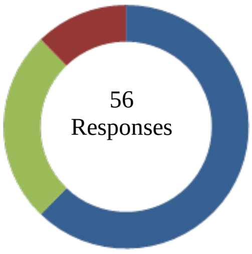
Responses from PPV Partners

Do you think NHS England values PPI?



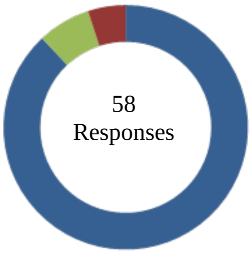
To a great or some extent 78%
Hardly or not at all 17%
Don’t Know 3%

Do you feel that your contribution as a PPV Partner has had an impact on the work area?



To a great or some extent 61%
Hardly or not at all 25%
Don’t Know 12%

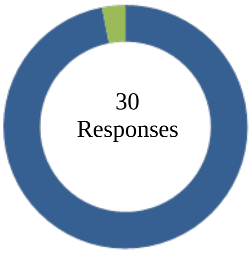
Does the committee you are part of value PPI?



To a great or some extent 88%
Hardly or not at all 7%
Don’t Know 5%

Responses from Chairs

Does NHS England value Patient and Public Involvement?



To a great or some extent 94%
Hardly or not at all 3%
Don’t Know 0%

Figure ‘three (above) summarises headline responses to completed surveys from NHS England’s PPV Partners and committee Chairs with PPV Partner members.

Consultations quality sample
Data from review and assessment of a sample of NHS England consultations to follow in future iterations

CCG compliance with 14Z2 statutory guidance

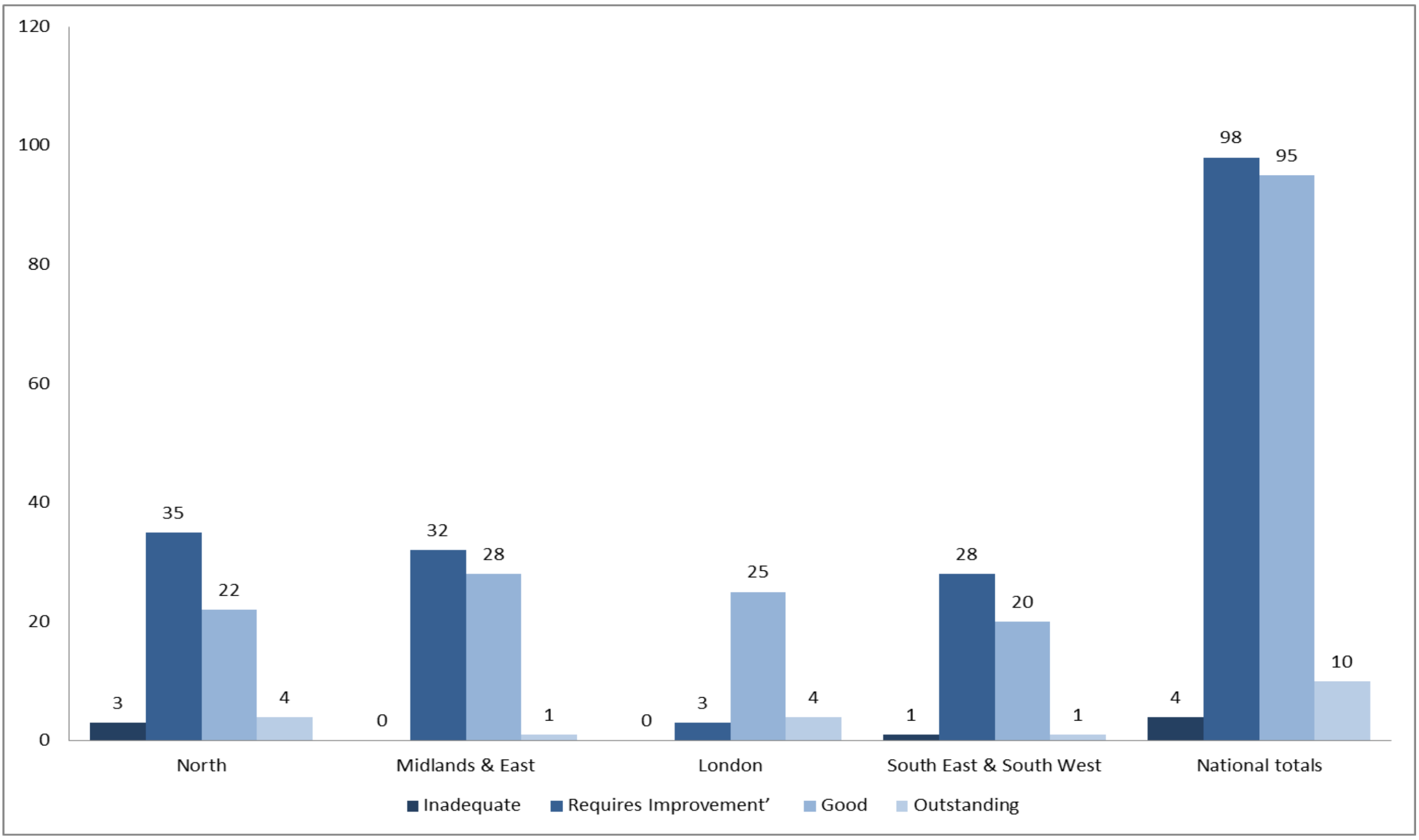


Figure four (above) shows overall scores for CCG public involvement by regions, based on the CCG Improvement Assessment Framework ‘engagement indicator’ assessment.

CCG compliance with 14Z2 statutory guidance

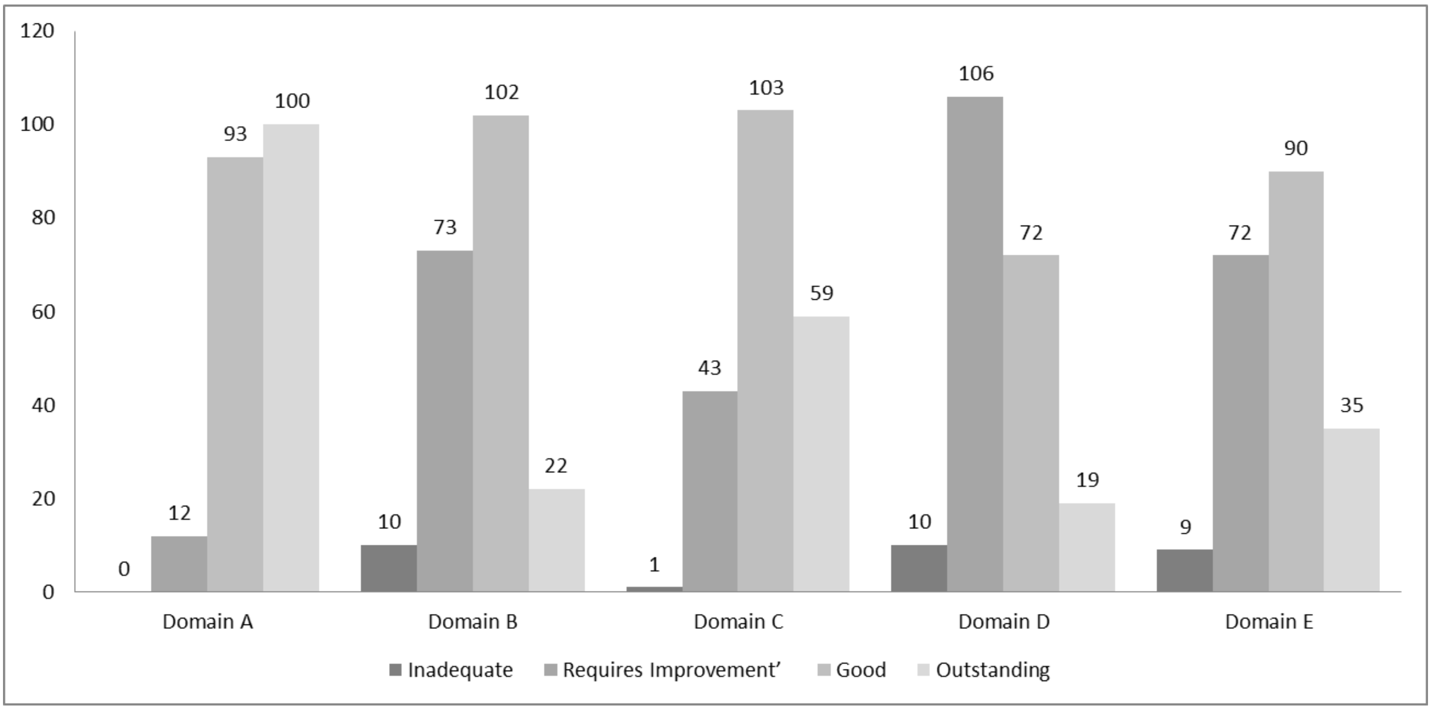


Figure five (above) shows overall scores for CCG public involvement by domain, based on the CCG Improvement Assessment Framework ‘engagement indicator’ assessment. The domains are: A: Governance. B: Annual Reports. C. Commissioning. D: Feedback and Evaluation. E: Equality and Reducing Health Inequality.

Local partner perceptions of CCGs

01.04.16 – 31.03.17

All Stakeholders (Except CQC)

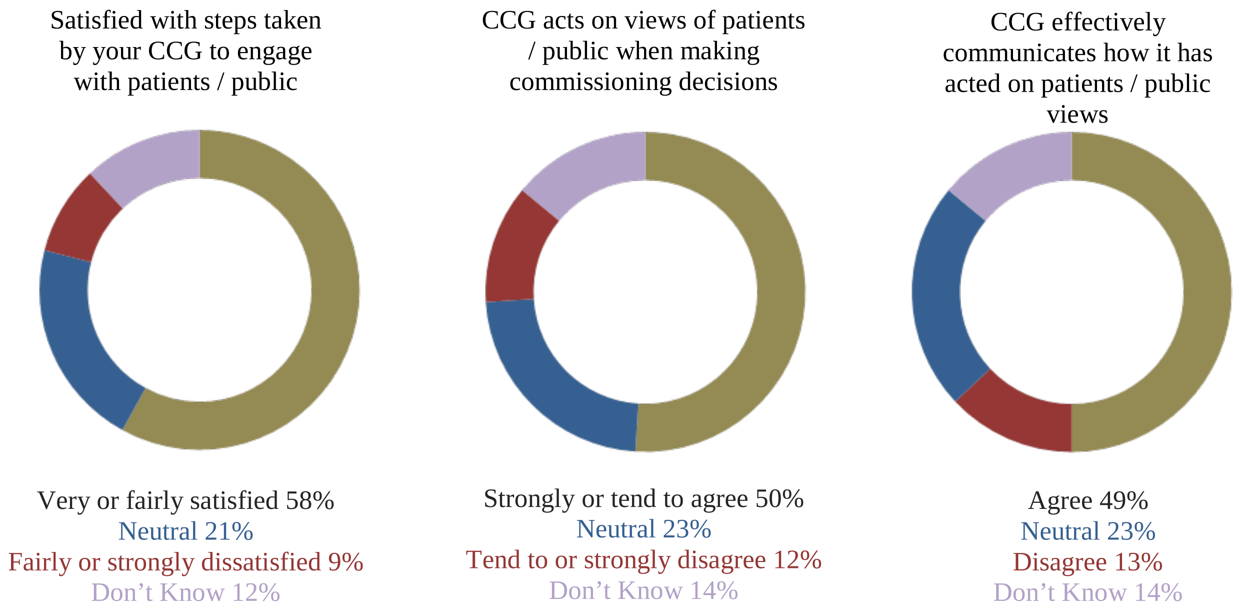


Figure six (above) summarises responses from all respondents to the CCG 360 survey to key questions relating to patient and public involvement.

Healthwatch and Patient Groups (Only)

Working relationship with their CCG

Good 84%
Poor 3%
Neutral or unspecified 12%

Engaged by their CCG in last 12 months

Engaged 84%
Not engaged 15%
Unspecified *% (less than 0.5%)

How their CCG has engaged them

Satisfied 78%
Dissatisfied 9%
Neutral or unspecified 13%

Steps taken by their CCG to engage with patients / public

Satisfied 64%
Dissatisfied 16%
Neutral or unspecified 20%

CCG acts on views of patients / public when making commissioning decisions

Agree 53%
Disagree 17%
Neutral or unspecified 30%

CCG effectively communicates how it has acted on patients / public views

Agree 49%
Disagree 21%
Neutral or unspecified 30%

Extent CCG engages with 'seldom heard' groups

Great deal 44%
Not much 33%
Unspecified 22%

Figure seven (above) summarises responses from local Healthwatch organisations and patient groups to key questions from the CCG 360 survey.

STPs emerging practice

Widening participation in the West Yorkshire and Harrogate STP

West Yorkshire and Harrogate ICS aim to widen participation across their whole footprint, using a number of engagement approaches including the development of a ‘people’s panel’, sharing patient stories at ICS meetings and developing their relationships with the voluntary sector. For example, an event in April engaged with chairs of patient and community groups to explore how they want to be involved and hold the ICS (then STP) to account, supported by the NHS England Public Participation team.

Another great example of this widening participation approach was the #selfcareeverywhere last July in Bradford. This was a multi-partner event and included young people, the then STP, Bradford Council, NHS England and others. 200 young people attended. The event showcased how working with young people can be fun, inspiring, informative and very effective in developing appropriate policies and delivering strategies. The themes developed with young people included exploring how young people can be involved with the NHS at a strategic level, crisis support, asthma and long term conditions, body confidence and wellness, mindfulness and dealing with emotional and mental stress. Impacts are still being captured but so far include:

- A ‘Happiness Champions in Schools’ pilot launched by one young person with plans to develop the scheme across his cluster of schools
- #freeourstreets, a new partnership project between young people, the University of Bradford and Bradford Council to tackle street harassment
- Training and development for the #selfcareeverywhere volunteers on a leadership programme

#selfcareeverywhere is now a brand and is being linked to other areas of work including Takeover Day and the self-care week in November. This is a great example of practice, learning and impact that NHS England is sharing with other STPs/ICS’ to widen the participation of young people across the country.

NHS England

APPENDIX 2

Letter from the Empowering People and Communities Taskforce to the Mental Health Programme

NHS England
Quarry House
Quarry Hill
Leeds
LS2 7UE

11th June 2018

Claire Murdoch, National Director,
Mental Health

Dear Claire,

Thank you for coming to the workshop on mental health organised for the Empowering People and Communities Taskforce. Our remit, as you know, covers the participation of patients and communities in decision-making, the quality of patient experience and partnership working with the Voluntary Community and Social Enterprise (VCSE) sector. We have been taking a new approach, looking at each of the NHS England priority areas in turn and inviting internal and external stakeholders to join us in these discussions. The Five Year Forward View for Mental Health was therefore of great interest to us, having been co-produced in partnership with over 20,000 people with mental ill health and involving 'experts by experience' in the development of all care pathway documents and service recommendations. My fellow Taskforce members and I are grateful for the time and effort invested in helping us understand what has been achieved and what ambitions remain to be delivered. We were delighted to see the passion you and your team displayed as well as the deep commitment to co-production shown by your team.

Diversity in Involvement & Co-Production

We were pleased to hear strong examples of co-production by the national team as well as by local providers and some commissioners. You clearly recognise the scale of the inequalities experienced by some groups, notably people from BME communities and people with severe mental illness, as well as the need to pay particular consideration to intersectional discrimination, arising for example as a result of people's sexuality, age and race. We noted that you have a number of initiatives in place to address this, such as peer mentorship, personal development and skills training targeted specifically at Black men in secure care. We were also pleased to hear about your planned collaboration with the Equality and Human Rights Commission on using behavioural insights to increase IAPT usage. We also heard that more needs to be done to strengthen the diversity of people and communities that we engage and we appreciate that you recognise this point. This is a common challenge for the NHS and not one by any means that is exclusive to the mental health programme. Nevertheless we face particular obligations in mental health, where disproportionate numbers of service users are from BME backgrounds and yet Black people can still report being the only Black face in the room when we engage service users and families, especially the further people go up our governance structures. The best providers have demonstrated the importance and effectiveness at engaging experts by experience and we need to replicate diversity at each level of decision-making, from quality improvement in services to commissioning. We would ask that you give further consideration to how we can ensure that we can demonstrate tangible involvement and influence over decisions at all levels by a diversity of service users and that this diversity in participation is maintained the higher up people go in our governance structures.

The importance of co-production was emphasised in the Mental Health Strategy and some particular perspectives emerged from our discussions about commissioners, who have an important part to play, both in demonstrating co-production themselves but also ensuring that proposals they consider have been co-produced before they are approved. We heard that understanding of co-production by commissioners is variable and that commissioning can still happen at a distance from service users. We hope that you can identify ways to strengthen co-production among commissioners as well as better support patient and public voice partners and grassroots VCSE organisations in the commissioning process.

Integration of Care

We heard about the work that is being done to ensure that our investment in priority areas by the mental health programme is securing care at the right time, in the right place and to the right quality standard, yet we have more to do to improve care at the boundaries between services. Patient experience is often poorest at these boundaries and your strategy clearly recognises the need to reduce barriers and improve care at transition points. Young people in particular indicated that more needs to be done here. We heard about the benefits of a more flexible transition from CAMHS to adult services, providing continuity of care up to age 24. We also heard from young people about the anxiety they can experience in transitions between school, university or training and employment and the difficulty in maintaining appropriate support. Other people raised the need to smooth integration in other areas, such as between physical and mental health care.

The development of Integrated Care Systems provides a valuable opportunity to join services up and improve user experience and we heard examples of this in practice as well as evidence from pilots that major reductions in use of acute services are possible if appropriate mental health interventions are available. This requires strong engagement with the local VCSE sector who provide many such interventions but we heard that this is patchy and some grassroots organisations reported either limited opportunities for involvement, short-term commissioning decisions that failed to recognise their contribution to preventative care or alienation with our paperwork, procedures and technical language. Again this is not a challenge distinct to the mental health programme alone, yet the VCSE sector has a particularly important role to play in mental health and wellbeing. We would welcome your thoughts on how we might strengthen the VCSE involvement in the work Integrated Care Systems are doing to deliver aspects of the Mental Health Strategy.

Data and Measurement

You very clearly articulated how the programme will invest in areas of care where improvements are most needed, which were themselves identified through feedback from service users, families and clinicians. A final theme of our workshop discussion concerned how we would know whether people’s experiences of care are improving as a result of this investment and whether any groups of service user are being left behind. We recognise that data about mental health services have improved significantly as a result of the new strategy but remain concerned about the availability of data from service users themselves, as opposed to activity data, and the extent to which any data sources can be broken down by protected characteristics, such as ethnicity. Data collected about the experiences of patients can provide rich insights yet compared with other priority programmes, there are limitations in the information we get from service users about how they access services and their experiences of care. We recognise that there are other ways of assuring quality, as well as data, and were impressed by examples of outstanding practice in embedding human rights and user voices in quality assurance processes, such as training services users in quality improvement and their involvement in quality circles. It would be helpful to understand better what data and other assurances we will achieve for services that have been prioritised by the strategy, such as CAMHS and maternity care and how we will know whether these programmes are narrowing inequalities as well as improving experiences for the majority.

Next Steps

We are required to report on the progress of the Taskforce to the Board and I would also like to ensure that we give feedback to those who attended either the workshop or engaged with us on social media. I would therefore be grateful if you could send me your thoughts on the areas I have raised above. Once again, I am grateful to you and your colleagues for helping us plan and deliver our workshop. I will be very interested to hear how you and your team felt the workshop went, so we can learn for next time.

Best wishes for the continued success of the programme. I would be happy to meet with you personally, if I can be of assistance in taking forward any of our suggestions.

Lord Victor Adebowale
Taskforce Chair
Non-Executive Director, NHS England