## 1. Are there specific aspects of existing, effective models of engagement through advisory bodies (national, regional or local) that we should draw on to develop the NHS Assembly?

*We think that the National Director for Diagnostics role is working. However, split role of National Cancer Director now confusing as to where the division of labour/influence/roles actually sit. Also, lack of transparency as to where NCD role interfaces with the board charged with implementing 5 year forward view.*

*NIODB – unclear as to its effectiveness at the moment but potentially links NHSE/I functions and has professional representation from all aspects and colleges. Advisory committees on various aspects of medicine e.g. breast cancer screening seem to play a useful function.*

*Relationships between 5 Year Forward View Implementation Board and CRGs for cancer (chemotherapy and radiotherapy especially) are unclear. On a regional level, the STPs and the Alliances / Vanguards are not co-terminus, so overall accountability for cancer care not clear.*

## 2. What should the purpose of the NHS Assembly be?

We believe that it is important for the Assembly to have a very clear and succinct stated purpose. The Assembly will be an advisory body and will not have decision making powers. We think that the Assembly's purpose should encompass:

- Discussion of progress on the later stages of implementation of the NHS Five Year Forward View to 2019.
- Discussion and advice on implementation of the new NHS 10 Year Plan

*If purely advisory, what will the implementation routes be?*
*We are concerned that advisory bodies can end up with no power or influence to change things and can be ignored (with no explanation) so unlikely this arrangement will have measurable outcomes. NHS bodies need teeth to deliver not just mouths for talking.*

## 3. What should the focus of the NHS Assembly's work be?

What should the priorities and balance be between advising on?

- Support embedding initial delivery of the Plan

- Helping to ensure coherence across the different strands of work
- Shaping the detail of the second 5 years of the Plan
- Working to progress enablers to underpin delivery

*Plan needs to be developed first and foremost – we believed that this was the primary remit of the Assembly but this question suggests otherwise? Further, the plan needs input & support from the whole NHS & needs to include social care. If aim is to give advice then assembly needs to have representation from all areas including social care / primary care / secondary care / CRGs and STPs, but if has no powers then what support can it realistically offer?*

*Can it be clarified if this is a new plan or the extant plan revised and updated in light of what has/has not been achieved?*

## 4. What should the Assembly's governance arrangements be?

We propose that the NHS Assembly should report to the NHS England and NHS Improvement Boards meeting in common.

*This seems sensible and would reduce duplication. Need to understand where the "advisory" role best feeds into in terms of the statutory bodies remit so that effective use of time made.*

## 5. What size should the Assembly's membership be?

We think that the Assembly should be large enough to encompass a broad membership but not so big as to inhibit meaningful discussion and consensus.

Should the core membership be relatively small e.g. no more than 50, or larger e.g. up to 100?

*Difficult to get this right. In basic terms, a larger assembly will be expensive & unwieldly, but a group of 50 is likely to exclude key stakeholders, potentially giving the impression of side-lining/ignoring particular areas/professions within the NHS. However, even an assembly of 50 are very unlikely to find consensus any major contentious issue – (i.e. still too large!).*

What challenges/issues do you see arising from a smaller or larger membership?

*As above. Need all stakeholders to be able to give their input, but whatever size the group is, effective chairmanship will be the key to garnering any reasonable output.*

Should the Assembly have wider participation in working groups in addition to the core membership?

*Core membership with wider more inclusive working groups may address some of the 'inclusion/exclusion' issues above and is likely to be more productive bring focus to the issue in hand. However, membership of multiple working groups may prove problematic for smaller specialties/staff areas that cover the spectrum of NHS delivery.*

*Indeed, if "extended" members are in working parties that could address the issue of representation, but these members will not have necessarily bought into the Assembly's agreed direction of travel. This could render contributions ineffective, or keep certain groups feeling marginalised.*

## 6. Which constituencies need to be represented on the Assembly?

We think that the Assembly should have a broad membership that covers as many key constituencies as possible, whilst recognising that it will not be possible to have every interested party to be members. We believe that the Assembly should include a mix of national and local system leaders from different sectors, including the VCSE sector, front-line clinical leaders and younger clinicians, and lay members from people who use services. The balance is likely to vary between constituencies.

Do you agree that the constituencies listed above should be on the Assembly?

*Yes*

What lay membership should the Assembly have and how should those people be identified?

*There is a difference between "expert patients" - recruited because they have used specific services e.g. surgery - and "lay experts" who have diverse experiences of the non-NHS world. The latter are by definition UK population, so are users of the NHS. We feel that memberships should not be solely sought from existing expert patient groups (although it might be useful to have some members from those groups). We recommend actively seeking to recruit from the general population – perhaps with the stipulation of them not using private healthcare, if we wish them to respond as NHS users. However, we concede that this is potentially contentious as private healthcare experience could offer a valid and valuable counterpoint.*

*Fundamentally, lay advisers from diverse backgrounds are needed.*

## What front-line clinical membership should the Assembly have and how should those people be identified?

*From all the professions. Need to include smaller specialties in order not to replicate the status quo of the current system that is driven primarily by medicine, surgery & general practice (+ mental health). Need to seek practitioners with proven leadership skills, but with different experiences rather than the usual dynamic listed above.*

## Are there other constituencies you would add (please list)?

*HR, estates, hugely influential in delivering flexibility of workforce & NHS infrastructure to support changes in delivery of the NHS over next decades*

## Are there any constituencies that should have larger representation on the Assembly (list up to 3)?

*Doctors*