Healthwatch Norfolk Trustee Board
22 July 2024
10:00 – 12:30

IN PERSON MEETING AT
Wymondham Rugby Club, Barnard Fields, off Bray Drive, Reeve Way, Wymondham NR18 0GQ

No.	Item **Items for Action (A), Information (I), Discussion (D), Presentation (P)**	Time	Mins.	Page	A,I,D
Part I – Public Board Meeting					
1.	Questions from the general public	10.00	5		**D**
2.	Welcome, introductions and apologies for absence (PP) - Formal welcome to Chris Lawrence – Chair of Queen Elizabeth Hospital, Kings Lynn				**I**
3.	Declarations of any conflicts of interest relating to this meeting (All)				**I**
4.	Minutes of the meeting held on 15 April 2024 and action log (attachment)	10:10	10	3-8	**A/I**
5.	Matters arising not covered by the agenda				**D**
6.	Chair report	10.20			**I/D**
7.	CEO Report – this will include a contribution from the Chair of the QEH in respect of the Group Model discussion	10:30		9-23	**A/I/D**
8.	QA Subgroup Minutes QF Update Risk Register (attachment) Health and Safety	11.30		24-28	**I/D**

	(Finance subgroup minutes in part 2)				
9.	Any Other Business – Please provide the Chair with Items for AOB prior to the Meeting's commencement	11.55			**I/D**
10.	Dates of future Board meetings • 14 October 2024 • 20 January 2025 • 21 April 2025				**A/I/D**

Apologies should be sent to Judith.sharpe@healthwatchnorfolk.co.uk, telephone 01953 856029

Distribution:

Trustees

Patrick Peal (Chair)	David Trevanion (Vice Chair)
Elaine Bailey	Linda Bainton
Vivienne Clifford-Jackson	Willie Cruickshank
Andrew Hayward	Christopher Humphris
Mary Ledgard	Christine MacDonald
Bridget Penhale	

For information:

Stuart Lines	Simon Scott
Ciceley Scarborough	Peter Randall
Stephanie Butcher	Rachael Grant
Mark Burgiss	Louise Smith

Healthwatch Norfolk Trustee Board Meeting Minutes
15 April 2024
9:30 – 12:30

In attendance:
Trustees
David Trevanion (DT) Vice Chair
Andrew Hayward (AH)
Chris Humphris (CH)
Elaine Bailey (EB)
Linda Bainton (LB)
Mary Ledgard (ML)
Vivienne Clifford-Jackson (VCJ)
Christine MacDonald (CM)
Bridget Penhale (BP)
Willie Cruickshank (WC) - online

Officers
Alex Stewart (AS) Chief Executive
Judith Sharpe (JS) Deputy Chief Executive
Emily Woodhouse (EW) Business Development Director
Caroline Williams (CW) Head of Engagement
John Bultitude (JB) Head of Comms and Marketing

NCC
Ciceley Scarborough (CS)
Stephanie Butcher (SB) – online

No.	Item	Action
1	Questions from the general public There were no questions from the public.	
2	Welcome, introductions and apologies for absence. DT welcomed everyone. Apologies had been received from Patrick Peal.	
3	Declarations of any conflicts of interest relating to this meeting There were no new conflicts not previously declared.	

4	**Minutes of the meeting held on 16 January 2023 and action log.** EB requested deletion of a sentence at No 8, first paragraph (commencing EB expressed concern…) BP noticed her initials had been quoted as BH in error. Otherwise, the minutes were agreed as an accurate record. ACTION LOG: No. 127 AS reported that the NFST Mortality Group was meeting monthly and going through the data in detail. VCJ asked if HW Suffolk were involved with the review. AS advised that HWS is not participating. CH said this was a shame and asked if this was due to a lack of trust with NFST. AS said, he could not answer for HW Suffolk. VCJ wished to declare an interest as a member of the Prevention of Suicide Forum and Mental Health Providers Forum. AS suggested, he and VCJ meet to discuss this further. ACTION AS arrange meeting with VCJ. No. 130 EW spoke about the issue of better understanding of ethnicity in demographic data collection – in particular the "make up" of "white-other". HW England had suggested referring to a London LHW, however EW felt we need to make our data collection work for us locally. CS said that NCC have had similar issues and would be happy to see if she can help with this. ACTION EW contact CS to progress this.	AS EW
5	**Matters arising not covered by the agenda.** VCJ asked if there were an update about the virtual wards/online consultation but AS said there was not. ML asked about planned publicity regarding the Willow Centre opening. AS confirmed, he has received the criteria for admission and will circulate it, but any publicity is likely to be after purdah. ACTION AS. There was a discussion about the value of therapy-led units. EB added that the NNUH virtual ward seems to be thriving but there is concern that the NCH&C virtual ward is not yet set up.	AS
6	**Power Bi Presentation – Siobhan Thompson** ST shared a presentation of the PowerBI dashboard she has created from the feedback that HWN receives. She showed how it includes data gathered since 2015 and includes feedback received online and face-to-face, also data about helpdesk responses to signposting enquiries since 2022 (email and telephone). The feedback can be looked at by topic area (e.g. dentistry) and project summaries are included. ST explained that this is only available internally at this stage but that we are investigating ways to share externally without all	

	users having to have a PowerBI software licence. AS said, he was keen to progress this so we can share the information with colleagues at NCC and ICB. CS confirmed this reflects a commonality of approach with NCC and ICB and is a great way of presenting and understanding data. CM wished to formally record in the minutes that this is a brilliant piece of work and thanks go to ST for her hard work on this. AS also wished to record his thanks to ST for her work on this but also for HWN since 2018 as she shortly moves to a new position at UEA. There was a discussion about ensuring the information is looked at and to try and see beyond what is present to find what is missing and what topics/areas are not commonly looked at.	
7	Chair report. There was no Chair report.	
8	CEO Report AS said, he would take his written report as read. AS spoke about a formal letter of complaint received last week from Blakeney Parish Council in which HWN is accused of not acting in an independent way regarding the proposed closure of the surgery there. AS was comfortable that HWN has acted independently and in fact went "above and beyond" to provide opportunities for the public to have their say on the issue by supporting both the parish council and also the surgery with survey distribution and feedback gathering. AS spoke about how HWN staff were physically confronted and treated with hostility by members of the public at the meeting held when the hall was full and people had to remain outside. AH and EB both spoke about the challenge of Chairing such public meetings when opinions are strong and HWN is not necessarily recognised as being the impartial arranger of the meeting. AS said that there are likely to be similar requests for future surgery closures and he will be discussing this with the ICB to see if the process (AH confirmed there is a lengthy prescriptive process) can be improved as there seem to have been some lack of clarity from the ICB and slow reactions at times. ACTION AS discuss process with ICB. VCJ picked up the issue of how our staff were treated and suggested this needs adding to the risk register. ACTION JS CW confirmed that staff mostly do public engagement in pairs and are instructed to walk away/leave if they are experiencing aggressive behaviour.	AS JS

	AS spoke about the NCC MIG (Minimum Income Guarantee) Consultation. There had been a request for the consultation to be extended beyond May 17th, but this had been declined. AS said that 37 invitees will be attending the Partners/Stakeholders Meeting at Sprowston Manor on 2nd May. There was a discussion about the volume of appointments in health not being attended (DNA). EB asked how the numbers compare pre and post Covid. AS will try to find out. ACTION AS EW gave a summary of active projects and proposed new projects. EW spoke about HWN being asked to add Waveney back into our Community Mental Health Transformation project (with additional funding) as HW Suffolk had declined to do the work. HWS have full awareness that HWN will be undertaking the work and we have their consent to do this and they have agreed to promote the survey for us. EW spoke about staff changes in her team in recent months and EB asked if this is of concern to EW. EW said that she felt it will be Ok and that the engagement team can be called upon to help and also individual consultants if necessary. CW reported that the engagement team are completing a 5-week period of engagement visits to care homes. 16 homes have been visited so far and feedback reports are in the process of being written up which may be helpful to the homes for CQC inspection purposes. Future engagement events planned include PRIDE events, a Diabetes Day, Dementia Carers event, SEND festival as well as GP practices, libraries and other community events. Engagement with 7–11-year-olds is being planned for September. Currently awaiting the FLOURISH survey results to see if that dictates the topics we will focus on. Also looking to link with the Fire Service "Crucial Crew" to help with the young people engagement. CH asked if future engagement might look at the efficacy of Mental Health and wellbeing services available for young people. CW spoke about poor feedback being received from patients of East Harling surgery. This has been escalated to Sadie Parker at the ICB. HWN has been undertaking engagement in the location and this will be written up and shared with the ICB. JB spoke about the planned Dental Summit event in September (19th) which seems to have already attracted media interest. JB said that the new website is now live. NCC have helped with advice about accessibility and there is still more to be done in this regard. JS wished to record thanks to JB for his hard work over several months to get the new website up and running.	AS

	JB advised that HWN is working with the ICB regarding the closure and future use of premises of Benjamin Court in Cromer. This will include some community engagement in North Norfolk and a survey circulation.	
9	QA Subgroup & Projects update (DT & EW) EW referred to the QA Action Log: No 29. JSp will lead discussion on multi-year project at the next QA meeting. No 25. EW will take forward this outstanding action as part of the NCH&C engagement project. DT said that No. 33, regarding future Chair of the QA Subgroup, would be discussed in Part 2 of the Board meeting.	
10	Finance, Risk Register, Quality Framework and Health and Safety update JS referred to the Finance Subgroup action log: Nos. 60 & 67 are still in progress (AS and JS/EW) with the transition to Xero accounting software from this month intended to help the tracking of project costs. No. 79 Revised Terms of Reference of the Finance subgroup and Financial Standing orders policy had been shared in the Board papers and were accepted and agreed. In future the budget will be approved by the full Board and not just the Finance subgroup and this might require email approval with a maximum 2-week response time. The Risk Register had been updated to reflect current activity and mitigations but there were no changes in scores or new additions. VCJ reiterated that the issue of public aggression to staff should be added within the People section. EW added that this should also include consideration of long-term mental health projects on staff. ACTION JS There were no items relating to Health and Safety to report. JS advised that a meeting was to be held today with EB, AS and JS to discuss the next steps for taking forward the Quality Framework – following the summit held last month. EB commented that it would be good to ensure the Power BI dashboard information feeds into future QF activity.	JS
11	Any Other Business AS spoke about Trustees being able to express their wishes on their involvement in different aspects of HWN work. It was suggested that a skills audit should be completed which would also help in future Trustee recruitment. JS ACTION	JS

	EB asked about the progress of the Pay Policy Review group. JS said that meetings were being held every 8 weeks and that the consultant has produced an example policy for review with fewer pay bands and grades for the groups' consideration at the next meeting. The consultant is also reviewing contracts, policies and the staff handbook. JS is in the process of writing a simple Terms of Reference for the group. CS thanked HWN for the excellent work done last year on NHS Health checks. CS said that there has been significant improvement in NHS Health Checks numbers - both offered and delivered. So much so that Norfolk for the last quarter data now performs first in the Eastern Region and 9th Nationally, and there has been a recent case study published by the LGA. Getting under the bonnet: Implementing the NHS Health Check | Local Government Association CS also reported that Kings Lynn Borough Council, the ICB in the West and Public Health are working together with the institute of Health Equity (Director of IHE at UCL is Prof Sir Michael Marmot) for West Norfolk to become a Marmot Place – the work will take place over the next 2 years and will provide a system wide focus on health inequalities and what can be done to reduce them, with learning for the rest of Norfolk from the approach to be shared. CS also mentioned the recent Director of Public Health's annual report which focuses on smoking in Norfolk and this being a key area of work for Norfolk with 12% of the population smoking compared to 8% nationally.	
12	Dates of future Board meetings • 22 July 2024 (and AGM) • 14 October 2024 • 20 January 2025	

Part 1 of the meeting ended at 11:42

Date	22 July 2024
Report to	Healthwatch Norfolk Board
Report by (name and title)	Alex Stewart, Chief Executive
Subject	CEO Report

1.0 Reason for Report

The purpose of this report is to provide Board Members with a range of Information on matters which are pertinent to Healthwatch Norfolk. The report is in a new format and will be providing "headlines" in relation to the following: -

- Priorities in the next quarter & issues arising
- Financial Savings within the NHS
- Group Model
- Health and social care system news
- Projects update
- Engagement, feedback and impact tracker update
- Communications

2.0 Priorities in the next quarter & issues arising

QEH Youth Council –

Young people aged 16 to 25 are getting the chance to have their say on what happens at the Queen Elizabeth Hospital in King's Lynn.

It is setting up a Youth Council which will ensure the voice of young people is heard by decision-makers at the hospital and members can also update their friends and communities about what is happening there.

The group will set their own priorities, work closely with departments in the hospital, and be a crucial new way of boosting the links between the QEH and the local community.

The project launched on the 9th July, the hospital will be partnering on the project with Healthwatch Norfolk. A recruitment campaign will run across the summer with the Healthwatch Norfolk team visiting schools, colleges, and community events to encourage new members to sign up.

Anyone interested in finding out more and signing up for regular updates can log onto www.teamqehyouth.co.uk

During the early autumn, the first fifteen youth council members will be selected.

They will then meet every six weeks and decide on the first areas to focus on.

Youth council members will not get paid as this is a voluntary independent role, but they will be reimbursed for their travel and other expenses relating to their role.

Alice Webster, Chief Executive of the Queen Elizabeth Hospital considers that it is important that we make sure we are hearing from the young people in the communities that the hospital serves. Their ideas, suggestions and connections are so important to us all in terms of continuously improving the care we give and helping us shape our new hospital.

The Council will be open to anyone aged 16 to 25; it will provide a fantastic opportunity to find out about healthcare opportunities, as well as other areas of employment, e.g., IT, maintenance, portering, administration, logistics, and communications.

Antonia Hardcastle, the hospital's Lead Governor considers that the Youth Council will be vital in helping us understand the issues, concerns, ideas, and views of the younger members of the communities cared for by the Queen Elizabeth Hospital. Being part of the Youth Council will also be a useful springboard into further education, apprenticeships, or work.

The recruitment campaign and the first year of its operation will be overseen by Healthwatch Norfolk. It fulfils one of Healthwatch's core role's, i.e., ensuring the voices of the community help shape the care people in the county receive. Working with the hospital team will help to embed that vital feedback into its work and help gather those all-important voices from the local community.

NCH&C Willow Unit Project –

The unit is set to be up and running by the end of August. A temporary site is being used to accept patients and initial outcomes are looking extremely positive with an average length of stay being about 7 days as opposed to 14. Initial

feedback from patients and carers suggests that the extra rehabilitation has made a significant impact on their long-term goals.

Blakeney Surgery – **Key operational considerations** for possible new sites for medication collection**:**

- Accessibility – is it possible for disabled or less able bodies patients to access the site?
- Parking – is there enough parking within a reasonable distance of the site?
- Public Transport – is it near a Coasthopper bus stop?
- Space – is there enough for a storage cabinet, a member of staff, a desk/counter, a fridge?
- Utilities – is the site connected or can it easily become connected (as it would need lighting, electricity, and possible temperature regulation)?
- Facilities – is there a toilet? Can they make a hot drink?
- Security – when unmanned, is the room/site lockable and secure?
- Possible Opening Hours – will depend on the site and resources.

Useful Information for sites considering this opportunity:

- The current medication collection service operates 8am – 1pm, Monday to Friday.
- On average, there are 35 patients visiting/collecting a day.
- The following expenses would be reimbursed:
    - Rent (up to £9k p/a)
    - Equipment (such as storage cabinets, fridge, desk and chair)
    - Any agreed enhancements to security/facilities the site might require.
- Opening Hours – do not need to mirror the existing times or days. For example, the new site might prefer to open 9am – 12pm, Mon, Wed and Fri.
- We anticipate that at least one day a week (for at least the first 6 months) will be manned by a member of staff from HMP.
- We are hoping that the new site's existing personnel will eventually staff the service in combination with a team of local volunteers. Initially, and until the new site is established, Surgery staff will continue to staff some of the hours/days at the new site.
- HMP will provide everyone with any necessary training.
- There will be a direct way for the site to communicate with HMP during opening hours.
- There will be enhanced confidentiality measures in place (as collections are happening outside of the Surgery building) to preserve/enhance patient confidentiality regarding the medication they are collecting.

Learning from Deaths Action Management Group –

Doctor demands overhaul of NHS psychiatric care after brother's death https://www.theguardian.com/society/2024/mar/31/doctor-nhs-psychiatric-care-brother-death?CMP=share_btn_url

Following this article, I wrote formally to the Action Management Group as a collective - the gist of the email is set out below:

> I have attached an article that was in The Guardian over the weekend – I shared it with xxxx and it got the pair of us thinking about the work of the Mortality Review Group and how such a brutally honest narrative could perhaps help us in looking forwards and determining an approach that could be beneficial to relatives and patients along with possibly preventing a future death.
>
> I trust that you will agree that the article is very well balanced and, coming from a professional does not try to deflect blame etc. It is more about seeking to address many of the issues that colleagues working in the system face on a daily basis and maybe too "afraid" to articulate; it is also something which successive governments have failed to address with mental health services and they still remain the poor relation.
>
> XXXX and I were reflecting on the need to understand the number of serious cases awaiting a bed, and whilst waiting, what safeguards are in place to best ensure that someone is being kept as safe as possible whilst being exposed to the vagaries of remaining in the community.
>
> Many of you will be aware that Healthwatch is currently working on a three-year project with carers of SMI – we need to see how we can also ensure that the Mortality Review Group and the SMI group remain integral to each other whilst maintaining their respective independent briefs.
>
> We would like to propose that there is a specific standing agenda item which enables discussion to understand the issues outlined above. If you consider that this is the wrong forum for this to be discussed, please tell us how this issue can be looked at – all of us are trying to prevent deaths, sometimes they cannot be avoided but where there are systemic failures in the system across the country, we have a duty to ensure that the voices of Norfolk and Suffolk are heard.
>
> The email was originally sent on the 2nd April 2024; I contacted the CEO of NSFT and requested that a formal response should be provided to

Healthwatch and whilst she responded immediately, I still await the completed formal response from the original recipient of the email.

3.0 *Financial Savings within the NHS*

The Queen Elizabeth Hospital King's Lynn has a cost improvement programme of nearly £30m in 2024-25, equivalent to 9 per cent of spending, which is three times higher than the amount it delivered last year.

Trusts and commissioners were last month issued with new financial targets as NHS England attempted to bring down a £3bn forecast deficit for local organisations.

Other trusts with high levels of planned savings include Portsmouth Hospitals and Isle of Wight, on 7 and 8 per cent respectively; Oxford University Hospitals on 6 per cent, and the provider group covering Hull University Teaching Hospitals and Northern Lincolnshire and Goole, where board papers say the 6 per cent target is the "highest requirement ever for both trusts".

East Kent Hospitals, which recorded a deficit of more than £100m last year, has set itself a £49m cost improvement programme. This appears to be roughly 5 per cent of costs but is more than three times the £13m achieved in 2023-24.

Elsewhere, a trust executive in the North of England said they had been offered extra funding in exchange for upping their efficiency target to a "ludicrous" figure. They asked to remain anonymous.

In the years before covid, the average annual savings planned by providers were around 4 per cent, but repeatedly fell short of those levels. Since the pandemic, trusts have relied on one-off accounting flexibilities which are now running low.

A message to QEH King's Lynn staff from chief finance officer Chris Benham earlier this month, seen by *HSJ*, said: "Along with many other NHS trusts, we have a large financial challenge ahead. The scale of our challenge at The QEH is a cost-saving of £29.5m between April 2024 and March 2025.

"This is a 9 per cent efficiency target – increasing from the previous 8 per cent we communicated to you last month. This is because there is a national ask for all trusts to be in a financially affordable position. It is currently cost[ing] us £867k a day to run the hospital. We need this to reduce by £80k a day."

The trust is also reviewing vacancies, temporary staffing rates and overtime payments for existing workers, the message said.

A spokeswoman told *HSJ* the trust had already identified three-quarters of the £30m and said, "we believe that there are further efficiencies in our system, which would see us go further than the 3.1 per cent achieved last year."

She added: "All cost-saving initiatives go through a robust process to make sure that they will not impact patient safety or clinical care provided by the trust."

Healthwatch must keep alert to the fact that such savings could potentially impact on patient safety and quality of care. If this were to occur at any of the Trusts, it would be a retrograde step and potential have major ramifications for successful patient outcomes.

4.0 *Group Models* - What is the NHS hospital group model?

The term 'group model' can be applied to a range of different organisational forms. It can be applied to a single provider that creates internal divisional or management units, for example to manage several sites or services, such as Barts Health NHS Trust operating a group model for its four major hospital sites.

The Model Health System is a data-driven improvement tool that enables NHS health systems and trusts to benchmark quality and productivity. By identifying opportunities for improvement, the Model Health System empowers NHS teams to continuously improve care for patients.

What is the NHS model of change?

Change Model

The model, provides a useful organising framework for sustainable change and transformation that delivers real benefits for patients and the public. It was created to support health and care teams and organisations to adopt a shared approach to leading change and transformation.

Resourcing Collaboratives

Provider collaboratives are developing across the country. While some have existed for several years in a range of formal and informal arrangements, others have formed recently in the context of the national policy direction and the experience of mutual aid during the pandemic. Whether establishing new collaborative arrangements or evolving existing ones, trusts have needed to address some common tasks associated with developing and progressing a joint programme of work, including establishing their membership, scope and priorities; agreeing ways of working; and setting up governance and decision-making arrangements.

Some collaboratives bring together a group of trusts of the same sector. Examples of this approach include the Acute Hospitals Alliance (AHA) which is made up of the three acute trusts operating across the Bath and Northeast Somerset, Swindon and Wiltshire ICS. Similarly, there are well established collaboratives in mental health and learning disability services – for instance, the South London Mental Health and Community Partnership has supported collaboration between three mental health trusts in south London since it was established in 2016.

Other provider collaboratives bring together all the trusts within an ICS footprint – for instance North Central London ICS has an 'all in' collaborative, known as a provider alliance or the 'UCL Health Alliance'. Some at scale collaboratives have memberships which reach beyond the statutory trust sector, for instance including voluntary sector providers and social enterprises as formal delivery partners. An example is the West Yorkshire community provider collaborative, which includes Leeds Community Healthcare NHS Trust and two community interest companies: Locala Health & Wellbeing and Spectrum Community Health.

In some systems, collaboratives – particularly NHS-led mental health provider collaboratives – have a wider membership beyond the provider sector, including commissioning/planning bodies (such as ICBs) and they are starting to move away from the provider collaborative terminology to reflect this. For example, Northamptonshire ICS is working through four collaboratives, each of which has a thematic focus either on a cohort of service users (e.g. children and young people) or a group of services (e.g. mental health, learning disability and autism). In addition, provider collaboratives are looking to develop relationships with wider

system partners, including local authorities, primary care and place-based partnerships, to ensure priorities and delivery are aligned, and developed with people and communities.

There are some collaboratives which span several ICSs or regions. Some of these focus on services which benefit from being planned on larger footprints and delivered to larger populations, such as specialised services and ambulance care. For example, the East of England specialised services provider collaborative spans six ICSs and includes seven acute and specialist trusts across the region. Provider collaboratives will also need to work closely with ICS- and multi-ICS level clinical networks, building on established relationships and forums to develop clinical strategies and support service redesign and improvement.

There is flexibility in the national policy framework for trusts to develop collaborative arrangements that make sense in their local context, and as a result collaboratives vary in the form they take. Trust leaders have been concentrating on shared priorities, which will then shape the structural and governance arrangements underpinning the collaborative.

National guidance highlights three main governance models for collaboratives:

Lead provider. This model involves a single trust holding a contract with a commissioner and sub-contracting with other trusts in the collaborative to coordinate service delivery and improvement. In some cases, a lead provider may use its existing governance arrangements to support decision-making within a collaborative. For example, Devon Partnership NHS Trust is the lead provider for the Southwest Provider Collaborative, a mental health partnership including several trusts, independent sector partners and community interest companies to improve specialised mental health care.

Shared leadership. This model involves multiple trusts appointing a single person (or group of people) to fulfil key leadership roles across the collaborative – particularly the chief executive role – while maintaining specific leadership capabilities for each member trust within the group. This approach is used in the Foundation Group in the West Midlands where three trusts – South Warwickshire NHS Foundation Trust, Wye Valley NHS Trust, and George Elliot Hospitals NHS Trust – operate with a shared chief executive and chair and have a committee in common governance arrangement.

Provider leadership board. This model involves senior leaders from participating trusts establishing a joint forum to shape a collaborative agenda. The joint forum may operate with delegated authority to take decisions for the member trusts. West Yorkshire Association of Acute Trusts is an example of a collaborative operating in this way.

These three models are not mutually exclusive; a trust could be part of more than one provider collaborative arrangement each with different priorities or delivering its own programmes. Additionally, some trusts are deepening their collaboration through other approaches based on what makes sense in their local geographies. For instance, in Somerset ICS the trusts have opted to pursue a full merger to maximise opportunities to bring their services and capabilities together.

Looking ahead, the ambition is for provider collaboratives to play a central role in delivering service change and improvement within ICSs. National bodies have suggested that to play this role, it will be important for collaboratives to have certain capabilities. For example, the Act enables collaboratives to take on functions and budgets from ICBs via delegation, where appropriate (although NHSE does not expect ICBs to implement delegations in 2022/23). The Act also allows trusts to come together via a joint committee to make legally binding decisions which some provider collaboratives are considering adopting. We understand that NHSE plans to set out some more information on how provider collaboratives could relate to ICBs in the future, including via delegations.

Thoughts from the Kings Fund

In order for Group Models to work, The Kings Fund consider the following to be important principles to continually bear in mind:

- Develop a shared vision and purpose: this requires a shift from a reactive problem-solving mindset to creating a positive vision of the future built around the needs of local populations
- Organisations must have frequent personal contact: face-to-face meetings enable leaders to build rapport and understanding and to appreciate and acknowledge each other's problems and challenges
- Organisations must enable conflicts to surface and be resolved: this depends on leaders' ability to recognise conflicts, work them through and create the conditions in which it is safe to challenge

- Organisations must behave altruistically towards each other: to work together in a collaborative way, leaders need to move away from a traditionally competitive style and to focus on the bigger picture
- Organisations must commit to working together for the longer term: leaders need to invest time and energy in forming effective long-term relationships and to resist the pressure to focus on the immediate, transactional issues.

The Board need to reflect and consider the stance Healthwatch should adopt particularly in relation to keeping the public informed and look at identifying appropriate ways to ensure that there is effective engagement between the Trusts, their respective workforces and the general public.

5.0 Health and Social Care News

Report back on Amanda Pritchard Speech at the NHS Confederation Conference

A "startling" change to system working along with other opportunities means the NHS can succeed where it failed in the past to shift more care into the community, the NHS England chief executive has claimed. *Source HSJ*

Speaking at the Confed Expo Amanda Pritchard declared her ambition to make the NHS "the fastest improving health system in the world". She said that by incentivising community services, the NHS could improve patient care, shift demand away from the acute sector, and deliver better value for money.

The other key "opportunities", said Ms Pritchard, were presented by the long-term workforce plan and the greater use of technology, especially the NHS App. Healthwatch Norfolk are working with the ICB to actively promote the NHS App.

Incentivising community care

Ms Pritchard considers that the service needs to both "grow" and "do things differently", starting with the "bedrock of the NHS", primary care.

The "GP workforce" will need to grow and "in some parts of the country faster than others", she acknowledged. However, the 2022 Fuller Stocktake has provided a much-needed "modern vision for primary care".

Pilots across seven integrated care boards designed to deliver the stocktake's goals of "streamlined access to urgent care or advice, and proactive,

personalised care for patients with long-term needs" would soon produce results that would be "integral to the future of the NHS", she said. HealthWatch Norfolk are actively working with representatives at a national and local levels to see how we can help "orchestrate" a shift in approach. Further updates will be provided at future Board Meetings.

Ms Pritchard said: "Our ambition is to be the fastest improving health system in the world, so improvement has to be everyone's business."

To achieve this, she said: "We're doubling down on our work through NHS IMPACT to support delivery of clinical and operational excellence, with a clear focus on our biggest challenges, [and] supporting both better care and productivity."

In a reference to the improvement body set up by the last Labour government, Ms Pritchard said NHSE was "learning from the successes of the Modernisation Agency" and it would be soon "setting up improvement collaboratives and networks".

She also stressed the importance of boards "having the right information, whether that's up-to-the-minute operational data from within the organisation or evidence and best practice from outside".

In another reference to an NHS initiative undertaken with the last Labour government, Ms Pritchard said NHSE was "learning from the successes of the past [projects] like [the] Intelligent Board guides, and from those organisations which are already doing this. NHSE have been working across organisations to try and pull together the best practice, evidence and ideas to shape how all organisations including NHS England use the information available to better deliver for patients, communities, and staff. In summary:

Change contracts and incentives to support community care; acknowledge previous attempts "didn't stick" but there is now the opportunity to make it work and have a modern vision for primary care needed and ensure that the GP workforce is enabled to grow.

6.0 Projects

Projects Update

Projects Published April – June 2024:

- Prior to Purdah, the organisation didn't publish any reports in April or May. As a result of purdah, we have been unable to publish reports during this period. This means that there will be a backlog of reports to be published in the next quarter and care will be taken to prioritise these to have the biggest impact.

Projects in progress

- Purdah has also had an impact on our ability to promote active projects that could be politicised in any way, e.g. The Community Diagnostic Centre project with JPUH. The promotion of this project will commence w/b 8/7
- Digital Tools Evaluation in Primary Care (year 3/3), awaiting publication delayed by Purdah.
- QEH Governors and Youth Council (Year 1/2), outstanding school/college visits, QEH Youth Council to launch 9/7/24.
- Carers of people with Serious Mental Illness (year 1/3), report awaiting commissioner response, publication expected July/August.
- 65+ Experiences of Adult Social Care (Year 1/3), report awaiting commissioner response, publication expected July/August.
- HIE Focus Groups about how people's data is used. Project complete.
- Mental Health Community Transformation Evaluation in Norfolk (Year 3/3), in analysis and write up.
- Mental Health Community Transformation Evaluation in Waveney (Year 3/3), in data collection, to be published Winter 2024.
- NCH&C Transformation Engagement (Year 1/3), in data collection, to be published November 2024
- Marie Curie Survey Promotion, actively promoting survey.
- Digital Tools Evaluation in Primary Care (year 4/6), in project planning.
- ICB Community Voices, Lung Health Checks, in development

Prospective Projects

- A bid was submitted to Morrisons Foundation to engage with people in Great Yarmouth. This was rejected.

- Discussions are taking place with the ICB to potentially roll out Health Inequalities training with professionals. This training has already been successfully tested with some practices.
- Discussions have taken place with Caring Together re some engagement with young carers to identify the challenges they face.
- A bid will be made to National Lottery to fund a new CRM system, some initial work needs to take place, involving the Information and Signposting Officer to engage with the public around what a good feedback centre looks like.

News from Project Team

- Rhys Pugh has joined the team 9/7 as Information and Signposting Officer (previously named, Information Analyst).
- John Spall has published a paper in relation to his work with people with LD and autism in residential care.

7.0 Engagement, feedback and Impact Tracker Update

From April – June 2024 we have received **721** reviews about **103** different services, compared to last quarter of **251** reviews about **62** different services.

Type of service	Number of reviews	Average star rating (out of 5)
Care Support	7	5
Pharmacies	15	4.8
Hospitals	87	4.3
Adult Residential Care	50	4.1
GPs	529	4
Community Services (NCH&C ECCH)	4	4
Adult Social Care (NCC)	5	3
Opticians	2	3
Mental Health Services	3	2.2
Dentists	17	1.8
Urgent Care	2	1

We produced 20 engagement reports for individual **care homes** and one combined care home report, which can be found here https://healthwatchnorfolk.co.uk/reports/experiences-in-norfolk-residential-care-homes-may-2023/

Examples of some actions taken by homes in response to our reports:

- Introduction of individual milk jugs for those who want it for breakfast cereal and introduction of a hot option in the evening which they did not do before.
- Another home researched different options to limit the noise of the call buttons, especially at night, and is getting pagers installed instead.

We have produced 13 individual **GP reports**.
Long waits on the phone at GPs surgeries to get appointments continues to be a frustration, although a couple of surgeries have introduced a call back function which has had a positive impact. Once people get appointments most people are happy with the level of care they receive.
We continue to hear worrying experiences about **East Harling and Kenninhall surgery**, this has been brought to the attention of the ICB and the CQC.

We have had a total of 64 signposting enquiries. **Dentistry** continues to be the topic we have the most enquiries about.

The engagement team is currently working on a delivery plan to engage with year 6 children as part of the NCC funded Crucial Crew coordinated by the Norfolk Fire service in 2024-25. We have enlisted two local schools to involve their year 6 pupils to help develop and pilot our session. This initiative has the potential to reach 1000 pupils a week for a maximum of 7 weeks.

We plan to attend 3 market stalls across Norfolk this summer and have invited the fire service to join us to create more interest and work with them on public engagement.

For details of where and when you will find the engagement team Out and About - Healthwatch Norfolk

8.0 Communications

Media coverage April-June 2024

Media coverage has been a little sparse in this quarter mainly due to the impact of the pre-election coverage rules relating to both the council elections and the General Election.

Just before the restrictions hit, we did secure some coverage on BBC Radio Norfolk, the EDP, That's Norfolk TV and The Dentist to publicise our dental summit which is being held in the autumn.

While we have not been able to directly comment on some issues, we have referred journalists to our previously published statement on the Right Care Right Person system for mental health care and the My Views Matter report in response to media inquiries. Normal service resumes post-Election with media campaigns getting under way on a number of campaigns.

These include the Queen Elizabeth Youth Council which is formally launched on July 9. We have been working on a comms package, video and social media assets, an assembly, a package of assets to take on college and community visits and creating content for a digital van for major events.

Other projects launching after the election including a comms project to link in with engagement around the community diagnostic centre at the James Paget University Hospital mixing media and social media, a joint engagement and comms project with Marie Curie Cancer Care around palliative care, setting up a series of visits through the summer and autumn at LGBT+ events and with young people around accessing health care digitally, and preparation for our autumn dental summit.

Website use

(this is only based on June figures as the new monitoring has only just begun)

618 users. Average time on site 1m 05 seconds. Biggest number of users (381) found through a Google Search.

Most read pages Get Involved (147 views), Reports Archive page (76), Healthwatch Norfolk Dental Summit (71)

Social media coverage

X/Twitter 3216 followers, 11,492 impressions, 331 engagements

Facebook - 1113 followers, 25,155 reach, 186 engagements

Instagram - 686 followers, 772 accounts reached, 295 account interactions

LinkedIn - 14,384 unique impressions, 521 interactions

Quality Assurance Subgroup

Minutes of meeting held on 8 May 2024

10:00 – 12:00 Healthwatch Office Board Room, Wymondham

Chair: David Trevanion

Present:

David Trevanion (DT), Elaine Bailey (EB), Linda Bainton (LB), Chris MacDonald (CM), Judith Sharpe (JS), Emily Woodhouse (EW), Caroline Williams (CW), John Spall (JSp) Andrew Hayward (AH)

Apologies:
Alex Stewart (AS)

Kath Edwards (KE) minute taker

Copies:
Patrick Peal

No	Item	Action
1	**Welcome and Apologies**	
	DT began the meeting by welcoming everyone. EW introduced John Spall (Research and Project Manager) to the group. JSp was given an overview on the purpose of the QA subgroup.	
	Apologies were received from Alex Stewart	
2	**Minutes from the last meeting (1 February 2024) and action log**	
	The previous minutes were accepted as a true record. **Matters arising:** **NCHC (3-year commission)** Uncertainty was expressed regarding the nature of research involved due to a redesign (previous minutes page 2). Due to a change of CEO at NCHC, a halt was initiated on the project with a new plan written. EW explained the new project outline. There will be a Change programme in the next few years which has resulted in HWN being invited to Board and other meetings. The changeover in staff has presented challenges in rebuilding relationships but improvements made, through the Chief Nurse. The team have completed a schedule of engagement visits to NCH&C sites across the county. The report will function as a bit of a baseline for discussions with NCH&C to see in which areas we	

	might target our future engagement. We have already met with our NCH&C contacts who have seen and signed off on the new project plan. NCH&C see this project as on ongoing change process. Finance questioned, are we giving value for money? We need to stipulate what we have done and impact. Valerie Hartley (Project Officer) to be introduced to hospital staff who will be involved in the project. NSFT project concludes June (Carers of adults with SMI) Cindee is finalising the Community Mental Health report that Rachael was working on. 6 extra days over the summer have been allocated for her to complete this. **External Consultant policy** The policy has been presented to Trustees. There were suggested amendments regarding the recruitment process. **Action** - JS to amend and recirculate. It was confirmed at the Board meeting on 15 April that the policy can be approved via email.	**JS**
2a	**Action Log**	
	Most action points are complete: *Item 25 - Confirm response to dementia care report* NCHC Focus Group – completed. *Item 33 - Trustees to consider replacement Vice Chair of Board and Chair of QA Subgroup. DT Term of office ends 31 July* An email from AS has been recirculated for Trustee response.	
3	**Review and discussion of current projects (see paper)**	
	Paper taken as read.	
	NHS England NHS England has commissioned us to recruit and deliver 2 focus groups with a set number of participants. They have provided a list of questions, report template and groups to be contacted. The deadline of May/June is very tight. We will submit a report back to NHS E on the focus groups. A brief discussion followed regarding the financial process of commissions. **Digital Tools Years 4-6** A contract has been signed, with a plan being set out for the year, commencing in June.	

	Patient Experiences of Community diagnostic centres An introductory meeting to team members is scheduled tomorrow. EW will have a pre meeting with Dan and Jess today. It was questioned whether this may be a route into NNUH. EW to contact EB if contacts are needed. It was reiterated that communication with patients is vital and should be included in the report. **Adult Social Services** JSp noted a positive increased response to the survey. There are no concerns. **Staffing** The group were advised of the appointment of Valerie Hartley (Project Officer) and the departure of Siobhan. The JD and advertisement for Siobhan's role has been reworded and will hopefully prove fruitful in a replacement very shortly. A debate ensued regarding concerns on the project process re proposals/costings. Robust discussions are required before proposals are accepted, including resources which may compromise other live projects. The discussion included the process of data collection difference on owned and customer owned projects and the need for transparency with an audit trail. It is felt that a discussion should take place (before commissions undertaken) on how are the projects going to directly benefit the population? It was confirmed this is covered in the scope of the evaluation form. **Action** – DT to raise the issues associated with new project proposals at the next monthly Senior Managers meeting	**DT**
4	**Impact Tracking – Review of Recommendations & Outcomes**	
	EW gave an overview, including an update on the Patient Partner project, whereby the practice manager had provided an update to the recommendations we made. This was an interesting piece of work and easy to speak with patients. Congratulations to be passed to Jess on this piece of work. Suggested, the number of times HWN chase for information are noted on the tracker. Also, we have made a change to our	

	process and make sure we advise the commissioners a date when press releases are being issued.	
5	**3 Year project working discussion**	
	A report was supplied by EW and JSp (to be attached with the minutes when distributed for full information). **Summary:** • In the last 2 years more 3-year projects have been taken • 3-year projects are positive in that staff are able to take time but challenges re costs which could change, mitigated in contracts. • Clear on overall outcomes • Potential for project to become bigger than originally set out • Bigger projects require more planning, Trustee expertise could be very useful • Elevated risk to reputation and potential long-term funding • Staff motivation and emotional impact working on same project • Should one member of staff have more than one long term project? **Methods:** • More inductive approach – allow public to focus on what to research years 2 and 3 • Track policy change of commissioner and research impact on patient; feedback before completion • Organisation change can cause issues - building relationships can instigate delays • Could we develop a baseline study to compare changes? • Suggested: Track same people over period of time • Suggested: down time between years to evaluate and see what way the project goes. JSp gave a brief overview of ASSD 3-year project to date. It was suggested a project on carers opinions would be invaluable in the future.	
6	**Project to be presented at next Board meeting**	

	The project to be presented at the next Board meeting on 22 July will be Adults Accessing Social Care. John Spall to attend and present.	**JSp**
7	**Review of Quality Framework action plan**	
	Going forward; there will be similar bimonthly meetings with fewer groups. An invitation will be circulated for those wishing to participate. A further summit will be scheduled around October. **Action** – JS to rewrite Terms of Reference. A summary will be shared with HWE on remaining framework items being reviewed.	**JS**
8	**Any Other Business**	
	DT was thanked for all his work as Vice Chair, Chair of QA Subgroup and especially reviewing the reports.	
	The date of the next meeting is 1 August 2024	

The meeting ended at 11:45