Healthwatch Norfolk Trustee Board
20th April 2026
09:30 – 12:30 – Buffet Lunch will be provided at 12:30

Board Room – Healthwatch Offices
Elm Farm, Norwich Common Wymondham NR18 0SW
OR THE MEETING MAY ALSO BE ATTENDED VIA MICROSOFT TEAMS

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	09:30	5		D
2.	Welcome, introductions and apologies for absence (PP)				I
3.	Declarations of any conflicts of interest relating to this meeting (All) and confirmation of the updated register of interests.			3	I/A
4.	Minutes of the meeting held on 19/1/2026 and action log.	09:35	10	5 and pdf	I/D
5.	Matters arising not covered by the agenda	09:45	10		I/D
6.	CEO Report (AS, CW & EW) - Incorporating • Intelligence, Engagement, Projects and Communications updates • HWN Strategy 2026-29 • HWN Operations Plan 2026-7	09:55	60	15 32 pdf	A/I/D
7.	Chair Report	10:55	10		I/D
8.	Quality Assurance Subgroup (EW&EB)	11:05	10	45	I/D

9.	Risk Register and Health and Safety update (JS) (Finance Minutes in Part 2 of the meeting)	11:15	10	51	I/D
10.	Any Other Business – Please provide the Chair with Items for AOB prior to the Meeting's commencement	11:25	5		I/D
11.	Dates of future Board meetings • 20th April 2026 • 20th July 2026 • 19th October 2026				I/D

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

Distribution:

Trustees

Patrick Peal (Chair)	Christine MacDonald
Elaine Bailey(Vice Chair)	Linda Bainton
Vivienne Clifford-Jackson	Andrew Hayward
Christopher Humphris	Sue Crossman
Louise Smith	Anna Gill

For information:

Tom McCabe	Ian Wake
Suzanne Meredith	Simon Scott
Mark Burgiss	Sugmesh Clear
Rachael Grant	Rachael Parker
Chris Butright	Lisa Nobes

Register of Interests – April 2026

Name	Position	Details of interests
Patrick Peal	Chair	Chair, London Children's Camp Director, ACP Farming LTD Director of Mundesley Golf Club Ltd.
Alex Stewart	CEO	None declared
Chris Humphris	Board Trustee	Independent Self-employed Consultant working primarily with groups supporting their individual local Community Hospitals in England and Scotland Associate Member, Community Hospitals Association Undertaking a project for HWN between February and early June 2025
Chris MacDonald	Board Trustee	Independent self-employed consultant for health and social care in Norfolk Independent person for Norfolk County Council Stage 2 & 3 complaints re Childrens Services
Linda Bainton	Board Trustee	Trustee of the Norwich Centre, Norwich.
Elaine Bailey	Board Trustee	Self-employed consultancy service currently working with Norlite Ltd, London, SW1 9SA Membership of the NNUH Council of Governors
Andrew Hayward	Board Trustee	NHSE GP Appraiser East Harling Parish Council Member Norfolk Armed Forces Covenant Board Member

Vivienne Clifford-Jackson	Board Trustee	Vice President Royal Norfolk Show and a Member of RNAA Council Member Liberal Democrat Party, President South Norfolk Branch. Hon Alderwoman South Norfolk Council Trustee Voluntary Norfolk Member of Wymondham Abbey Church of England, Member of Friends of the Abbey and the Guild of St Benedict Ambassador Alzheimer's Norfolk Prevention of Suicide in Norfolk Network member Mental Health Providers (Norfolk) Network member
Dr Louise Smith	Board Trustee	Deputy Director UK Health Security Agency GMC Registered Doctor Fellow Faculty Public Health
Sue Crossman	Board Trustee	Trustee on Board of Tapping House Hospice Independent Consultant Registrant Member of NMC
Anna Gill	Board Trustee	Deputy Chair East of England Community Health and Care NHS Trust

Healthwatch Norfolk Board Meeting Part 1 - DRAFT MINUTES

19th January 2026
09:30 to 12.00

In person meeting at the Healthwatch Norfolk Offices, Elm Farm, Norwich Common, Wymondham, NR18 0SW and online via Microsoft Teams.

In attendance

Trustees

Patrick Peal (PP) Chair
Andrew Hayward (AH)
Chris Humphris (CH)
Elaine Bailey (EB)
Linda Bainton (LB)
Vivienne Clifford-Jackson (VCJ)
Christine MacDonald (CM)
Anna Gill (AG)
Sue Crossman (SC)
Louise Smith (LS)

Officers

Alex Stewart (AS) – Chief Executive
Judith Sharpe (JS) – Deputy Chief Executive
Emily Woodhouse (EW) – Business Development Director
Caroline Williams (CW) – Head of Engagement
Sarah Nichols (SN) – Information and Support Officer (minutes)

Also in Attendance

Ian Wake (IW) – Adult Social Services NCC (Norfolk County Council)
Chris Butwright (CB) – Public Health NCC
Rachael Grant (RG) – Adult Social Services NCC
Sugmesh Clear (SCl) (online) – Public Health NCC
Simon Scott (SS) (online) – Public Health NCC

No.	Item.	Action
1.	Questions from the general public	
	There were no questions from the general public	
2.	Welcome, introductions and apologies for absence	

	PP welcomed everyone to the meeting, particularly IW, RG and CB. Apologies were received from Mark Burgis – ICB.	
3.	Declarations of Interest (new or pertaining to items on this agenda)	
	There were no new conflicts of interest.	
4.	Ian Wake – Executive Director of Adult Social Services	
	IW had been asked to speak about his observations on arrival at NCC in October 2024, the changes implemented and the future vision for adult social care in Norfolk. IW wished to highlight three key points: 1. Adult social care throughout the country is underfunded as a whole, but Norfolk is funded comparatively well, in terms of proportion of council spend. However, Norfolk does experience a greater proportion of residents who access services, causing over-demand. As an organisation, it needs to shift into prevention and sharing this demand with other services in Norfolk. 2. Currently when people request services, the process assesses what people are eligible for and offers it, or if not eligible, sends them away (and they often come back, more unwell and needing more support). IW wants to change the initial conversation to… "what matters to you? what are your goals? what can you do for yourself and what can you do with help from family, friends and your community?." The statutory element should be a part of several considerations including community and third sector resources, forming a more holistic approach. 3. IW said that there is still system-working in silos when peoples' care needs often overlap with multiple services. (e.g. mental health, housing, addiction, debt etc). This causes numerous onward referrals and people can "bounce around" the system, using resources but not actually getting their needs met. IW spoke of the need for a neighbourhood system where services are connected, accessible and integrated.	

	IW talked of changes to commissioning processes that have freed time and increased capacity of social workers by creating a new team of experienced, integrated commissioning officers. IW said that there is overuse of residential care, due to not having developed other care models sufficiently such as supported living and that this needs to change. There was then opportunity for questions, with many trustees contributing. In response to the questions IW said: - he wants to achieve this change within two years, - he wants Adult social care to be fully integrated into neighbourhood teams built around PCN networks. - they have set out the "what" and "why" and that HWN can help look into the "how" this will work. Work needs to be done to engage with communities, and HWN's links and expertise can assist with this. LS asked if the impact on people had been considered and whether people may view the new approach as "you can't have what you used to have". LS spoke about voluntary sector infrastructure organisations being used to help with the establishment of community-based co-ordinated help. LS asked if HWN plans to get feedback from the public regarding neighbourhood working. AS and EW explained that HWN has supplied two relevant bids for work with NCC. One is to work alongside the ASC neighbourhood teams, engaging with people in the community and key providers as part of an initial evaluation of neighbourhood working in a limited number of PCN groupings. This may later be expanded to all PCN areas in Norfolk. The initial phase would be for 6-7 months and the second phase, 18 months. This work will incorporate ongoing feedback over time and not just provide a snapshot at one given moment. The second piece of work is to explore the quality of care in residential care homes. It would involve visits to a selection of care homes over a 9-month period, seeking to demonstrate quality improvements in that time.	

5.	**Minutes of the meeting held on 20th October 2025 and action log.**	
	All agreed the minutes of the meeting on 20th October 2025 to be an accurate record. Action log items: • 163 – (re. HWN being gatherer of data/feedback) on hold until outcome of ICB structure. • 167 – (re. a Health Inequality Trustee Champion) this is complete. • 174 – (Webpage with help and support for hearing loss) this is completed and live on the website. • 176 – (HWN representation at PLACE boards) AS will continue to pursue this. • 188 – (investigating scope of work for patients being cared for at home) Already covered by EW/AS (Page 3) awaiting outcome of bid proposals. • 191 – (creating a place hold document for proposed restart of Quality Framework) Now completed by EB, circulated to Trustees and will be covered within this meeting. • 195 – (AS to update board following Stakeholders meeting on 24/10) AS reported this is ongoing but no formal update yet. • 196 – (Re. ICB Health Inequalities self-assessment form) JS has shared with AG, and that the ICB offered to support further development. • 197 – AG to send summary of Health Inequality Champion meetings to Board members – AG confirmed will share as and when needed. Action can be marked as complete. • 198 – (PP to share notes from meeting on 22/10 with HWE and DHSC re future local Healthwatch arrangements) Complete. PP advised that the next meeting is 4th February. CH asked if any more had been received regarding the future of LHW. AS reported that HWE had shared communication from Dept, Health &Social Care that LHW must continue to be commissioned by local authorities for 2026-27. 199 – (LS to share information re Dash Review from national quality board) Complete.	

	• 200 – (EB to feedback re PALS after NNUH council of governors meeting) EB explained the meeting had defaulted to an informal one, so conversations did not happen. However, she has met with Ian Walker, who is the new group interim director of corporate governance. Can close action. • 201 – (AS to progress suggestions of engagement and the mapping of services relating to methods of accessing GP appointments) – CW confirmed engagement is booked at Sharrington Village Hall and Wiveton Parish Room In February as a trial. All of the engagement team will be present. AH said there should be reports to the ICB Primary Care Commissioning Committee about the accessibility of GP appointments. Action to remain live.	
6.	Matters arising not covered by the agenda	
	There were no matters arising that were not covered by the agenda.	
7.	CEO report	
	AS said that following discussions at the last QA subgroup meeting, he is focusing on intelligence, engagement and impact, as these are the core of the work that HWN does. AS provided some updates: - AS is in the process of redrafting the HW strategy and will circulate once completed. - HWN has welcomed Annabel Ditton who has joined the project team. - It has been announced today that the new Hospital Programme will not be completed until 2038. All agreed this is unwelcome news for the QEH. - It has been announced that the Electronic Patient Record (EPR) has been delayed by 12 months to April 2027. JS explained that the majority of feedback comes via face-to-face engagement with the HWN team. As there was focus in the quarter on GP practices, this is where the majority of feedback has originated. JS said that some services have received only a small number of reviews and this may not be representative. JS	

	said that feedback often says that *once* people are able to access a service, they feel well cared for and listened to – but concerns are often about the length of wait or difficulty accessing the service. PP asked how we decide where to focus engagement. JS and CW said that intelligence from feedback, phone calls and emails is used to identify issues of concern or gaps and to decide future engagement, balancing this with commissioned work. CW said that from Nov until Feb the engagement team is working on two projects from NCC, one on NHS Health checks and the other on smoking cessation services. The team is working in many different venues to increase reach to a wide range of people including supermarkets, community group meetings, libraries, pubs, a football club and an asphalt plant. When someone is not eligible for a survey, the team can still collect general feedback. LS appreciated the focus and value of general engagement, as this can reveal valuable information that should be investigated further. There was discussion about the value of small numbers of feedback on some services. LS felt this data is still valuable, but we need to be careful how we interpret the statistics. AS felt that people are often too tired to complain, meaning that any negative reviews received are likely to be the tip of an iceberg. SC and LB suggested that services with small numbers of reviews and low ratings should indicate services for the engagement team to focus on. LS said it would be valuable to look at trends over a longer period of time, such as a 6-month rolling average. AG suggested the data could be presented in graph form to show the trends over time. **ACTION:** SN to investigate improvements to the intelligence and engagement report such as adding 6-month rolling averages. AG raised that the report shows four reviews for community services but does not show which specific services within community services, meaning it is harder to see if there are trends in particular areas of community services. **ACTION:** SN add AG to quarterly report mailing list which shows full reviews including the breakdown by service. SN will also investigate amending the report to ensure this breakdown is clearer.	SN SN

	The board also discussed what is done with this feedback and the impact that it has. AW said he attends the ICB Primary Care Commissioning Committee and shares this data. Additionally, the reviews are shared via a circulation list with the ICB and many other service providers on a quarterly basis. JS said there is a finite resource in the engagement team and when the current work for the two NCC Public Health projects has finished there will be capacity for other topics of engagement. She also noted that such feedback happens in concentrated efforts as there is not adequate resource to maintain high levels of engagement on all services at all times. CW agreed and spoke about engagement carried out 18 months ago on pharmacy services after receiving and noticing a trend of negative reviews. CW advised that there are HWN (pink) travelling post boxes at NCH&C which are able to receive feedback from a variety of their services without the team having to attend. AH asked what happens to this information when it is shared and if it is acted upon. LS agreed and felt the conversation should not be about a criticism of the amount of feedback, but we should be confident in asking providers to take it all on board. CM raised that while our numbers may be small, providers may be receiving similar feedback from other systems. PP agreed and said it is a missed opportunity that there is no one central resource that collates and manages health and care feedback gathered in Norfolk. In response, JS said that SN moderates every review received (from both the public and engagement team), and so is able to notice small trends, raise these in team meetings for consideration for further investigation or communication with providers. JS gave the example of when we identified a series of poor feedback reviews about the NNUH pain clinic and were able to raise this with the ICB. SC asked for the addition of a small description of each project within the project section of the CEOs report for better understanding. **ACTION:** EW to add a description after project	EW

	titles in the board report. and KT to add in hyperlinks to the published reports in the comms section. EW brought forward the new AI policy for Board approval. PP expressed uncertainty about approval as there had been concerns and comments raised by some Trustees via email prior to this meeting. After discussion it was proposed to approve the policy with a further Board review in 6 months' time to reflect and include any latest developments or knowledge. Eight trustees (majority) voted to approve the policy. ACTION EW to continue ongoing review of the policy and bring to the Board in July for further review. VCJ left the meeting at 11:04	KT EW
8.	Chair's Report	
	PP advised that quarterly update meetings with senior leaders at NSFT had been reinstated. PP had attended NSFT's AGM and felt that good progress is being made with good recruitment to the senior management team. He is still trying to persuade NSFT attendance at the Health and Wellbeing Board and to enable better relationships and integration with other services. PP has been seeking someone to join the board of trustees with additional finance expertise and has a meeting on Wednesday with someone.	
9.	QA Subgroup	
	EW reported that the group last met just before Christmas. The focus has been on project outcomes and demonstrating impact and this focus will continue in 2026. One notable example from John Spall's work on the SMI carers project is that a new SOP has been developed. This means that patients are not immediately discharged from services when well, which means they can more easily access support should they become unwell again. EW also spoke about the new ethics form that has been introduced to assess risk for both people and staff. Also discussed at the group meeting was the new impact survey for people to rate how HWN has helped them. This has recently been refined to be clearer about what they are rating.	

	EB confirmed the focus on outcome and impact and how this has benefitted the work of HWN. EW referred to a summary document of the work of the QA Subgroup over the past year, and thanked those trustees involved for all their hard work.	
10.	**Risk Register, Quality Framework and Health and Safety update**	
	JS said that the direction of change of risk has been added to the risk register but there had been no directional change this quarter. However, on reflection, JS said No. 9 "External Relationships and Partnerships" has probably reduced in recent weeks as restructures and new appointments progress within in the local H&SC system and new relationships are being built. AS agreed with this. ACTION JS amend No 9 in the risk register. JS has also added a risk appetite column as discussed at the October Board meeting but is unsure how to categorise or rate each risk. LS said that risk appetite should be considered as a board, there will be risks that will be delegated, treated, turnaround plan created and or tolerated. ACTION: LS and JS to discuss the risk appetite and bring a proposal back to board. AG suggested that the "risk appetite" would be an agreed board statement (rather than a score or category) defining when we (The Board) are prepared and not prepared to take risk. AG offered to share an approach relating to risk appetite. ACTION: AG to share information on risk appetite statements with JS to aid with creating our statement. Health and Safety – no incidents to report. JS is meeting with a consultant to do a review and gap analysis assessment of our health and safety in a couple of weeks.	LS & JS AG
11.	**Any Other Business**	
	Quality framework (QF) JS spoke about the document EB had prepared which explains the background of the Quality Framework and our current status. The HWE self-assessment tool was previously used by	

	mixed groups of staff, trustees and volunteers. Considerable progress was made and people valued the relationship building across staff/trustees/volunteers. JS said the QF remains important for continued self-assessment and good governance but should be more firmly embedded in all processes rather than "sitting aside" as separate meetings. For example, JS said it can be used within objective setting during annual appraisals. EB also suggested this could be included in our induction processes. EB also feels we should find a way to continue good relationship-building between staff, trustees and volunteers as the QF meetings have ended. **ACTION:** JS convene a small group (JS, EB plus 1 other trustee and one other staff member) to discuss the future of quality framework and how good staff/trustee/volunteer communication can be maintained and bring a proposal back to the April Board meeting. There were no further points of AOB raised.	JS
12.	Dates of future Board meetings • 20th April 2026 • 20th July 2026 • 19th October 2026	

Meeting ended at 11:27

Date	20th April 2026
Item	CEO Report
Report by (name and title)	Alex Stewart - CEO
Subject	CEO Report

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 will be providing "headlines" in relation to the following: -

1. What the public are telling us (Engagement, Intelligence and Impact Report)
2. Business Development Update
3. Communications Update
4. Feedback from Stakeholder Awayday – verbal
5. Healthwatch Norfolk Strategy Refresh 2026-2030, Plan on a Page – set out in Appendix A
6. Staffing Update

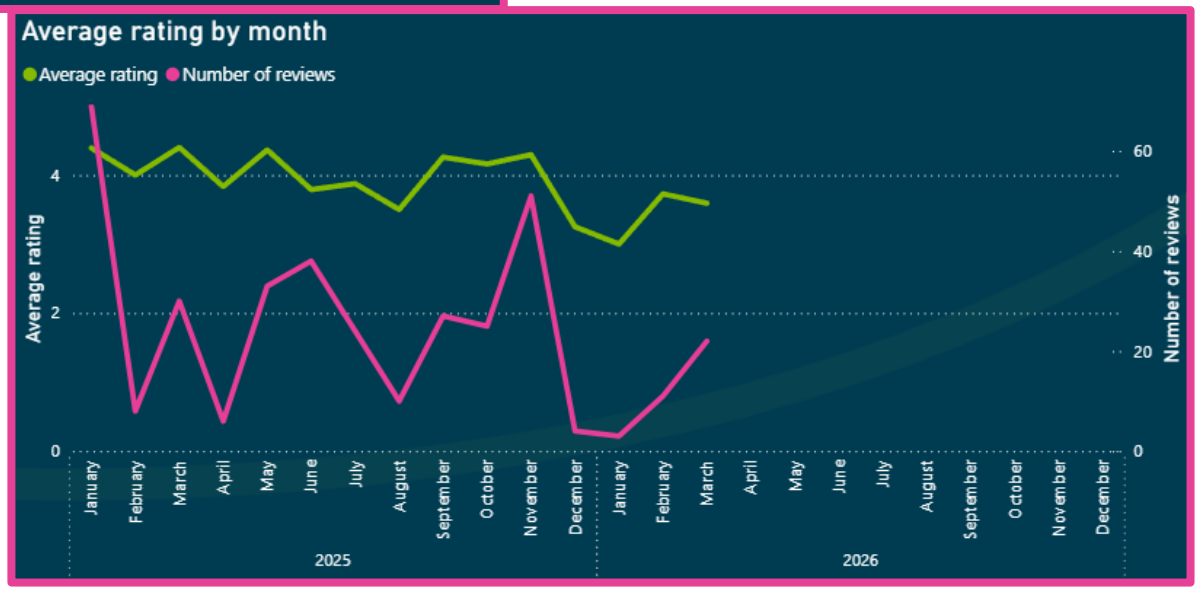
1. What the public are telling us: Engagement, Intelligence and Impact Report January - March 2026
(Sarah Nichols and Caroline Williams)

From January 1st 2026 – March 31st 2026, we have received 186 reviews about 73 different services

Type of Service		Number of reviews	Average star rating this quarter (out of 5)		Average star rating for previous 6 months (out of 5)	
	GP's	112		3.7		4.3 – 1295 reviews
	Community services	2		5.0		4.2 – 26 reviews
	Hospitals	36		3.6		4.1 – 141 reviews
	Adult Residential Care	1		5.0		3.5 – 6 reviews
	Pharmacies	14		2.3		2.1 – 14 reviews
	Care support	7		5.0		4.8 – 21 reviews
	Other	4		3.0		4.3 – 3 reviews

	Mental Health Services	4		4.5		2.1 – 11 reviews
	Urgent care	2		5.0		3.0 – 4 reviews
	Dentists	2		3.0		3.9 – 16 reviews

Average rating and number of reviews for GP surgeries per month



Average rating and number of reviews for hospitals per month

Interestingly, these graphs show that on average, the number of reviews correlates with the average star rating. This suggests that the months we do more engagement the average reviews tend to be higher, suggesting that the reviews provided by members of the public unprompted tend to be more negative than feedback we collect ourselves.

The largest themes emerging this quarter are:

Theme	No. of reviews	% positive	% negative	% neutral
Staff Attitudes	104	79%	17%	4%
Appointments/Opening Hours	81	42%	37%	21%
Staff Training	61	72%	23%	5%
Administration/ Organisation	47	53%	40%	6%

Staff attitudes continue to be the most positively reviewed theme; however, there has been a noticeable decline in positive feedback compared to the previous quarter:

- For GP surgeries, 82% of reviews relating to staff attitudes were positive, a decrease from 93.3% in the last quarter.
- Hospitals saw a reduction from 98% to 78%.
- Pharmacies recorded the highest proportion of negative feedback in this area, with 67% of reviews reporting negative staff attitudes.
- This was followed by opticians at 50%.
- Encouragingly, while the previous quarter included only one review for mental health services, which was negative, this quarter saw two reviews, both of which were positive. Despite this improvement, further engagement is recommended to determine whether these reviews are representative of broader patient experience.

In the previous quarter, 84.5% of negative feedback relating to appointments and opening hours was attributed to GP surgeries; this has since decreased significantly to 23% in the current reporting period. In contrast, the proportion of negative feedback from hospital reviews has remained relatively stable, increasing only slightly from 11.3% to 13%. It is important to note that the total number of reviews collected this quarter was considerably lower, declining from 645 to 186. Correspondingly, the number of reviews relating to GP surgeries also fell from 528 to 112, which may have influenced the proportional distribution of feedback. The reason for the decline in reviews received is that the engagement team have been predominantly working on the NCC public health projects relating to NHS Healthchecks and Smoking Cessation Services this quarter.

The theme of staff training encompasses how well patients feel staff have been trained, either within the workplace or in their clinical training. This encompasses attributes such as the use of shared decision making and explaining things well for patients as well as how confident patients are with staff's abilities to diagnose and treat correctly

Signposting and Impact:

A total of 76 signposting enquiries were received during this quarter, comprising 30 telephone calls, 31 emails, and 15 interactions at engagement events. The most common area of enquiry was advice on **how to raise concerns and complaints**, accounting for 44 enquiries. Of these, 17 related to hospitals, including 10 concerning the NNUH, five relating to JPUH, and three to QEH. The predominant issues raised included communication challenges, waiting list and referral times, and a lack of response from Patient Advice and Liaison Services (PALS). A further 11 enquiries related to GP surgeries, with complaints primarily focused on difficulties in securing appointments, perceptions of inadequate support, and concerns about not being listened to.

The second most common theme related to **accessing services** (excluding dentistry), accounting for eight enquiries. Of these, three concerned mental health, including two individuals seeking guidance on support for complex PTSD, one related to neurodiversity assessments, four concerned GP surgeries, and one related to selecting residential care. During this quarter, no enquiries were received regarding accessing dental services; however, two individuals did seek advice on how to make a complaint about their current dental practice. It is important to note that the absence of enquiries regarding access to dentistry should not be interpreted as an absence of need. Rather, it may indicate that individuals have become discouraged from seeking access due to repeated difficulties in obtaining dental care.

Impact

During the quarter we helped many people via emails, telephone calls and engagement events. To give just a few examples of the impact we had this quarter:

- We were contacted by the stepdaughter of a current inpatient at the NNUH who had sustained severe injuries following a motorcycle accident, who had been awaiting major surgery for over a week without a confirmed date and remained nil by mouth throughout. The uncertainty and ward environment has significantly impacted his mental health, leaving him distressed and suicidal. Despite escalating these concerns to the ward and to PALS, no response had been received after one week, prompting them to seek our support. With consent, we escalated the concerns the same day to senior staff at the NNUH. A response was received within an hour confirming they would be undertaking an urgent investigation. The patient and their family were met the same day, and an action plan was implemented. This plan included being moved to

a side room, mental health support, multiple clinical reviews and efforts made to expedite surgery. Nursing concerns were also addressed with the ward manager. We followed up twice with the family to ensure the actions were carried out and that appropriate support was in place.

- Someone who has regular appointments at the QEH contacted us with concerns as they found that since December 2024 the care they receive from the ophthalmology department has gone downhill. Appointments are always delayed now, and they only actually get an appointment if they chase it with PALS. They had tried doing this again but had not had a response to PALS. They were left overdue for an appointment and unsure what to do next, hence them contacting us. This concern was passed to senior management and AS raised this with the CEO and Chief nurse at QEH who agreed to follow this up.

- We were contacted first in January by the daughter of a lady who had received poor wound care at the NNUH which led to harm and complications. She had contacted PALS in September and had chased in early January and had contacted us due to having had no response. We advised she contact again CCing in us and that we would also contact with PALS to chase from our side. At the time this was unfortunately unsuccessful but after they got back in touch with us, we reached out to the Head of Patient Experience at NNUH in March, and the daughter has confirmed they have now had a response and resolution from PALS and are grateful for our help.

Customer Impact Survey

The customer impact survey has now reached 19 responses, 5 of which were received during this quarter. We are still sending follow up emails to people asking to fill this in as well as advertising it on social media and in the newsletter. We will make further effort during the next quarter to also ensure those who contact us over the telephone are asked to fill this out and given help to do this if they do not have access to the internet.

All five people found us easy to contact. Three reported that they got the information they were looking for, that we were helpful and that they felt listened to. Things they described feeling after contacting us included “reassured” and “more confident”.

Regarding the two neutral/negative feedback, one person said they somewhat got the info they were looking for, as they were provided with the correct contact details they needed, but had not received a response from that person yet (which is beyond our control). Another person said they had not got the information they were looking for. They had contacted us to raise concerns that the NNUH had sent them an appointment letter without calling first to check if the time was suitable. They had contacted PALS as we had suggested but were told there are not enough staff to call each patient to book people individually. This individual was disappointed and felt HWN "should have checked procedures".

Additional quotes people left for us included:

- "The help I needed to direct my complaint to the right people"
- "Really warm in tone and gave great signposting instructions. Unfortunately the staff members of the service I was signposted to haven't responded even after chasing them but I am thankful for the Healthwatch employee for directing me to them!"

Demographic breakdown of the 645 reviews 1.1.26- 31.3.26

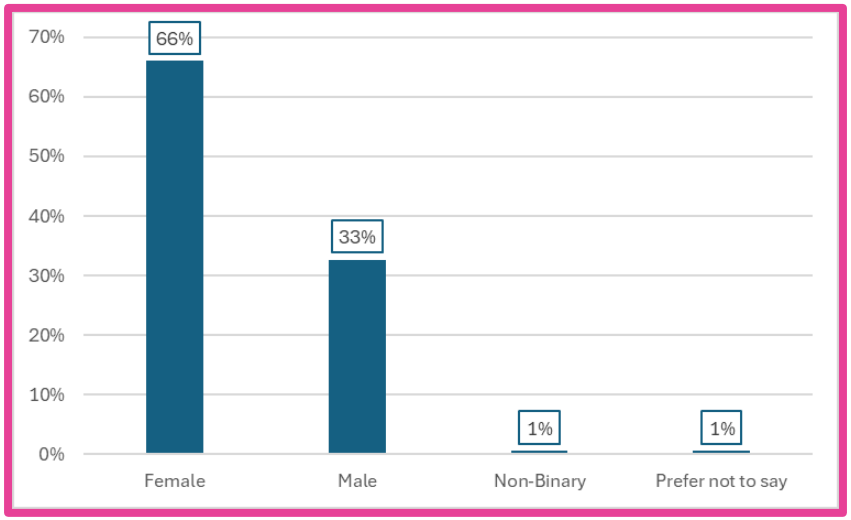
Ethnicity	Percentage
White English/ Welsh/ Scottish/ Northen Irish/ British	91%
White and Black African	1%
Other White Background	4%
Other Black British Background	1%
Prefer not to say	3%

Ethnic group data

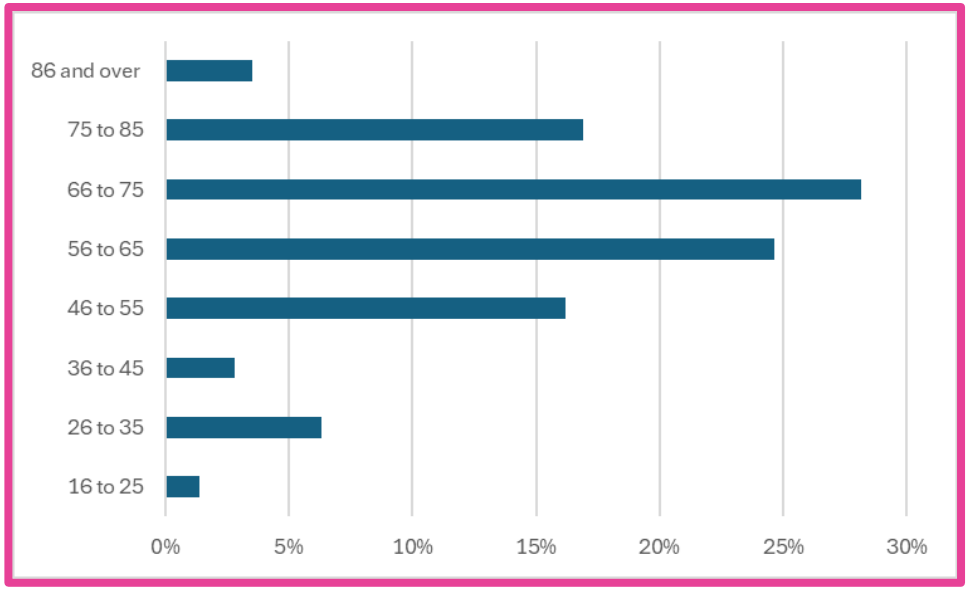
18

People reported having a physical or mental health condition/illness lasting, or expected to last 12 months or more

Disability data.



Gender data



Age data

Engagement Report
(Caroline Williams)

NCC Public Health Projects

During this quarter the majority of the engagement team's time has been spent on two NCC projects on NHS health checks and smoking cessation services.

The team spent a week in each patch gathering survey response for both projects. Engagement visits included supermarkets, shopping centres, community cafés, GP surgeries and food banks. In total we made over 65 visits to different sites.

We received over 500 responses for the health checks project. We found that the NHS Health Check programme in Norfolk is generally well received and valued by those who attend, with high levels of satisfaction and willingness to re-attend. However, the evaluation identifies ongoing challenges related to awareness, understanding, invitation and consistency of delivery.

The smoking cessation services project requires engagement with a "hard to reach" demographic of people. We needed to find people who smoke or had smoked in the last 10 years. We arranged visits at Wetherspoon's pubs, local football matches and even a construction materials manufacturing site, showing the lengths we will go to, to find the people we need to speak to. The report for this is being written at the moment. Early findings are that people find help to give up smoking - which includes moving to vaping - but that there is no help to give up vaping.

VILLAGE HALL DROP-INS

In February we held two community drop-ins at Sharrington and Wiveton Village Halls (in North Norfolk) for people to share their views on health and social care. This was a trial activity for us to reach rural communities that don't have easy access to libraries, community centres, or other places where we usually meet people.

In Sharrington, 15 residents joined us and there was lots of lively discussion and questions. In Wiveton, it was a quieter session with two residents attending and to whom we were able to give advice and receive their feedback.

What people told us:

- **Transport and access to services** — Many people shared how difficult it is to reach GP surgeries, especially with no public transport and long driving distances.
- **GP appointments and waiting times** — Residents told us they often wait 2–4 weeks for an appointment, and that the closure of Blakeney surgery has made things more difficult.
- **Pharmacy access** — One resident raised concerns about the local pharmacy closing at lunchtime, which makes it difficult for people who rely on limited transport options.
- **Patient Participation Group (PPG) visibility** — Feedback included frustration that the PPG does not advertise for new members or make it clear how to join.
- **Consistency of care** — Some attendees felt it was difficult never seeing the same doctor twice, though this was balanced by general praise for the kindness and professionalism of staff.
- **Concerns about ageing in a rural area** — People were accepting of rural living but worried about what it will mean as they become older or less mobile.
- **Understanding how the system works** — Many appreciated having changes to the health service explained, including why you may not always see a GP first and how decisions are made at local and national levels.

Two people raised very specific individual issues and hoped we might be able to take direct action on their behalf. We explained how Healthwatch Norfolk uses collective feedback to influence services and can provide information about how to complain but are not able to intervene in individual cases.

Attendees said they found the sessions helpful and would like us to return in future.

The engagement team are researching other rural areas to repeat the events - making sure we are visible and that people in these areas have the chance to have their voice heard.

General engagement update

Looking back over the last year (April 2025 to March 2026) the team have attended over 279 engagement events across the county. These range from libraries, community cafes, food banks, doctors' surgeries and hospitals. This is more than 5 every week.

Summer is a busy time for events, and we are planning to attend both Norwich and Kings Lynn Pride, "Now that's what I call autism", Care for carers, Dying Matters and an event hosted by Opening Doors which is for people with Learning Disabilities.

The engagement team are working with the project team on several projects: ECCH patient feedback evaluation, Digital Tools (ICB) and the NCC care home visits for which we have recently trained the team in the HWE enter and view process.

We are in the early stages of scoping some work for people who are blind or visually impaired. We have received reports of long waits at the hospitals to obtain a diagnosis and also long waits for sensory support services from NCC – and so want to investigate this further.

2. Business Development Update

(Emily Woodhouse)

The Quality Assurance Subgroup met 17/03/2025. The minutes are available within the Board papers.

Projects Published January to March 2026:

- **NCC Adult Social Care**
  A three-year project commissioned by NCC Adult Social Care to provide a rolling programme of engagement with service users, carers and staff – looking at services foir older people.
  Published report: Year 2, report 1 of 3: Preparing for Later Life report
- **NCH&C Transformation**
  A three-year project commissioned by NCH&C to support their transformation programme.
  Year 2 report: Experiences of Patient General Rehabilitation report

Projects pending review/publication:

- Experiences of Adult Social Care of people who are 65+ - year 2 report, reports 2 and 3 of year 3, will be published following a delayed response from the commissioner.

Projects in progress:

- Downham Dementia Evaluation (live)
- SMI Carers, year 3 (live, final contract year)
- Adult Social Care, year 3 (live, final contract year)
- Digital Tools, year 5 (live, penultimate contract year)
- NCH&C Transformation Engagement, year 3 (live, final contract year)
- Patient Feedback review and engagement project for East Coast Community Healthcare (live)
- East of England Genomic Transformation Project (live)

Projects in planning:

- ASC Community approach with NCC

Pending and Prospective Projects:

- ICB multi-year proposal (pending outcome)
- Geoffrey Watling Charity, LGBTQ+ access to healthcare follow up. (bid to be written with work being proposed to further investigate findings of HWN PRIDE survey)

3. Communications Report

(Kirsteen Thorne)

Reports published:

12 March – Experiences of Inpatient General Rehabilitation

Report page: https://healthwatchnorfolk.co.uk/reports/experiences-of-inpatient-general-rehabilitation/

News article : https://healthwatchnorfolk.co.uk/news/assessing-inpatient-general-rehabilitation-services-in-norfolk/

Report publication publicised on social media and in newsletter, Friday 13 March

30 March – Adult Social Care Year 2, report 1: Preparing for later life

Report page: https://healthwatchnorfolk.co.uk/reports/preparing-for-later-life-in-norfolk/

News article: https://healthwatchnorfolk.co.uk/news/how-people-in-norfolk-are-preparing-for-later-life/

Report publication publicised on social media and in newsletter, Friday 10 April

Surveys published:

Digital Tools Yr 5: Share you views on digital technology and healthcare

Web page: https://healthwatchnorfolk.co.uk/get-involved/share-your-views-on-digital-technology-and-healthcare/

Survey publicised on social media, including community groups on Facebook, and in newsletter, Friday 13 March and Friday 10 April.

East Coast Community Healthcare Patient Feedback review

Web page: https://healthwatchnorfolk.co.uk/get-involved/east-coast-community-healthcare-patient-feedback-review/

Comms shared with ECCH and Knowing Works (HW Suffolk), discussions held with Knowing Works about their comms plan. Posters and flyers for ECCH sites designed and posted to ECCH comms teams.

Survey publicised on social media, including Facebook community groups, and in newsletter, Friday 13 March and Friday 10 April.

Media appearances

16 January – Alex featured in EDP and Evening News article, 'Fresh concerns over future of walk-in centre': https://www.edp24.co.uk/news/25769204.fresh-concerns-future-norwich-walk-in-centre/

24 January – Opinion piece about future of HW, 'Peter Franzen: Norfolk is under remote control from Whitehall': https://www.edp24.co.uk/news/25787039.peter-franzen-norfolk-remote-control-whitehall/

13 February: Alex appeared on BBC Radio Norfolk Breakfast Show and again on the Daytime show, in response to hot seat with the CEO of EEAST

16 March: Alex appeared on Greatest Hits Radio discussing the increase in people paying for private healthcare.

Alongside these media appearances, we have also secured a monthly features slot in the Eastern Daily Press. Alex will be guiding EDP readers through the changing national and local health and social care landscape, while exploring and explaining how the current era of change may impact them.

The first article was published on **Wednesday 25 March**: https://www.edp24.co.uk/news/25948380.healthwatch-norfolk-looks-major-changes-nhs-services/

A list of potential future topics to cover in the article has been sent to the EDP Deputy Editor, and includes dentistry, a detailed look at the 10-Year Health Plan, a focus on feedback, communication in healthcare settings and accessibility.

Website use

2.8k new visitors from 6 Jan 2026 – 8 April 2026

406 returning visitors during same period.

Biggest spike in new visitors occurred on Wednesday 1 April, coinciding with the launch of the new Norfolk and Suffolk ICB.

Other spikes in visitor numbers coincide with a social media post about more people turning to private healthcare, and a social media post about the release of our report on NCH&C Inpatient General Rehabilitation services.

Most viewed pages 6 Jan to 8 April 2026:

1. Home page

2. Reports archive

3. Get Involved (links to surveys)

4. Information and Advice

5. Digital Tools 5 survey page ('Share your views on digital technology and healthcare')

6. NHS Health Checks survey page ('Share your views on NHS Health Checks')

7. Smoking cessation services survey page ('Your experiences of stop smoking support services in Norfolk')

Social media

Followers across all social media channels, 6 Jan – 8 April: **3,472**

followers

This is a **3.2%** increase from **3,365** during the previous quarter (1 September – 5 Jan)

Popular social media posts:

- NNUH doubles robotic surgery capacity, and Carer Money Matters roadshow posts (Jan 30)
- Work begins on new bus stop at QEH, and HWN newsletter posts (Feb 11)
- Contact Us post (Feb 20)
- Details of Easter pharmacy opening hours, and King's Fund report posts (Mar 20)
- New Norfolk and Suffolk ICB launch date announcement, and Power of Patient Feedback posts (March 27)

The recent data suggests stories about developments within wider healthcare services continue to be of interest to audiences (ie new ICB launch date, robotic surgery at NNUH, building developments at QEH) and they value our position as a trusted voice on local NHS news.

Newsletter

Subscriber numbers now stand at **5,304,** this is a **0.95%** increase on the previous quarter.

Whilst we have had a good amount of people subscribe through the website sign-up form and imported manually following engagement activities, a number of people have also unsubscribed. Many of these are NHS staff members who have left their jobs (and we have unsubscribed them after receiving an 'out of office' stating they have left their post). This suggests current staff changes within the NHS are having some impact on our subscriber numbers.

4. Feedback from Stakeholder Awayday – verbal (AS)

5. Healthwatch Norfolk Strategy 2026-2029 – Ratification and decision required

With the advent of a potential White Paper outlining the Government's intentions about the 10-year plan along with the recent tender award for

Healthwatch Norfolk to continue to provide statutory services along with the most recent announcement about Local Government reorganisation, it is imperative that we remain fleet of foot.

Appendix A sets out the new strategy, a Plan on a Page along with the Operations Plan. All of these are reviewed annually and updates are provided as appropriate to Trustees at Board Meetings. Additionally, Norfolk County Council meet with the Senior Management Team regularly to ensure that we are compliant with all objectives set out in the Tender Specification.

There are additional checks and balances undertaken by the Board's various sub-Committees; for example, the Finance Sub Committee scrutinise the quarterly Management Accounts that are prepared by our accountants. We also adhere to both Charity Commission regulations as well as the legal requirements of Companies House.

It is recommended that the Board adopt the Strategy 2026 – 2029, the Operational Plan and the Plan on a Page which outline how we intend to progress moving forwards.

6. Staffing Update

It is with great pleasure that I can inform the Board that Anabelle Ditton was awarded her Doctorate from Exeter University following a gruelling viva on the 8th April 2026.

Appendix A

healthwatch Norfolk

Strategy 2026 – 2029

Healthwatch Norfolk is your local consumer champion for health and social care.

How to contact us

Call us on 0808 168 9669

Email us at enquiries@healthwatchnorfolk.co.uk

Look at our website http://www.healthwatchnorfolk.co.uk/

Write to us at Healthwatch Norfolk, Suite 6, Elm Farm, Norwich Common, Norfolk NR18 0SW

Follow us on Twitter @HWNorfolk

Please contact Healthwatch Norfolk if you require an **Easy read**; **large print** or a **translated** copy of this report.

IN TRAN® communication for all

Your voice can make a difference...

healthwatch Norfolk

Healthwatch Norfolk works with health and social care services in Norfolk to make sure that your views and experiences make a difference to the services we all use.

Call us on 0808 168 9669

Website: www.healthwatchnorfolk.co.uk Email: enquiries@healthwatchnorfolk.co.uk

Follow us on Twitter: @HwNorfolk Like us on Facebook: facebook.com/healthwatchnorfolk

Table of Contents

Introduction

Healthwatch was established under the Health and Social Care Act 2012 to understand the needs, experiences and concerns of people who use health and social care services and to speak out on their behalf. We exist on a national and local level, working towards the same goal of enabling people to have a voice about their health and social care systems. Healthwatch Norfolk is an independent charity and a company limited by guarantee, with a Board of Trustees who are also the Company Directors.

Our Charitable Objects are set out in the Articles of Association which governs how Healthwatch Norfolk operates. The objects of the charity are the advancement of health and the relief of those in need by reason of youth, age, ill-health, disability or financial hardship for the benefit of the entire population of the county of Norfolk by:

- Providing information and advice to the general public about local health and social care services;
- Making the views and experiences of members of the general public known to health and social care providers;
- Enabling local people to have a voice in the development, delivery and equality of access to local health and social care services and facilities;
- The promotion of high standards by health and social care providers; and
- Providing training and the development of skills for volunteers and the wider community in understanding, scrutinizing, reviewing and monitoring local health and social care services and facilities

There are a myriad of issues facing the Norfolk and Waveney Health and Social Care System, such as:

- Implementation of the 10 Year Plan and the Dash Review
- Social Care Reform
- Implementation of the newly formed Integrated Care Board and the Group Model for acute service provision across Norfolk and Waveney – potential implications for service provision
- Local Government reorganisation – Theoretical shadow form in 2026 with full integration by April 2027
- Impact of local elections – May 2026
- Embedding a comprehensive prevention agenda across systems
- Impact of "system-wide" CQC Inspections
- Workforce

Our vision and ambition

Our vision is to help shape a health and social care system where people's health and social care needs are heard, understood and met.

In order to help address these issues, we will: -

Listen and engage with people, especially the most vulnerable, to understand their experiences and what matters most to them;

Influence those who have the power to change services so that they better meet people's needs now and into the future;

Inform local people and helping them to get the most from their health and social care services.

Our Ambition

Whilst we are a statutory body, we work for the residents of Norfolk and we are inclusive, influential, independent, credible and collaborative. We welcome the funding that comes down from the Department of Health to the County Council as well as the additional funding provided by Public Health

However, to be increasingly more effective, the resources provided are inadequate which requires us to seek additional funding through undertaking commissioned work which contributes towards the wider health and social care agenda and provides our partners with credible and reliable information to help them define service provision. Currently (2026/27), we are anticipating securing approximately 60% of monies through commissioned activity.

We want to do much more work but our statutory funding is limited. Our strategy is to pursue project funding from the health and social care sector. To succeed, our ambition is to continue to develop as a high performing specialist commercial market research organisation that could compete nationally.

We will continue to provide this outstanding service for our stakeholder partners.

How we decide what to focus on

Our strategy is currently based on the statutory activities we are required to undertake, which remain the guiding reason for doing what we do. *Source: Health and Social Care Act 2012. Local Healthwatch organisations; Activities relating to local care services; (Section 182).* *http://www.legislation.gov.uk/ukpga/2012/7/section/182?view=interweave*

These are:

- Promoting and supporting the involvement of local people in the commissioning, the provision and scrutiny of local care services.
- Enabling local people to monitor the standard provision of

local care services and whether and how local care services could and ought to be improved.

- Getting the views of local people regarding their needs for, and experience of local care services and importantly to make these views known.
- Making reports and recommendations about how local care services could or ought to be improved to the people responsible for commissioning, providing, managing or scrutinising local care services and to Healthwatch England.
- Formulating views on the standard of provision and whether and how the local care services could and ought to be improved and sharing these views with Healthwatch England.
- Providing advice and information about access to local care services so choices can be made about local care services.
- Making recommendations to Healthwatch England to advise the Care Quality Commission (CQC), to conduct special reviews or investigations, or making such recommendations direct to the Care Quality Commission (CQC).
- Making recommendations to Healthwatch England to publish reports about particular issues.
- Providing Healthwatch England with the intelligence and insight it needs to enable it to perform effectively.

However, the potential scope of our work is vast – we have a responsibility for health and social care services for all adults, children and young people in Norfolk with particular reference to those who are most vulnerable or may be excluded - this includes acute services (hospitals), community services (NCH&C, ECCH and NSFT), Primary Care (GP Practices) as well as adult and children's social care.
This means we have to prioritise the issues we focus on and be smart about the way that we work.

Our Board of Trustees look carefully at these activities and consider where Healthwatch Norfolk are able to add most value. By thinking about the external factors that affect local Healthwatch and about our own strengths and weaknesses as an organisation, the Board identified five key priorities. These priorities were selected to show how we will fulfil our statutory role and ensure that all of our work is clear, targeted and focused.

After identifying five key strategic priorities, we tested each one through the following steps:

1. We ensure that our priorities fit with our role and responsibilities. This ensures that we are delivering to our statutory remit.
2. Then we consider how much the issue matters to local people. It must be something they care about as we are here to be the

voice of people in health and social care.

3. Alongside that we look at policy debates and developments at both a national and local level to assess how much change we can bring about. This enables us to make sure we are choosing areas where we can have the greatest impact. This is important to deliver the greatest return for our budget.
4. We then ask whether the change needs to come from us so we aren't focusing on things that others can do more easily and effectively.
5. Finally, we consider all the priorities together. It is important that our plans are balanced and will have the greatest impact for people using health and social care services.

Our strategic priorities at a glance

As the local consumer champion for health and social care, we believe it is vital that our plans for the next three years help us to achieve our mission:

- **Representing local people**…by becoming the leading source of feedback on health and social care, for both local people and professionals in Norfolk.
- **Meaningful engagement**…by working efficiently and effectively to reach diverse communities across the county.
- **Real improvements**…through an intelligence driven approach to making recommendations for local services
- **Providing a sustainable service**…by maintaining the funding and expertise required to provide an independent and effective local Healthwatch
- **Influencing locally and nationally**…by working with other organisations to ensure services are safe, effective, compassionate and high-quality and **Expanding our horizons by** being ready to stand alone in the event of changes in legislation

1. Representing local people

…by becoming the leading source of feedback on health and social care, for both local people and professionals in Norfolk.

What we know:

- Constraints on funding and reduction of staffing pose a real risk to the quality of local health and social care services – e.g., Local Government reorganisation, merger of Norfolk and Suffolk ICBs, merger of NCH&C with CCS, fledgling Group Model and acute DGH Restructures
- Measuring people's experience of care supports continuous improvements to the way services are delivered
- User feedback helps people make informed decisions
- Commissioners and providers of health and social care services value quality feedback and analysis

What we will do:

1. We will do more to make the views and experiences of local

people known to the commissioners and regulators of local health and social care services.

2. We will use our website to make feedback from local people more accessible and encourage more people to share their experience publicly.
3. We will make it easier for local organisations providing health and care services to access up to date feedback and we will ask them to evidence how they use this information to make improvements to their services.

How we know when it's done:

- We can formulate views on the standard of health and social care provision by collecting the views and experiences of the members of the public who use them.
- Local people have their views and experiences represented as part of the commissioning, delivery, design and scrutiny of health and social care services.

2. Meaningful engagement - by working efficiently and effectively to reach diverse communities across the county.

What we know:

- We have an established track record of engaging local people effectively.
- We want to make sure we're reaching all sections of the community.
- We will advance equality of opportunity for local people to influence decisions affecting their local health and social care services
- It is critical that we are able to explain our role clearly, to different age groups and all communities effectively, in order that their voice is heard.
- The health and care system are complicated and can be difficult to navigate.

How we will do it:

1. We will go out to people in their communities to ask about their experience of using local health and care services.
2. We will provide advice and expertise on community engagement and consultation techniques to commissioners and providers of local health and social care services.
3. We will help people to navigate the complex health and social care systems by signposting people to specialist information and advice agencies or to the appropriate point of access for their local services.

How we know when it's done:

- Local people who share their experiences with Healthwatch

Norfolk are from all areas of the county and all sections of the community.

- Local commissioners and providers are involving local people effectively.
- Awareness of local information, advice and advocacy services is increased through our engagement with local people.

3. Real improvements

…through an intelligence driven approach to making recommendations for local services.

What we know:

- Our remit is vast – we have a responsibility for health and social care services for all adults, children and young people in Norfolk.
- It is important for us to demonstrate impact and value for money.
- There are key challenges in Norfolk for some conditions, services and communities.
- We must be responsive to a rapidly changing health and social care landscape

What we will do:

1. We will review our operating model to ensure that the processes for identifying and undertaking Healthwatch activities are fit for purpose

2. We will gather the experiences of local people from multiple sources and triangulate this data to identify priorities on an ongoing basis.

How we know when it's done:

- Healthwatch Norfolk activities increase the extent to which the voices of the public influence strategies and commissioning.
- Our reports formulate views on the standard of health and social care provision and identify where services could be improved by collecting the views and experiences of the members of the public who use them.
  Overall, our programme of activities significantly increases the extent to which the voices of underrepresented groups are heard and influence social care and services.
- Any recommendations we make improve the quality of local services.

4. Providing a sustainable service

…by maintaining the funding and expertise required to provide an independent and effective local Healthwatch.

What we know:

- The majority of our funding comes from Norfolk County Council

- Norfolk County Council must deliver further savings
- We have a reputation for delivering high quality projects and reports
- Undertaking regular research, analysis and engagement helps to maintain high quality standards

- What we will do:

1. We will provide a 'best value' service delivering the greatest possible return for our budget.
2. We will use our expertise and reputation to provide research, analysis and engagement expertise to other organisations working in health and social care.
3. When our services are commissioned by other organisations working in health and social care, we will ensure that the work we undertake does not conflict with our statutory role. It will enhance the overall effectiveness of our organisation to further improve the information for commissioners and providers of services.

How we know when it's done:

- The quality and quantity of our output and outcomes are not diminished by reductions in funding.
- Healthwatch Norfolk has trusting, collaborative relationships with key local decision makers where its role as a critical friend is understood.

5. Influencing locally and nationally

…by working with other organisations to ensure services are safe, effective, compassionate and high-quality

What we know:

- Health and social care services are under strain
- Regulators find it difficult to assure quality across the sector and their budgets are being cut
- We underuse our statutory powers to Enter and View local services

What we will do:

1. We will work in partnership with the Care Quality Commission (CQC) and other stakeholders to complement local, regional and national inspection programmes and quality assurance strategies.
2. We will design and implement a sustainable, coordinated and effective Healthwatch Norfolk Enter and View service, supporting our volunteers to scrutinize, review and monitor local health and care services and facilities.
3. We will continue to work with Healthwatch England and the network of local Healthwatch organisations to promote best practice and affect change at a national level.

How we know when it's done:

- Whilst still in existence, Healthwatch England receives the intelligence and insight it needs to enable it to perform effectively.
- Quality assurance and monitoring of local health and social care servicesis improved.
- Enter & View reports provide advice about local health and social care services to the public.
- Enter and View visits enable local people to have their views, ideas and concerns represented as part of the scrutiny of health and social careservices.

Achieving our ambition

We have set out a strategy for a more responsive, targeted and sustainable Healthwatch service that ensures we continue to fulfil our purpose. We cannot do this alone and we will work closely with others to deliver our shared goal – a community where people's health and social care needs are heard, understood and met.

Our operational plans will detail what we need to do to achieve our ambitions over the next three years of the strategy. The Healthwatch Norfolk Board of Trustee will use several sources of information to manage our performance and we will keep these measures under review.

The table below sets out Healthwatch Norfolk's "Plan on a Page".

Healthwatch Norfolk's vision is to help shape a health and social care system where people's health and social care needs are heard, understood and met.

Representing Local People Improving patient outcomes		**Meaningful Engagement Ensuring patients/carers at the heart of all decision making**	
How	**Outcomes**	**How**	**Outcomes**
Wider range of evidence collated specifically looking at what patients wish to see as improvements to service provision. Use of surveys, focus groups, communities of interest etc. Views and experiences shared with commissioners to enable them to accurately reflect service user requirements. Comprehensive reports to be prepared in suitable formats detailing specific recommendations for commissioners to action where appropriate. Developing a process to aggregate partner feedback data	The Healthwatch Norfolk Board can demonstrate that they understand the experiences of people who use services in Norfolk, including carers and the wider community. Professionals have access to the views and experiences we gather and can evidence how they use it. Local partners, including commissioners and providers of health and social care services, feel that local Healthwatch feedback and reports are constructive, independent and clear about the rationale for the evidence used. Central hub for data collection enabling both HWN and partners to drill down in areas of concern.	Specific targeting including protected characteristics Make use of JSNA to ensure wider public involvement Logging signposting and using information to help determine priorities Stakeholder feedback session to be held annually	Who we have engaged with, where they live and their characteristics How we have contributed to better local involvement and public participation The number of signposting referrals we make Local partners, including commissioners and providers of health and social care services, feel that local Healthwatch feedback and reports are constructive, independent and clear about the rationale for the evidence used.

<table>
<tr><th colspan="2">Showing real improvements
Impact tracking</th><th colspan="2">Nurture and Manage (an outstanding Team)</th></tr>
<tr><td>Reaching as wide an audience as possible to tackle health inequalities

Following up on any recommendations to measure differences made for patients and carers – use Impact Tracker Tool

Seek feedback from stakeholders to determine additionality</td><td>Who has participated in our activities, where they live and their characteristics
Outcomes achieved following Healthwatch Norfolk recommendations; ‘You said, we did.’

Local partners, including commissioners and providers of health and social care services, feel that Healthwatch projects bring added value through the incorporation of strong public voice – particularly from seldom heard people and communities</td><td>Successful recruitment
Personalised Development

Competitive salaries

Good management

Good working environment

Good forward planning and financial probity</td><td>Cohesive and rounded team delivering outcomes

Benchmarking

Appraisals
Training development support

Attractive productive workspace
Active care of staff wellbeing

Sustainability of organisation</td></tr>
<tr><td colspan="2">Ambition – How
To be seen as the “Go-To” organisation for engagement and research in relation to health and social care

We want to do much more work but our statutory funding is limited so we will pursue project funding from the health and social care sector and beyond both sectorally and geographically.</td><td colspan="2">Ambition – Outcome
Increased sustainability -build up reserves
Broader spectrum of work undertaken
Greater benefits to all residents of Norfolk and Waveney
To succeed we must develop as a high performing specialist commercial market research organisation that will compete nationally.</td></tr>
</table>

DRAFT MINUTES

HWN Board – Quality Assurance Subgroup

Meeting held on 17th March 2026

10:00 at Healthwatch Norfolk Office, NR18 0SW

Present: Elaine Bailey (EB), Linda Bainton (LB), John Spall (JSp), Andrew Hayward (AH), Chris Macdonald (CM), Judith Sharpe (JS) and Sarah Nichols (SN)

Apologies: Emily Woodhouse (EW), Patrick Peal (PP) and Alex Stewart (AS)

Minutes:

No	Item	Action
1	**Welcome and Apologies**	
	Apologies were received from EW, PP and AS. Additionally JS was not present for the start of the meeting.	
2	**Minutes from the last meeting and action log**	
	CM – raised a typo on page 6 where CH had been written not CM. SN to amend.	
2a	**Action Log**	
	Action **47**: *Have internal discussion around report layout, prioritising outcomes and recommendations to ensure we reach our audiences and demonstrate impact*. – This action will remain ongoing and be reviewed on a quarterly basis. It was agreed that the current report structure is good. It was suggested that a supplementary document be developed alongside the full report, containing a summary and key recommendations. Action **99**: *Arrange a discussion with Shane Gordon (and equivalents at JPUH/QEH) regarding the role of HWN in supporting the Norfolk Hospital Group.* – An update was requested on progress, including engagement with Shane Gordon and any developments relating to PALS. SN reported that feedback we received regarding PALS across NNUH, QEH, JPUH, NCH&C and NSFT were collated and passed to AS for onward communication. **ACTION:** Follow up with AS regarding	

	the status of Hospital Group PALS feedback and to update at next meeting. Action **100**: *Share KT's ICB video on NHS App and digital tools with Anne Heath as part of the Digital Tools project, ensuring the ICB have seen it.* – The video is on the HWN YouTube channel and has also been shared with Anne Heath Action **104**: *Share draft AI policy with trustees for review and comment ahead of approval at Jan Board.* – Clarification was sought when this policy will be reviewed. **ACTION:** Confirm when AI policy is due for review and ensure this is added to the board agenda. All other action points were noted as satisfactory.	**SN** **EW**
3	**Review and discussion of current projects**	
	NCH&C – A positive response to the Year 2 report was received and has been published. There is a delay to the Year 3 report, as the originally agreed topic is no longer appropriate and a revised topic has not yet been confirmed by NCH&C. The second theme will focus on high intensity users. Clarification was sought regarding what is stated in the contract regarding delays, at what point can we no longer fulfil requirements and whether escalation is required. **ACTION:** Escalate identification of year 3 project topic with NCH&C. JS joined meeting at 10:36. ASC Year 3 – Delays to the project were noted due to lack of response from the commissioner. The proposed project involves engagement with care homes to gather feedback followed by a subsequent visit to assess improvements. Due to project time constraints, it is proposed that each care home is visited once, with follow-up conducted via telephone or survey. The practicalities of this approach will require further consideration. The engagement team will be helping with care home visits.	**AS**

	Concerns were raised regarding a lack of communication from commissioners and how best to manage and work effectively within these constraints. It was noted that challenges are more common in longer term projects as people, the landscape and context may change over time. It was raised whether this could be discussed at the partners day to see how we can best work with and support commissioners. ASC Year 2 – The reports are complete and ready to be published; however, ASC has requested that these are not published publicly. This goes against the contractual requirement for publication and discussions are ongoing to explore potential compromises such as limited promotion and publicity. **ACTION:** Discuss publication of ASC year 2 report at the managers meeting 18/03/2026. A meeting was recently had to discuss our communication strategy and how to best use staff time to have the largest impact. This is still being drafted but means communication efforts may change to target those to impact. Additionally, it was asked whether we are able to do work which does not get published and is only for the commissioner. JS was unsure whether this is specifically stated in our objects but is something that can be considered in our future. Digital tools – The project is on track. One focus group remains outstanding and the survey is now live. SMI Carers – An amendment was provided by JSp to the update provided at last QA regarding the development of the new SOP for CMHT, clarifying that this applies to a small cohort who will not be discharged from services and not all patients. Further inpatient discharge processes are being reviewed, and outcomes will be shared with us in due course. Regarding the current project the team have interviewed a number of carers.	**JS**

	Challenges were noted in recruiting staff participants for interviews, with two completed to date, with a goal of recruiting five to six. Downham Dementia – The project is on track, and the survey has been approved. Genomics – Initial findings will be presented by EW at a workshop next week. Some disruption has occurred due to the withdrawal of the project consultant; however, the project continues to be managed effectively and remains on schedule. ECCH – The project is on track. Targeted engagement has been scheduled to improve survey response rates. JS mentioned she routinely tracks the tender portal for both items related to Norfolk and Healthwatch. **ACTION:** Set up routine search alerts for the tender portal to support income generation.	**EW**
4	**Review of project ethical considerations**	
	There were no ethical considerations to discuss	
5	**Review of Impact Tracker and Project Recommendations**	
	An overview of the impact tracker was provided by SN. Still receiving large amounts of feedback regarding frustrations with PALS response times. No new themes have emerged over the past three months. It was expressed how a majority of the issues raised with us are surrounding inadequate communication. Examples of demonstrated impact were highlighted. There was also a discussion regarding patients on hospital waiting lists and how they appear to fall through a gap where the GP is unable to manage their condition and the hospital will not do anything while they are still on a waiting list which can cause distress for the patient, and often additional work for the GP through expedite letters. JS raised concerns regarding colonoscopy biopsy result waiting times at NNUH of up to six months, following receipt of correspondence indicating delays of several months. The NNUH	

	stated this was an admin error however it is unknown how many patients were affected by this, and we know of patients who have waited this long. **ACTION:** Forward patient colonoscopy biopsy letter to EB for investigation at NNUH.	**SN & EB**
6	**Review of Project outcomes**	
	Feedback was sought from the team on recent changes to report writing. Initial views from JSp were positive, although there has been limited opportunity to fully test this. Work is also underway to define what constitutes a "light touch" analysis. This was trialled by AD for the analysis of a focus group which was reported to be successful.	
7	**Project to be presented at next Board meeting**	
	EB provided positive feedback on the QA annual wrap-up presented by EW at the previous board, suggesting this becomes an annual presentation. A proposal to deliver a presentation on challenges and barriers in report writing and project delivery, along with potential solutions, was discussed. It was agreed that this would instead be incorporated into the QA section of the board meeting. It was also proposed that the two Norfolk County Council Public Health reports (NHS Health Checks and Smoking) be presented at board to highlight the engagement team's hard work in gathering engagement and their use of innovative approaches to engagement across a range of settings. This was agreed to be the project presented at board.	
8	**Any Other Business**	
	Multiple people are unable to attend the QA meeting on 30th June 10-12 and asked if this can be rearranged. **ACTION:** Reschedule next QA meeting.	**SN**

	Additionally, it was agreed that an item on the use of consultants and learning outcomes be included on the agenda for the next QA meeting. – **ACTION:** Use of consultants and learning item to be added to the agenda for next QA meeting	**EW**
	Date of next meeting: • 30th June 10:00 – 12:00 • 29th September 10:00 – 12:00	

Meeting ended 12:10

Healthwatch Norfolk – Strategic and Operational Risk Register (April 2026)

	Risk Category	Risk Description	Context	Risk score	Direction of risk	Risk Appetite	Indicators	Mitigation / Controls	Contingency Response	Risk Owner
1	Strategic Future of Healthwatch	Uncertainty surrounding Healthwatch's long-term future following national policy proposals for dissolution.	NHS 10-Year Plan and government reforms may alter or absorb Healthwatch functions into ICB or LA structures.	4x4=16	→	**Open:** Trustees willing to consider all potential delivery options that provide an acceptable level of reward.	Policy announcements from DHSC / NHSE	~Active engagement with HWE, LA, ICB and service providers ~Scenario/transition planning ~ Maintain advocacy for local voice retention ~Maintain positive stakeholder relationships	~Transition & continuity planning/options appraisals incl. emergency contingency planning ~Negotiate continued delivery roles ~Ensure core public voice functions are embedded in any successor body	CEO / Board
2	Financial Sustainability	Insufficient or reduced funding to sustain operations. Unexpected mid-term contract cancellations	Public funding constraints or shift of budgets to ICBs	5x5=25	→	**Cautious:** Trustees have preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	Fewer contracts and reduced values. Delayed payments	~Diversify income (grants, commissioned projects) ~Ongoing financial review including forecasts, projected income, reserves, project margins, cost control. ~ cancellation clause has been added to project agreements	~Prioritise essential functions ~Emergency budget controls as required	CEO/D CEO/ Finance Sub-committee
3	Workforce Stability and Retention	Loss of staff or volunteers due to uncertainty, morale issues or limited progression.	National uncertainty re HW tenure Short-term contracts Role ambiguity.	3x3=9	→	**Open** Trustees prepared to invest in our people to create innovative mix of skills environment.	Rising turnover, vacancies, staff feedback	~Open communication ~Wellbeing support ~Training and career development ~Retention incentives ~Proactive line management	~Maintain 'skeleton team' for continuity ~Rapid recruitment or interim cover plans ~Maintain 'expert' consultancy list (& use if needed	CEO/D CEO

						Responsibility for non-critical decisions may be devolved.				
4	Reputation and Stakeholder Confidence	Loss of credibility or public trust in Healthwatch's independence and impact	Structural reform could create perception of diminished influence.	3x4=12	➡	**Averse:** Trustees have zero appetite for any decisions with a high chance of repercussion for the organisations' future	Negative media commentary Partner disengagement Declining public enquiries	~Clear communication strategy ~ Promote evidence of impact ~Proactive media engagement ~continuation of HWN public events	Stakeholder reassurance campaign	CEO/D CEO/ Board
5	Governance and Compliance	Weaknesses in governance, legal, or statutory compliance during structural change.	Ambiguous responsibilities during transition	3x3=9	➡	**Cautious:** Trustees willing to consider actions where benefits outweigh risks. Processes, oversight and monitoring enable cautious risk-taking. Controls enable fraud prevention & detection.	Audit findings/ Breaches Unclear lines of accountability	~Regular board reviews ~Governance training in accordance with policies ~Legal & accountancy advice on future models	Establish interim governance arrangements as required Maintain audit trails	CEO/D CEO/ Board
6	Operational Continuity	Service delivery disrupted by funding, staffing,	Contract ends or major reform enacted with short notice.	2x4=8	➡	**Open**: Trustees support innovation with clear	Late project delivery/missed KPIs	~Business continuity plans ~cross-trained staff	Emergency continuity plan Prioritise statutory duties	CEO/D CEO

		or transition changes.				demonstration of benefit/improvement in management control. Responsibility for non-critical decisions may be devolved.	Stakeholder complaints	~ digital documentation		
7	Data Management & Information Governance	Loss of data, breaches, or failure to comply with GDPR.	Staff turnover, system change, or transition to new data environment.	3x3=9 (12)		**Cautious:** Trustees accept need for operational effectiveness with risk mitigated through careful management limiting distribution.	Data breaches, access issues, loss of IT capability	~Data protection & Cybersecurity training ~ regular audits ~Use of MFA ~Cybersecurity insurance ~Emergency plan with IT provers	Data restoration plan; notify ICO if required; rebuild records from backups	CEO/DCEO
8	Impact Delivery	Failure to demonstrate tangible impact or meet stakeholder expectations.	Focus diverted by national uncertainty or reduced resources.	3x4=12		**Cautious:** Partners have preference for safe delivery options that have low degree of inherent risk and may only have limited potential for reward.	Poor or lack of impact metrics Low survey responses Weak engagement	~Clear impact audit framework ~Regular monitoring with regular board oversight ~ 1/4ly contract meetings with NCC ~regular report sharing with stakeholder of impact	Review priorities Prioritise maintenance of impact tracker	CEO/BDD/QA Sub-committee
9	External Relationships & Partnerships	Breakdown or loss of key partnerships (ICB,	Changing system architecture or loss of confidence in Healthwatch role.	3x3=9 (12)		**Open:** Trustees support innvovation with	Reduced collaboration leading to fewer	~Regular engagement meetings ~Initiation of MOUs ~Joint working groups	Rebuild trust through joint projects; escalate via Healthwatch England	CEO/Chair/ BDD

		VCSE, local authority)				demonstration of benefits/improvement in service delivery.	commissions of work Funding losses	~Proactive relationship management			

RISK MATRIX:	Likelihood				
Consequence	1 – Rare	2 – Unlikely	3 – Possible	4 – Likely	5 – Almost Certain
1 - Negligible	1	2	3	4	5
2 - Minor	2	4	6	8	10
3 - Moderate	3	6	9	12	15
4 - Major	4	8	12	16	20
5 - Catastrophic	5	10	15	20	25