Board Meeting

Date of Meeting: Tuesday 17th December, 2024
Healthwatch Birmingham Board Meeting
Time: 4 pm – 6.30 pm
Venue: Hybrid meeting

Public Session

Attendees

Board Members in attendance		
Richard Burden (RB) - Chair	Andy Cave (AC)	John James (JJ)
Janet Bailey (JB)	Ruby Dillon (RD)	Jasbir Rai (JR)
Jane Upton (JU)	Rosi Sexton (RS)	Marcus Parsons (MP)
Anna Wittkop (AW)	Marcia Lewinson (ML)	Tim Phillips (TP) – HWB Volunteer Board Representative
Di Hickey (DH) – Minutes		
Public in Attendance		
There was one member of the public in attendance to observe.		

Apologies

Jenny Newman (JN) – HWS Volunteer Board Representative	Peter Rookes (PR)	

1	**Welcome & Introductions - Noting any members of the public in attendance and Apologies**	For Noting
	RB welcomed everyone to the meeting. A special welcome was extended to AW and ML (new NEDs) to their first meeting and Sulhyia Ilolova (Volunteer).	
	Declarations of Conflict of Interest	For Noting
	There were no additional conflicts of interest declared, that aren't already on the register.	
2	**Minutes of previous meeting (15th October, 2024)**	For Approval
	The minutes of the previous meeting were agreed as a true record. There were no matters arising.	

3	**Actions Arising – All** **Action log**	For Action For Noting
	AC updated as follows: <u>Actions from meeting on the 15th October, 2024</u> Whistleblowing - still in progress and building into future thinking and ways of working and will bring back to a future meeting – ongoing. Meeting with Joanne Rooney – booked in for February, 2025 with AC and RB – closed. Arranging the briefing from the Community Trust and the Mental Health Trust - Will try and slot that in before the March board meeting – ongoing.	
4	**Appointment of New NEDs**	For Approval
	The appointment of AW and ML to the Board was approved, subject to completion of the necessary checks and paperwork.	
Operational Performance		
5.	**Impact Stories**	
	AC reported as follows and highlighted two pieces of impact which were driven through the impact tracker: Lack of wheelchairs at Heartlands Hospital – this issue was raised with the hospital after feedback from the community engagement team that there were not enough wheelchairs for the frail and people with mobility. They noticed a number of frail older people struggling to walk or leaning up against walls. As a result of this the hospital has reviewed the number of wheelchairs, distributing more wheelchairs across the site. Birmingham City Council consultation on Day Opportunities – In our consultation response we highlighted the impact of the consultation process itself can have on service users and carers. Increasing anxiety and uncertainty about the future. We suggested that they should link users of the service and their carers to mental health support during the consultation period. This learning has been included in their new consultation process for Care Centres, citing us as the reason for increased support. Whilst the issues tracker is a huge document and growing all the time, it is doing what we intended it to do, tracking the range of issues and the actions we have taken which were previously missed. (AC). It's valuable to track our impact, especially with the positive outcomes on day centres where our input has made a difference. However, it's also important to highlight instances where we didn't achieve the desired impact. For example, despite efforts from several Birmingham Councillors to call in BCC's plans to close multiple day centres for further scrutiny, the Commissioner overruled the request. We supported this initiative, as maximum scrutiny was essential. While it's encouraging that consultation and engagement with service users are being strengthened, significant concerns remain about the substance of the plans themselves. (RB).	

6.	• **Performance Update Healthwatch Solihull and Healthwatch Birmingham**
	  o **Feedback Heard**
	  o **Community Engagement**
	  o **Information and Signposting**
	  o **Investigations and Consultations**
		For Noting

	AC reported as follows: <u>Feedback Heard</u> This KPI is usually subject to a payment by results model, however in our extension period we are not subject to this. We are on track in Birmingham and performance is where we need it to be at this point of the year. A large percentage of feedback is heard through face-to-face engagement which is where we get the best quality data from. Solihull are behind target for end of quarter one and continues to be behind target for the end of November. This is mainly due to the leap needed to increase by 30%, this is a large increase for Year 5 of the contract. We had a long-term absence within the team but are now back to full capacity and have put plans in place to recover where we are at. We do very well when we come together as a team and come up with different ways of working to recover our KPIs and have a good track record of doing that and are confident we will get back on track (AC). <u>Information and Signposting</u> Birmingham is ahead of target and are where we are meant to be by the end of November. Eighty percent of Information and Signposting activity now comes through community engagement which is a huge increase from where we were two or three years ago when it was mainly through the telephone system and email. We are slightly behind in Solihull which has been rag rated as amber. Now that the Information and Signposting Officer is back, we should catch up quite quickly. <u>Investigations and Consultations</u> Consultations are on target for both Birmingham and Solihull. The two to note were Day Opportunities in Birmingham and our joint response to the NHS Change Consultation, 10-year plan. In terms of investigations in Solihull we have written a draft report on women's experiences of menopause diagnosis and treatment in Primary Care. The draft report has been shared with Primary Care Networks and with the Integrated Care Board (ICB) for which we have received a response. (AC). What recommendations are coming out of the menopause report? (ML). There are three key areas, the main one is around a real lack of awareness of symptoms in Primary Care. It highlights that access to appointments is poor but when women are able to access to talk around their symptoms they are often classed as something else other than menopause, so diagnosis is difficult. Communication of menopause symptoms to the	

	public is poor. It was also identified that treatment options are not very well explained particularly around HRT. We found that women were not offered HRT, however NICE guidance has changed around that since we did the survey. Similar things came out in our menopause study to what came out in the national women's reproductive health report which was also released. The national report very much talked around women not being believed when going to Primary Care and the stories that came through us really chimed well with the national report. We did respond to the Women's Reproductive Health Consultation and our response was cited. Did the report directly influence the NICE guidance? (MP) No, it was just a coincidence that it happened along the same timelines. (AC). The ICB did have the ex-CEO of the Royal Orthopaedic Hospital heading up the menopause work and she was good in terms of trying to get something moving on that. She has now moved on to Shropshire, we still try to identify who in ICB has got ownership of driving this issue forward (RB). This is a topic that I regularly have conversations with people about, it is something where I notice that there are huge health inequalities, as with anything that involves access to Primary Care. People who live in poor areas, or have less awareness of how health systems work, or are less articulate, are less likely to be able to get appointments. People who can't articulate their symptoms well often get brushed off. I wonder if there is a piece of work to be done around access to Primary Care and health inequality and the differences in that access. That is something that I would very much like to see done (RS). With regard to the menopause topic, I know that Birmingham and Solihull are separate but there is a lot more awareness in the medical community that women in ethnic minorities experience the menopause at a different age with different symptom complexes. Is there any mileage in doing a similar thing in the Birmingham area where that's going to be an even bigger issue. (AW). Even though we did it for Solihull, our conversation with the ICB is for both Birmingham and Solihull. We don't have a local women's health strategy yet and that would be a good way to influence. In terms of Primary Care access and inequalities there are a number of lines on the issue tracker that pull that in. In particular, we are hearing about online only appointment systems which are causing people issues and even when people are going into book their appointment face to face or over the telephone, people are still being told to go online. It is a continuous conversation that we have with the ICB around Primary Care, and we are working with the GP Provider Support Unit on a number of initiatives that they are trying to do to improve it. It is going to take a long time to work through what needs to change. The other message that we give out loud and clear to our local system is that Primary Care isn't just GPs, the Primary Care Strategy is only focussed on GPs and doesn't pull in the work that Pharmacy does. The issue tracker is so important so that we can track those conversations which we couldn't before (AC).	

	It is important to note that whilst health inequality is always a focus for us, if the study or investigation isn't designed to identify inequalities then we just have to be careful not to read too much from the data or try to answer questions it wasn't designed to answer. (AC). My question would be why wasn't it designed in that way, as it's a fairly obvious issue that we know that anything that involves Primary Care access at the moment will have an inequality component to it, so surely we should be looking for that as a default (RS). When we look at general population, there are things coming through and we can slice the data. When we are looking at specific inequalities, we will do a specific report like we did with the Maternity services for Black Caribbean and Black African women in West Birmingham report because that will give us richer data and it doesn't necessarily come through when we do a whole population approach. When we talk about inequalities there are a lot of different groups and because we only do a certain number of reports a year there's a limit of how many individual topics that we are going to be able to look at (AC). The issue I keep highlighting at the moment is access to healthcare for neurodivergent people. We already know there are significant health inequalities, differences in life expectancy, and widespread concerns about access to healthcare. It's something I would really like to see explored further. I'm not sure whether we have the scope to address it in a separate report, but it should certainly be considered alongside other key issues. As ever, factors such as ethnicity, income, and education inequality come up time and time again in these discussions. (RS). They are all interesting points and ideas to shape our future ways of working. (AC). In addition to that report, Solihull we are looking at individuals' experiences within care homes. For Birmingham we are looking at individuals' experiences of domiciliary care. It is important for us to have a focus on Adult Social care. The surveys are live now (AC). The one that is pretty much imminent in Birmingham is the investigation that we did into hospital discharge, which is clearly going to be very topical around winter pressures. (RB). It is specifically looking at patient and carers involvement in the discharge process. We know that if people aren't involved or have clear communication around what to expect when they come out, that they will end up going back in or going back to Primary Care (AC). I noticed in one of the key risks highlighted for the Care Home investigation, is if providers are uncooperative for us to have access to patients and families. Is there anything we can do to raise the profile and role of Healthwatch to minimise that (JB). We have worked closely with the Commissioners at the Council who have supported the promotion and have put their support behind this project to encourage care homes to let us in. Equally we have presented at the Care Home Provider Network. We have started some of the engagement and will use that as case study examples of how that has worked. We do have	

	the power of Enter and View if needed. We are also combining that with promoting the Survey online and at events to maximise our reach. (AC). Do you have criteria that would apply as to when you would use Enter and View (RS). It is through the investigation protocol planning stage, so if that is the most appropriate tool to get the results that we need we would use it (AC). Are there situations where if a care home is being uncooperative, would it be helpful to have a policy as to when we would apply that (RS). It is outlined in our procedure for relevant decision making. (AC). It would be worthwhile us reviewing that, I think my instinct is that it would be difficult to have a catch all set of criteria, because when you reach the point of saying this is where we need to press the button it will vary, with a care home it probably will be when we want to. In relation to the other end of the scale in terms of size of organisation, Hospital Trusts might need a different methodology of decision making. (RB). Overall, there are different levers that we can pull to get the results that we want so it is that last resort but will use it if needed (AC).	
7.	**Volunteer Update – Volunteer Reps**	For Noting
	TP reported as follows: The last volunteer meeting was held on the 11th December where we talked about the face-to-face training that was held in October which was very enjoyable. A December Thank you event for volunteers was held in December which included staff and Board members. This get together was held in Solihull for the first time by request of the Solihull volunteers. It was enjoyed by everyone in attendance. A standing item on the agenda was on impact and investigations and Birmingham research for a care at home study was held on the same afternoon. Volunteers who attended found the session interesting and CKN fed back to GB how helpful it had been inputting the research survey. At the Volunteer get together we talked about the impact of volunteers on organisations over the last year including how representative our volunteer are of our local communities. It was a real celebration of everything the volunteers have achieved. We even had a Board with quotes from staff and Board members thanking volunteers (AC). The Board expressed their thanks to all the volunteers for their support and help over the year, the tributes that were paid to the volunteers at the Xmas event were very genuine and widespread (RB).	
8.	**Our Values – Feedback from Volunteer event**	
	A joint Xmas celebration was held on the 3rd December. AC did an informal exercise at the December get together at looking at our values	

	as an organisation. This was to compare our current values with the new Healthwatch England Values. (RB). NEDs, volunteers and staff were asked if we should adopt the HWE values, which on the face of it are a much simpler set of values. Overwhelmingly the feedback received was that whilst HWE values are simpler, the wording behind our current values was much better. The Board is asked to approve this approach and for a new set of values to be drawn up combining the two. If required as part of the tender process these values will be approved via email.- (AC). It should be theoretically possible because the two sets of values are compatible, and my instinct is that the headlines would probably be the HWE one with an explanation of what that means in the local context, generally I think that ours get across a lot better what we are saying, except in one area which is independence as one of the core values which kind of runs through ours but may be worthwhile of making it more explicit (RB). In addition, it was pulled out that equity and collaboration can be strengthened as not strong in our current values, which people really liked. The feedback was really useful. (AC). **Action – Board members to contact AC with any feedback on the values.** It would be really useful to adopt the HWE value behaviours as this will really strengthen the final document. (JB). **Action - AC to circulate behaviours to board and board to feed back in order to incorporate with Values.**	
Sharing Information - Public		
9	• **System Updates** o **Dash Review** o **Change NHS – 10-year plan** o **Winter Pressures** • **Key Issues Tracker – Board Involvement**	For info
	AC reported as follows: <u>Dash Review</u> At the last meeting, I reported that Penny Dash had been asked to review patient safety organisations as part of the regulatory system, following her work on the CQC. This review includes six organisations, including HWE and local Healthwatch, focusing on regulation and patient involvement. In October, we expressed our interest in being part of the review, and I reached out to HWE, securing a place as one of ten local Healthwatch involved. The report will be published in early 2025. <u>Change NHS – 10-year plan</u> AC reported as follows:	

The NHS 10-year plan is currently under consultation. Healthwatch has contributed its insights in response, despite a short timeframe for organisations to engage. Efforts were made to encourage public participation, though the process was complex. Additionally, Healthwatch is working with the ICB, which has a longer response period, to ensure patient voices are central to their submission.

The plan outlines three key shifts: (i) from hospital-based acute care to community care, (ii) from illness treatment to prevention, and (iii) from analogue to digital healthcare. (AC)

Its concerning that there is such a lack of detail, particularly regarding digital implementation. Poor execution could worsen inequalities and disrupt patient care rather than improve. (RD)Part of our response was around the inequalities around digital, the detail isn't there to be honest. (AC).

A significant concern is the diminishing focus on personal relationships in healthcare, with patients increasingly directed towards digital tools or seeing different practitioners each time. This lack of continuity is particularly problematic for those with chronic conditions. (RS)

Our involvement can continue in three ways: (i) encouraging public engagement via social media, (ii) feeding into Healthwatch England's national response, and (iii) contributing to the local Birmingham and Solihull ICB response.(RB).

It was noted that Healthwatch England's Chief Executive is co-chairing a national committee on the plan, offering an ongoing route for influence.

<u>Winter Pressures</u>

We have had a few meetings with the ICB and met with UHB recently and the main focus of our conversation was around winter pressures. We are potentially going to have the worst winter ever locally, and this is seen nationally. The main driving force is the number of people in hospital with influenza. There is also a warning of norovirus as well (AC).

There has been a big increase in respiratory illnesses amongst children, and an ongoing thing which has been growing throughout the year is an increase and steady flow of people requiring mental health support at A&E. (RB).

I know we have done work in the past looking at variations in uptake and inequality access to childhood immunisations. Have we ever done it looking at adult immunisations in terms of prevention. We are talking about influenza and Covid and they are talking about a norovirus vaccine in the future (JJ).

It is an issue that came up at the Integrated Care Partnership (ICP) a few weeks ago that JB and I were at. The issue of poor uptake of vaccinations in particular parts of Birmingham and Solihull is a big issue. Very broadly it reflects the communities where there is poor take up around covid, they say they are learning some of the lessons of what happened during Covid, where there was some quite imaginative work done to increase take up during that time but there is still a big pressure point on that (RB).

	We have not done a specific report, however we have supported the work of the ICB around it. There is a clear understanding of the reasons why people are not taking up vaccinations and immunisations, particularly in terms of user engagement. However, the challenge lies in how the system responds to this knowledge. The key issue is ensuring that conversations within communities continue. With no additional resources available for further work, the focus must be on how the health and social care system can maximise every opportunity to promote vaccinations to individuals. (AC). Do we have any insight into how the changes in geography will impact capacity following the relocation of City Hospital? Specifically, will there be any changes in capacity, and how might this affect pressure on the QE, given that patients from City Hospital will now be travelling to Midland Met? Could this pose any risks in terms of capacity or patient flow? Would it be worth investigating further? (AW). A model was conducted before the hospital opened, which suggested there would be no impact on UHB, with the effects expected to be more towards Dudley and Sandwell. However, we don't have any scheduled data on this, so we will add it to the agenda for our next discussion with UHB. Patient feedback on Midland Met indicates that it feels significantly understaffed, particularly in the Emergency Department, with reports of negative experiences at the new hospital. (AC). <u>University Hospitals Birmingham - Update</u> We continue to meet regularly with the Chair and Chief Executive of UHB. While structural changes have been implemented—each hospital now has its own executive director—leading to positive feedback on increased ownership and accountability, most of this comes from senior leadership. Informal visits suggest improved relationships between directors and frontline staff, with a less hierarchical culture emerging, though this will take time to embed. However, concerns remain about the pace of cultural change and how embedded this really is. (RB). <u>Key issues tracker – Board involvement</u> This is a standing item on the agenda to keep you informed about the range of issues we are tracking at the moment. If you hear of any issues, please flag them with us to add to the tracker. (AC).	
11	**Any Other Business**	
	There was no other business to discuss. The meeting closed at 17:40. Date of next meeting: 4 pm on Tuesday 18th March, 2025.	