Minutes of Healthwatch Cornwall Board meeting
Thursday 21 July 2022, 2pm
Truro Library

Present:
Directors: Anna Pascoe (AP) – Chair; Christine Hunter (CH), John Evers (JE), Julia Wildfire-Roberts (JWR), Tracey Camps (TC)

In Attendance: Mario Dunn (MD), Anne Oliver (AO), Morwenna Gee (MG) - part

PART 1: In public agenda

1. Welcome and Introductions

1.1 AP welcomed all to the meeting and said it was lovely to see Directors new and old in person, as active contributors to the Board. She explained that Deborah Came and Margaret Abban had submitted their resignations. She thanked them for their participation over the years they had been Board member and thanked them for their contribution and service to the Board. AP also informed members that Bridget Sampson had decided not to take up the Directorship after all.

1.2 JE said that he would also be stepping down although he was happy to remain until a replacement could be found. We have a recently retired GP who has already expressed interest in joining the Board and it was agreed that MD should approach this person initially, with a view to being nominated at the next Board meeting in October.

2. Apologies

2.2 Roger Sinden was unable to attend the meeting and had sent his apologies.

3. Questions and comments from the public

3.1 No formal questions or comments have been received.

4. Conflicts of Interest

4.1 JWR said that the company she works for is a provider of Mental Health First Aid and ASIST training, it was clarified that HC access this training for the staff, rather than provide the training.

4.2 AP said that any potential conflicts of interest could also be raised during the meeting and the Board to give guidance at the appropriate time.

5. Minutes of the last meeting: 28th April 2022

5.1 Minutes were agreed and ratified as a true record.

6. Actions / matters arising

6.1 AO has received the Declaration of Interests from new Directors and the 2022 Register of Interests will be circulated to Directors prior to being published on the website.

6.2 Ethnicity groups are now published in alphabetical order.

6.3 Sir Robert Francis's letter to local LA Chief Executives on the new ICSs and future funding of the Healthwatch network will be circulated to Board members.

7 Board Opportunities

7.1 MD introduced this paper which had already been circulated to Directors.

7.2 He highlighted the two internal appointments – one to replace Margaret Abban on ODAG and one to represent the Board on one or more of our Partnership Boards to replace Deborah Came who had attended the Carers PB both as a carer and a HC Director.

7.3 Also Jon McLeavy had sat on both the Safeguarding Adults Board as HC representative giving the SAB appropriate status, and the South West Clinical Senate Citizen's Assembly which is an overarching public body from a clinical perspective.

7.4 JWR volunteered to be representative on SAB and the Partnership Boards, given her experience in both fields.

7.5 TC volunteered to be representative on ODAG given her HR experience.

7.6 CH volunteered to be representative on the South West Clinical Senate Citizen's Assembly.

7.7 All nominees were proposed by AP and seconded by JE and approved. MD to send emails to introduce each nominee to the appropriate contact. AP offered to sub if any of the new nominees couldn't make meetings.

7.8 Linked to this work, AP circulated a proposed Board Directors development schedule and asked for initial thoughts and comments. This is planned to start with developing as a new group, then meeting staff, then moving to reviewing the effectiveness of the Board and Directors.

7.9 CH said that it was good to have a mixture of skills on the Board and for them to be informed so they can understand how the System works.

7.10 TC said the Directors need to be passionate about the aims of HC and to be willing to work as a team.

7.11 JWR said that is important for HC to be as representative as possible, especially considering the Transformation agenda. This involves health and social care staff working together, including the Third Sector, which makes health and social care more accessible to people.

7.12 JE said there were two paths to consider: being experts in the process of governance; and the clinical side with current or recent experience in both health and social care. He noted that services for older people are not getting better and he would be happy to contribute in any way once he has retired his Directorship.

7.13 AP said that it is important to learn from each other to work within the aims of the organisation. She thanked everyone for their comments and asked them to feedback any thoughts to her, as she appreciated this was the first time Directors have seen the document. She will then amend and re-circulate for approval.

8 Work Plan 2022/24

8.1 MD introduced the Workplan which had been circulated previously to Directors for them to approve and be adopted.

8.2 He explained that due to the nature of the HC core contract and the fact that health and social care challenges are enduring, a 2 year plan will facilitate review of our contract in 2024. The Workplan has been produced in consultation with the management team and the wider staff team at an Awayday,

8.3 It is aimed to be less output prescriptive, with three main headlines. Outcomes are about specific issues within a particular topic.

8.4 JE said that it was an impressive document. He commented that he is concerned that we are able to concentrate on the basic things that are important, such as access to mental health, GPs, dentistry and social care. He suggested that the quarterly report to the

Board details how we are getting on these areas and makes them as focused as possible.

8.5 CH said that it is also important not to lose sight of emerging issues such as hospital waiting times, issues at West Cornwall hospital and social care. TC said that people with specific issues, such as a pregnant woman, also need to be heard and would focus on, for example, the work of KMVP and KPJ.

8.6 AP said that we are commissioned to do certain pieces of work which have to be included in the Workplan.

8.7 MD noted that we are currently undertaking two pieces of work around mental health – the Mental Health Suicide Prevention project and Carers for those with Dementia research, which are big topics in Cornwall.

8.8 JWR said it's important that we talk about the work we do.

8.9 JE said that the issue with dementia is not just diagnosis, but access to care.

8.10 MD said that future CEO reports would be consistent with the Workplan as well as outlining current work.

8.11 JE proposed and CH seconded that the Workplan be approved and this was approved and adopted by the Board.

9 CEO Report

9.1 The CEO report had been circulated prior to the meeting. MD highlighted two areas, the new ICB and staffing.

9.2 **ICB update**

9.2.1 The new ICB came into being on 1st July with the CCG becoming redundant. MD sits on the ICB and the Integrated Care Partnership (ICP) wider Board. The ICP is due to meet next month. MD has attended two meetings of the new ICB.

These have primarily involved processes such as finance, staffing and incorporating previous CCG governance processes into the new structure.

9.2.2 There will be sub-committees including the Citizen Engagement Committee chaired by Carol Theobald. This has not met yet and Jody Wilson will be our HC nominee. This is likely to be where the meaningful work regarding public engagement will take place, including via the 3 ICAs who have GPs as Managing Directors and will be the key focus of place-based services.

9.1.3 MD said it is crucial that meaningful engagement takes place with the public and to ensure reality matches rhetoric. Services are to be commissioned more locally, and they must meet the needs of people especially those who are not currently accessing services.

9.1.4 Recruitment for an Engagement & Communications Director is ongoing who will be working with organisations like ours. There is potential for HC to have a role in assessing the activity and monitoring the performance of the ICB.

9.1.5 Prior to the launch there was a 2 day conference, True North, at which 75-100 key stakeholders across health and social care contributed to an ambitious and interesting event.

9.1.6 MD will continue to update the Board on an ongoing basis about developments with the ICB. He noted that John Govett (Chair) and Kate Shields (CEO) are committed to Citizen's engagement.

9.1.7 JE commented that the structure is the wrong way round, it should have People with empowerment of Place at the top. MD said that this was expressed at True North but the Government directive is top down. He said that HC have not

had a definitive conversation about our role but noted that having a voice in commissioning in Cornwall would be too large for our current staffing level.

9.1.8 AP agreed that the True North presentation (circulated as an appended document to the CEO report) is jargonistic and management speak, and that there is some way to go, although she believes in John Govett's commitment to health and social care.

9.1.9 MD said there seems to be a continued reluctance for different Trusts and organisations to share data. TC said that looking from the outside, there are a number of disparate groups not joined up in any way.

9.1.10 MD agreed that the ICAs are crucial. JE added that the PCNs meaningful role is crucial. MD said that the West ICA is more developed than the central and north and east ICAs.

9.1.11 AP agreed that Cornwall has particular challenges because of rurality, geography and poverty. It is hard to see how one body can deliver equity in Cornwall. MD said that having one local authority and one ICB is helpful in one way, but a challenge over such a vast area.

9.1.12 TC asked why the West ICA is moving ahead faster than the other ICAs. Directors agreed that it was down to leadership, and JE gave the example of social prescribing starting in the West.

9.1.13 MD said that once the Citizens Engagement Committee is set up we will have a better understanding of how patient and public involvement is working within the ICB.

9.2 **Staffing issues**

9.3.1 MD said that the Recruitment & Retention Policy, which is an agenda item later in the meeting, is linked to this.

9.3.2 Our Communication & Campaigns Manager has handed in his notice. The management team have decided to defer recruitment to September but the vacancy will be disruptive and a challenge.

9.3.3 AP asked if there are any current staff interested in more hours, or contracting out part of the work? MD said that is an option but we are at maximum capacity for the hours staff want to work.

9.3.4 TC said that the retention issue is widespread, it is not just affecting HC. She realised we can't increase pay, so it's finding a key to keeping staff – something that comes with your contract that you wouldn't want to lose.

9.3.5 JWR said "a day in the life", with end to end story of personal experience of working at HC – why it's good to work for us – would be good to promote vacancies.

9.3.6 AO confirmed that we currently recruit through Indeed, Voluntary Sector Forum, Cornwall Council jobs, Unlocking Potential, Inclusion Cornwall newsletter and Linked In free posts, as well as circulating through our comms contacts and staff personal contacts and paid contact on social media.

9.3.7 JE suggested a recruitment drive into Universities and Colleges, as we offer pathways both in IT and health & social care.

15 Update from staff member

15.1 At this point AP brought forward this item and Morwenna Gee was welcomed to the meeting to present her update on Kernow Parenting Journey (KPJ) and Kernow Maternity Voices Project (KMVP).

15.2 MG started with HC as Project Officer for KPJ 12 months ago, and a lot has changed in this time. KPJ was commissioned by the Local Maternity & Neo-natal Service (LMNS)in the immediate aftermath of the preliminary Ockenden Report (this had been commissioned following the news of 200 females directly impacted by baby or infant death).

15.3 A review of Better Births in 2016 was the first active change happening from the Ockenden report. This review acknowledged that parent education, especially around infant feeding, is not good enough. The only existing ante-natal training was the Bump to Baby programme, consisting of 3 delivery sessions. This had only 17% attendance across Cornwall & IoS and most didn't finish the course. The main issue was clinical pressure on services, exacerbated by Covid when it went online. It was not centred around trained facilitators and consists mainly of a slide show with no guidance or support.

15.4 The only other training available was the Solihull programme which is 8 sessions online, but no access to face to face support.

15.5 MG has been able to capture information by hearing about what's missing – for example, not having the guidance and support.

15.6 The work is divided into 3 phases:

15.6.1 Research – looking at the multi-agency offering including health visiting, Healthy Cornwall, family hubs. Support has been fragmented and not offered at appropriate times.

15.6.2 – Engagement – with 300 service users and shared surveys. MG has been surprised by the negative tone of the response with

loneliness, lack of face to face breast feeding support, lack of support for Dads and Partners being common themes.

15.6.3 –the Developing offer phase – to fit alongside health and family services taking in a lot of learning from the voluntary sector – consisting of 6 months of trailblazers called Early Implementors and to become embedded in the offer moving forward over the next 3 years. This will involve lot of co-production with KMVP and being prepared to make mistakes and tweak as necessary.

15.7 MG is working with the commissioners to identify funding for the next two years following the end of the initial project in December, to oversee the programme.

15.8 The programme is for pre-pregnancy up to two years and has thrown up some gaps. In particular, C sections and birth interventions – unplanned or emergency births – have risen; and informed consent – the personalised care plan – is owned by parents so RCHT are unable to evidence.

15.9 MG is very excited about the new KPJ website launching soon which will be the shop window with a focus on branding and comms, (Easy Read, clear buttons) that will feed into the back information controlled by the services that provide support. This will be a pilot and will eventually move under ICB control.

15.10 Early Implementors will be setting up healthy pregnancy classes which will provide early health messages, Walk and Talk sessions, peer to peer support, and signposting. There will be a focus on working with Healthy Cornwall rather than midwives and they will offer early referrals for targeted service users.

15.11 Also there will be a focus on Early Intervention – how to reach those who are not engaging. Midwifery clinics will become Pregnancy Circle meetings lasting for 2 hours and held by Homestart Kernow.

15.12 Finally there will be labour and birth classes during pregnancy – the 4th trimester element. These will be practical sessions where mothers can meet the support available after the birth.

15.13 Early implementors will be in 3 areas – West, North and Mid. East operate slightly differently but KPJ will also be liaising with the Devon team who deliver services in that area.

15.14 CH asked if KPJ are working with perinatal mental health? MG said that within her KMPV role she works with the perinatal teams who will have oversight of all we do – and KPJ are also "magpieing" - showing videos used by the mental health team at the Pregnancy Circles and being able to signpost back via perinatal Health Visitors. The trauma informed approach also links to Early Intervention.

15.15 MG said that the team want to be able gather data over 3 years to measure effectiveness with KPIs including reducing referrals onto further support; reducing the number of those smoking at the time of delivery; speech and language; motor skills; impact on school readiness. It will be too soon to measure the pilots, but after 3 years the data should be available, sourced through KMVP feeding back this information to RCHT. CH said that reduced interventions would be a good result.

15.16 MG said there is an issue with demographics in that "white other" is not nuanced enough, but capturing further detail opens up difficulties in maintaining anonymity.

15.17 AP thanked MG for a really interesting presentation, especially around the theme of digital exclusion. Low level mental health, without face to face intervention, can lead to safeguarding issues. JWR said that the Recovery College is promoting Digital Champions to help people move forward digitally, it is not a finite thing. TC said that friends can be made for life at baby groups and peer support is vital. JWR said we live in social groups, and CH said the Early Implementor pilots would be especially important to those recently moved to Cornwall who may have no family or peer support available. MG spoke of Watch and Wonder – which is a model being delivered in schools around positive attachment. She wants to bring this into the pregnancy circle which provides ante and post natal care in the same place.

15.18 MG said that Directors are welcome to get in touch with her directly with ideas and suggestions.

10 Finance

10.1 AP presented the report which had been previously circulated.

10.2 AP explained that the finance sub-committee meets regularly to review the budget and contracts. It looks at detailed accounts and brings the summary to the Board. Attendance is currently AP, MD and AO but other Directors are welcome to join.

10.3 There are no significant overspends.

10.4 AO explained how income is recorded – Partnership Boards, KMVP and KPJ all have completely separate accounts and therefore the summary page is just for information. Income already received for KMVP and KPJ is included in its entirety. The Healthwatch account includes core income which is proportioned across the year and additional income from smaller projects. Partnership Board income is also proportioned across the year.

10.5 MD said we don't aim for a significant underspend and it can be carried forward during the life of a contract although there is potential to have to return it at the end of a contract.

10.6 AP proposed and JWR seconded that the accounts be approved, this was confirmed by the Board.

11 Risk Register

11.1 MD presented the updated risk register which had been previously circulated. AP asked if any Directors needed an explanation to contact her outside of the meeting.

11.2 AP had previously commented on the need for creativity in reducing the staffing risk and was happy with the mitigation in place.

11.3 JE noted that it is pleasing to see that there were no red items on the Risk Register.

12 HR Headline report

12.1 AO presented this report which had already been circulated and explained that the report came out of a recommendation from ODAG, and while it is now in its second year it is still work in progress and she welcomes suggestions and improvements.

12.2 AO highlighted the increased hours for 2 members of staff to take up some of the hours lost by one Engagement Project Officer leaving – recruitment is not planned due to the short-term nature of this particular role. Also that the new Admin Apprentice has in effect replaced the Admin Officer - this wasn't planned but made possible by the excellent skills and experience shown by the new postholder. Finance support remains under consideration.

12.2 There was a discussion around sickness absence and how Covid is managed. MD said he had noticed presenteeism and instructed staff to take sick leave if they have Covid.

12.3 MD also highlighted the voluntary engagement which is really coming on apace. Directors asked if there could be a more detailed process for reporting this, which will be followed up with the Volunteer Development Officer.

13 Quarterly feedback update

13.1 Previously circulated to Directors. MD said this is standard feedback and still mostly unsolicited but gives us anecdotal evidence.

13.2 AP noted that the Royal Cornwall Show had provided a good response which included solicited evidence

13.3 MD said that we use the feedback as an evidence base with the various Patient Experience teams.

13.4 JE commented that he learns more from the stories than the statistics.

13.5 MD said that some of the complex feedback received by email and by phone can be quite time consuming to process.

13.6 AO said that the Research Team are looking to compare our demographics with new Census information now that it is available.

14 Policies for review

14.1 **Recruitment & Retention policy**.

14.1.1 MD explained this is a new policy produced partly as a consequence of discussions at previous meetings as to how we manage staff turnover. It incorporates comments from AP and TC, and he asked that this be approved as a draft as staff have not yet been consulted. He proposed to review through ODAG and then consult with staff with a view to manage expectations over the proposed pay bands and to ensure financial sustainability.

14.1.2 TC asked about the rationale for a Return to Work interview after 5 days – MD advised this links to the period of self-certification before a fit note is required. Line managers conduct informal RTW conversations for all absences but currently these are not formally recorded.

14.1.3 AP proposed and TC seconded, the Board agreed to approve as a draft and look forward to receiving the policy for formal acceptance at a later date.

14.2 **Equal Opportunities & Diversity Policy and Capability Procedure**

14.2.1 AO explained that both sit within Employee Manual which will be reviewed at a future meeting, and content is overseen by our HR provider Mentor who also provides indemnity.

14.2.2 AP proposed and JE seconded that these be approved subject to minor amendments provided by AP.

14.3 **Conflicts of Interest Policy**

14.3.1 AP proposed and TC seconded that this be approved subject to minor amendments provided by AP

14.4 **Information Sharing Protocol**

14.4.1 AP proposed and CH seconded that this be approved subject to updating dates in DPA and other Acts.

14.5 The minor amendments in the policies referenced in 17.2 to 17.4 above will be incorporated and the policies recirculated to Directors for approval by e-mail.

16. Any other business

16.1 There was no other business.

17. Date, time, location of next meeting

17.1 Thursday 20th October, 2pm to 4.30pm, Truro Library.

Acronyms:

ASIST – Applied Suicide Intervention Skills Training
C section – Caesarean Section
CCG – Clinical Commissioning Group
CEO - Chief Executive Officer
CV – Curriculum Vitae
DPA – Data Protection Act
GP – General Practitioner
HC – Healthwatch Cornwall
HR – Human Resources
ICA – Integrated Care Area
ICB - Integrated Care Board
ICP – Integrated Care Partnership
ICS – Integrated Care System
IoS – Isles of Scilly
IT – Information Technology
KMVP – Kernow Maternity Voices Project
KPJ – Kernow Parenting Journey
LA – Local Authority
LMNS – Local Maternity & Neo-natal Service
MHSP – Mental Health & Suicide Prevention

PB – Partnership Boards
PCN – Primary Care Network
RCHT – Royal Cornwall Hospitals Trust
RTW – Return to Work
SAB – Safeguarding Adults Board

ACTION LOG:

ACTION	RESPONSIBLE	STATUS
Draft minutes circulated within 4 weeks of meeting.	**AO**	**Completed**
Update to staff following Board meeting – copy to Directors	**MD**	**Completed**
Contact person who has expressed interest in joining Board	**MD**	**Completed**
Circulate 2022 Register of Interest to Directors	**AO**	**Completed**
Send Sir Robert Francis's letter on HW funding to Directors	**MD**	**Completed**
Introduce Director nominees to contacts of ODAG, PBs, SAB and Citizens Assembly	**MD**	**Completed**
Feedback to AP thoughts on Board Development Plan	**Directors**	**Completed**
Detailed process for volunteer engagement	**AO**	**Ongoing**
Minor amendments to policies and circulate to Directors with minutes	**AO**	**Completed**