Minutes of Healthwatch Cornwall Board meeting
Thursday 22nd July 2021, 1pm
Via Teams

Present:
Directors: Jon McLeavy (JM) (Chair), Roger Sinden (RS, Christine Hunter (CH), Deborah Came (DC), Margaret Abban (MA), John Evers (JE)

In Attendance: Mario Dunn (MD), Anne Oliver (AO)

PART 1: In public agenda

1. **Welcome and Introductions**

1.1 JM welcomed everyone to the meeting and acknowledged the disappointment that we had been unable it to hold as planned in person. However, it was agreed that a meeting with a combination of those attending in person and those attending remotely is not practical therefore the meeting would be wholly remote.

2. **Apologies**

2.2 There were no apologies.

3. **Questions and comments from the public**

3.1 No formal questions or comments have been received.

3.2 There were no exceptional issues or themes raised by the public during the quarter outside of those covered elsewhere in the meeting.

4. **Advising of any other business**

4.1 None declared.

4.2 JM noted that ICS update had been agreed to be a standing item on the agenda, this had been replaced by the planned ICS update by Carolyn Andrews prior to this meeting. This was unfortunately postponed but the ICS update would be covered in the CEO report to the Board.

5. **Conflicts of Interest**

5.1 None declared.

6. **Minutes of the last meeting: 29th April 2021**

6.1 Minutes were agreed subject to correcting MA's initials in para 8.8 and ratified as a true record.

7. **Actions / matters arising**

7.1 JM noted that the weekly Managers' update, which is now shared with Directors as well as staff, is helpful and informative. RS agreed but noted that a staff member had asked for a reciprocal arrangement be made for staff to receive an update from the Board meeting. JM said it is difficult to distil this to a summary of three items. MD said that he had sent a comprehensive e-mail to staff from his first Board meeting in April and it was agreed that future updates be sent to Directors as well as staff.

7.2 The Quality Assurance policy is published on the website, under the Our Board section of What We Do. Arrangements are being made to include all ratified policies in this area of the website.

7.3 The publication of the Annual Report had followed on quickly from the last meeting, but MD will review the Quality Assurance data to ensure it is included in next year's Annual Report. RS noted that NHS bodies publish Quality Accounts, eg complaints and trends and how they seek to incorporate the information into continuous improvement. MD acknowledged this is possibly not as overt as it could be in the current Annual Report. RS asked if Healthwatch England have a policy on publishing salaries in banded form – MD/AO to check.

8. **Finance Report**

8.1 Headline Q1 report for 2021/22 had previously been circulated to Directors.

8.2 The finance sub-committee had examined the detail of the accounts and noted that when we receive income at the beginning of the year, it is apportioned throughout the period to which the income relates. Similarly with expenditure, rent is paid quarterly in advance and AO has been asked to work with the finance team at CRCC to apportion these payments in the same way.

8.3 There is also an additional finance item, that is the setting up of a bank account for Trestadow. HC may need to seed-fund to make it go live (likely to be a nominal amount) and the Board approved the finance sub-

committee's recommendation that this could be taken from HC reserves and contingency.

8.4 DC asked that we consider moving away from Lloyds for the Trestadow bank account and consider ethical banks such as The Charity Bank that no longer invest in fossil fuels, as an example.

8.5 RS noted that most organisations have a register of contracts, which would include the value of the contract, when it is due to be renewed and who is responsible for monitoring them. MA seconded this and MD agreed it is an excellent idea that would also help with continuity and information that can be passed on the event of personnel changes. This will be actioned and referred to the finance sub-committee.

9. **Risk Register**

9.1 MD apologised that this had been omitted from the Board papers. It will be sent separately for approval by e-mail following this meeting. Any changed risks are highlighted with comments.

10. **Business Continuity Plan**

10.1 This is due for annual approval and has been updated to include how to manage the organisation during a pandemic, as well as reflecting key staff contact changes and key commissioning contact changes.

10.2 The new plan will be circulated to staff and a copy provided for staff to access out of the office. RS and JM agreed it needs continuous review as a working document, and suggested it be reviewed when the Risk Register is reviewed by the operational team.

10.3 The Business Continuity Plan was approved.

11. **ODAG Report to Board**

11.1 RS presented the ODAG report.

11.2 RS noted that the volunteer survey had been completed as scheduled but as only 4 responses had been received, Michelle Hooker is planning to meet with the volunteers to see if this response can be improved. It is not likely to tell us much as volunteering opportunities have been limited following the pandemic. The intention is to provide key headlines at the next Board meeting.

11.3 RS commented that he is part of a national group of volunteers, and it is fascinating to see how volunteering has been impacted and how roles need to be clarified for volunteers in health and social care settings.

11.4 There has been some use by staff of the Employee Assistance Programme and ODAG are grateful that this support has been in place for staff. The Board accepted ODAG's proposal that this be renewed for the current year.

11.5 Following clarification received at the meeting as to who sets the Real Living Wage, the Board agreed with ODAG's proposal that as an ethical organisation, HC should sign up to this.

11.6 RS noted that once the Equality & Diversity Network statement is agreed, this should be brought to Board for formal approval. ODAG will monitor and update the Board accordingly.

11.7 AO gave a short presentation on the headline HR report submitted with the ODAG papers.

11.8 JE asked whether presenteeism during working from home is a factor in reducing sickness absence, in that staff are not signing off sick but may not be working effectively. There is no current way of recording this accurately.

11.9 One element of training is opportunities to shadow staff, JE asked if staff are versatile and flexible and can fill in gaps. MD said that moves are already in place in that all new roles have a requirement in their JD to be able to work across the organisation as required, and it is a clear expectation on staff within their annual objectives.

11.10 CH asked about training around sensitive and difficult conversations which she felt was very important especially to help with conflict resolutions.

11.11 JM said that the Board appreciate the agile staff team and providing budget can be made available within the existing overall spend, the Board would support staff to be able to receive the training they require.

12. **Policies for approval**

12.1 **Employee Handbook** – The Board were asked to approve the changes proposed in the summary included in the Papers to the Board, and the Grievance and Disciplinary Policies contained within the Handbook which are due for review and are unchanged.

12.2 **Health & Safety Manual** – The Board were asked to approve the Health & Safety Manual which is due for review and is unchanged.

12.3 The Board approved both documents.

13. **Draft guidelines for return to office**

13.1 MD presented this report which had already been circulated to Directors and explained the intention is to send to staff for consultation after

receiving comments from the Board. There is a desire for staff to return to the office for at least some part of each week but to ensure this is managed in a safe way. Staff comments would be taken back to ODAG.

13.2 DC asked if any roles could be fulfilled entirely from working away from the office, MD felt this was not an optimal way of working given the need for team collaboration. Vulnerable staff and those living with vulnerable people could be exempt through clinical need, but beyond that working away from the office all the time would not apply.

13.3 MA asked if it is a mandatory requirement, would sanctions apply? MD would not want to go down this route.

13.4 JE questioned the need to complete the guidelines now in view of the volatile situation around Covid. MD said there was a caveat that the guidelines would be reviewed if there is a marked deterioration in the situation, but he is seeking to establish the principle.

13.5 MD asked if HE had provided guidance. A colleague is attending a webinar today (which clashed with this Board Meeting) and will report back to the Management Team next week.

13.6 RS welcomed the guidelines and felt the only issue was around the date. He would prefer to see wording such as "to work towards when circumstances allow". He also noted that some organisations are planning to never return to the office and dispose of their assets, but to look to meet team needs by block-booking conference facilities. He would like the Board to have the opportunity to consider such options.

13.7 JM summed up the discussion by saying the Board welcome the guidance and risk assessment and would like to see the outcome of the consultation with staff. It was agreed that at this point, given the uncertainty over infection rates, that a start date for this process would remain fluid.

13.8 MD said we had already discovered issues with mixed meetings (some virtual, some in person) and believed that providing risks are met appropriately it is preferable for departmental or team meetings to be face to face.

13.9 RS believed the best way forward was to consult staff whilst recognising there are key tasks best undertaken face to face – which does not necessarily have to be in the office.

13.10 Directors were in agreement with amending that staff should be required to attend the office for meetings essential to operational running of the organisation, rather than being required to attend the office one day a week.

13.11 MD thanked the Board for their helpful comments which have clarified his thoughts on how to take the guidelines forward. He would keep ODAG and the Board updated.

14 HE Quality Framework Action Plan

14.1 AO gave a presentation on the Action Plan to achieve the HE Quality Framework, focusing on the rationale and how the management team would lead on the individual themes, while seeking to involve staff, volunteers and Directors in completing the document as a whole.

14.2 MD noted that the initial presentation to the management team had been adapted after they had questioned why we were doing it. He said this is a vital piece of work and the rationale demonstrates this.

14.3 RS said he is a great fan of external accreditation, and this is a well organised action plan with clear leads identified. Volunteers can contribute an external gaze and challenge where necessary. He asked if there is any other external challenge that could be identified.

14.4 JM noted that this is an important strategic decision with benefits to staff and offers insight to the organisation.

15 Directors' reports from meetings attended

15.1 No formal reports received from meetings attended.

15.2 RS attended a Care Home meeting when it was revealed that there is now a critical staffing situation within social care. It is anticipated that the requirement for staff to be vaccinated will have a further impact on those waiting for social care.

16 Representation List

16.1 MD presented a spreadsheet previously circulated to Directors which has been pulled together by colleagues, partly to help him identify the various groups and Boards we attend and partly for the Board to look at, check those where individual Directors are listed and suggest others they wish to be involved with.

17 CEO report

17.1 MD presented his report which had previously been circulated to Directors.

17.2 He highlighted that the Integrated Care System will create a Shadow Board in place by the end of September, KCCG will become the ICS in April 2022 when the Health and Social Care Bill receives Royal Assent.

17.3 MD is very optimistic that Healthwatch Cornwall can play a key role in the operational work of the ICS.

17.4 Previous drafts of the Memorandum of Understanding had not been circulated to Directors as there have been several versions, but the most recent will be sent to Directors.

17.5 HC will have a seat on the Shadow Board, but it is most important to get a meaningful flow of information from local level up to the ICA board.

17.6 Structure will be ICS at top, with the three ICAs feeding in, using input from the 15 PCNs. There is no firm proposal as to how to do this and each ICS throughout the country may have a distinct individual approach.

17.7 Discussions as to this can be achieved at are an early stage and there is an expectation for HC to put proposals forward to engage at a local level and to identify our overriding objectives. However, no funding is available for this although they are seeking ideas.

17.8 MD is slightly nervous of committing resources and whether our structure has the capability to facilitate engagement; or is our role merely to scrutinise the engagement carried out by the ICS? The next step is for MD to get thoughts on paper after consulting with colleagues internally.

17.9 This is a profound change that will affect our services and we need to be sure of what we want and how we want to do it.

17.10 JE asked if there is a fixed timetable or whether it is moveable. MD said the Shadow Board had to be in place by September and for the ICS to exist on a statutory basis by April 2022, at which point they will have funds.

17.11 MD said we are currently essentially performing a quality assurance function but there is a prospect for one organisation or a group of organisations to facilitate engagement with the public on a level that has only previously happens in hospitals. There is no current actor to fulfil this function and we need to consider what HC's role should be.

17.12 JE asked for an update on Ageing Well – MD gave a brief summary and will forward to him Lesley Pearson's recent presentation to staff.

17.13 Directors were invited to send any questions on the CEO report direct to MD.

17.14 RS noted that the consequence of the quality and timeline of reports has led directly to the quality of the debate at the meeting.

18 Presentation on CRM update

16.1 No longer part of the agenda

19 Any other business

16.1 There were no matters raised under this item.

20 Date, time, location of next meeting

20.1 Thursday 21st October at 2.00pm at Truro Library, pandemic circumstances permitting; otherwise virtually by Teams.

20.2 MD to re-arrange meeting for Board to meet Carolyn Andrews early September with a date for a workshop to follow soon after.

Acronyms:
CEO - Chief Executive Officer
CRCC – Cornwall Rural Community Charity
CRM – Customer Relationship Management
KCCG – Kernow Clinical Commissioning Group
HC – Healthwatch Cornwall
HE – Healthwatch England
HR – Human Resources
ICA - Integrated Care Area
ICS – Integrated Care System
JD – Job Description
ODAG – Organisation & Development Advisory Group
PCN – Primary Care Network
QA – Quality Assurance

ACTION LOG:

ACTION	RESPONSIBLE
Draft minutes circulated within 4 weeks of meeting.	AO
Update to staff following Board meeting – copy to Directors	MD
All ratified policies published on website	AO
Investigate HE's policy on publishing salary bands	AO/MD
Apportion large expenditure items over the year	AO/CRCC
Establish Register of Contracts	AO
Circulate Risk Register to Directors for approval by e-mail	AO
Review Business Continuity Plan quarterly or as operational needs require	AO/MD
Consult with staff over guidelines for returning to office, update ODAG and Board accordingly	MD
Reinstate ICS update as standing agenda item	MD/AO
Arrange date with Carolyn Andrews to meet with Board	MD
Set up workshop on ICS for Board (following CA meeting)	MD/AO