MINUTES:	Ageing Well Partnership Board
DATE and TIME:	16th May 2024, 2:30pm
LOCATION:	Room 2N:03, New County Hall, Truro TR1 3AY and via Microsoft Teams

ATTENDANCE

Name	Position	Organisation
Councillor John Tivnan (JT)(Chair)	Elected Member	Cornwall Council
Robert O'Leary (RO)	Partnership Boards Engagement Officer – Lived Experience	Healthwatch Cornwall
Dr. Allison Hibbert (AH)	GP Lead Launceston Community Hospital – Interest in Older Adults	Cornwall Foundation Trust
Caroline Ellis (CE)	Strategic Lead, Integrated Admiral Nurse Service	Royal Cornwall Hospital NHS Trust
Craig Hanford (CH)	Partnership Manager – Older Adults, Health and Communities	Active Cornwall
Gary Donnell (GD)	Community Connector	Mencap
Gayle Andrews (GA)	Team Lead for Cornwall	FILO project
Gemma Foley (GF)	Dietician	Cornwall & Isles of Scilly Integrated Care Board
Helen Rundle (HR)	Social Prescriber and Health Coach Manager	Pentreath
Henri Sloane (HS)	Social Prescriber Link Worker	Bodriggy Health Centre
Jenna Button (JB)	Registered Manager	Trevaylor Manor Nursing Home – Specialising in Dementia Care
John Wilman (JW)	Lived Experience	
Karen Hills (KH)	Location Manager (over 55s), Hyle	Anchor Housing
Kate Alcock (KA)	Head of Commissioning: Older People and Carers	Cornwall Council
Keith Judkin (KJ)	Lived Experience Participant/Non-Executive Director	Healthwatch Cornwall
Kirsty Dexter (KD)	Network Coordinator	Memory Café
Lorraine Coriggan – Turner (LCT)	Community Partner	Mencap
Mike Hooper (MH)	Partnership Boards Coordinator	Healthwatch Cornwall
Sarah Keast (SK)	Commissioner	Cornwall Council

Sharon Stanley (SS)	Over 55s Development Scheme Manager	St Austell
Stuart Cohen (SC)	Deputy Lead for Adult Mental Health, Learning Disability and Autism	Cornwall & Isles Of Scilly Integrated Care Board
Sunnie Jarvis (SJ)	Community Partnership Manager – Independent Living for over 55s	Anchor Hanover Group
Wendy Gauntlet (WG)	Carer	Penzance Carers Group

APOLOGIES

Name	**Position**	**Organisation**
Alison Short	Advocacy Coordinator, Cornwall and the Isles of Scilly	The Advocacy People
Beccy Summers (BS)	Patient and Public Involvement & Engagement Lead - Research	Penarc, University of Exeter
Chris Wolstenscroft		Cornwall Fire & Rescue Service
Debbie Stubbs	Volunteer Officer	Age UK Cornwall & The Isles of Scilly
Jo Higson	Project Manager, Older People's Project	Women's Centre Cornwall
Cllr John Bastin	Councillor, Chair of both the Health and Social Care Overview and Scrutiny Committee and the Carers Partnership Board	Cornwall Council
Kate Mitchell	Intermediate Care for Adults	Integrated Care Board
Mark Neeld	Public Health Practitioner (Adv)	Cornwall Council
Raman Subramaniam	Relationship Manager	Cornwall & Isles Of Scilly Integrated Care Board
Samantha Mokarram	Advocacy Coordinator	The Advocacy People
Sandra Ward	Lived Experience, Co-Chair of Carers Partnership Board	Parent Carers Cornwall
Sarah Scoltock	Community Link Officer - St Austell, Mevagissey, St Blazey, Fowey & Lostwithiel	Cornwall Council

	Agenda Item	Actions
1.	**Teams Guidance: Meeting Etiquette and Introductions**	
	The meeting recording commenced. The Chair (JT) opened the meeting by welcoming the Board members and ran through general housekeeping and online meeting etiquette. Board member introductions were made and apologies received, as detailed above.	
2.	**Minutes of the Meeting Held on 15 February 2024, Actions and Matters Arising**	
	The Chair proposed that the minutes of the previous meeting be confirmed as a true record. The Board agreed. No current actions to report from the previous meeting. There were no matters arising.	
3.	**Update from Attendees**	
	Active Cornwall: CH provided the following update. Ageing well physical activity Public Health are Commissioning a Healthy Productive Ageing Project, the funding is in circa of £1.5 million over next 5 years, focusing on falls prevention. The work was in partnership with iCareiMove, who deliver services and talks about the ageing pathway and managing chronic health conditions as you age, and was focused upon strengthening, physical activity and balance. Active Cornwall, in collaboration with Age UK, Public Health and others, are planning a conference to be held on the 26th July 2024 in response to the Chief Medical Officer's (CMO) report *Health in an Ageing Society*. It is hoped that Chris Whitty (CMO) will be attending.	

	The event will be looking at the recommendations of the report and how this translates for Cornwall, identifying the scale of the challenges and understanding the benefits of a collaborative approach, with a focus on the Age Friendly Communities Model. Cross-sector contributions to the event were encouraged in relation to the domains of outdoor spaces and buildings, transport, housing, social participation, civic participation in employment, health and community, communications and information. Any interest in attending the conference and to help shape the project, please contact CH. Active Cornwall are working with a number of health-related charities to look at physical activity and the value of bringing the groups together. The charities that Active Cornwall are individually in discussions with to date are The Arthritis Trust, Age UK, Parkinson's UK, MIND, MacMillan and MENCAP. <u>Questions and Comments:</u> JT stated the importance of transport considerations when selecting a venue in order to ensure inclusive attendance. CH said that there are many considerations in terms of selecting a venue, such as transport links, accessibility and inclusion, not least the availability, and it is yet to be confirmed. CH would forward invites to all Board members via the Partnership Boards team.	
4	**Dementia Strategy for Cornwall**	
	KA greeted the Board and shared the presentation slides. Cornwall and Isles of Scilly Dementia Strategy and Delivery Plan: Making Dementia Everybody's Business. This work is a collaboration between Cornwall Council, the Isles of Scilly Council and the local NHS Integrated Care System. Following commissioned engagement work undertaken by Healthwatch Cornwall to really understand all the issues that people living with Dementia and their carers/families face day to day, there were an extensive number of recommendations made. From those	

	recommendations, the aim was to form a robust, fit for purpose strategy for Cornwall. The Strategy sets out the ambitions for the future, supporting everyone living with Dementia, identifying the Pillars of the Well: • Preventing Well • Diagnosing Well • Treating Well • Supporting Well • Living Well • Dying Well With Guiding Principles of Researching Well, Educating Well, Integrating Well, Commissioning Well, Reducing Inequality Well. SC stated that the Strategy also shows both the significant national and local numbers of people with Dementia from 2020 with the predicted increase of prevalence up to the year 2050. Recording of diagnosis and other factors, such as no formal diagnosis, influenced the numbers captured for Cornwall, showing a reduced number from prediction. Much work has been undertaken to improve the recording and diagnosis rate in Cornwall to show a truer picture of prevalence. From the analysis, overall expectation is that working on a prevalence of 6% of the population of people over the age of 65 and up to 100 years, the national target for those receiving a diagnosis is 67%. That equates to an expected prevalence of those with a Dementia diagnosis in Cornwall to just under 10,000 whilst the actual number is just under 6000 (nearing 60%). In terms of preventable factors, higher numbers of Dementia diagnosis would corollate to areas of deprivation. However, the reverse is true in that those living in deprivation are often further from receiving a diagnosis and in greater need. This has helped the delivery plan to focus on increasing the numbers of people with access to Dementia assessment and diagnosis services. The analysis informs the strategy in terms of the areas that are lower in receiving diagnosis and where the work is most needed to improve this.	

	KA added that the Framework of National Policy and Good Practice, NHS England's 'The Well Pathway for Dementia', will be observed in the development of the local Strategy, future design of Dementia Pathway, and co design of future health and social care services, showing what Local Policy and Good Practice involves. One element that has already been identified in the plan is the need to increase the support services for housing for those with Dementia and how this can be achieved. The Adult Carers Strategy work has been informed by the Healthwatch Cornwall 'Hear our Voice' engagement with those receiving care and their Carers, understanding and meeting the many challenges to improve the support. Dementia is included in this. The delivery plan's challenges, needs and achievements to date were shared. The top successes include: • Increasing the numbers of people receiving a diagnosis by 50 per month. • Aiming to reduce the number of people with Dementia needing temporary or permanent care home placement. • 100% of people diagnosed with Dementia have access to a Dementia Support Worker. • Increasing the quality of life for Carers. The delivery plan, that will be implemented in three phases; immediate, short term and long term, will be funded by existing health and care budgets or included in future funding arrangements and is an exciting programme of development. SC shared the link for the upcoming Dementia Conference online stream. <u>Questions and Comments</u> KJ commended the report and added that as an older person, the term 'beds', which is widely used across the health and care system, is not what KJ would want for meeting Dementia or older person care needs. A unit of care that, following acute phases, provides ongoing rehabilitation and access to functional everyday life activities is needed rather than just 'beds'.	

	KA acknowledged KJ's comment and added that to meet need up until April 2024 the only offering for supporting Carers was respite care – a bed in a care home with contracted support. A pilot was conducted where Health and Social Care Commissioning bought some Direct Access beds, which showed some real benefit for those needing urgent support. However, feedback was received from Carers, asking what support could be provided without the need to move the person receiving the care out of their homes. Following on from this and conversations regarding current alternatives, it was acknowledged that the delivery plan will need to include a range of available options for providing the right care and meeting the needs for individuals with and affected by Dementia. KJ asked if it is felt that the situation for Dementia diagnosis and support is deteriorating? SC responded that in terms national predicted numbers, in 2011 the people receiving a diagnosis in Cornwall were amongst the highest rates due in part to initiatives such as the award-winning Primary Care Practitioners. Unfortunately, as the Dementia care provision was built on supporting a set number of people and did not include the growing numbers of people with Dementia, this resulted in the services stagnating. This strategy drives the plans to support more people within our communities, including increases in: • Prevention • Early recognition • Different models and ways of providing care and support projects. There was a good model in 2011 but, as mentioned, this dipped in the following years. However, it is now increasing again and the Strategy will drive this improvement to equal and hopefully surpass that good practice. GF added, as a Dietician for the Integrated Care Board, delivering training to various teams involved with caring for those with Dementia, at what point of diagnosis are people screened for malnutrition? SC responded that malnutrition, often a major condition	

	for older people admitted to hospital, can lead to a diagnosis of Dementia. GF asked if there is a malnutrition screening tool or pathway used? SC responded that usually diagnosis take place in the Memory Assessment Service, which is Psychiatry led. Most people will be seen by the Psychiatrist and Doctor, providing a holistic approach to assessment. GPs are also encouraged to follow the guidance for diagnosis, often when the condition is advanced, meaning the diagnostic services are medical led. SC offered to feedback the question to the Dementia diagnosis services. AH added that as part of the Dementia screening there are a set of blood tests that can help identify malnutrition. It may be that this is mainly identified following initial diagnosis. RO provided feedback from a recent Supporting Ahead Programme event to raise awareness. A gentleman whose wife had been diagnosed with Dementia approximately 2 years ago was concerned that after diagnosis many of his wife's other conditions seemed to be ignored at Primary Care level. He felt that his wife was seen as a burden to the GP Practice and after unsatisfactory outcomes in relation to other and new health conditions, they stopped contacting the GP, increasing problems. AH acknowledged the great work that the Supporting Ahead events led by the Admiral Nurse service provided and added that the feedback is very helpful to inform the training for health professionals. It is important to take a holistic approach to the health of those with Dementia. People should be receiving an annual health review with the Dementia Primary Care Practitioners and their GP. AH added that people with Dementia and their Carers are often more vulnerable in our communities and should receive almost VIP status. The hope is that through raising awareness and education this will improve the knowledge for health professionals. The new support worker roles will help people to navigate the system and open doors to relevant support and care. RO added that despite the move to Dementia friendly communities, this is Still happening. AH agreed.	

5.	**Comfort Break**	
	The Board agreed to have a 5 minute comfort break	
6.	**Social Prescribing - Pentreath**	
	HR distributed leaflets to attendees. HR is the Manager for the Social Prescribers and Health & Wellbeing Coaches who are based within GP Practices in Cornwall and can cover up to 2 practices. Social Prescribing has existed for a quite a few years now, however, funding from the NHS started in around 2019. Referrals routes are varied and received from GPs, other clinical staff within the GP Practices, health and social care professionals and self-referrals from those in need. They can be employed directly by a group of GP Practices known as a Primary Care Network or employed by the voluntary sector. Pentreath employ 6 Social Prescribers in the West of the Cornwall and many are employed by other organisations throughout the County, with a total of 50 in Cornwall and one on the Isles of Scilly. They are link workers with an expertise within communities and extensive knowledge of what is available. They have the ability to identify the gaps in support and improve facilities by helping to connect people to relevant groups and services. Often, people visiting the GP require community support that is not medical or clinical, such as guidance about housing issues, benefits application support, they may be isolated or lonely and wish to connect with more people, they may wish to increase their exercise levels. The GP will then make a referral to the Social Prescriber to create a plan to help them to set and reach their goals and to link them into relevant available groups or services. An example of support that has been started by Social Prescribers following gaps in services identified is a Diabetes Peer Support alongside Diabetes UK. With time limited intervention, the aim is for a volunteer to eventually run a group with Social Prescriber input.	

	HR handed over to HS. HS is a Social Prescriber Link Worker for Hayle, based at Bodriggy Health Centre. One of the real successes has been the creation of the Cuppa Companions, meeting a large need for people feeling isolated both from COVID 19 and/or through bereavement. The group was started one morning per week at a local pub, with the focus on bringing people together. It started small, being the first group created by HS, and after four to six months developed into a quiz morning that the attendees who are 55+ in ages loved. HS provided case studies and success stories for group members and with the group members' consent, shared photos of a meeting where separate funding was realised for fresh vegetable boxes, which were given to the members. There were also sessions created with the Citizens Advice Bureau that covered advice on scamming and avoidance. The Fire Service attended to provide advice on fire safety and alarms. Other services set up in the area are: • Memory Café • Pain Café • Link into the Hayle Day Centre, which has become the Community Hub providing many facilities and opportunities responding to need. HR added that this type of provision is in place or being developed all over Cornwall. <u>Questions and Comments</u> JT asked for clarification on where Social Prescribers are based and where they can meet with people other than within the GP Practices. The enquiry was in relation to the hurdles that can be created when meeting confidentially. HR responded that GP practices are particularly useful to initially link with people, helping them to move to support within the community. The GP will always ask people for their consent to refer them to the Social Prescribers, in line with data sharing agreements. GP Practice Information Governance have access to GP systems and patient	

	data. Other organisations employing Social Prescribers will have their own processes. RO requested to connect with HS to attend some of the groups and open up communication streams with the Board. HS agreed. RO asked if HS could provide a rough percentage of people over 55 that are seen and the main reasons for referrals of that age group? HS responded that for Hayle a rough estimate is approximately 60% of people seen are 50-55 and over, mainly being referred due to isolation, lack of transport and caring responsibilities. The biggest barrier to attend Cuppa Companions is the lack of access to transport, having unsuccessfully attempted to secure funding for this. JT responded that this is often the case throughout the County, as transport facilities are expensive. JT acknowledged the great and important work to keep people moving and connected. KJ asked if there are any differences to transport services in different parts of Cornwall as the further West you go in the County communities are much smaller. JT added that it is the same in the East of the County. HS responded that the big gap is the Buddying System that existed informally during the COVID 19 pandemic. As a Social Prescriber, despite efforts to prevent social isolation, people can feel very lonely in their own homes, making times such as Christmas a very solitary period. There are many people within communities who would like to help others in this way but due to GDPR and Insurances required in setting up this facility again, it has become more and more challenging and frustrating. WG commended the work of the Social Prescriber and thanked them for their help in Penzance, where they attend the Carers Group and assisted in setting up a Carers event this year, which will be held in Morrab Gardens on Monday 27th May 2024. RO asked about potential funding streams or bids for groups, events and transportation costs, wondering if funding came direct from Pentreath or external funding streams? HS confirmed that for one of the bids through the Community Hub for the Pain Café, transport costs were not within the criteria and therefore not covered, as is the case for the Cuppa Companions.	

	As a team the Social Prescribers are always on the look out for funding that can cover transport costs. She encouraged people to make them aware of any that are available.	
7.	**Filo Project**	
	GA was urgently called away from the meeting prior to presenting this item. MH circulated her presentation to all members via email. It was agreed that the item be deferred to the next meeting.	15/08/24 agenda item
8.	**Any Other Business**	
	The Partnership Boards and New Healthwatch Cornwall Contract KA reported. Cornwall Council are responsible for commissioning Healthwatch Cornwall and their statutory function. As a separate contract' Healthwatch Cornwall will be asked to continue delivering the Partnership Boards for Ageing Well, Learning Disability, Autism and Carers, with an additional fifth Board for Mental Health. As part of the delivery there will be continued development, engagement that some of the Board members may have been involved in have taken place to inform future plans, with a lot more focus on the voice of those with lived experience to drive the changes at a strategic level and community service planning. Funding has been made available for Healthwatch Cornwall to encourage involvement from those with lived experience to attend and review services to help understand what and why services are not working. Projects to date have shone a light on the Emergency Service and Dentistry. Payment in the form of a wage for those people with lived experience working with Healthwatch to access and review services will be made available as well as the ability to involve them in Cornwall Council's commissioning activities. The new contract is definitely a move forward and an exciting time for helping to meet the needs of people in our communities, reframing the format by measuring the value that has been added rather than output.	

	The Ageing Well Strategy, similar to the 'Hear our Voice' research, will have a life course approach to engagement; Start Well, Live well And Age Well feeding into the Integrated Care Strategy, setting out consistency in the overall health and care system to commissioning services for Cornwall. The Board will play a key role in this, informing the Strategy and commissioning. <u>Questions and Comments</u> KJ welcomed the approach and added the importance of asking people what they need for their care. HR said that this is exactly the approach that brought about the Social Prescribing, identifying what matters to people. KJ added that the difference with the new Strategy is about bringing that Social Prescribing approach into mainstream thinking and service provision. SS said that alongside this, especially for the older people, there also needs to be a provision that can help people manage urgent situations, for example in terms of sorting their medication. With everything moving more online, a phone line or something similar with a person on the other end to help them sort the urgent issues is needed. The problem often lies in the lack of communication between different services and the person needing their assistance is left no further forward. HR added that something like the Buddy system that HS mentioned earlier is a possible solution but needs funding. When The Community Gateway service was set up, it's purpose was to help people with their urgent medication/prescription requirements, not an emergency service but helping get their medication to them where difficulties arose. That did not seem to happen. KA confirmed that Community Gateway was specifically set up to help these situations, however, it is not 24/7. The NHS 111 service can help, as can the lifeline service. KJ asked how widely throughout the county is access to the Community Gateway services and enquired as to the publicising of the service? KA responded that this was a good question, the service	

	should be countywide, the details of publicising the service to be answered at the next meeting. SS asked if the Gateway was accessible by phone? KA responded yes, between the hours of 8am and 8pm. MH added that when these topics arise at the Board Meeting, there is a question – '*what can the Board do to make a difference and help the situation?*' In order to prevent losing theses important conversations there has been a suggestion that the Board meetings have a key theme per meeting, allowing in depth discussions to identify effective actions, we do not want to lose these conversations. SS added that the Strategies are good but if the older people cannot access services and information, this needs to be addressed in the process. The Dementia care provision needs to include a hub or centre for carers to go and have some time away, providing relaxation and recuperation for them rather than the person with Dementia leaving their own homes for respite. With the transport situation, bigger companies may be willing to help with this, providing vehicles to support their community responsibilities. KA responded that the personal budgets were designed to help with this, allowing individuals to choose what will help them. MH added that RO is tasked with engagement with groups, organisations and individuals to grow awareness of the Partnership Board and to feed back key themes identified. **Date of next meeting:** Thursday 15th August at 2pm. Hybrid with venue TBC. JT thanked everyone for attending and closed the meeting.	Update to 15/08/24 meeting