SHAPING OUR FUTURE

Cornwall and the Isles of Scilly Health and Social Care Partnership

Shaping Our Future Wave 3 Co-production Workshops

East Cornwall – Liskeard Public Hall

To report on the information and feedback received at the Wave 3 co-production workshop held on 26 February 2018 at Liskeard Public Hall.

Contents

Executive Summary

This was the fourth in a series of 'expert coproduction' workshops, which were conducted across Cornwall during February and March 2018 as part of the third wave of Shaping our Future's expert coproduction programme. It was held at the Liskeard Public Hall. The aim of Wave 3 was to i) share lessons learned during and since Wave 2; ii) update colleagues on the production of linked datasets; iii) share the preferred method for calculating travel times; and iv) seek views on the draft local Urgent Treatment Centre (UTC) specification, the approach being taken to review existing sites and the assessment criteria on which to determine the potential number and location of urgent treatment centres. As such, these events aimed to build on information gleaned during and since Shaping Our Future's previous coproduction workshops held in July and September 2017 to further develop the options for the new place-based models of health and care that had begun to emerge.

As previously, the workshops were attended by health and social care staff within the statutory and voluntary sectors (also referred to as local 'experts by delivery') that have direct experience of providing some kind of health and/or care support to people. They were joined by people who have had experience of receiving services or work for groups/ organisations that represent patients and/or the local community (also referred to as 'experts by experience').

Attendance

In total, 38 people representing 10 organisations and filling 30 different roles attended the Wave 3 workshop for East Cornwall. This includes people from local third sector organisations, GP practices, Health Education England, the Shaping Our Future citizen advisory panel and local patient representatives. Elected councillors and representatives from across health and social care were also in attendance. A full list of the roles and affiliations of participants is provided in Appendix A.

Feedback

An agenda showing the workshop content and activities is available in Appendix B. Throughout the course of the workshop, participants were asked to share their views and expertise on a range of topics including the proposed methodology to calculate travel times, the criteria needed to determine the number and location of urgent (unplanned) care facilities and what services should be provided from them.

Shaping Our Future priorities

The plenary session at the end of each workshop was led by a local clinician who added local context to each table's suggestions. This added further depth and detail to the Shaping Our Future team's understanding of local services and community health needs. A summary of the topics that each table prioritised for discussion during the plenary are summarised overleaf.

East Cornwall Plenary Topics

Key themes identified by participants

Topic	Explanation
Prevention & Self-Management	• Emphasis on prevention health promotion and self-management – increase access to rescue meds to prevent admissions. • Get people fitter – target school children • Make every contact count. NHS requirement. Do we know how that's being implemented in Cornwall? • Children – Big six conditions e.g. respiratory – gastro. • Utilise the 'handy app' – greater use of technology • Choose Well campaign – Advertise the NHS Quicker App (provides MIU Waiting times) • Care planning – access to records – IT • Out of hours – linked information (IT) – robust discussions with patients about risk. • Use of community pharmacies – personal responsibility – self-care – educating patients • Promotion of community pharmacists – pharmacists taking assessments • Community strategies/groups to link people - not always about a medical need. • More social contact – community responsibility to try new things – peer support • Active Signposting – GP Voice • Support assistive technology too e.g. telecare. • Learn from the Robin Unit Robin Community - a community based service that has been specifically designed to enable treatment and tests to be completed without the need for a hospital stay.
Workforce	• We need more GPs in primary care…this is a problem in the east. Try and design service that meets need not demand with a critical mass of patients to avoid occasional practice. E.g. physio – MH practitioner across locality not per practice. • Stop robbing one another – be smarter – work together. • Review current MIU spec inc. resilience = 10 Care Capability. • The right training, education and support to care homes and nursing homes and care agencies could prevent the need for urgent care services. • Community matrons should target the frail. Connect with wider nursing team (better integration) – nurse practitioner led UTCs to address GP capacity issues. • Community pharmacists (upskilling to diagnose and prescribe) • Enhanced intermediate care teams – acute care at home – home first (pull and push) to support timely assessment bed discharge • Ageing workforce – focus on retention. Need to attract

	younger workforce to Cornwall – rotational posts – shift in culture and attitude. • Education/clarity/signposting – consistent message across county. • GP portfolio careers in acute medicine could support recruitment. • Is this going to be attractive recruitment opportunity? • You need to balance cost with population need and workforce capacity • Will GPs be overstretched if they have to cover UTCs as well? • UTC – does a GP need to be in situ and cover a broader patch – yes ideally, but where will the funding come from?
Short Stay Assessment Beds	• MDT approach is needed • Step up assessment is a good thing • Need criteria in and out. • Need another support function to enable short stay assessment beds to be effective • Time to think – staff will need night/skills for monitoring • Learn from Robin Short Stay Unit (a community based service in Plymouth that has been specifically designed to enable treatment and tests to be completed without the need for a hospital stay).
Financial Considerations and Sustainability	• Resource implications for this. There is a lack of money and people available. • Additional spec/resource is great - is this realistic? • They are planning a dual carriageway from Saltash to Bodmin (Feasibility study) (Cuts out Glynn Valley) (20 years away) • HUB: Acute GP in every locality • HUB: Liskeard as a good place to admit to. • Offer block contract incentives with place based budgets
Point of Care Testing	• Point of care testing will reduce acute admissions • What is the rationale for UTC not being 24 hr? • We use Cumberland Centre because x-ray opens until 21:00 • X-ray – need radiographer and radiologist (access)
Assessment criteria for UTC sites?	• Consideration of current estate • Accessibility - geographically “Trerulefoot is centre of the East and on the A38” • Travel time – distance – transport links – affordability – population need. • Consideration of what is already in place and evaluate new ways of working: Rosedean – paramedic – nurse practitioner – takes pressure off the GPs. E.g. Oaktree has physio on site • What technology links would be required in other areas in the east?

1. Background

The Shaping Our Future programme held a third wave of co-production workshops with health and care staff, those working in the community and voluntary sector and patients who have had direct and recent experience of receiving care in February and March 2018. Reports for each of the first and second waves of coproduction workshops are available at the Shaping our Future website here.

The aim of Wave 3 was to

- share lessons learned during and since Wave 2;
- share the preferred method for calculating travel time; and
- seek views on the draft local Urgent Treatment Centre specification, the approach being taken to review existing sites, and the assessment criteria on which to determine the potential number and location of urgent treatment centres.

The expert coproduction programme were designed to build on Shaping Our Future's previous phases of public engagement between late 2016 and early 2017 when the team were identifying and agreeing Shaping Our Future's overall priorities.

The coproduction programme, of which these workshops are a part, is designed to provide opportunities for the insight and views of the people who provide health and social care, the voluntary sector and local people that strategically represent patients and/or the communities they live in to collaboratively develop a range of place-based model of care options. However, these workshops are only one of various forums where the emerging models of care are being developed with delivery staff, voluntary organisations and community representatives. More information about some of the other coproduction work that has been carried out was presented to the people who attended the East Cornwall Wave 3 workshop and is available here .

Hence, the expert coproduction workshops being held across Cornwall and Isles of Scilly are not public events, but a series of working meetings specifically designed to discuss and test out ideas for how health and social care could be improved for each of six specified integrated care communities in Cornwall in addition to the Isles of Scilly. The final options that emerge from this expert coproduction will then be subject to targeted, place-based informal public engagement followed by a full formal public consultation. However, the public are invited to share their views on the emerging models of care as this work progresses by emailing the team at shapingourfuture.cios@nhs.net

1.2 Methodology

All feedback and insight is considered by the Shaping Our Future team, with changes made to the workshop programme in response to feedback as soon as possible. Consequently, the agenda and content for some of the subsequent

workshops during Wave 3 differed from the information below either in response to feedback at a previous workshop or as a natural development of local discussions during and since Wave 2. Full reports on what local experts said during the previous two waves of coproduction and all materials that were shared at those events are available here. Information in the remainder of this report refers solely to Wave 3.

1.2.1 Participants

Participants' were invited from a wide range of expert practitioner groups. In addition, a range of third sector (non-profit) organisations, elected town, parish and council members, lay 'experts by experience' and union representatives were also invited.

In total, 38 people representing 10 organisations and filling 30 different roles attended the Wave 3 workshop for East Cornwall. This includes people from local third sector organisations, GP practices, Health Education England, the Shaping Our Future citizen advisory panel and local patient representatives. Elected councillors and representatives from across health and social care were also in attendance. A full list of the roles and affiliations of participants is provided in Appendix A.

1.2.3 Agenda and Workshop Content

The agenda and structure of the workshops were developed with members of the Shaping Our Future Model of Care Delivery Group and approved by the Shaping Our Future Portfolio Board (available in Appendix B).

Each workshop followed a similar structure: presentations followed by table top discussions. Topic guides and templates for notetaking were created to facilitate discussions and ensure feedback was gathered consistently. Presentation slides can be downloaded here.

The following information was also given to the workshop participants at each event. A copy of these handouts can be downloaded here

- A comparison of what people had said in East Cornwall with other communities in Cornwall during Wave 2
- Actions the team had completed in response to what they had learned during Waves 1 and 2
- Progress in developing the model since Wave 2 with detailed descriptions of primary care locality plans
- The proposed method for calculating travel times
- The national Urgent Treatment Centre specification (also circulated a week before the meeting)
- A draft service specification for a Cornwall-specific GP led urgent care model of mixed provision (a mix of strategically placed GP Local Enhanced Services, Minor Injury Units and Urgent Treatment Centres - also circulated before the meeting)

- A written explanation of the team's emerging thinking about how urgent care could be delivered in Cornwall, which had been further shaped after discussions with Shaping Our Future's Citizen Advisory Panel (also circulated before the meeting) as part of the preparation for Wave 3.

1.2.4 Presentations

To allow time for as much group discussion as possible presentations were reduced to key/core information, with additional written information provided in hardcopies at each table (please see list of handouts below).

Copies of the slides presented are available to download here

1.2.5 Handouts

Hardcopy handouts provided more detailed information about the topics below.

- An update on the production of linked data sets
- GP Locality plans
- Outputs from a community health event held in Kerrier organised by Cornwall Council and Cornwall Partnership NHS Foundation Trust to showcase 30 different community groups that are available to support wellbeing in the local community
- Dates of a range of workforce transformation workshops that had been held for various groups of people working in different specialities and areas
- Outputs from a second cross-sector SPRINT workshop that had been held in East Cornwall
- A summary explanation and slides describing the travel time methodology
- Workshop slides
- The national Urgent Treatment Centre specification for those who had not registered to receive this in advance
- The draft emerging service specification for a Cornwall-specific GP led urgent care model
- A written briefing explaining the draft urgent care model in more detail.
- Advertising materials for a community health event due to be held on the 19th of March in Perranporth[1] similar to the one held in Kerrier organised by the Chair of Shaping Our Future's Citizen Advisory Panel and the staff and patient participation group members of Perranporth GP practice.

Handouts are available to download here

[1] This event was later rescheduled due to severe driving conditions. The new date is Monday 30 April, 2-5pm.

1.2.6 Posters

The outputs from the Wave 2 workshop for East Cornwall that was held in September 2017 were also presented on large posters to share what we had heard and explain how this had influenced the team's thinking. Posters are available to download here

1.2.7 Video

A detailed 13 minute video explaining the travel time methodology was considered too long so a shorter three minute video was shown to those who attended the first (Mid Cornwall) workshop. Feedback received at that workshop suggested people would prefer to have access to both videos to review outside of a meeting. Consequently neither video was shown at the East Cornwall meeting in favour of a short summary of the key features and strengths of the proposed software. The links to these videos can be requested from benmitchell@nhs.net

1.2.8 Equality Monitoring Data

Equality monitoring data was collected at each event and venues were vetted for Equality Act compliance to ensure each workshop was equally accessible to everyone regardless of disability status.

1.2.9 Table top discussions

During Wave 3's table top discussions participants discussed the travel time methodology and answered the following questions to help develop local urgent (unplanned) care options for East Cornwall.

- What services do we need to have in place in primary/community care to stop people from needing to attend an Urgent Treatment Centre (UTC)?
- What else would we need to have in place in this locality to make sure the "short stay assessments bed" worked as intended?
- What else do you think about the draft enhanced UTC specification?
- What would a mixed model of provision look like in your locality –
    - what if more GPs were able to offer the minor injury service?
    - What type of pharmacy provision might be needed?
- What assessment criteria should we use to assess potential UTC sites?
- What assessment criteria should we use to assess options for the number of UTC sites

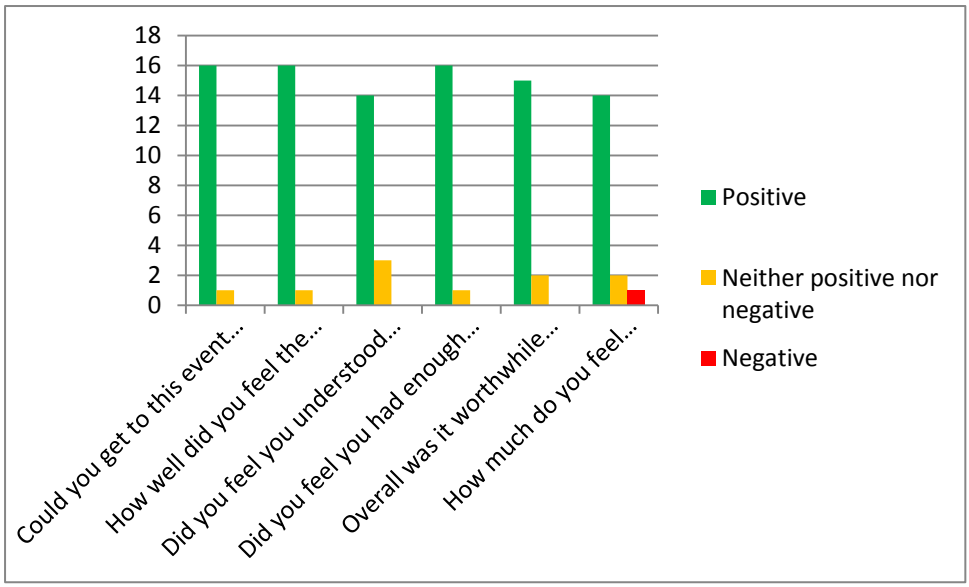
At the end of group discussions, a local clinician led a plenary session where each group fed back the main points discussed at their table. A broad thematic analysis of these discussions is summarised below.

2. Feedback (you said)

2.1 Feedback about the event

As previously, participants were asked to complete an event evaluation questionnaire. The overwhelming majority of feedback received was positive (see Table 1), with participants welcoming the opportunity to co-design integrated community based models of care with a range of people that they would not normally work with.

Table 1 Overview of East Cornwall Wave 3 Event Evaluation



However, whilst some participants commended having the opportunity to “have structured questions around urgent care.” others were concerned that the agenda was “too focused on health and not social care”, with “insufficient time for everyone to contribute”.

As previously, evaluation feedback for all three waves will be considered when planning the rest of the coproduction programme.

2.2 Feedback related to the Linked Data Sets & Urgent Care

Participants stressed the importance of having linked data, particularly in relation to population need, deprivation and lifestyle related risk factors as this information should drive decisions regarding where to locate urgent treatment centres (UTCs) and other aspects of the model.

> *“What are the correlations between demographic factors and presentation for primary or urgent care? These are the populations that use services the most.”*

> *“Target UTC eligibility based on social deprivation and lifestyle.”*

"The specification should define the population the UTC covers based on population needs and demographics."

"There is a lot of research on the big six reasons for children going to hospital. Two of the key reasons are respiratory and gastric. We need more data like this to decide what services need to go where."

People also highlighted the need to consider potential increases to population figures as a result of new housing developments to ensure the new model can adequately cope with future demand.

"The new building developments in towns brings with it new patients, which is impacting on GP capacity. Where will the additional capacity come from to deliver the model in 10 years' time?"

2.3 Feedback about the Travel Time methodology

N.B. Information in quotes is paraphrased from table top discussion notes or from evaluation forms and is not verbatim.

Understandably people want to know what effect any potential changes to the health and care system might have on them. A common concern is 'how long will I have to travel if you move a service that I need?' Consequently, Shaping our Future has commissioned the South West Academic Health Science Network to calculate how long it takes to travel by all modes of transport (including by foot) using the most robust and objective method available.

Basemap's 'TRACC' software was selected because Basemap already manage many of the UK's largest travel calculation databases and national public transport timetables and TRACC can calculate travel time between an origin point and destination address using the full range of travel methods including all modes of public transport, walking, cycling and private car as well as any combination of these. It does so using public transport and highways data from the National Public Transport Data Repository (NPTDR), which is available from www.data.gov.uk .

2.3.1 Transport & Access

After hearing a brief explanation about how the TRACC software works people's comments centred on the need to consider planned developments to the infrastructure and the need to calculate travel times for people attending services in Devon.

"Plans have been submitted for a Saltash to Bodmin dual Carriageway. This will be a better link road eventually but will take over 20 years and cause interruption while it is happening."

"There is no Devon Cornwall border when it comes to health. So you need to work with Devon on locations over there that people in North and East Cornwall could go to and include that in travel data."

2.3.2 Seasonal Fluctuations

People also suggested that journey times should be calculated for each season to account for increases in congestion related to the influx of students and tourists at different times of year.

"Consider the peak season flow of patients and the travel times in holiday times."

2.3.3 Reasons for current usage

Others considered the usefulness of travel times to be limited unless the reasons why some people use the current system inappropriately are better understood.

"My experience is people tend to go to the nearest service first, but will travel further if they think they will get seen more quickly even if their symptoms don't warrant that so I'm not sure how useful the travel time data will be."

"Look at the barriers to people presenting to the right service for their level of need now. Unless you can address those, people will still go wherever they choose even if it is further."

"Travel time methodology has to be considered, but in the context of why people choose to attend where they go."

"People phone me (their GP) for immediate help and will ignore our advice to wait until the next GP appointment and travel further to go to ED (Emergency Department) if you can't see them quickly enough."

"To make the new model work you need the population to make rational decisions about where to go when they have different types and level of need so they go to the correct place. They don't do that now and drive much further to go to ED when they don't need to, so what difference will the travel time and how you calculate it really make?"

2.4 Feedback about the Draft local Urgent Treatment Centre service specification

Although a national service specification for urgent treatment centres was published in July 2017, feedback obtained during the previous waves of coproduction in Cornwall suggested a one size fits all solution across the mainland would not meet local needs. As a result, Shaping our Future's urgent care work stream developed a draft local specification for a mixed model (comprised of urgent treatment centres, MIUs and GP local enhanced services) that offers more than the national specification. This draft local specification was presented to participants for them to consider and further develop.

In the main people supported the development of a local urgent treatment centre model and thought "*a lot of the spec is exciting".* However, a number of gaps in the model were also suggested.

2.4.1 Mental Health, Social Care & Allied Services

As in the previous two waves, people stressed the importance of including mental health, social care and allied health services in the model. However, there were mixed views regarding whether there needed to be mental health expertise permanently located in UTCs or whether more effective links and greater access to community mental health crisis teams, social care, 111 and the police would suffice.

"The model needs to include a community crisis response Team so if a patient had a social care crisis they would assess the patient and look at care packages."

"At Gunnislake Practice they are looking at ways things could be managed differently by working with physios and the mental health nurse. This needs to be included in the spec."

"Physios in the surgery are a great idea. You can see someone about muscular injury within 10 minutes that may otherwise have gone to the acute hospital. Mental Health nurses are also an excellent idea in surgeries, but you could put them in UTCs to cover a wider area."

"We need enhanced intermediate care, for example acute care at home services, home first services and advanced clinical assessment. For example, an Advanced Falls Team could go out with ambulance crews to assess patients at home (the best place for carrying out falls risk assessment)."

"Using the teams we have now better by having a coordinated multidisciplinary approach in the community is what the model needs to reflect."

"We need an enhanced community team working together to undertake clinical history/exam and to coordinate care proactively with community matrons providing proactive support for patients with Long Term Conditions (in particular frailty)."

2.4.2 111 and Out of Hours Primary Care

The importance of having strong links between Urgent Treatment Centres (UTCs) and other parts of the system, such as care homes, home care services, patient transport and the 111 service were also consider important to ensure people are seen in the correct place for their need.

"How do we make the best of what we have? 111 has got to be more efficient at keeping people out of hospital."

"Where people go depends on timeliness and age. Older people want to see their GP or if they feel really sick they will phone an ambulance who will take them straight to ED as a precaution. So it's not just about telling the public where to go it is also about managing 111 and the ambulance service."

"You need more experienced clinicians triaging people at 111. They don't have enough of them at the moment. They ask questions based on algorithms and then because they fear litigation they err on the side of sending people to hospital anyway."

"There may be a requirement to triage patients before they can present at a UTC. If people are not able to access a GP appointment they default to MIU or call 999. 40 – 45% of people who have called 999 are conveyed to A&E (Accident and Emergency) on a daily basis. When the ambulance service went on strike GPs helped to triage the calls and reduced the patients going to A&E by 20%. So if you are serious about wanting to reduce A&E attendance you need GPs at the point of triage."

"The intention is for the UTCs not to be walk in, but 111 led referrals. I'm not sure about that."

"Perhaps we should increase the number of care homes to make it easier to get people out of hospital and back into the community. Could St Barnabas be a care home site? Perhaps a private investor might want to buy the site, knock it down and build a care home on it instead."

"111 has improved greatly since December, but they still don't triage properly because they are risk averse so the default is to advise everyone to go to the acute hospital."

"My mother recently needed unplanned care up North and ended up at Scunthorpe Hospital, Lincolnshire. The 'unscheduled care team' up there coordinated all of her care. The service is supported by 111 with nurses who have all received ED training. It's purely a nursing led service, with support when needed from a GP. This service could call a district nurse if required as part of the care package in Cornwall."

2.4.3 Prevention, Self-Care & Multidisciplinary Teams (MDTs)

As previously participants also wanted to see greater emphasis on prevention, self-care, social prescribing, joint working with the voluntary sector, opticians, dentists and district nurses in the model.

"Cornwall needs more health promotion and health education. Teaching people how to learn to manage their conditions properly is key if you want to keep them out of A&E and away from GPs. Knowing when one needs help at home and what is required rather than waiting for something to become 'urgent' is vital."

"We need to support the local community infrastructure and voluntary services in the provision of social interaction and social prescribing to address the negative effects of social isolation."

"Could we give the £30 million challenge savings to non-NHS initiatives like the singing for lung health club or training for PPGs so they can signpost people to local activities that would improve people's health? That way when people do social prescribing that prevents someone needing treatment that would cost £300 then £100 could go to pay off the deficit, £100 could go to the GP that socially prescribed and £100 would go to the group you socially prescribed to."

"The council are running a pilot with Volunteer Cornwall's community makers to map out what community services are available locally and what impact social prescribing has on patient outcomes. The findings should help the STP calculate the potential savings if the new model includes social prescribing and community makers."

"A lot of local initiatives are social rather than medical. Millbrook has the Rame Community Trust. Torpoint has CHAT (Community Health Around Torpoint). These groups help with the preventative side of health, but also have reasonable knowledge about what support is available in the community."

"Care plans have to be right and support the public to accept responsibility for maintaining and managing their own health."

"Health Promotion needs to be better and link more with schools."

"We need to ensure community nursing teams are supported as part of the model, with access to suitable prescribing capability."

"Include opticians for minor eye issues, foreign bodies, abrasions to the eye etc. in the UTC model as a lot of people currently go to A&E with those problems."

"Physios in the surgery are a great idea. You can see someone about muscular injury within 10 minutes. Mental Health nurses are also an excellent idea. However, seeing dentistry as a minor illness is a retrospect step".

2.4.4 The role of pharmacy

As in previous waves, participants suggested pharmacists could be utilised more to increase capacity and reduce pressures in the system, particularly in relation to assessing, signposting, health promotion, monitoring and treating minor illnesses. However, the public would need to be aware of what support and information they could get at their local pharmacy for this to be effective.

"Pharmacists are skilled at doing blood pressures. However, we need to change perception of what pharmacies can deliver to the public."

"Receptionists are being trained on when to direct people to pharmacists and we could do more promoting self-care and community wellbeing in pharmacies."

"Some GP practices are employing pharmacist to assess patients which frees up some of their time."

"Include involvement from a pharmacist in the model. They can discuss the medication and other medication with the patients to make patients aware of the cost and the alternatives."

"Supplying medication can be an issue out of hours so you need to include pharmacy in the model.

2.4.5 Short Stay Assessment Beds

When considering whether to support the inclusion of short stay assessment beds, people stressed the need to ensure there are adequate wrap around services and clear guidelines regarding eligibility and length of stay to support speedy referral and discharge.

"You need to have the services available to support the discharge or you will end up with blocked beds."

"Make the short stay beds exactly what they were intended to be: Short Stay. So you would need to make them more efficient at discharge than the current system."

"We need clear guidelines around the care provided when a patient is occupying a 'short stay' assessment bed. It used to be 72 hours, but it will depend on the level of clinician provided at the UTC. Once the GP goes off shift, what will be the competency of the clinician at the unit be? It will need to be a trained person that can manage a range of clinical needs - as a minimum a qualified nurse - with an onward referral process."

"This would require a 24 hour service wrapped around it to facilitate diagnosis and discharge."

"We need routes in and out of short stay beds to be properly managed."

"If these are just day assessment beds, it will be important to consider how to handle the end of the day in order to avoid increased demand for ambulances late in the evening as the service closes - either transferring patients to hospital or to an overnight assessment bed elsewhere. This would be less of an issue if the UTC Short Stay beds/chairs are based in a community hospital (with a short stay assessment "ward"). However, it would be difficult to prevent extended occupation if community hospital beds are full, which would defeat the initiative."

2.4.6 Workforce & Capacity

As previously, concerns were also raised about the additional medical and nursing workforce and coordination between services that would be needed to deliver an

effective urgent treatment service. Indeed, current issues around recruitment and retention made people question the operational viability and sustainability of the model.

"Workforce pressure across all roles (not just GPs) is an issue. Early retirement is a significant issue. Experienced staff leaving early impacts on GP capacity to lead and support replacement staff coming through. Well placed UTCs with sufficient footfall might be useful in supporting staff training and career development, but will it attract new recruits."

"GPs used to be available for nurses to call them and get advice and now they're not."

"Where will you get all the clinicians you need for UTCs? We have hundreds of vacancies in Cornwall that we already struggle to fill."

"Near patient testing has the potential to reduce lots of admissions, but will it create more work for local GPs? I am really supportive of the STP plan, but I don't think we have the capacity locally to implement it."

"What sort of workforce is needed? It's about supply and demand. Do we have enough supply to meet the demand?"

"The GP surgeries in the area are so overrun with patients they would not have the capacity to take on a minor injury service."

"A number of GPs would be interested in working in acute services some of the time, but many would not be interested, particularly practice partners who are already struggling to cope with their normal primary care duties."

"You need more than one clinician to meet things like lone working policies and avoid isolated practice so that if one clinician suddenly collapses you have back up."

"Is the need to buy into a partnership putting GPs off coming to Cornwall?" – "No, we advertise jobs where we give people the choice of applying to be a partner or a salaried GP. People still don't apply."

"A mixed model is helpful given our geography/rurality so we have GPs offering local enhanced services similar to a minor injury unit in remote areas where MIU/UTC facilities are further away. However, small GP MIU services scattered across the county might adversely affect the workforce capacity in the larger MIU/UTCs if there are too many. So it's not just how many UTCs, but how many local enhanced GP services, we can have."

"East Cornwall has a shortage of GPs. An inability to recruit means people queue up to see a GP. The demand for a GP has quadrupled since the days of GPs working 24 hours a day so I don't see how you can staff the model."

"Two in five GPs will leave the profession in the next 5 years. We have to make working in Cornwall an attractive job. We have to stop competing with other organisations."

Participants offered a number of suggestions for how GP capacity issues could be addressed such as blending roles by upskilling existing staff and delivering a greater range of support in care homes.

"How will you resource the GP led services, given there are already significant capacity issues in primary care? While GP "presence" is important in avoiding onward referrals, we need to recognise the resource pressure. We should invest effort to upskill community nurses and pharmacists to carry some of the demand."

"Upskill care home staff to care so they can do more for patients on site so symptoms don't escalate instead of sending them to a UTC."

"It's about upskilling the whole team so we can be more clever with the skills we have."

"If a portfolio career can be offered to prospective GPs, it's a more attractive thing and might bring people back to Cornwall."

"If you cannot get enough GPs could we make greater use of nurses? Lots of nurses are keen to take on a wider role. We have a new nurse practitioner who regularly does things over and above the protocol for her role who finds being stretched in this way exciting. You do need to have really good clinical supervision in place for this to work though." – "That's ok in theory, but all the nurses would need additional training and University of Plymouth won't come to Cornwall to train our nurses so we have to use the Open University. Cornwall Foundation Trust and the Clinical Commissioning Group have raised this with Health Education England, but we've seen no progress."

"Some people have an issue with telling an untrained receptionist any detail of their illness because they don't feel it is appropriate to discuss with the 'receptionist'. Uncaring GP reception do not help with the flow of patients to A&E."

"A GP could be present in the UTC, but also responsible for the wider area to make the limited resources we have go further."

"Recruiting staff into Cornwall is an issue. We need to change some culture and attitudes in the workplace and harness development opportunities for all staff right through the [salary] bands. Developing new and enhanced roles could attract workforce if the jobs are sustainable with sufficient footfall to maintain skillsets."

"As a GP we don't provide suturing at the moment and we would need to retrain before we would agree to do so as we're out of practice. We would also need

additional funding as we currently do lots of work that isn't included in our contract and we simply can't keep adding to that list. It would really depend how many people needed suturing to justify the additional expense. At the moment the requirements and expectations on GPs just keep increasing whilst we get paid less to do more. It's not sustainable."

"Staff may be required to be multi-skilled to deliver this."

"Consideration is needed about safe staffing of the unit. We could upskill community nurses and pharmacists' to take some of the demand off GPs, but only if it was safe."

2.4.7 Communication

Some people were concerned about the potential for a more complex mixed model to lead to greater confusion among the population about where to attend under different circumstances. Hence, the importance of clear communication and consistency were also stressed.

"Making every contact count should include advice about where to go for different health and care needs. People need to be comfortable with the system and not have to recount one's story every time."

"You need consistency of services across the county. Consistency is important in helping the public and health/care services to understand what services are available where. We need to recognise the current situation where there is significant confusion about what is provided where, which is leading to unnecessary ED (Emergency Department) attendances. Even staff in the system do not always understand which services to access."

"We need to have robust discussions with patients about risks. Who is responsible if things go wrong? We have to manage the risks that go with the community working better to create 'healthy communities' so there needs to be a discussion about where clinical governance sits.

"Does it matter if some people go to the wrong place even after the new model is in place? Surely a small reduction in hospital admissions and ED attendance could make a positive difference at the start and then people will start to use the new system properly over time as they start to trust it."

"People go where they want, not where they need. We need local resources in place and clear communication about where people need to go if you want to change that."

"The public need to receive some help in accessing a service and clear information about which service to access including at home basic care. Possibly add care navigation, first aid and self-care advice into antenatal class so young parents can consider how to treat a child at home before visiting a GP, MIU or A&E. First aid is already part of the school curriculum."

"Improve patient education to encourage patients to go to the pharmacy. Early presentation of patients at pharmacies would reduce the need for urgent intervention."

"We should provide clear signposting on where services are and when/how people can access them. There are various opportunities for providing information points of contact for signposting services."

2.4.8 Financial Considerations, Capacity & Operational Viability

The financial and operational viability of the emerging UTC model were also questioned particularly in terms of its ability to relieve current pressures on GPs and the accident and emergency department at Royal Cornwall Hospital.

"How does all this fit with the push on extended access to GPs? How will GPs manage the additional extended hours as well as leading the UTC service if we don't have enough GPs and no money to buy in the extra people we need? All GPs have to provide extended access, but there aren't enough people to provide it, so the need to prioritise one is likely to undermine our ability to deliver UTCs. What does the government want us to prioritise first?"

"There aren't enough people to staff lots of UTCs so that will restrict the number we can have right there. Then you need money to double run current and new services until we know whether the new UTC model is more effective than the current model at improving people's outcomes whilst reducing hospital admissions and/or GP attendance. So where will that extra money and the staff to simultaneously run both services come from?"

"We have leg ulcer clinics and other local initiatives like having physios in GP practices go on locally because staff see a need for it and make it happen, but this just creates additional work for GPs that they don't get paid for so there's a limit to how many new initiatives we can support without additional capacity and funding."

"The local plan needs to feed into future plans so it is sustainable. Look at where we could get the most for your money. Integration of a lot more services provides the most benefit for the most people."

"We need to be very careful that the model does not become dependent on packages of care as these may not be available long term due to companies not finding them financially viable."

"Do we want to pay for a local enhanced service (LES) or just pay for UTCs up front and say this is dependent on you reducing activity in A&E? I'd like to review the LES service specification before I decide which is better for people in East Cornwall."

"Capital investment should be offered for a big enough area."

"The CCG, NHS England and the Council are looking at new ways of commissioning so GPs would get paid more fairly for what they do in future. The message coming down to STPs and from our leaders to us is 'if you are doing right by your patients you won't get into trouble if you act outside of current contracts."

"Fast forward 5 years. Is this going to be future proof? We've got to be open to and prepared for anything."

"The integrated care system needs to look at how we pay for bits of care so we can accurately cost any potential new models and ensure we pay for people's whole package of care from beginning to end."

"At the East Cornwall locality meeting we were sharing ideas for meeting the £30 million challenge last month. The idea is that if we provide better care we will save money and those savings can be shared with the Clinical Commissioning Group to reduce the deficit and a third of the savings will go back to the GPs so they can invest the money to support new ways of working so future care is more integrated and sustainable."

2.4.9 Digital Solutions & Shared Care Records

As previously, people also suggested that greater use of various digital technologies could reduce some of the time practitioners currently spend monitoring patients and provide fast access to reliable information to help people navigate the health and care system and self-manage. People also highlighted the need for compatible IT systems to facilitate the sharing of patient records between different teams

"There is a 'Handy App' available that provides assistive technology. This includes someone you can call up for advice. The use of technology would greatly help with avoiding UTCs. A lot of people do not have access to an MIU so talking to someone via an app would be beneficial."

"The 'NHS Quicker App' is a useful tool and contains waiting times in emergency departments and other good information such as useful phone numbers for access to NHS dentistry."

"Surely we should have an IT system that enables us to talk to each other in different organisations so we can have access to shared care records by now."

"The model should include remote ways of supporting patients. We should be utilising telecare as part of the system more."

"St John Ambulance and Red Cross provide excellent apps. As part of a social prescribing guide they signpost people to well recognised apps as a first point of reference before heading to someone's GP, MIU or A&E."

"We need better use of technology for reporting of scans and films. Then these can be reviewed electronically by a GP or specialist in another part of the county."

2.4.10 Diagnostics & Triage

People supported the inclusion of point of care testing in the UTC model, but highlighted the need for additional resources and specialist skills across a range of disciplines to adequately utilise scanners, x-rays and blood tests at UTCs.

"GPs send people to RCHT because the courier deadline for same day testing is 10am so if anyone needs a test after 10 we won't get the results in time so it's quicker to send them to hospital. If we could just do the testing locally we could keep people out of hospital."

"If a CT scanner is being made available then it would be better to use it for more than just UTC patients and have it made available 24 hours to make it cost effective. That will need staffing."

"Point of care testing requires people who know how to interpret the various test results. There is a clinical assessment module available which radiographers could undertake and physios, pharmacy can also access this course."

"Point of care testing is a good service to have at a UTC, but it's not as simple as it sounds."

"The Point of Care Testing in the UTC model could make a huge difference in preventing unnecessary ED attendance. Extended access to x-ray into evenings and weekends with a radiographer and radiologist on site would be valuable. These facilities would tie in well with the Short Stay Assessment beds too. We have had similar services before that we could learn from such as the Mount Gould Frailty Assessment Unit."

2.4.11 Location of UTCs

Participants also made a number of suggestions in relation to where UTCs could be located, including the consideration of estates not currently owned or rented by statutory services, and the assessment criteria that would need to be applied. Criteria included the consideration of population density, service quality, the cost of converting existing estates versus building new, availability of parking, access to transport and the potential to co-locate or link with other services (for example, children, pharmacy, fire and police services).

"Retro fitting properties is very expensive compared against new builds."

"One thing the NHS misses is thinking about what the community can do. Saltash people raised the money to build St Barnabas in the first place. Get the public to raise the money for a new hospital where we could have the UTC."

"The travel time methodology looks good, but the criteria should include road access, high population and transport infrastructure. While local access to services is important, sustainable quality is the most important factor. In this respect, fewer sites will be more appropriate."

"When I was fighting to reopen the MIU at St Barnabas which was temporarily closed a year ago the CCG locality manager circulated the MIU service specification so we could see what St Barnabas needed to provide. Is it not better to have a GP Local Enhanced service than an MIU?"

"Site visits and financial modelling should tell us whether a new building is more cost effective than repurposing an old building. We need that information before we can properly answer this question."

"Penzance is not the best place for a UTC despite having the West Cornwall Hospital there. You need accessibility from all directions. Liskeard Hospital takes everyone from the surrounding area."

"When choosing where to put UTCs look at affordability, population need, the distance and what support is already there."

"One criterion should be scope for expansion to allow other services to be bought in to the area."

"West Cornwall hospital is not always being utilised so you need to consider current bed availability and usage across the county overall in the assessment criteria when deciding where to put UTCs."

"Historically Trerulefoot is the heart of East Cornwall. It is eight miles from Liskeard, eight miles from Saltash and eight miles from Looe. It is also served by a bus route."

"I am heartened to hear you talk about the mixed model rather than you only have a UTC or you have MIUs. I could see this working well in Saltash. People love St Barnabas and don't want to see it being closed, but why can't we have an MIU like the Cumberland Centre instead of St Barnabas?"

"The UTC model is great, but the idea that you can close beds based solely on UTC criteria isn't going to work. Urgent care has to be part of the whole system rather than considered in isolation. This needs to be part of the assessment criteria – how well will it link to the other services it needs to link with?"

"The number and location of UTCs will be constrained by the facilities we have and the population you can see in a particular location."

"It will need to be Liskeard Hospital because of the facilities and land it has."

"Parking for GP's in Liskeard is a major issue. The Oaktree surgery is used by people that are not attending the site because of the free park and ride for residence. At the other practice parking is free in the town after 4pm, so people request appointment after 4pm. So you need to consider parking when reviewing potential UTC sites."

"Most practices do not have the physical space to take on more services or patients so that would rule them out."

2.4.12 Co-location

Indeed co-location with allied services and applying technology to conduct more activity remotely were seen as primary ways to make the model more cost effective and affordable.

"Have pharmacy, GPs and an MIU all co-located."

"You need a community hub to have a truly mixed model with ease of access and local control. UTCs are only a small part of that unless you house everything under one roof."

"Potentially out of hours GPs could work in treatment centres alongside normal GPs so that their co-location gives both services greater resilience."

"Co-locate some of the out of hour GP services into the UTC centre to share resources."

"There is a great need to start co-locating GP services with other services to create a fit for purpose service. Locally there is an argument to keep the GP surgery in the town which also brings people into the town centre. There is also a need to provide an out of town GP service to reduce traffic into town."

"Technology could also be a factor in determining the number and location of UTCs that are required. How do they do distance treatment in Australia or in the United States? Would we need so many if we applied that learning?"

3. East Cornwall Plenary Topics

After the table discussions had concluded, each group discussed the main points they had discussed with the local clinical lead. This information has been collated into themes and is presented below.

East Cornwall Plenary Topics

Key themes identified by participants

Topic	Explanation
Prevention & Self-Management	• Emphasis on prevention health promotion and self-management – increase access to rescue meds to prevent admissions. • Get people fitter – target school children • Make every contact count. NHS requirement. Do we know how that's being implemented in Cornwall? • Children – Big six conditions e.g. respiratory – gastro. • Utilise the 'handy app' – greater use of technology

	• Choose Well campaign – Advertise the NHS Quicker App (provides MIU Waiting times) • Care planning – access to records – IT • Out of hours – linked information (IT) – robust discussions with patients about risk. • Use of community pharmacies – personal responsibility – self-care – educating patients • Promotion of community pharmacists – pharmacists taking assessments • Community strategies/groups to link people - not always about a medical need. • More social contact – community responsibility to try new things – peer support • Active Signposting – GP Voice • Support assistive technology too e.g. telecare. • Learn from the Robin Unit Robin Community - a community based service that has been specifically designed to enable treatment and tests to be completed without the need for a hospital stay.
Workforce	• We need more GPs in primary care…this is a problem in the east. Try and design service that meets need not demand with a critical mass of patients to avoid occasional practice. E.g. physio – MH practitioner across locality not per practice. • Stop robbing one another – be smarter – work together. • Review current MIU spec inc. resilience = 10 Care Capability. • The right training, education and support to care homes and nursing homes and care agencies could prevent the need for urgent care services. • Community matrons should target the frail. Connect with wider nursing team (better integration) – nurse practitioner led UTCs to address GP capacity issues. • Community pharmacists (upskilling to diagnose and prescribe) • Enhanced intermediate care teams – acute care at home – home first (pull and push) to support timely assessment bed discharge • Ageing workforce – focus on retention. Need to attract younger workforce to Cornwall – rotational posts – shift in culture and attitude. • Education/clarity/signposting – consistent message across county. • GP portfolio careers in acute medicine could support recruitment. • Is this going to be attractive recruitment opportunity? • You need to balance cost with population need and workforce capacity • Will GPs be overstretched if they have to cover UTCs as well? • UTC – does a GP need to be in situ and cover a broader patch – yes ideally, but where will the funding

	come from?
Short Stay Assessment Beds	• MDT approach is needed • Step up assessment is a good thing • Need criteria in and out. • Need another support function to enable short stay assessment beds to be effective • Time to think – staff will need night/skills for monitoring • Learn from Robin Short Stay Unit (a community based service in Plymouth that has been specifically designed to enable treatment and tests to be completed without the need for a hospital stay).
Financial Considerations and Sustainability	• Resource implications for this. There is a lack of money and people available. • Additional spec/resource is great - is this realistic? • They are planning a dual carriageway from Saltash to Bodmin (Feasibility study) (Cuts out Glynn Valley) (20 years away) • HUB: Acute GP in every locality • HUB: Liskeard as a good place to admit to. • Offer block contract incentives with place based budgets
Point of Care Testing	• Point of care testing will reduce acute admissions • What is the rationale for UTC not being 24 hr? • We use Cumberland Centre because x-ray opens until 21:00 • X-ray – need radiographer and radiologist (access)
Assessment criteria for UTC sites?	• Consideration of current estate • Accessibility - geographically “Trerulefoot is centre of the East and on the A38” • Travel time – distance – transport links – affordability – population need. • Consideration of what is already in place and evaluate new ways of working: Rosedean – paramedic – nurse practitioner – takes pressure off the GPs. E.g. Oaktree has physio on site • What technology links would be required in other areas in the east?

4. Next Steps

The results of the co-production workshops are currently being considered by the Shaping Our Future team and will be used to inform the further refinement of the emerging models of care and transformation options for Mid Cornwall that will subsequently be consulted on with the public.

Feedback is being considered by:

The Shaping Our Future New Models of Care Group
The Shaping Our Future Portfolio Board

The Shaping Our Future Transformation Board
The Shaping Our Future Clinical Practitioner Cabinet

Information about the remaining coproduction programme will be shared in due course.

Glossary

Accountable Care System (ACS) – now called Integrated Care System	NHS England has recently outlined ambitions for sustainability and transformation partnerships (STPs) to evolve into 'accountable care systems' (ACSs). ACSs' come in a variety of forms ranging from closely integrated systems to looser alliances and networks. Hence, there is no single model, but they should contain the following three core elements. First, they involve a provider or, more usually, a group of providers that collaborate to meet the needs of a defined population. Second, these providers take responsibility for a budget allocated by a commissioner or group of commissioners to deliver a range of services to that population. And third, ACSs work under a contract that specifies the outcomes and other objectives they are required to achieve within the given budget, often extending over a number of years. N.B. In its recent planning guidance, NHS England directed STPs to make the distinction between Accountable Care Systems in England with other parts of the world more obvious by adopting the term Integrated Care System to describe the models of integrated care and partnership working being developed in England under national the STP programme that the work described in this report is part of.
A&E	Accident and Emergency
Acute Care at Home services	The Acute Care at Home service provides advanced nursing care and support to patients in their own homes. The aim is to prevent an admission or support an early discharge from hospital.
Better Care Fund (BCF)	A joint initiative between the council and NHS to work together to join up care across Health and Social. Further information around the Better Care Fund can be found on the NHS England website: https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/
Business Change Managers	The Business Change Manager is responsible, on behalf of the Senior Responsible Owner, for defining the benefits, assessing progress and

	achieving measured progress towards development of the new models of care presented in the pre-consultation and full business cases.
Care Coordinator	The person responsible for ensuring that a patient gets the health and social services they need by bringing together the different specialists whose help the patient may need.
Clinical Commissioning Group (CCG)	CCGs are local organisations responsible for commissioning (paying for) and procuring (obtaining) local NHS services. NHS Kernow CCG commissions services for people living in Cornwall and Isles of Scilly.
Community Connectors	A network of volunteers being identified and recruited at locality level to develop their skills to become 'Community Connectors'. These key people may already be actively volunteering within their communities, are well-respected and evidence a desire to enhance community cohesion and build capacity. With this model of community support, Community Connectors will enable hundreds of residents' voices to be heard, new volunteers to be recruited to support community initiatives, and new ideas to address local issues to be aired, shared and acted upon.
Cornwall's Health and Social Care Overview and Scrutiny Committee	This Committee provides democratic scrutiny of services which look after the health and social care needs of people in Cornwall. This includes local NHS organisations, Public Health, Adult Social Care and Children's Social Care. The Committee has a key role to play in ensuring that health and social care providers are providing the most effective and efficient outcomes for the people of Cornwall.
CPN	Community Psychiatric Nurse
CT Scan	A computerized tomography (CT) scan combines a series of X-ray images taken from different angles and uses computer processing to create images that provide more detailed information than plain X-rays.
Discharge to Assess	The principle behind discharge to assess is that once a patient no longer requires an acute level of care, they should not remain in hospital simply because they are waiting for assessments to take place.
District Nursing	District nurses are one of the many different types of nurses who manage care within the community,

	rather than in a hospital or private clinic. They visit patients in their homes and provide the necessary advice and care regarding wound management, continence care, catheter care and palliative care amongst others.
DNA	DNA refers to people who 'do not attend' medical appointments.
Early Intervention Service	Information about the early intervention service in Cornwall can be found at https://www.cornwall.gov.uk/media/3623097/EIS-patient-information-leaflet.pdf
ED	Emergency Department (Formerly called A&E – Accident and Emergency)
End of Life Care (EOL)	End of life care is support for people who are in the last months or years of their life. It helps people to live as well as possible until they die, and to die with dignity. The people providing care should ask patients about their wishes and preferences, and take these into account as they work with the patient to plan their care. They should also support their family, carers or other people who are important to them. People can receive end of life care at home or in care homes, hospices or hospitals, depending on their needs and preference about where they would like to die.
EPIC	Ehealth Productivity and Innovation in Cornwall and the Isles of Scilly (EPIC) is a collaborative project partly funded by the European Regional Development Fund with additional financial support from the South West Academic Health Science Network. University of Plymouth and partners aim to improve the use of technology in both health and social care hoping to improve health and wellbeing of people in Cornwall and improve the Cornish economy in this sector. The EPIC project started in May 2017 for three years.
Full Business Case	The full business case describes the new model of care that has been the subject of local stakeholder engagement and reflects the results of that engagement.
HbA1c	By measuring glycated haemoglobin (HbA1c), clinicians are able to get an overall picture of what

	our average blood sugar levels have been over a period of weeks/months. For people with diabetes this is important as the higher the HbA1c, the greater the risk of developing diabetes-related complications.
Home First	The aim of the Home First service is to provide short-term re-ablement support to help people recover at home safely whilst they are unwell. Homefirst will work with patients to identify what support they need and how it can be provided, if required.
Information Governance	Information governance, or IG, is the management of information at an organization. Information governance balances the use and security of information. An organization can establish a consistent and logical framework for employees to handle data through their information governance policies and procedures. These policies guide proper behavior regarding how organizations and their employees handle electronically stored information to ensure information is appropriately secured and protected.
Inpatient beds	An inpatient bed is a bed in a hospital that provides 24 hour nursing care.
Integrated Care System (ICS)	Please see Accountable Care System
INR	International normalized ratio (INR) is a calculation made to determine the clotting tendency of blood per measure of warfarin dosage, liver damage, and vitamin K status.
Local Enhanced Services	Primary care services other than those set out in the standard GP contract. These can include additional procedures such as providing x-ray and/or out-of-hours services.
Mixed Model of Urgent Care	A mixed model of care is one that includes different vehicles for providing urgent care in a community such as a mix of urgent treatment centres, minor injury units and GP local enhanced services.
Model of Care	A model of care describes what support should be routinely available for someone under particular circumstance. For example, a model of care for cancer could include public health initiatives to prevent cancer, referral for tests to diagnose cancer provided by a GP, surgical or pharmaceutical as an in- or out-patient treatment provided by an acute hospital, follow up tests

	ordered by a consultant, psychological support, support from social care to support timely discharge.
MSK	Musculoskeletal
Near Patient Testing	See Point of Care Testing
OT	Occupational Therapy refers to support given to enable people to perform particular activities as an aid to recuperation from physical or mental illness.
Outpatients	This refers to all the procedures and assessments a person can have without being admitted to hospital as an inpatient.
Patient Activation Measure	Patient activation describes the knowledge, skills and confidence a person has in managing their own health and care. People are assessed in terms of the willingness to manage their own health and care against four levels where level 1 is 'disengaged and overwhelmed' and Level 4 is 'maintaining behaviours and pushing farther'. You can find out more about patient activation in the King's Fund report: 'Supporting people to manage their health'.
Patient Participation Groups	There is no single or definitive model for a Patient Participation Group. Each group is different. They are a forum for patients to advise and inform a General Practice on what matters most to patients and to help identify solutions to problems.
PDSA Cycles	The PDSA cycle is shorthand for testing a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act).
Point of Care Testing	Point of Care Testing (POCT) is defined as medical diagnostic testing performed outside the clinical laboratory in close proximity to where the patient is receiving care. POCT is typically performed by non-laboratory personnel and the results are used for clinical decision making.
Pre-consultation Business Case (PCBC)	The PCBC is made up of two parts; Part 1 focuses on the case for change, vision and proposed solutions to achieve the best health and care for all residents of Cornwall and Isles of Scilly. Part 2 provides the evidence base and other technical information that supports the final decision to consult the public on the proposed solutions.

Primary Care	Services by general practitioners, practice nurses and other professionals usually out of GP practices.
Reablement	Reablement is a short and intensive service, usually delivered in the home, which is offered to people with disabilities and those who are frail or recovering from an illness or injury. The purpose of reablement is to help people who have experienced deterioration in their health and/or have increased support needs to relearn the skills required to keep them safe and independent at home. People using reablement experience greater improvements in physical functioning and improved quality of life compared with using standard home care.
Recovery College	A *recovery college* takes an educational rather than a clinical or rehabilitation approach to improving mental health.
Rehabilitation	Rehabilitation refers to actions taken to restore someone to health or normal life through training and therapy after imprisonment, addiction, or illness. Rehabilitation includes assisting the patient to compensate for deficits that cannot be reversed medically. It is prescribed after many types of injury, illness, or disease, including amputations, arthritis, cancer, cardiac disease, neurological problems, orthopedic injuries, spinal cord injuries, stroke, and traumatic brain injuries.
Repatriation	Repatriation refers to the steps taken to return someone back to their community after they have been treated.
Rescue Medication Pack	A Rescue Medication Pack contains a supply of standby medications to start if your condition gets worse before you are able to see your doctor.
ROVI	Rehabilitation officer for visual impairment
Senior House Officer	A junior hospital doctor.
Senior Responsible Owner	In this instance, The Senior Responsible Owner (SRO) is the visible owner of the workstream's programme of work overall. They are accountable for successful delivery of the work and are recognised throughout the organisation as the key leadership figure in driving the workstream programme forward.
Shaping Our Future (SoF)	The Sustainability and Transformation Plan for Cornwall and the Isles of Scilly is called Shaping Our Future. Shaping Our Future is a live document

	and will develop as our ideas develop by listening to local people. All information related to Shaping Our Future can be found at https://www.cornwall.gov.uk/health-and-social-care/shaping-the-future-of-health-and-social-care-services/ and http://www.healthwatchcornwall.co.uk/shaping-our-future/ and www.shapingourfuture.info Shaping Our Future is about improving health and wellbeing of the local population; improving quality of services; and delivering financial stability.
Shaping Our Future Partnership	Locally, NHS organisations (commissioners and providers of services) have been asked to work together with local authorities to produce Sustainability and Transformation Plans (STPs). These STP partners are working together to develop the plan so it describes exactly how they will respond to the Five Year Forward View. The Partnership for Cornwall and Isles of Scilly includes local authority and clinical commissioning group commissioners of health and social care services for Cornwall and Isles of Scilly, Royal Cornwall Hospital Trust, Cornwall Partnership NHS Foundation Trust and NHS England.
Social Prescribing	Social prescribing is about doctors and nurses being able to refer people for things other than drugs and medical treatment, such as social or physical activities in their community that are thought to have a wide range of benefits that could include: • Improved fitness • Increased mobility • Depleted levels of anxiety • Managed depression • New skills learned • Reduced isolation & loneliness • Lasting friendships & acquaintances
SPRINT workshop coproduction	SPRINT workshops come from the business world to describe a process for answering critical business questions through design, prototyping, and testing ideas with the people who deliver and use services.

Statutory Services	Health and social care services that must be provided by law.
Step Down Services	An intermediate-care unit which provides temporary placement of a person who has been discharged from hospital, needs minimal or no monitoring, and is awaiting placement in a long-term care facility, care home with nursing or care home.
STEPS	STEPS - the short term enablement pathway service. This service supports people at home for a limited period following a health or social care crisis when temporary care at home is required to help people until they are well enough to live independently.
Step up Services	Step Up Services are community reablement services for people who are tipping into or have tipped into a care crisis and who have a care need that cannot be managed within their own home or they cannot be left safely at home. At this time they may benefit from being stepped up into a community reablement bed. Any patient stepped up will be deemed medically stable by the referring clinician.
Sustainability and Transformation Plan (STP)	In October 2014, the NHS published its Five Year Forward View to set out the need for health and social care services to become sustainable over a five year period. Locally, NHS organisations (commissioners and providers of services) have been asked to work together with local authorities to produce Sustainability and Transformation Plans (STPs). These STP partners are working together to develop the plan so it describes exactly how they will respond to the Five Year Forward View. There are 44 STP Partnerships across England.
Therapies	Therapies is a term used by health professionals to describe a range of different services that a person might need to help them return to independent living after a period of being unwell. These might include physiotherapy, neurorehabilitation, occupational therapy, psychosocial support, hydrotherapy.
The 3 conversations model	The model was developed by Partners for Change, a social care consultancy firm that works with local authorities to deliver personalised social care within austerity. The aim is to remove the traditional ‘assessment for services’ approach and

	create a new culture where social care practice is based on three conversations that practitioners have with the people who need social care. More information about how this works can be found at http://www.communitycare.co.uk/2016/05/03/three-conversations-changed-way-social-work/
Third Sector/Voluntary Sector	Used interchangeably and refer to non-governmental and non-profit-making organizations or associations, including charities, voluntary and community groups, cooperatives, etc.
TRACC	TRACC is software that enables travel time to be calculated using a wide range of available data.
UTC	Urgent treatment centres aim to ease the pressure on hospitals by treating most injuries or illnesses that are urgent but not life threatening. For example sprains and strains, broken bones, minor burns and scalds, minor head and eye injuries, bites and stings. This leaves other parts of the health system free to treat the most serious cases and/or long term conditions.
WRVS	Women's Royal Voluntary Service

APPENDIX A – East Cornwall Wave 3 participants

Liskeard 26th February 2018

	TOTAL NUMBER		
People who attended (regardless of role):	38		
Organisations represented:		CFT NHS Kernow Cornwall Council NHS England RCHT Health Education England GP Practices • Old Bridge Surgery Volunteer Cornwall St Germans Parish Council SWAST	7 Reps 11 Reps 5 Reps 2 Reps 2 Reps 1 Rep 1 Rep 1 Rep 1 Rep 1 Rep
Lay people (include HW PPG and CAP members in this)		CAP Member Experts By Experience Health and Social Care Visionary	1 Rep 4 Rep 1 Rep
Professional roles represented		Head of Service, Adult Social Care Locality Director Cornwall Councillor Events Officer Health Dean Workforce Transformation Clinical Lead Programme Manager Deputy Director of HR and OD Chair* Chief Officer Pharmaceutical Advisor Finance Manager General Practitioner* Executive System Lead for Urgent and Emergency Care Falls Lead Social Action Coordinator Designated Nurse, Children in Care SOF Head of Stakeholder Engagement and Inclusion Parish Councillor Healthy Lifestyle Team Lead Operations Officer Head of Locality Support	1 Rep 1 Rep 3 Rep 1 Rep 1 Rep 1 Rep 1 Rep 1 Rep 1 Rep 1 Rep 3 Reps 1 Rep 2 Reps 1 Rep 1 Rep 1 Rep 1 Rep 1 Rep 1 Rep 1 Rep 1 Rep 1 Rep

		Integrated Care Programme Manager Integrated Community Manager Admin Support Director of HR and OD Patient and Public Involvement Manager Children and Young People's Commissioner	1 Rep 1 Rep 1 Rep 1 Rep 1 Rep 1 Rep

APPENDIX B - Wave 3 Agenda

Agenda for Wave 3 Co-production Workshops

Activity	
Arrival and registration	
Welcome, and introduction • Lessons learned during Wave 2 *(detail to be sent ahead of meeting & summarised on posters)* • The emerging picture of community based care and support in the future to meet local needs *(on posters for each table)* • Purpose of tonight's session and note another wave to follow Full reports available at www.shapingourfuture.info	Host
Presentation: Travel Time methodology *Plenary: Support FAQs to be shared and questions for any points of clarification*	AHSN to provide voice over and FAQs sheet
Presentation: Urgent Treatment Centres • How Wave 2 feedback has shaped thinking • The local service specification • The approach being taken to review current sites to assess their feasibility to upgrade to an Urgent Treatment Centre • Current thinking on the methodology to determine the potential number of Urgent Treatment Centres	SRO/BCM
Table top discussion: What do you think?	
Plenary: Feedback on Urgent Treatment Centre approach	Led by the Clinical lead
Next Steps and close	Host