SHAPING OUR FUTURE

Cornwall and the Isles of Scilly Health and Social Care Partnership

Shaping Our Future Wave 3 Co-production Workshops

West Cornwall – Penwith College, Penzance

To report the information and feedback received from the Wave 3 co-production workshop held on 20 February 2018 at Penwith College, Penzance.

Contents

Executive Summary

This was the second of the third wave series of 'expert coproduction' workshops, which were conducted across Cornwall during February and March 2018. It was held at the Knowledge Spa, Truro. 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 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 or organisations that represent patients and/or the local community (also referred to as 'experts by experience').

Attendance

In total 37 people representing 16 organisations and filling 32 different roles attended the Wave 3 workshop in West Cornwall. This includes people from local third sector organisations, GP practices, Healthwatch Cornwall, the Shaping Our Future citizen advisory panel and local Patient Participation Groups. The lead for children and young people's services and Head of medicines optimisation as well as various elected councillors and representatives from the Care Home sector 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 below.

West Cornwall Plenary Topics

Key themes identified by participants

Topic	Explanation
Pharmacy services	Using a pharmacist to treat minor ailments has to be able to accommodate private consultations. Confidentiality and privacy are very important.
	Raise awareness that average waiting time to see a pharmacist is 7 minutes to reduce pressure on GPs. Expand

	their role.
	Is there a greater role for supermarket based pharmacists?
Assessment/short-stay facility	A buildings based criteria restricted to existing estates might not get the best outcomes. Consider expanding the review to look at other locations as well.
	Does the assessment/short stay facility have to be bed based? Unless it's an overnight assessment could it be chair based? Why immobilise the patient?
	The short stay/assessment bed criteria must be able to work alongside the UTC criteria.
	Short stay/assessment could include telehealth and assistive technology as part of the solution of keeping patients local
	Short stay/assessment beds must be protected from being 'poached' by the acute sector.
General Practice	It's not all about having enough GPs. There are many other skilled staff who can play a vital role.
	GP extended hours might be of limited use. If a patient cannot make a 9am appointment it makes little sense to offer them 8am instead?
	Is all of what's being proposed too dependent upon GPs?
	The Stennack model (GP provided minor injury service) is a good one that practices working collaboratively can replicate.
	The 'Worry' clinics set up by the Helston practices looks to be effective at prevention things leading to health problems (a Saturday morning clinic where GPs can see or speak with patients they have concerns about).
Public education/information	The public must be informed about which service to use in which circumstances, and to know where those services are and when they are open.
	People should be encouraged to take ownership of their own health. For example, should pharmacies make people aware of the cost to the NHS of their medication?
Use of data	Can we use the travel mapping to ensure that someone in the west of the county is not offered an appointment at 9am at a hospital 40 miles away?
	The number of UTC sites should be informed by data analysis of need and viability, and also recognise the workforce capacity, skills and career opportunities.
Other issues	A crisis intervention service (early help hub model) can keep complex patients local through early identification of problems and a multi-disciplinary team to address them.
	A personalised care plan is crucial to using short stay/assessment beds. Speak to the patient 'this is me at my best' to develop a wellness recovery plan.
	There needs to be access to safe mental health services as part of the overall provision.
	Children's services (particularly for the under 2s) must be available to make an impact on hospital attendances.

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
- seek views on 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 the workshops are a part, is designed to provide opportunities for the insight and views of the people who provide health and social care, including the voluntary sector as well as local people that strategically represent patients and/or the communities they live in. This information is then fully considered in order to 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 West Cornwall workshop and is available here .

As such, 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 across Cornwall in addition to the Isles of Scilly. The final options that emerge from this expert coproduction will then be subject to informal public engagement followed by a full formal public consultation. However, the public are invited to share their views on ideas 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 and 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 the discussions that had started during previous waves. Full reports on what local experts said during the first 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' at all expert coproduction workshops were invited from a wide range of expert stakeholder 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 37 people representing 16 organisations and filling 32 different roles attended the Wave 3 workshop in West Cornwall. This includes people from local third sector organisations, GP practices, Healthwatch Cornwall, the Shaping Our Future citizen advisory panel and local Patient Participation Groups. The lead for children and young people's services and head of medicines optimisation as well as various elected councillors and representatives from the Care Home sector 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 all 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 in West 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 briefing explaining the team's emerging thinking about how urgent care could be delivered in Cornwall, which was further shaped after discussions with Shaping Our Future's Citizen Advisory Panel (also circulated before the meeting)

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 North 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 North 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.

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

Handouts are available to download here

1.2.6 Posters

The outputs from the Wave 2 workshop for West Cornwall that was held in September 2017 were also presented on large posters to share what we had heard and explain how this had shaped our 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 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 West 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 were asked for their views on the travel time methodology and to answer the following questions to help develop local urgent (unplanned) care options for West 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

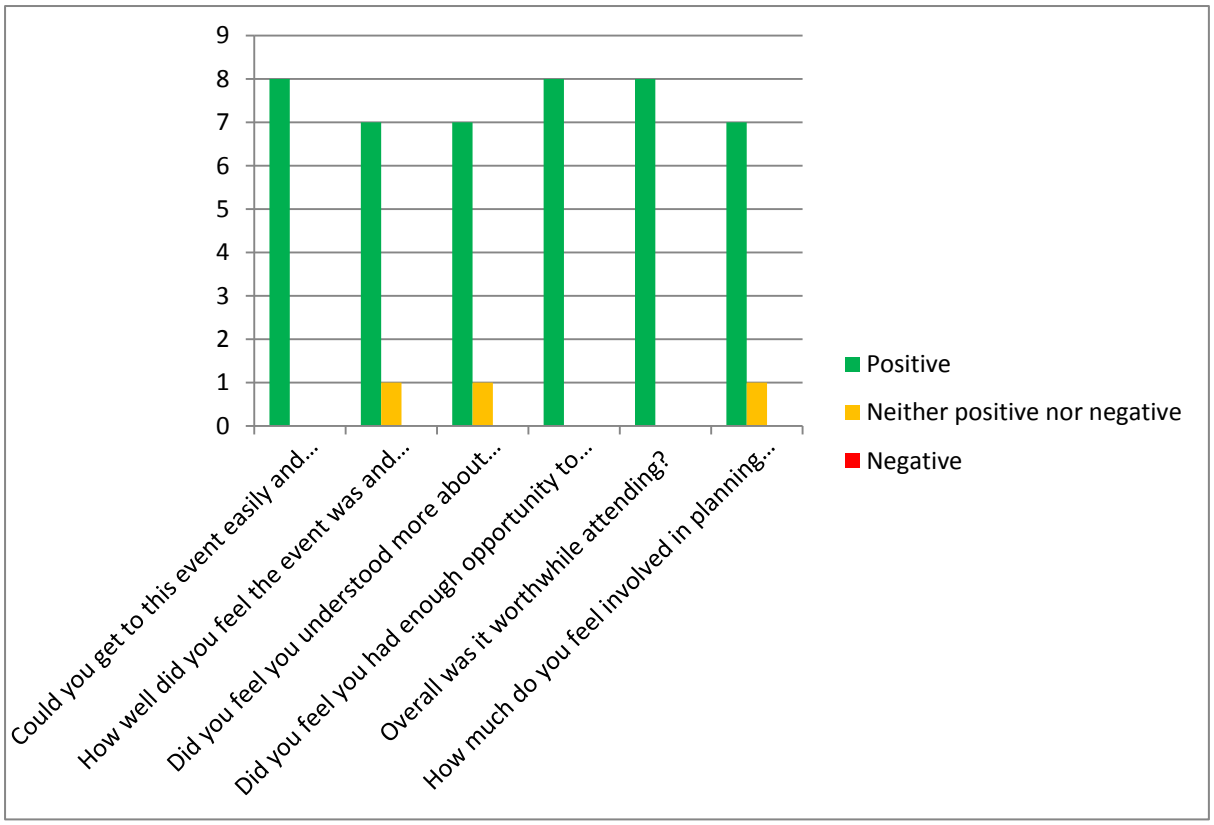
At the end of group discussions, a local clinician led a plenary session where each group fed back the main points discussed at their table. A broad thematic analysis of these discussions is summarised below.

2. Feedback (you said)

2.1 Feedback about the event

Participants were asked to help the team meet its aim of ensuring engagement activities are meaningful and effective by completing an evaluation questionnaire. The overwhelming majority of feedback about the event 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 West Cornwall Wave 3 Event Evaluation



Whilst several people praised the organisation of the event and said they would like to see Shaping our Future's coproduction approach "regarded as standard practice", one person requested better signposting and more discussion time for participants to answer all of the questions more thoroughly. In response, the introductory presentation was shortened for all subsequent workshops.

Evaluation feedback for all three waves will be considered when planning Wave 4.

2.2 Feedback related to the Linked Data Sets and Urgent Care

As in previous waves, people requested population data related to need, demand and a critical evaluation of current services and workforce capacity to deliver the draft model to help them to more confidently advise the team on what urgent care services are needed locally.

"We need data to explain the peaks and troughs in service usage and demand, including pharmacy data."

"Data must exist to inform this discussion otherwise we're not sufficiently informed to make sensible suggestions."

"Data analysis needs to be done. Check the date and postcode on presentations at the Emergency Department to determine which locations have greater need. For example what is the number of admittances that could be done by a GP? This could determine how many UTCs you need and what you would need in them."

"Not having the right equipment in the right place is a problem that leads to more A&E admissions. There can be rapid deterioration of patients not having the right medication, syringe drivers etc., especially within residential homes. Understanding the reasons why people attend A&E is vital because there may be alternative solutions."

"The most frail patients have some form of health or social care input. They are usually known somewhere in the system such as GP, therapist, District Nurse. They are known to services. What we need to know is where they are, how many of them are there, what they need, whether there is a lack of skill to manage the cause of their frailty and staff have the headspace to detect and identify early changes before things become urgent or whether there is a coordination gap between services."

"Do we have data on who uses A&E now? Are there any key cohorts who use it more than others?"

"How many UTCs should we have is the wrong question to ask us. If the planning is done properly, with the right information about population need, reasons for emergency admissions and presentation to A&E etc., then you will come out with 'x' number needed."

"Some data about mental health needs to be included in this discussion. For example, people with a diagnosis of mental health; mental impairment; dementia; some figures about attendance at Emergency services would really help identify what the population need is."

"We need data to understand what GPs and pharmacists etc. can cope with before you include a greater role for them in this model."

"To determine location and number of UTCs look at the data and the access by population, considering deprived populations and need."

"We need to accept that one size does not fit all. Meeting local need might mean some variation across the county. So what is the need in West Cornwall?"

"Health needs should be included in a review because you need to understand the demographics of the area. Otherwise these discussions are of limited value."

"Be explicit about different cohorts who need to use UTCs as their needs are different depending on whether they are children or have a mental or physical health need."

"Target population data depending on needs such as deprivation, age etc."

"Analyse the data re: unsafe and delayed discharges from Treliske so we know what provision might reduce this problem."

"We need to know type of conditions for that population, deprivation data etc."

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 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 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 transport timetables. TRACC also enables us to calculate travel time between an origin point and destination address using a 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 .

After hearing a brief explanation about how the TRACC software works people's comments centred on factors that might influence a person's decision about which service to attend under different circumstances (such as availability of transport, parking and immediate access to support without an appointment) rather than the distance or length of time it takes to get there.

"Transport facilities are a must at urgent treatment centres otherwise people won't use them."

"People want easy access to services that have the capacity for them to turn up and be seen quickly. They want a walk in centre."

"Parking (for UTCs) would be essential and transport data is key."

"How do people get to a UTC? Is there education around for the people taking them to ED as an alternative? The key is having a contingency plan in place."

"Transport remains an issue. Some Day Centres have mini buses that are wheelchair enabled, but there is a need for a local transport coordinator service running between 8am-10pm. Lots of volunteer transport is available, but it needs coordination."

"We need to consider what local factors will lead people to attend Emergency Department in 3, 4 or 5 years' time. UTCs need to be able to meet those needs to address those factors."

"We need to consider the transport needs of the elderly more. They can't drive anymore and need more mobility support because of the rurality of Cornwall. If you can't drive and you don't have easy access to public transport how do you get to a UTC?"

"For West Cornwall most people are able to get to Penzance, but any further than that becomes a problem."

"There isn't good public transport in West Cornwall so people either need to go to Helston or Penzance."

"The genuinely positive thing about the development of UTCs is that if you're really poorly, you won't need to travel as far. In theory when you would've gone to RCHT (Royal Cornwall Hospital Trust) you can go from home in St Just to a UTC in Penzance. So we will be promoting that."

"We need to consider that Penzance is a large area, with many small isolated rural villages with isolated people. Availability of good transport links is as much of an issue as the time it takes to get somewhere."

"Our supermarket pharmacy works well due to the availability of parking. There are also good transport links from town to supermarket. The footfall at any site will increase if the purposes are diversified, but there is a need to look at the infrastructure around parking and travel when deciding what services go where."

"Why have NHS 111 booking appointments when people who need urgent care will turn up anyway to a walk in centre? Pre-booking urgent appointments doesn't seem right. Do not turn away the walk-ins."

"We can be more flexible in the way we do things, for example, the Fire Service doing home assessments or a postman/woman keeping an eye on someone. However, we may also need to be aware that some people make medical visits for social contact and will go where they like the staff."

"People sometimes use a GP appointment just to talk to someone so we need to give them alternatives."

"If it's on their doorstep people will turn up regardless of what services are being provided."

"Part of the problem is that we are not very good at saying no or not that good at advising people that they need to see their GP rather than the A&E department. Also, people will go to their GP for something and might not be given what they had hoped so they try with the Emergency Department (ED) instead."

"It's a hard job to think about logical criteria for selecting where to put urgent treatment without knowing the community view because they need to like the service and understand it before they will use it."

People also suggested the impact on staff travel times also needs to be considered when deciding the location of services.

"Do not forget travel time for staff."

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 would not provide a model that meets local needs. Hence, 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) for Cornwall 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 thought the draft specification provided *"a helpful summary"* and were pleased that Shaping our Future had acted on their previous suggestions that Cornwall needed its own specification. However some thought each locality needed its own bespoke UTC specification based on the resources available and the needs of that particular community.

"There needs to be a hybrid of specifications that would work in different localities. Not one size fits all."

"The specification needs to be sustainable and flexible to changes in/across populations/demographics in Cornwall. What we need and what we already have differs in different communities."

"There is lots of duplication across programmes and a need to link up services across Cornwall so the specification needs to avoid duplicating and be clear about what people can access that they cannot access anywhere else."

"The draft spec. needs to reflect local population needs including paediatric patients. Kerrier have a lot of learning disabilities and the seasonal effects of tourism also have to be reflected in the model."

2.4.1 Mental Health

As in the previous two waves, people stressed the importance of including mental health and support for people with dementia in the urgent care model, although there were differing views regarding whether there needed to be mental health expertise permanently located in UTCs or available in the community with strong links between the UTC and community mental health crisis teams if that were the case.

"We need better mental health crisis teams. People need access to mental health and mental impairment teams perhaps not via a UTC, with more obvious access points."

"The model needs to be able to meet mental health and social care needs."

"We need to remember that the Mental Health spectrum is huge and the need for urgent care is linked. For example, people with personality disorders would need to speak to someone immediately to de-escalate, so we would need to have people present at the UTC who would understand mental health, like crisis mental health teams, who are able to have conversations face to face."

"It seems like everything is compartmentalised and the NHS is in the business of repeating themselves. My late wife had a stay in Treliske and I had to leave her with a note reading "my wife has dementia". During that visit we had to repeat many times the reason for the visit. With dementia, the repetition drives them further down the road and there is a negative knock on effect to carers. The current system is very reactive. The new system needs to address this and think about what support people with dementia need in addition to the physical reason they may be there for."

"There's the option to ring out of hours, but a lot of people with mental health issues need face to face to de-escalate and staff need skills for this, but it doesn't necessarily need specialist mental health staff. It just needs an understanding of what in and out of hours mental health support is available. For example-GPs should be able to talk to people in a crisis and be able to refer them quickly to specialist support when necessary."

"It's more important to support people with mental health issues locally, to keep them close to their potential support. Keep them in their local network as it's much safer. They will be more known and supported in their network."

"There is a need for a crisis response for mental health. We need to talk about mental health problems in local areas because there are differences in need in different parts of Cornwall in terms of how/where people feel safe to be seen. This may not need to be the same place as a UTC."

"The mental health skills could feasibly be in place in each UTC setting 24/7 (24 hours a day, seven days a week) as the individuals may be known to mental health teams and the out of hours team could be alerted to those people with mental health diagnoses who are at the UTC."

"We need a countywide mental health trauma service like the one that exists in Cheltenham."

"The model needs community liaison for people to go to for advice. We also need more rapid response teams for mental health teams and we need data to inform this."

"How do we equip the community and our partners on how to deal with dementia in this model?"

"Rapid response dementia services could be effective to support people in their own homes if they were included."

"There is a group of people with dementia and learning difficulties who cannot determine their 'need'. How does the model work for them?"

"Inclusion of mental health services in urgent care would need to be informed by demand. In smaller units it might not be cost effective if the need is not there, but it is so essential to have good links with community mental health. Psychiatric liaison could support it if widened to be countywide."

"We need to change from a culture of walk in, but won't they mostly be vulnerable people? Who makes the decision that they are not urgent?"

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, 'out of hours' primary care and the 111 service were also highlighted.

"Intelligent Question and Answer (or Intelligent Voice Recognition) systems are an automated system that leads people through to the point where the system can link them with an appropriate real person. The system is designed to be like having a conversation rather than the more obvious 'choose from the following menu' type of automated system. If 111 designed one for mental health situations, that might help."

"NHS111 is not yet on top of mental health support, so apart from using apps how can we address that?" - "You could create this with an improvement to the out-of-hours services. I'm sure they can be improved with some pre-empted effort and support to become more standard practice."

"Access to enhanced therapists is not seen as an urgent service, but can clog the system as it can be six weeks for Speech and Language Therapy and dieticians' input following requests. This is too long."

"Many people with a mental health problem are not known to the health system and look to social media for support groups. From personal experience I think the current statutory services are often not in place, are hard to access, lacking compassion, coercive and unsafe. We need a similar system to the Samaritans." [N.B. Cornwall 111 is currently working with the Samaritans so they can improve their mental health related crisis support and signposting.]

"The 111 response needs to be local and enhanced to Cornwall so the person on the phone knows the location and services well enough to advise people appropriately. It must be a locally run service and ownership with a local directory of services."

"We do not have to anticipate all problems, just enough to be manageable. We can anticipate the needs of the patient population in that area by utilising the individualised care plan, with actions to take, when to take them, where and what to do. Work through those scenarios and ensure there are 'in' and 'out' of hours scenarios. There is too much pressure on 111 and the default is to ring 999. We need to design a model that reduces that."

2.4.3 Prevention and Self-Care

Participants also wanted to see greater emphasis on preventing the need for urgent care provision by taking a holistic approach to address the known causes of illness such as social isolation, inadequate self-management of a condition and lifestyle factors such as smoking and obesity. Hence, the model needs people across the system that are skilled at identifying and intervening when someone is at risk.

"There needs to be more investment in the community nursing service to prevent people needing urgent care, such as 24 hour district nursing. Alternatively, invest in NHS111 and existing out of hours' services to meet the need."

"A frustration on the ill health prevention side is not only what we don't have some services, but the services we do have but we don't know about them." - "That should improve because South Kerrier locality is feeding into a website hosted by Age UK to address access to information about what local services are available." [http://cornwall-link.co.uk/]

"To stop people getting sick we should ask the GPs to identify the patients they worry about and what they need to address those worries so these don't escalate to urgent health problems. Helston locality GPs have set up a Saturday morning 'worry clinic' specifically to see/speak to those patients."

"What is needed is a crisis intervention service. Currently there are teams comprising community nursing, matrons, rehab, Home First, Acute Care At Home and these are not necessarily aligned and have less capacity. The current arrangement could be developed to become a crisis intervention team aimed at

identifying when someone is not feeling very well. If you can pick the patient up at the first sign of failing; for example a fall or urinary tract infection that may quickly decline. There are lots of teams out there that are not currently set up to provide the service at that level at the moment due to the upskilling and education required."

"What can people do for themselves? That's the question we should be asking."

"Some services are fragmented and not focused on prevention or continuous care. For example there is no link between obesity, prevention/self-management and the cardiac pathway. People are seen urgently, treated, discharged, and come in to be seen again for the same medical issues."

"A focus on prevention is required to reduce the number of people with problems that escalate to needing urgent attention."

"We need to adopt a one phone call philosophy. A lot of time is spent phoning around for resources. It has got to be as easy to keep people out of hospital as it is to send them to ED (the emergency department), but we don't because we don't have time to ring round trying to get the support in place that would prevent the need for ED."

"We don't do health promotion well. We need to empower people with their own health, e.g. weigh management and exercise. We don't train GPs about this. We need to tackle the broader health issues as well as deciding where to put urgent treatment centres."

"People need their cupboards at homes to be equipped with basic supplies, for example paracetamol, mouth ulcer gel, not trotting off to A&E (accident and emergency) or their GP every time they have earache or a sore throat."

"Invest on prevention before something becomes a crisis."

"Spend time changing the culture, providing information before something happens rather than creating new services to intervene when it does."

"When a community nurse goes into a patient that consistently has a trauma wound they need to ask why? If it's because they are falling then they can arrange for a full assessment so that sorting the issue of falling will prevent the need to visit urgent services so regularly. Otherwise it's a false economy."

"People need access to high quality advice from experts. Cornwall needs investment into a frailty initiative for example - a service that involves giving advice to prevent emergency admissions and having outpatient appointments instead."

"If you really want to reduce the pressure on A&E, give people good access to (legitimate) smart phone apps and websites to facilitate ill health prevention and long term condition maintenance."

"Teach people about healthcare to let them take ownership of their long term conditions. Then you'll have less of them attending A&E."

"We need to take a step back from coming up with finding solutions to when someone's health goes wrong and promote our own responsibility to improve our physical health instead. It's not just doing physical exercise, but other things like having good, decent friendships. How can we deal with people who need urgent care today and also consider those who need it tomorrow if we don't address the causes?"

"Relationships in people's lives are key to keeping people well when they have been sick. When things start going wrong for the frail and elderly their support and social networks shrink. Health/social care services go in and 'take over' people/networks, and then subsequently back off. Staff should ask 'who do you have to support you now?' and build on this, not ignore it or make it redundant."

"We need to recognise the importance of neighbourhoods and building knowledge of what matters to people in those communities instead of assuming we know what they need."

2.4.4 The role of pharmacy

As in previous waves, participants suggested pharmacists could help to reduce some of the pressures experienced in other parts of the health system, particularly in relation to signposting, health promotion and treating minor illnesses.

"We have a valuable pharmacy service especially treating children and minor ailments that we could use more. We have 103 pharmacists across Cornwall who are good at treating, not diagnosing. They always work with the caveat that they would advise that if people are not better they should see a GP. They should be a trusted service as pharmacists have a low tolerance for things like when people unnecessarily need to go to a GP, 999, MIU, but they are able to safely recognise their limits."

"It depends on the environmental set up because waiting in a queue in the chemist shop is not very private for consultation."

"Could we use hospices more? For example, they often have access to a lot of volunteers and pharmacists and other types of expertise on site that could be utilised if they were collocated with a UTC."

"People need an easily accessible navigation service so they can understand what is available and where. Signposting is underestimated, but without it people do not know where else to go. Signposting within GP surgeries, libraries, local paper, schools, supermarkets, anywhere there is access to health care provision, for example pharmacies, back of public toilet doors, bus stops, enclosed information with repeat prescriptions etc. Most people do not pay attention until a health service is needed though."

"People are unsure of what services can be given by the pharmacist so would go direct to another service anyway unless you are really clear about the dos and don'ts and communicate that really effectively."

"Can we get faster pharmacy reviews of medications? Lots of surgeries have pharmacy provision. What we need is more co-location so we use the resources more widely. Some people forget that nurse practitioners are prescribers."

"Every pharmacy should have minor injury treatment provision. A lot have extended hours. We need to extend this to minor injuries and ailments."

"What is minor injury? Things like falls and sprains. 12,000 people a year with minor injuries go via GPs. Some could go via community pharmacy."

"What could we extend the pharmacy minor aliments service to include? Upper respiratory tract infections, dermatitis (e.g. daffodil farm workers), snake bites, burns, scalds. Some of these are seasonal demands that could be treated over the counter."

"We could consider offering more support to children out of community pharmacies."

"We should remind the public that you don't need an appointment for pharmacists to encourage them to use them more."

"Pharmacies need to have a private facility. If they have one you have to ask to use it. We need to remove the stigma and the privacy issue."

"Pharmacists are a vital service in primary care but are underused. The French health care system uses them more. Why can't we?"

"Can a pharmacist prescribe, and if so can they do so for free for patients who are prescription charge exempt?"

"As they are already open weekends in most cases it would make sense if pharmacies were to provide extra in terms of minor injuries or illness. Most have a consulting room so it offers privacy."

"Public perception is that pharmacy is just a dispenser and not an expert so there is a need for education. In Penzance Sainsbury's, lots of people pop to the pharmacy while shopping. There is an opportunity there to expand their role."

"Tesco in Pool deal with a lot of UTIs (urinary tract infections) and a range of minor ailments, and meet a large demand that way. Smaller pharmacies do tend to advise people to see a GP as they are risk averse though."

"Should pharmacies be able to access records if they take on more?"

2.4.5 Short Stay Assessment Beds

Participants were largely supportive of the inclusion of Short Stay Assessment Beds in UTCs, but highlighted the need to ensure there are adequate services linked to them to allow speedy referral and discharge and the delivery of an integrated care plan. Hence, concerns were raised about the additional medical and nursing workforce and the coordination between community services and the UTC that would be needed.

"To have two or more beds ring fenced for short term with some quick timed diagnostic plan not longer than two days is a good thing."

"The STEP service part of CorCare and reablement is linked in with the hospital to get people out of hospital so these beds would also need to be linked in with that."

"The hospitals hosting the beds must ring-fence them for their intended use as a step-up rapid turnover resource."

"A presenting condition may have more to it than first appears so you need to make sure the skilled people are all there."

"GPs linking in to other parts of the system is good, but they are being asked to take on more and more including caring for patients who are discharged to home too soon so where is the capacity to lead UTCs going to come from and what steps will be taken to ensure any that end up in an early assessment bed aren't also sent home too soon?"

"Having assessment beds is a huge change for what is essentially a GP led MIU to include overnight stay beds in terms of additional medical and nursing cover. Therapist support would be critical and would need to be immediate and rapid. There has to be co-location to some degree in the model to make this affordable and sustainable."

"They must be short stay beds defined as 48 hours maximum."

"They need to be located in such a way that other services cannot take them, or arrange it so that only a GP can admit someone to them."

"What about 'time to think' beds? What is the eligibility criteria and referral routes? That will tell you how many you need."

"What stops the 'time to think' beds from just becoming another longer term placement?"

"There is pressure on use of beds. These short stay beds could be a place of safety for patients not requiring a lot of medical input. In practice when people should go to a residential bed it can be time consuming to identify an available bed. How will you ensure we don't experience the same problems with these beds?"

"The early assessment beds could work if there is a quick route in, rapid assessment, diagnostics, scanning and then a very quick exit route out with support from HomeFirst or Adult Social Care. Without that you could just create more bottlenecks for people to get stuck in."

"A watertight discharge package needs to be in place or the patient will bounce back."

"The key thing is to focus on is 'short' stay as people can stay too long. There needs to be proactive therapy in the model, not necessarily assessments. It will need a multi-disciplinary team to manage this and people's care efficiently. You can't design urgent care without also linking it to community services and primary care and all the services in between."

"There could be a discharge coordinator at UTCs using Peninsula Community Health legacy money to fund it."

"Community staff could reach into local hospitals. GPs used to see patients in hospital and that worked. Need in-reach from community staff who know the patient when they are admitted into a UTC assessment bed."

"This local access to people that work in the community for people who are in hospital is a crucial part of community healthcare and needs to be included in the model."

"We need flexibility in the model, for example to have the ability to bring in an end of life (EOL) consultant who is based locally at St Julia's. West Cornwall Hospital has not been able to do that as RCHT (Royal Cornwall Hospital Trust) specialists come in instead. This is not efficient if an expert is already on the doorstep. What if you think someone needs EOL support when they're assessed and you would like a specialist opinion?"

"There is a key need to provide a locally coordinated transport service to get people home from hospital. We have many different transport options to get people home including the voluntary sector, but it's the coordination we don't have. An enhanced service in a UTC could also ensure a volunteer goes home with them, sits with them, stays overnight to support someone for the first 24 hours and makes sure they have food and feel safe and confident. We need to put people back in their own place safely."

"It would need a very quick turnaround such as 24 hour observations only."

"Such beds need to be able to stop elderly people being admitted to Royal Cornwall Hospital, as once there they lose mobility and independence."

"Do they need to be beds? Why not a chair if there is no need for the patient to stay overnight? Or have a chair/bed mix, with beds only being used for anyone who will stay overnight or is not able to walk."

"I imagine it would be more like a frailty unit so up to 3 days stay."

"There would need to be a specific criteria looking at lessons learned from the frailty ward in Royal Cornwall Hospital as they do end up staying longer there."

"The service would need to be supplemented by welcome home packages, geriatrician and therapy."

"Therapy input to these beds is critical. The patient would need functional goals based on them when they are well and not a generic baseline though we would need some way of knowing this when they come in."

"They need a Personalised Care Plan, linked back to the GP. The Personalised Care Plan would need to be patient held because of all the potential organisations and people who would need access to it."

"To enter the frailty unit, it would have to be by GP referral only, but a mechanism would need to be in place for times when a GP might not be available"

"It would also help people to understand what services can be provided at home to avoid admission."

"The assessment service could be a more planned intervention with joining up of GP and out of hours primary care to give a more coordinated approach."

"Care in the community needs to be linked in so it is started in the hospital but is time limited."

"Need to have available support in the community in a timely fashion to get patients home again."

2.4.6 Workforce & Capacity

As in previous workshops, participants raised concerns about the current workforce's capacity to deliver the new model and suggested that this could be addressed by widening the range of people who could fill the various clinical functions that are needed.

"Assessment beds in a UTC need dedicated Rehab team and a social worker to assess the home situation. Are there enough rehab teams to do it?"

"We have difficulty accessing care in the community now due to a lack of agencies. How will this be addressed so we don't have the same problems getting people what they need so they can be discharged from an assessment bed?"

"The Memory Café I run is supported with Community Psychiatric Nurses locally though they are stretched and trying to get patients into the system it doesn't seem to tie up."

"There is the lack of headspace with community nurses being so busy trying to get through the day with no time to step back and assess how to work differently. Penwith are much further on than some areas. A Single Point of Access is in place as a starting point, and from that they are recognising those people that call in often. That information is then being fed into the "virtual ward" model with a multidisciplinary approach. We need that rolled out."

"Workforce is an issue. There is a shortage of nurses nationally. Where will the extra staff come from?"

"Have alternatives to GPs for routine primary care issues where it is safe to do so, which then frees GPs up to work out of the UTCs."

"Lots of MIUs close because we don't have enough staff with MIU training. The trouble is that we have never looked at a system-wide workforce taking into consideration GP, practice nurses, West Cornwall Hospital, ED, colleagues in Devon etc. If we approach this as a whole workforce with rotational posts and joint recruitment then we might not have as much of a workforce problem."

"For me, there is one big query. The specification is centred on GPs and we don't have enough. 20% are over 50 years old. I worry from what I read that we won't have them around to deliver this."

"I'm a member of the PPG in Helston and one partner left and they can't recruit to cover."

"If practices were able to say there are options for GPs other than pure primary care then spending a day per month in a UTC might be attractive It would allow for development into specialisms."

"Think about the fire service diversifying. For example, home assessments could be done by fire, police, and paramedics. Is there more scope for a tri- generic function like this?"

"Stop thinking so much about the 'where' and think about expanding the 'who'. Have paramedics and mental health practitioners in GP surgeries so you have more expertise in one place taking some of the workload from GPs."

"I think we should accommodate additional services in general practice to support the resilience of practices. The GPs are not necessarily at the centre any more, but the primary care team as a whole with the variety of skills involved are very important because they can take activity away from the GPs."

"You need to have advanced nursing in GP practices to support complex assessment and take away some of that activity to support the GP. It's really scary that GPs have to make that decision in such a quick space of time and have to see so many people in one day."

"The new model needs prioritised/dedicated care packages, but there is not the people/provision in some areas to provide these packages because of the massive shortage in the workforce. No skills in the right area or high turnover of workforce etc. all limit what we can deliver. We need to value these workers more. Working tax credit is a limiting factor as people on lower grades like domiciliary care workers only will work to their tax credit limits. This is a perverse incentive. At the moment if wages were increased and it would breach the limit for benefits then some staff will reduce their hours."

"How will Treliske's pathology staff be able to support this if it is across UTCs? Where will there be staff to do this, the skills to do it and resources to do it?"

"There is the issue of GP workforce capacity. The specification says they need to be on site, could they be on call instead? Isle of Scilly have 24/7 access to an on call GP. They could be full-time at peak times and on call in quiet times. Or could we use nurse practitioners instead?"

"When we talk to young GPs they want to work more in a Multi-Disciplinary Team way and provide support to their community hospitals. It could be really good for the workforce to work like that and help address some of the capacity issues."

"Are there other roles (staff) who could be on site to fulfil the role instead of GPs at UTCs?"

"We are asking GPs to do everything but we aren't paid accordingly. There is some governance around this e.g. Helston Hospital."

"Could a rota system be in place so we don't entirely lose GPs from primary care?"

"We need a multidisciplinary team to go to the surgery so that they could deal with everything and you need social workers. What about the 3 conversations model? You need case coordinators for that to work. Where will you get all these people?"

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 the correct place to attend under different circumstances. Hence, the importance of clear communication to ensure a) the population could provide us with 'informed' views when we consult them on the draft models and b) any new model is used appropriately was also stressed.

"From a customer point of view it feels as if the support mechanisms are uneven. There's a perk with a child where you will go straight to the urgent centre first and that is accepted, but culturally we may go there as a default first for all things. If someone has conjunctivitis they could go to the pharmacists to have

the conversation and ongoing treatment there, but they choose to visit A&E or their GP. Try something, if it doesn't work come back again. But it takes time to build up that confidence and knowledge to know where to go to. For example, we can go to our GP for a flu jab, but some people don't realise they can also get jab from Sainsbury's for around £7. We need to change perceptions to help the public realise those services are available."

"The model also has to have communication facilities and an agreement for UTC staff to access contact with relevant specialists quickly."

"Cardrew taught people to simply turn up. When it (Cardrew) closed, the Minor Injury Unit and GP walk-in service was treated the same way by the people who previously used Cardrew so you need to tell people what to do if you change from the current model."

"You need to be aware that these people cannot necessarily self-identify when they or their carers' are at crisis and need urgent care support so it's up to us to tell them clearly and consistently until it becomes common knowledge."

"Patients might not know if their immediate health issue is 'routine' or not, so waiting for a normal GP appointment versus going to an urgent treatment centre could be beyond their ability to assess."

"Everyone needs a cycle of education about the whole system and we should not assume that people are always in need/crisis. We need to be clear what is and is not 'urgent'."

"Public information/education is key to making any health and care system effective and efficient."

"Do people know what is available and which services are provided where now?"

"We need to offer something consistent and communicate it clearly and consistently too. If services are patchy and not always open or people get different advice depending on who they get it from, then people don't try to use it."

"Provide high quality public information across a range of media that is non-preaching and people will get the message."

"This might require a gradual tightening of the criteria of what is reasonable use, becoming more defined as people get used to and accepting of UTCs. So to start with, it might be necessary to accept some degree of inappropriate use, but over time we can educate people as to the real function of the UTC and what lower level alternatives exist for lesser conditions."

"People have their own personal view of what constitutes urgent, so it will be helpful if we can understand why people do what they do."

"We need to understand what people think is a reasonable cause to use a UTC otherwise they might not use them appropriately when the time comes."

"We need education for the public as they do not think to go to a pharmacy with minor illnesses because it is not a traditional approach."

"We need to have real examples of people/ages/conditions to think through, which will aid public engagement about the model."

"We need to be able tell the public that if we take something back like Minor Injury Units and create something better in the form of UTCs we also need to be clear how what we've 'taken' will help fund what is 'better'."

"Communication and awareness raising for the public is essential if this is to work."

"What is the plan for public relations and the timing for informing the public about changes to reassure people?"

"We need someone who is good at talking and explaining things to spend time with people to gain their trust in the new system. We need to build the relationships over time."

"You need to be really clear about the difference between primary and urgent care needs so that people access services appropriately."

2.4.8 Financial Considerations, Capacity & Operational Viability

The financial and operational viability of the model were also discussed particularly in the context of pressures on the current system and the ongoing struggle to meet demand. Hence, as in previous waves, participants suggested the model needs to include explicit roles for the voluntary sector and the communities in which people live.

"It makes no sense to force patients to go to another place at a higher cost when they could be seen by their GP who knows them and has their complete records."

"Think about the transport costs to the NHS and patients. The model is too expensive."

"Unplanned care needs to be organised in such a way that GPs providing a minor injury service are paid in a way that helps to secure the viability of their practice. GPs currently do lots of things they don't get paid for."

"Where do the family fit in and their education to care and support the patient? We shouldn't assume the NHS has to pay for everything otherwise the model isn't affordable. A carer or a friendly neighbour could support people to prevent them needing urgent care or providing support to enable them to be discharged

more quickly than if a care package delivered by professionals had to be found. Family education with advice, training and support would be needed though."

"Volunteers are often elderly so any model that relies on them might not be sustainable."

"The county is full of experienced carers, which is a resource that is not utilised. We need to be creative with solutions. Yes, be risk adverse so we consider how to protect the patient and the volunteers, but statutory organisations can't do everything on their own."

"If the NHS can't fully fund this we need to shift towards using voluntary sector and communities more. Sometimes there are people and volunteers who are underutilised, but we do need to be careful that if we promote more use of the voluntary sector that demand will outstrip the available resource as need is great. There is a need to look at the resilience of the voluntary sector."

"If you include assessment beds in the model you must also include therapist support such as OT/physio if required, but essentially to encourage the short stay assessment patients to be mobile. We should look at what data exists to see if this is even viable first though."

2.4.9 Digital Solutions & Shared Care Records

As previously, people also suggested various digital solutions to relieve pressure on staff by reducing some of the time practitioners currently spend monitoring patients with long term conditions and as a platform for providing information to help people navigate the health and care system.

"Could we use robotics and technology more, such as toy seals that take vital signs/calm people, home sensors and GP tracking for with people with dementia?"

"Thinking about technology and rurality, could we use skype more?"

"People can be monitored at home via Telehealth, and/or provide a telephone support service for vulnerable people including mental health support so they don't escalate to needing urgent care ."

"We need to ensure we link with the EPIC project and the work that it happening to engage with the small, medium enterprise companies. [See further information at www.creativeengland.co.uk/tech-and-digital/epic]

"The model would absolutely need technology to support it. We need to build a confidence in some of the IT solutions like GPS trackers, monitoring like Telehealth equipment and support. There could be a training area to enable patients to learn how to manage their own conditions with Telehealth. There could be GPS activity monitoring to understand people's routine and provide support accordingly."

"Technology should help the public understand access and options at the tap of a button. We need to understand what's open/available."

"People are tired of saying that having shared, accessible, integrated care plans and the IT systems to see them no matter who you work for could shave 20 minutes off contacts by enabling us not to have to ask the same questions. Think how many more patients we could get round just by sorting out that one thing."

"We need the ability to access IT across all systems by having unified IT systems."

"All patients should leave a UTC with a Wellness Recovery Action Planning smart phone app, which encourages the person centred care and integrated care planning approach."

"The Healthy Schools work lets teachers educate children about health including apps, but who is educating the older generations?"

"Remember not everyone has a smart phone or internet access."

"I'm unsure why electronic prescribing would be required. What the community requires should inform the specification not the other way around because not everyone uses smart phones and computers."

2.4.10 Diagnostics & Triage

There was mixed support for the suggested inclusion of a CT scanner in the UTC model as additional resources and specialist skills across a range of disciplines would be needed to adequately triage and diagnose using scanners at UTCs. Instead, some people suggested x-ray equipment and access to shared care records may be more useful.

"The inclusion of a CT scanner is good."

"It is really important to have rapid turnaround of diagnostic tests."

"I'm not sure a CT scanner is needed in the specification for a UTC. It depends on activity thresholds. For example, a CT scanner in a UTC means the threshold would be high so the scanner was cost effective, but I'm not sure this would necessarily stop people going to ED. Stennack surgery have enhanced services without a scanner and an informal arrangement with ambulances to bring patients to be seen at the surgery. This is a hybrid model and the surgery sends very few patients to ED and captures most aliments/illnesses. However the CT Scanner could offer other services in that 'hub' to make it worthwhile."

"Rather than a scanner we need portable x-ray on some dedicated ambulances to help avoid admissions to ED. That would stop admissions for suspected illnesses, and maybe you could also provide some other low diagnostic equipment on ambulances to rule out other conditions."

"We're not sure whether stroke/suspected stroke patients should be sent to UTCs because you would need to have access to the stroke clinicians who understand how best to use the network of scanners you are proposing to put in UTCs. Then you need to consider if treatment will be safe in an UTC instead of an acute hospital if someone needed urgent vascular surgery for example."

"You would need better triage to put patients in the right place, supported by the right level of staff. But it comes back to the staff who triage now like 111 being risk adverse and then having enough staff with the necessary skills."

"Think about the potential for CT scans to be read remotely. There will need to be a technician in situ, but an appropriate clinician can view immediately remotely. The question is what skills would the clinician need to be 'appropriate'? Different specialists are able to confidently recognise and diagnose different things depending on the condition."

"You would need better triage to put patients in the right place, supported by the right level of staff. But it comes back to being risk adverse." - "The risk adverse mentality affects all services. Everyone refers to the acute hospital just in case something is missed and is then seen to be at fault. There is a fear of blame."

"It will need a triage facility for a pre-assessment and/or an initial conversation to determine needs."

"For the decision about whether someone needs to go to a UTC, ED or seen at home at point of diagnosis to be taken you need to put in place contingency plans should something go wrong like who to call if symptoms escalate."

"Triage and identification of level of need - is the current NHS111 service enough for this model? This requires proper triaging of a person. You need people to help talk through an issue to signpost to the correct service, a bit like the Samaritans."

"We need to have a reliable telephone triage system if UTCs and ED are to be used appropriately. So the triage arrangements really need to be part of the local specification."

"At the moment there are no shared notes and electronic systems are different so information sharing is not easy. However, the Early Help Hub use the 'only tell my story once' approach so patients aren't having the same thing to each different person they come into contact with. There is a central point of access and they have access to all seven systems as part of the triage process."

"An ambulant person (able to walk) will think carefully about where they present because of the diagnostic facilities available, for example x-ray. Everyone knows if you think you've broken a bone you go where there's an x-ray machine. People don't know when they would need a CT scan in the same way."

2.4.11 Location of UTCs

Participants made a number of suggestions in relation to where UTCs could be located and the criteria for assessing potential locations including the consideration of non-hospital settings and co-location with other services such as services for children, community pharmacies, fire and police services.

"Look at the accessibility and location of then site. Could the venue be in town in a non-hospital site, for example at a library or supermarket to aid access and have the support where community will see it and have it in their mind's eye?"

"Do not be restricted to just current NHS sites and estates available. Summercourt is very central and could be a prime location. It would be interesting to do the assessment on sites where there are not buildings currently. Optimal sites could also be low ranked in terms of what is currently available because of the investment needed to change its use."

"Cape Cornwall Surgery in St Just would be an ideal location for enhanced local services in the far west of Cornwall. It currently has a Minor Injury service for its own patients, but the Stennack model might translate well."

"If the plan involves closing some Minor Injury Units in rural areas, what do people do? Do they drive or call an ambulance? That's the risk."

"Hayle pharmacy on the industrial estate could be utilised more to become a UTC."

"Assess UTC sites based on the ability to co-locate with other services to make it sustainable. For example, work with One Vision to co-locate services for children."

"The UTC need to link directly with One Vision as adults going to UTCs have children, so there will be a need to tie up with them and link with a wider community hub."

"Consider more co-located-tri services [fire, police, paramedics] somewhere in Hayle."

"MDTs are already operational in the Penwith area. For example, Stennack is funded differently and anyone can attend as you do not have to be registered so why can't you just develop that?"

"Stennack has a minor injury service. The guidelines state that if a GP is within 3 miles of ED or Minor Injury Unit (MIU) they cannot provide a Minor Injury service. Any practices outside this parameter can provide that level of minor injury service, but only tend to do this for their registered patients. Perhaps we could look into how we lift the ban to allow more GPs to do this as it might it be better for patients."

People also had mixed views about whether co-locating an urgent treatment centre on the acute hospital site in Truro would relieve pressure on the accident and emergency department.

> *"Depending upon on the time and day, it can be possible to turn up at Royal Cornwall Hospital (RCH) and see a GP; for example on a Saturday morning. If you were going for an urgent treatment facility then there is an option to co-locate at RCH to enable people to be seen differently than when in the Emergency Department. People can be seen quickly and it might be a solution."*

> *"I'm not sure about having a UTC on the main acute hospital site as most people will just go there and the hospital could get swamped."*

People also suggested that the criteria for selecting where to locate UTCs should be driven by population needs rather than a list of aspirational factors that may not be affordable or needed.

> *"I think when you are considering sites you just need to find what is good enough for the community without having the gold standard which we probably couldn't find or afford. It's also about sharing risks and patients being looked after in an acceptable manner. We cannot always have perfection."*

> *"You take the number of frail patients for example and then look at high users to determine where they might be placed. Skills will need to be retained by avoiding occasional practice so demand will need to be high enough to ensure this. That tells you how many and where."*

3. West 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.

Topic	**Explanation**
Pharmacy services	Using a pharmacist to treat minor ailments has to be able to accommodate private consultations. Confidentiality and privacy are very important.
	Raise awareness that average waiting time to see a pharmacist is 7 minutes to reduce pressure on GPs. Expand their role.
	Is there a greater role for supermarket based pharmacists?
Assessment/short-stay facility	A buildings based criteria restricted to existing estates might not get the best outcomes. Consider expanding the review to look at other locations as well.
	Does the assessment/short stay facility have to be bed based? Unless it's an overnight assessment could it be chair based? Why immobilise the patient?
	The short stay/assessment bed criteria must be able to work alongside the UTC criteria.
	Short stay/assessment could include telehealth and assistive

	technology as part of the solution of keeping patients local
	Short stay/assessment beds must be protected from being 'poached' by the acute sector.
General Practice	It's not all about having enough GPs. There are many other skilled staff who can play a vital role.
	GP extended hours might be of limited use. If a patient cannot make a 9am appointment it makes little sense to offer them 8am instead?
	Is all of what's being proposed too dependent upon GPs?
	The Stennack model (GP provided minor injury service) is a good one that practices working collaboratively can replicate.
	The 'Worry' clinics set up by the Helston practices looks to be effective at prevention things leading to health problems (a Saturday morning clinic where GPs can see or speak with patients they have concerns about).
Public education/information	The public must be informed about which service to use in which circumstances, and to know where those services are and when they are open.
	People should be encouraged to take ownership of their own health. For example, should pharmacies make people aware of the cost to the NHS of their medication?
Use of data	Can we use the travel mapping to ensure that someone in the west of the county is not offered an appointment at 9am at a hospital 40 miles away?
	The number of UTC sites should be informed by data analysis of need and viability, and also recognise the workforce capacity, skills and career opportunities.
Other issues	A crisis intervention service (early help hub model) can keep complex patients local through early identification of problems and a multi-disciplinary team to address them.
	A personalised care plan is crucial to using short stay/assessment beds. Speak to the patient 'this is me at my best' to develop a wellness recovery plan.
	There needs to be access to safe mental health services as part of the overall provision.
	Children's services (particularly for the under 2s) must be available to make an impact on hospital attendances.

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.

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

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

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.
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, psychological therapies, hydrotherapy etc.
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 – West Cornwall Wave 3 participants

Penzance 20th February 2018

	TOTAL NUMBER		
People who attended (regardless of role):	37		
Organisations represented:		CFT NHS Kernow Cornwall Council NHS England RCHT Anson Care Services St Just Town Council* GP Practices • Stennack Surgery • Marazion Surgery Voluntary Sector • Memory Café • Cornwall Hospice Care • Carefree – Fostering Independence Cornwall • Cornwall Sports Partnership • Cape Cornwall Surgery PPG*	6 Reps 8 Reps 7 Reps 2 Reps 3 Reps 2 Reps 1 Rep 1 Rep 1 Rep 1 Rep 1 Rep 1 Rep 1 Rep 1 Rep
Lay people (include HW PPG and CAP members in this)		West Cornwall Healthwatch* CAP member Cape Cornwall PPG*	3 Reps 1 Rep 1 Rep
Professional roles represented		General Practitioners Workforce Transformation Facilitator Director of Primary Care Shaping Our Future Programme Support Senior Manager Children and Young People's Lead, Health Promotion Chair, Memory Café Medical Director Director of Strategy and Business Development Head of Prescribing and Medicines Optimisation Deputy Director of Human resources and Organisational Development Chief Executive	2 Reps 1 Rep 1 Rep 1 Rep 1 Rep 1 Rep 1 Rep 1 Rep 1 Rep 1 Rep 1 Rep 2 Reps

		Senior Practitioner	1 Rep
		Head of Strategy and Development	1 Rep
		Service Manager	1 Rep
		Joint Programme Lead, Long Term Conditions	1 Rep
		Senior Practitioner	1 Rep
		Town Councillor*	1 Rep
		Care Home Proprietor	1 Rep
		Director	1 Rep
		Patient and Public Involvement Manager	1 Rep
		Locality Manager	1 Rep
		Co-Production and Engagement Officer	1 Rep
		Cardiac Specialist Nurse	1 Rep
		Community Nurse Team Manager	1 Rep
		Project Manager Integrated Care	1 Rep
		Nurse	1 Rep
		Programme Director	1 Rep
		Deputy Director of System Resilience	1 Rep
		Senior Communications Manager	1 Rep
		Cornwall Councillor	1 Rep
		Chief Officer	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